

Screening and assessment instruments for use in Indigenous-specific alcohol and drug treatment rehabilitation

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Objective: The study's aim was to review instruments suitable for assessing Australian Indigenous clients' treatment needs, and changes in wellbeing while receiving treatment for substance misuse at a culturally competent residential setting in north Queensland, Australia.

Method: Searches of electronic databases, previously published reviews and websites was conducted. Instruments were selected according to their use in alcohol and drug treatment, developed for and/or validated with Australian Indigenous populations and applicability to measuring wellbeing.

Findings: Forty instruments were identified and their characteristics summarised according to five descriptive categories: (1) evidence of psychometric utility and previous use in alcohol and drug treatment settings, (2) developed for, used with, and/or validated specifically for Australian Indigenous populations, (3) a flexible administrative method of self-report and/or interview, (4) an administration time of less than 20 minutes and (5) freely accessible in the public domain.

Conclusions: Few instruments were found to have been validated specifically for use with Australian Indigenous people for use in drug and alcohol treatment. In order to measure wellbeing change and effective treatment, it may be possible to appropriately modify mainstream instruments, however, validation and sensitivity assessment of instruments for use with Australian Aboriginal and Torres Strait Islander people, is urgently required.

■ **Keywords:** Aboriginal and Torres Strait Islander Australians, drug and alcohol rehabilitation, wellbeing, psychometric instruments, therapeutic community, review

1. Introduction

Indigenous Australian communities struggle to avoid the impact of alcohol and other drug (AOD) misuse. Up to 37% of Indigenous people aged over 15 have engaged in binge drinking, and alcohol related disease accounts for the greatest proportion of the burden of disease for young men (Australian Bureau of Statistics (ABS), 2010). Rates of consumption and AOD-related harm among Indigenous Australians are generally twice those in the non-Indigenous population (Gray & Wilkes, 2010). Whole families and communities are adversely affected by violence, antisocial behaviour, unemployment and adverse impacts on unborn children (fetal alcohol spectrum disorder – FASD) (Department of Aboriginal and Torres Strait Islander and Multicultural Affairs

(DATSMA), 2010–2012; Gray & Wilkes, 2010; National Indigenous Drug and Alcohol Committee, 2012).

One in five Indigenous Australians over 15 used an illicit substance in 2008/09 with marijuana the most commonly reported illicit drug (Australian Institute of Health and Welfare, 2010). Recent studies of communities in Arnhem Land (Northern Territory) and on Cape York (Far North Queensland) indicate that 60% or more of those surveyed used cannabis at least weekly (Bohanna & Clough, 2011; Lee, Clough, & Conigrave, 2007). In the Indigenous

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populations of Far North Queensland psychotic disorders including schizophrenia, mood disorders, acute and transient psychoses are increasing and are linked with substance misuse (Hunter et al., 2012).

Federally funded Indigenous specific AOD services report high numbers of presentations of people with a range of social and emotional wellbeing and health issues (Office of Aboriginal and Torres Strait Islander Health, 2009). The dominant eudaimonic Western tripartite model of emotional, psychological and social wellbeing, however, underlies mainstream studies of mental health and mental illness (Keyes, 2005; Keyes & Simoes, 2012). The model has been shown to fall short when working to optimise the social, psychological and emotional health of Australian Aboriginal and Torres Strait Islander people. In the context of Australian Indigenous health, social and emotional wellbeing is a broad concept that recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect the individual (Zubrick et al., 2010). The physical and mental health status and outcomes of a person's care depend upon them and a balance then is sought to meet basic needs (Haswell et al., 2009). The distinction between mainstream and Indigenous meanings of mental health includes a broader understanding of social and emotional wellbeing:

‘Social and emotional well-being problems cover a broad range of problems that can result from unresolved grief and loss, trauma and abuse, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination, and social disadvantage. (Zubrick, et al., 2010)

There is an increasing coincidence of mental health disorders and illnesses associated with substance abuse (Hunter et al., 2012; Parker, 2010). Researchers were commissioned by the executive management body of a newly established rehabilitation service to collate a selection of culturally appropriate and validated instruments for the assessment of social and emotional wellbeing. Thinking holistically about Indigenous health and evaluating residents' changes in personal wellbeing within the context of their involvement within the residential setting was deemed by the service's managers and stakeholders to be an appropriate lens to measure the efficacy of treatment. The aim of this study was to compile a suite of reliable and validated instruments suitable for screening and assessment of co-morbidity risk at entry/during treatment, and changes in social and emotional wellbeing during treatment at the service.

