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Principles of Practice in Mental Health Assessment with Aboriginal Australians

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OVERVIEW

In this chapter, concepts and history of assessment and testing in the context of Aboriginal and Torres Strait Islander social and emotional wellbeing and mental health are discussed. Importantly, recently revised diagnostic guidelines and the *National Practice Standards for the Mental Health Workforce 2013*[1] and their appropriateness for meeting the distinctive needs of Aboriginal people are reviewed. Various assessment tools and measures that have been validated or proved appropriate for use with particular Aboriginal populations, i.e. youth, women and older people, are described. We conclude that practitioners need to be critically reflective in their role in assessment, and position themselves to play an important transformative role in conducting assessment. This extends to acknowledging and enacting culturally responsive principles, procedures and practices to ensure that Aboriginal people have access to effective, culturally secure mental health care.

INTRODUCTION

Mental health and psychological assessment of Aboriginal Australians has a complex and contested history. Several chapters in this book confirm that Aboriginal people's experiences, such as the forcible removal of children, have led to psychological distress and ongoing despair and trauma (see, for example, Chapters 17, 28 and 29). This situation reinforces the need for more culturally sensitive and appropriate assessment and testing of Aboriginal people who are experiencing extreme levels of trauma and grief and SEWB issues. While assessment procedures and processes are important tools for mental health professionals, it is widely recognised that the misuse of assessment has perpetuated stereotypes based on race, culture and ethnicity (see Drew, Adams and Walker, 2010 for further discussion).[2] Much of the suspicion that Aboriginal people have regarding assessment derives from its political nature as a process of social and cultural control. As Chapter 3 (Dudgeon and colleagues) describes historically, assessment was deeply rooted in the power differential (of coloniser and colonised) between Aboriginal people and other Australians. Notwithstanding the criticisms, assessment tools and procedures, when understood, developed and implemented appropriately and sensitively, can significantly enhance our capacity to make accurate diagnostic and standardised measurements to provide quality care.

Over the past decade there have been significant improvements in our understanding of the issues of assessment with diverse cultural groups within Australia.[3-7] The work of Aboriginal psychologist Dr Tracy Westerman on assessment regimes for depression and anxiety in Aboriginal communities is an outstanding example, and there are several other assessment tools listed later in the chapter. Even so, a recent review of various psychological, mental health, social

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and emotional wellbeing (SEWB) and cognitive assessment tools developed or adapted for use with Aboriginal individuals and communities confirms the need for further work in this area.[4]

WHAT IS ASSESSMENT?

It is important to understand the concept of assessment and how this is variously perceived within Aboriginal contexts. Current Australian perspectives on mental health assessment are derived from a clinical perspective embedded in a Western medical model. As the Social Health Reference group notes 'the concept of mental health comes from an illness or clinical perspective, and its focus is more on the individual and their level of functioning in their environment'.[8(p9)] The need for an immediate solution has many implications when assessing Aboriginal people, highlighting some fundamental differences in expectations between the practitioner, the client and their family, carer and community.

Given the cumulative, transgenerational SEWB and mental health issues experienced in Aboriginal communities, there is a need for assessment tools that are culturally appropriate and validated for Aboriginal populations. Without culturally appropriate assessments, 'the process relies heavily on the abilities and skills of the clinician which may lead to poor diagnosis'.[4(p21)] Inappropriate assessments resulting in poor 'test' outcomes not only perpetuate the marginalisation of Aboriginal people, but can result in inadequate treatment and access to appropriate services. Testing is only one part of the assessment process, one source of (potentially limited) information. Testing tends to produce normative quantitative information, while assessment is more holistic and includes the qualitative dimension[9], which more appropriately supports the SEWB model of working with Aboriginal people.