2. Methods

2.1. Context

A therapeutic community (TC) model has been developed in far north Queensland; a welcome addition to existing service provisions in the region. Presently, community-based substance misuse services, located mainly in regional centres

provide open access AOD-specific health promotion programmes, counselling and diversion programmes, pharmacotherapy and community and home-based detoxification. A culturally competent TC model is unique to the region (Stephens et al., 2012). Whilst the ‘evidence’ on the therapeutic community model lacks consensus, there is a sufficient knowledge-base to suggest that the model can provide a verifiable and effective treatment for some client groups (De Leon, 2010). The managers of the service are funded to provide equal and equitable access to psychosocial assessment and treatment, which includes therapeutic communities for those who would benefit (Campling, 2001), and are committed to ongoing evaluation research to contribute to a broader understanding of the evidence-base for effective therapeutic community practice.

2.2. Search methods

The reference lists of two reviews of instruments that were developed for, and are widely used in Australian AOD settings, Deady (2009) and Dawe, Loxton, Hides, Kavanagh, & Mattick (2010) (Figure 1a), were examined. Both studies reviewed instruments for use in AOD settings with Dawe et al. (2010) using search terms to find instruments ‘developed for’ or ‘specifically adapted’ for use with Aboriginal and/or Torres Strait Islander people. The reference lists contained peer-reviewed instruments of potential value to the new service. Twenty-three instruments from these sources were included in the review. Databases were then searched to find recent items. Over 78,000 records were identified in MEDLINE; PsycINFO and the Cochrane Database of Systematic Reviews using the terms; ‘co-morbidity’ and ‘assessment’ with ‘alcohol’, ‘drug’ or ‘substance’. These results were screened for ‘wellbeing’ leaving 403 texts searched for their relevance to Aboriginal and Torres Strait Islander Australians using the terms ‘Indigenous’ or ‘Austral*’ ‘Aboriginal’ AND/OR ‘Torres Strait Island’ (see Figure 1b). After duplicates with records found in Deady (2009) or Dawe et al. (2010), nine relevant instruments were included in the review. Eight websites were reviewed (Figure 1b); the National Drug and Alcohol Research Centre; Australian Indigenous Health Info Net; National Drug Research Institute, the Close the Gap Clearinghouse, the National Clearinghouse for Alcohol and Drug Information, the Register of Australian Drug and Alcohol Research, the International Well-being Group (Deakin University) and the Positive Psychology Centre (Penn State University), and eight additional items were included in the review.

2.3. Literature evaluation framework

Both screening and assessment instruments were included. Instruments with a demonstrated use in AOD settings that had been used and/or validated with Aboriginal and Torres Strait Islander Australian populations were included. Co-morbidity assessment instruments across mental health symptomology, general health and social functioning were included if they pertained to assessments of wellbeing. The

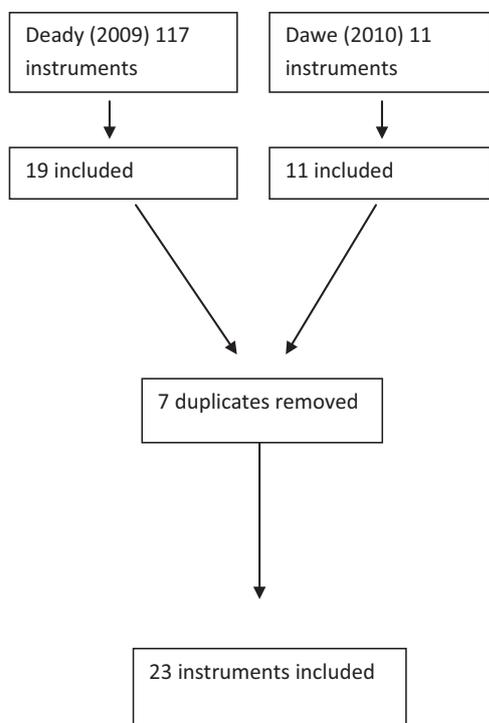


FIGURE 1a
 Selections from Deady (2009) and Dawe et al., (2010)

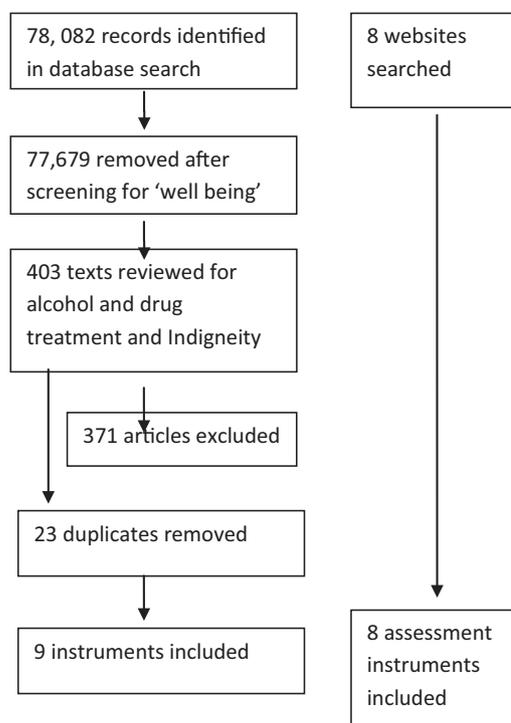


FIGURE 1b
 Details of database literature review and website based search

method of administration of the instrument was highly significant to the end-users of these instruments, as the service's staff, in the main, were non-clinically trained. Therefore, brief instruments that do not require high levels of clinical practice training and skill were included whilst instruments with high costs associated with implementation/training were excluded.

3. Results

A total of 40 screening and/or assessment instruments were selected to assist non-clinical staff evaluate the wellbeing of their clients in terms of their AOD recovery and mental health, at entry/admission assessment and/or during treatment. They were organised into five categories based on the nature of the instrument as a measurement tool. These were:

- a) General health and functioning instruments (4)
- b) Mental health and mental illness screeners (8)
- c) Specific psychopathology (6)
- d) Positive mental health instruments (17)
- e) General AOD Instruments (5)

The characteristics of each instrument were presented in a summary table for the commissioning agency (Tables 1a–e). Characteristics of the instruments are described in column headings, each reflecting a criterion. The five descriptive categories were:

1. Established psychometric utility and used in AOD treatment settings.
2. Developed for, used with, and/or validated specifically for Australian Indigenous populations.
3. Administered by self-report and/or interview.
4. Administration time < 20 minutes.
5. Freely accessible and in the public domain.

Instruments' psychometric utility and use in AOD settings was a key concern to build a collection of relevant tools. The second characteristic focused the search on Australian Indigenous-specific instruments or mainstream instruments used with Indigenous cohorts, and was recorded in the table as 'yes', 'no' or 'unknown'. A simple administration of self-report and/or interview was recorded, including the use of computer programmed versions, a symbol is provided for each of these. Flexibility in administration of the instruments was important to the commissioning agency, as AOD workers wanted a choice between interview, self-report and/or computerised versions to enable them to meet their clients' varying literacy levels. It also mattered to case workers that instruments help facilitate dialogue and build rapport between the client and their case worker. The physical and emotional wellbeing of clients on the day may also influence the method by which the instrument is performed. The brevity of the instrument (less than 20 minutes for the purposes of this review) was a characteristic of interest as well as its licence/purchasing cost to the centre. A brief description of the instruments' aim was included. This

TABLE 1a
General health and functioning instruments - key characteristics

Instrument	Aim	Descriptive categories					Notes
		1	2	3	4	5	
Health of the Nation Outcome Scales (HoNOS) (Royal College of Psychiatrists, 2006)	Measures health and social functioning of people with severe mental illness	✓	✓ ₁	◆	✓	✓	All Australian Mental Health Nurses must be trained
Life Skills Profile (LSP) (Rosen, et al., 2006)	Measure of those aspects of functioning life skills	✓	✓ ₂	◆	✓	✓	Abbreviated LSP – 16 or the long form (39 questions)
SF-36® Health Survey (SF-36; SF-12) (The RAND Corporation, 2012)	Health Survey measuring physical, social, and general mental health functioning	✓	X	• ◆ □	✓	X ³	
World Health Organisation Quality of Life – BREF (WHOQoL-BREF) (World Health Organization, 2004)	Quality of life assessment instrument for cross cultural settings	✓	X	•	✓	✓	

¹Development of Indigenous specific versions of HoNOS being developed by the Townsville Institute of Mental Health Services and Mental Health Clinical Improvement Team.

²Development of Indigenous specific versions of LSP being developed by the Townsville Institute of Mental Health Services and Mental Health Clinical Improvement Team.

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category distinguished between screening and assessment tools to provide guidance on the value of the instrument across the treatment spectrum. Some additional notes were

included if they concerned any of the five criterion. The columns in Tables 1a–e are descriptive and do not rank or rate the instruments.

TABLE 1b
Mental health and mental illness screeners

Instrument	Aim	Descriptive categories					Notes
		1	2	3	4	5	
Aboriginal Symptoms checklist – Youth (WASC-Y) (Indigenous Psychological Services, 2012)	Screening tool. Risk/cultural resilience. 13- 17 youth	❖	✓	• ◆	X	X	WASC-A (adult) currently being developed
Indigenous Risk Impact Screen (IRIS) (Queensland Health: Alcohol Tobacco and Other Drugs, 2012)	Early identification of DOA use and mental health risk. Not for use with adolescents	✓	✓ ₄	◆	✓	✓	
Primary Care PTSD Screen (PC-PTSD) (Prins et al., 2003, 2004)	Screening tool for post-traumatic stress disorder	✓	X	•	✓	✓	
Suicide Questions Answers and Resources (SQUARE) (square - suicide questions answers resources: Foundations for effective practice, 2007)	A suicide prevention resource for health professionals	✓ ₅	X	◆	✓	✓	Training required
Trauma Screening Questionnaire (TSQ) (Walters, Bisson, & Shepherd, 2007)	Screening tool for survivors of all types of traumatic stress	❖	X	•	✓	✓	
Mental Health Screening Form III (MHSF-III) (Carroll & McGinley, 2001)	Screener to identify clients who would likely require mental health services in addition to their chemical dependency services	✓	X	◆	✓	❖	
PANAS (Watson, Clark, & Tellegen, 1988)	Assesses positive and negative mood states	❖	X	✓	✓	❖	Used in tests to measure how emotional aspects evolve and are related to craving for alcohol
Modified Mini Screen (MMS) (New York State Office of Alcoholism and Substance Abuse Services (OASAS), 2001)	Screen for mental health disorders	✓	X	✓	❖	❖	Validated in North American ethnically diverse populations of known AOD misusers

⁴Developed in Queensland, Australia, by Indigenous and non-Indigenous researchers.

⁵Developed in South Australia by Relationships Australia and South Australian Department of Health and Ageing.

TABLE 1c
Specific psychopathology instruments - key characteristics

Instrument	Aim	Descriptive categories					Notes
		1	2	3	4	5	
Beck Depression Inventory (Beck et al., 1961)	Depression measurement tool	✓	❖	•	✓	X	
Depression Anxiety Stress Scale (DASS) (Psychology Foundation of Australia, 2011)	Assesses the severity of the core symptoms of depression, anxiety and stress	✓	✓	• ◆	✓	X	
Kessler psychological distress scale (K10) (NSW Institute of Psychiatry, 2005)	Global measure of distress based on questions about anxiety and depressive symptoms	✓	✓	• ◆	✓	✓	
Negative Life Events Scale (NLES) (Wills, Gibbons, Gerrard, & Brody, 2000)	This measure provides a continuous index of life stress, including specific information on personal stress and family-related stressors, among substance abusing adolescents	❖	✓	◆	✓	✓	Questions about the validity of the tool. Used as a population-wide health survey by the Australian Bureau of Statistics in Indigenous population
PHQ-9 (Esler et al., 2008)	Modified to measure culturally-specific symptoms of depression/anger	✓	✓	◆	✓	✓	Validated in Indigenous health settings with people suffering heart disease
PsyCheck (Turning Point Alcohol and Drug Centre, 2012)	Assessment to detect potential mental health problems	✓	❖	•	✓	✓	Designed for use by clinicians who are not mental health specialists in AOD treatment services

3.1. Overview of identified instruments

Tables 1a–e presents 40 instruments which include screening and assessment measurement instruments developed for mainstream or Indigenous-specific use. The instruments screen and assess for general health and wellbeing, specific drug and alcohol use and co-morbidity issues to generate a holistic view of a client's personal, social, emotion, spiritual and cultural wellbeing. Under 'general health and functioning instruments' (Table 1a) there are four instruments, two of which have been modified for Indigenous-specific practice, the Health of the Nation Outcome Scales (HoNOS) (Royal College of Psychiatrists, 2006) and the Life Skills Profile (LSP) (Rosen, Hadzi-Pavlovic, Parker, & Trauer, 2006). The 'mental health and mental illness screeners' (Table 1b) contains eight screening tools to identify co-morbidity issues. This category includes the Aboriginal Symptoms checklist – Youth (WASC-Y) (Westerman, 2003) for Aboriginal youth; and the Indigenous Risk Impact Screen (IRIS) (Schlesinger, Ober, McCarthy, Watson, & Seinen, 2007) developed for Aboriginal and Torres Strait Islander adults. Six assessment instruments to reveal 'specific psychopathology' were collected (Table 1c) and 17 instruments were placed in the 'positive mental health' range (Table 1d), which include several Indigenous-specific assessments, which will be discussed further below. The final category (Table 1e) contains five general AOD instruments (screeners and assessment instruments) that have widespread applicability to the AOD treatment sector, some with evidence of use with Indigenous cohorts. These include the Addiction Severity Index (ASI) (McLellan et al., 1992);

Australian Alcohol Treatment Outcome Measure (AATOM-C) (Melanie Simpson, Jan Copeland, & Peter Lawrinson, 2008; M. Simpson, J. Copeland, & P. Lawrinson, 2008); Alcohol Use Disorders Identification Test (AUDIT) (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001); The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) (WHO ASSIST Working Group, 2002); and the Severity of Dependence Scale (SDS) (Gossop et al., 1995). Several screening instruments may also be used in multiple time point analyses of client wellbeing gains.

3.2. Characteristics of identified instruments

Established psychometric utility/measure and used in AOD treatment settings. This category recorded validated instruments that may or may not have been validated within AOD treatment settings. Twenty-six of these instruments have documented evidence of use with AOD clients. There are eight instances where published evidence to this affect was not found therefore a symbol representing 'unknown' was recorded and eight of these were found to be positive mental health instruments. This does not preclude the likelihood of instruments such as the ASSIST and the AUDIT, being used prior to formal treatment intervention.

Developed for, used with and/or validated specifically for Indigenous populations. This category captured documented evidence of instruments, within this collection, being used within Indigenous populations; developed for, and/or validated with Indigenous populations. Tables 1a–e shows evidence of use for 18 of the 40 instruments. Seven instruments were developed and validated

TABLE 1d
Positive mental health instruments - key characteristics

Instrument	Aim	Descriptive categories					Notes
		1	2	3	4	5	
Aboriginal Mental Health Cultural Competency Test (CCT) (Westerman, 2012)	Assessment of cultural knowledge, resources and organisational influences	❖	✓	• ◆ □	✓	X	Provides an indication of levels of cultural competency
CogState (CogState, 2012)	Attention, learning, memory, psychomotor, executive functions. Social/emotional cognition if required	❖	✓	□	✓	X	Detects the relationship between AOD misuse and cognitive function
Curiosity and Exploration Inventory (CEI-II) (Kashdan et al., 2009)	Recognition, pursuit, integration of novel and challenging experiences	❖	X	•	✓	✓	
Dispositional Hope Scale (DHS) (Snyder, Irving, & Anderson, 1991)	Outcome measure: individual's perceived means available to achieve goals. Belief in ability to succeed	✓	X	•	✓	✓	
Gratitude Questionnaire - 6 (GQ-6) (McCullough, Emmons, & Tsang, 2002)	Client's disposition to experience gratitude	❖	X	•	✓	✓	
Growth and Empowerment Measure (GEM) (Haswell, et al., 2010)	Change in dimensions of empowerment: defined and described by Indigenous Australians.	✓	✓	• ◆	✓	✓	
Meaning of Life Questionnaire (MLQ) (Steger, Frazier, Oishi, & Kaler, 2006)	'Presence' of meaning and 'search' for meaning subscales	✓	X	•	✓	✓	
Mindful Attention Awareness Scale (MAAS) (Brown & Ryan, 2003)	Taps a unique quality of conscious awareness of and attention to what is taking place in the present	✓	X	•	✓	✓	
Personal Growth Initiative Scale (PGIS) (Robitschek & Kashubeck, 1999)	Measures active and intentional involvement in changing and developing as a person	✓	X	•	✓	✓	
Personal Wellbeing Index (International Wellbeing Group, 2006)	Quality of life	✓	✓	•	✓	✓	Validated with Indigenous adolescents
Quality of Life Inventory (QOLI) (Frisch et al., 1992)	Score/profile of problems and strengths in 16 areas of life	❖	X	• □	✓	✓	
Recovery Assessment Scale (RAS) (Corrigan, Salver, Ralph, Songster, & Keck, 2004)	Recovery processes: empowerment, quality of life, hope, meaning of life, and symptoms	✓	X	•	✓	✓	Documented use in the recovery from serious mental illness
Ryff Scales of Psychological Well-being (SPWB) (Springer & Hauser, 2003)	Multiple facets of psychological well-being	❖	X	•	✓	X	
Stages of Recovery (STORI) (Andresen, Caputi, & Oades, 2006)	'Recovery' as described by mental health consumers	✓	X	•	✓	✓	
Strong Souls Inventory (Thomas et al., 2010)	Anxiety, depressive and psychotic symptoms	❖	✓ ◊	•	✓	✓	Recommended as a screening tool in treatment services
The Silver Lining Questionnaire (SLQ) (McBride et al., 2008)	The role of, and belief in, the positive benefit of illness	❖	X	•	X	✓	Reflects personal growth enhanced by recovery/rehabilitation for chronic disease
Transgression-Related Interpersonal Motivations Inventory (TRIM) (McCullough, Hoyt, & Rachal, 2000)	Motivations assumed to underlie forgiving: Avoidance and Revenge	✓	X	•	✓	✓	

⁴Developed with extensive consultation with Indigenous and non-Indigenous mental health experts.

specifically for Aboriginal and/or Torres Strait Islander clients. Most of these are to assess Indigenous conceptions of mental health and emotional wellbeing. They included the IRIS; Aboriginal Symptoms checklist – Youth (WASC-Y);

Aboriginal Mental Health Cultural Competency Test (CCT) (Westerman, 2012) (these have not been validated with Torres Strait Islander people); the Growth and Empowerment Measure (GEM) (Haswell et al., 2010); and Strong

TABLE 1e
General AOD instruments - key characteristics

Instrument	Aim	Descriptive categories					Notes
		1	2	3	4	5	
Addiction Severity Index (ASI) (McLellan et al., 1992)	Assessment of AOD and psychiatric functioning of adults	✓	❖	◆	X	✓	Assesses frequency of use, not quantity
Australian Alcohol Treatment Outcome Measure (AATOM-C) (Melanie Simpson et al., 2008)	Assessment of AOD across five sub-sections: Demographic details; Health and Well-being; Alcohol Use; Other Drug Use; and Health Service Utilisation	✓	X	◆	✓	✓	Measures change over time
Alcohol Use Disorders Identification Test (AUDIT) (Babor et al., 2001)	Screening and outcome measure. Alcohol use, dependence, consumption and health problems	❖	✓	● ◆ □	✓	✓	Limited evaluation with Indigenous Australians, but extensive cross cultural applicability and recommended for use (Dawe et al., 2010)
The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) (WHO ASSIST Working Group, 2002)	Screening tool for problematic/risky use of AOD. Risk score obtained to determine intervention type	❖	✓	◆	✓	✓	Clinician administered. Promoted for use with Indigenous Australians by Flinders Aboriginal Health Research, Flinders University
Severity of Dependence Scale (SDS) (Gossop et al., 1995)	Measures degree of dependence experienced by users of different types of drugs	✓	X	●	✓	✓	Convergent validity with the IRIS

Souls (Thomas, Cairney, Gunthorpe, Paradies, & Sayers, 2010). There are modified versions of majority culture tools; the HoNOS (Pedro & Dillon, n.d.), CogState (Cairney, Clough, Jaragba, & Maruff, 2007); Life Skills Profile (Pedro & Dillon, n.d.), PHQ-9 (Esler, Johnston, Thomas, & Davis, 2008) and the Personal Well-being Index (International Wellbeing Group, 2006). Only one Indigenous-specific instrument, the GEM, has been the subject of study in a NSW residential treatment service (Berry, Crowe, Deane, Billingham, & Bhagerutty, 2012). The AUDIT and the ASSIST have both been widely validated among several culturally diverse populations (Dawe, Farnell, & Harlen, 2010; Deady, 2009) and the AUDIT is recommended for use with Indigenous Australians in AOD settings (Dawe et al., 2010).

Administered by self-report/interview or other. Ten instruments specified interviews, seven specified an either/or approach and 21 were self-report. Five instruments, the SF-36® Health Survey, the CCT, CogState, the Quality of Life Inventory (QOLI) (Frisch, Cornell, Villanueva, & Retzlaff, 1992) and the AUDIT, have been developed or adapted to be administered by computer. Flexibility of approach gives greater choice to the AOD workers.

Administration time. The brevity of administration was recorded. Brevity is defined as requiring less than 20 minutes to complete. The Addiction Severity Index (ASI), the WASC-Y, and the Silver Lining Questionnaire (SLQ) (McBride, Dunwoody, Lowe-Strong, & Kennedy, 2008) may all take longer than 20 minutes. All other instruments should take < 20 minutes to administer.

Accessibility. Tables 1a–e show that 32 of the total sample of instruments are in the public domain. This was important to the service which has limited available funding for licences of instruments. The SF-36® Health Survey, the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), the Depression Anxiety Stress Scale (DASS) (Psychology Foundation of Australia, 2011), WASC-Y, CCT, CogState and the Ryff Scales (Springer & Hauser, 2003) have varying costs associated with licensing of use and/or specific training/course requirements. This does not negate all costs associated with training and the use of the instruments, but these may be reasonably absorbed by the centre's programme and staff training operating budget.

4. Discussion

The suite of instruments represented in Tables 1a–e have desirable characteristics for use in the Indigenous-specific therapeutic community. The suite is also required to meet multiple objectives in terms of the needs of the service.

A priority concern was to collect instruments that screen for or assess an aspect of social, emotional or physical well-being. However, the important differences between the concept of mental health in Australian Indigenous culture and eudaimonic traditions that may result in a range of instruments being available to staff that do not promote cultural competency as they are lacking in the appropriate cultural adaptations for secure cultural practice in an Australian health setting. Cultural competency is knowledge, awareness and skills that promote and advance cultural diversity

and the recognition of the uniqueness of self and others in communities (Walker & Sonn, 2010). Western psychological concepts, such as individualism embedded within mainstream instruments, may limit the appropriateness of a tool (Kowal, Gunthorpe, & Bailie, 2007). For this reason a wide range of instruments were collected from the positive mental health tradition. The strengths-based and hedonic positive psychology movement directs researchers and practitioners to focus on positive perceptions of individuals through an understanding of positive emotions, positive individual traits, and positive institutions (Positive Psychology Center, 2007). The strengths-based approach is consistent with the therapeutic community model being established at the treatment facility and is more consistent with the Aboriginal and Torres Strait Islander conception of social and emotional wellbeing that takes a holistic approach where culture, historicity, social structures and ties are accounted for within the instrument. Half of the Indigenous-specific instruments found were categorised as positive health instruments (see Table 1d). The WASC-Y, CCT, modified CogState, the GEM, Personal Well-being Index, and Strong Souls Inventory assess cognition, satisfaction, empowerment and cultural awareness using a holistic, strengths-based approach.

The majority of instruments have documented use in AOD settings. Instruments with unknown documentation regarding their application in AOD treatment were many times found to be recommended for use and rated well on other descriptive criteria. Instruments that have a brief and flexible method of administration, are low cost or freely available in the public domain and require minimal levels of clinical skill were included. It is a requirement for both staff and clients that the instruments selected offer simple but effective methods of data collection. The AOD workers are, in the main, non-clinically trained and clients may have varying levels of literacy. Instruments that encourage and build rapport and promote dialogue between the client and worker have been deemed desirable by the staff. The service also required a selection of instruments that enable them to screen for co-morbidity issues to inform case management decisions in terms of external professional care and use of auxiliary services to the centre.

Measuring wellbeing through a range of social and clinical constructs broadens the range of individual-level outcomes and service-level processes that equate to good quality care. Several of the instruments have implications for the whole-of-service programme evaluation and evidence of service outcomes. Service accreditation frameworks, such as the recently launched Standard on Culturally Secure Practice (Alcohol and other Drug Sector) expect service providers to plan the service and individualised client care in accordance with evidence based practice (Western Australian Network of Alcohol and Drug Agencies (WANADA), August, 2012).

A competing request by staff concerns the detrimental impact on their clients if multiple sets of instruments are

employed with high frequency. It would be preferable to substitute one culturally-appropriate instrument for many. The GEM has been validated for use in AOD settings and was developed by and for Indigenous Australians to measure wellbeing changes over time (Berry et al., 2012). Its use may minimise the assessment burden upon both AOD workers and clients, albeit the administration time does not meet this review's definition of 'brief'. Nevertheless, the GEM is now being administered at three time-points during the course of a client's 6–9 month stay at the service.

The review highlights the urgent need for a wider selection of validated instruments for Indigenous populations. The review found few examples of instruments that have been specifically developed or validated for use with Indigenous populations and even fewer validated for use in AOD treatment settings. The current lack of validated or appropriately adapted instruments limits the capacity for gathering evidence about best practice clinical care, potentially constraining practice and placing an individual's health and wellbeing at risk. This is an ongoing project for researchers and health sector staff requiring both time and funding, however in the short term, where appropriate, instruments may be adapted or modified to better tailor assessments to Indigenous clients' needs to provide culturally relevant health care (Wilkes, Gray, Saggars, Casey, & Stearne, 2010; Wilson & Baker, 2012). Where possible the developers of the instrument and key stakeholders should be involved in the modification process (Burgess, Pirkis, Coombs, & Rosen, 2011). A staff training and implementation strategy has been undertaken at the centre with external consultants, researchers and, where possible, developers of the tools. Furthermore a process of review, consultation, implementation and ongoing quality control to modify and tailor screening and assessment instruments on a continuous improvement basis is in development with service staff.

5. Conclusion

The study collated a suite of instruments that can be used in the assessment of Indigenous social and emotional wellbeing in a residential AOD treatment setting. Several instruments were found to be designed specifically to measure Indigenous notions of social and emotional wellbeing. Mainstream instruments have potential and relevance, but may require appropriate adaptation with the service prepared to absorb the costs associated with those processes. Modifications must be undertaken with care to involve AOD workers and clinical supervising staff in the processes, and may be regarded as a step towards the design of a culturally competent health service.

Given the level of harm caused by substance misuse in Indigenous communities' however, poor quality evidence is unacceptable and research for validation and sensitivity assessments of instruments acceptable for use with Indigenous Australians in AOD treatment, is urgently required.

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