The Need for Culturally Appropriate Assessment

There is increasing acknowledgement that assessment tools must be developed, used and understood within the complex collection of information obtained from the assessment process. As cited in Brown 2001, the *National Mental Health Strategy 1995* states:

> *A thorough assessment, effective treatment, protection, care and rehabilitation of people who have mental health problems or mental disorders should be available at the highest standards of practice.[10(p34)]*

More specifically, the Social Health Reference Group (SHRG) explains that:

> *Culturally valid understandings must shape the provision of services and guide assessment, care and management of Aboriginal and Torres Strait Islander peoples' health problems generally and mental health problems in particular.[8(p6)]*

For Aboriginal people mental health is holistic, bound up in the social, emotional, spiritual and cultural life of people and communities. See Chapter 4 (Gee, Dudgeon and colleagues). Aboriginal SEWB is also holistic in nature, incorporating mental health. The concept of *Strong Spirit Strong Mind,* for example, reflects Aboriginal cultural practices where wellbeing 'encompasses the body, mind and spirit'. See Chapter 26 (Casey). A full appreciation of this holistic notion of health and mental health is absolutely vital as part of the contextual matrix within which assessment takes place (see Dance of Life, Table 16.1).

It is anticipated that the revised *practice standards* will require mental health practitioners to use culturally appropriate assessment instruments and techniques where available and appropriate, and to take into account cultural issues that may impact upon the appropriateness of assessment, care and treatment, including the need to involve family/carers. Practitioners are also required to comply with culturally-specific principles and practices included in relevant national, state and local guidelines, policies and frameworks.

ASSESSMENT GUIDELINES AND STANDARDS

There have been a number of approaches to assessment suggested in the literature.[11, 12] All grew out of the imperative to provide culturally appropriate assessment to minority groups. Australian frameworks emphasise the importance of relationship-building and engagement as crucial to success. Some of the more appropriate guidelines and approaches are briefly discussed here.

Increasingly, diagnostic guidelines and practice standards (including the DSM-5)[13] acknowledge that assessment needs to be systemic, taking into consideration individual, family and community factors to avoid inadequate or incorrect diagnosis. For example, the DSM-5 Appendix 111 includes questions which acknowledge that the intersection of conceptions of race and mental illness can be detrimental to the overall SEWB and mental health of an individual or group. This is important as a recent report by the Aboriginal Disability Network of New South Wales found that Aboriginal people with disability (including mental ill health) often face multiple layers of discrimination at the intersection of their Aboriginality and disability, resulting in their underrepresentation in receiving positive diagnosis, treatment and care.[14]

International Assessment Guidelines

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV-TR)[12] has been one of two internationally recognised manuals of mental health disorders—the other is the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision* (ICD-10)[15]. The DSM IV-TR has been revised and was recently released as DSM-5.

Diagnostic and Statistical Manual of Mental Disorders (DSM-5)

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, was released in May 2013 as the most comprehensive, current, and critical resource for clinical practice available for mental health clinicians and researchers.[13] These manuals are designed for use by mental health professionals with clinical training. All categories of mental health disorders and the diagnostic criteria required to meet them are based on a comprehensive literature review of available research to establish a firm empirical basis for all classifications. The revised manual has involved hundreds of international experts (including mental health experts from Australia) in all aspects of mental health to improve diagnoses, treatment, recovery and research. It aims to:

- create a common language for clinicians involved in the diagnosis of mental disorders using a range of agreed upon, clear and specific criteria;
- facilitate an objective assessment of symptom presentations in a variety of clinical settings— inpatient, outpatient, partial hospital, consultation-liaison, clinical, private practice, and primary care; and
- take into account the biological, psychological, social, cultural and spiritual factors as well as the broader historical and socioeconomic context .

The DSM-5 includes guidelines for cultural assessment of people from diverse cultural backgrounds. These guidelines separate the cultural elements from the context of psychiatric diagnosis and labelling to identify some key dimensions to be explored in any assessment process:

- cultural identity;
- cultural explanations of the illness;
- cultural factors associated with psychosocial and environmental functioning;
- cultural elements of the relationship between the client and the practitioner; and
- overall cultural assessment.

The information is intended to be used by general practitioners and health professionals,

including psychologists, counsellors, nurses, and occupational and rehabilitation therapists, social workers and forensic and legal specialists. It has the potential to improve interdisciplinary care by providing clear information and a common language to help mental health practitioners and caregivers improve both diagnosis and clinical care.

Despite these intended aims, the DSM-5 manual has received some criticism regarding its tendency to pathologise the ordinary, as well as criticism regarding the cultural appropriateness of the revised diagnostic categories.[16] For example, the Australian Psychological Society (APS) submission on the DSM-5 to the American Psychiatric Association (APA) notes that:

> *Any classification that primarily focuses on problems or deficits at the expense of personal achievements, resources and preserved aspects of functioning or wellbeing runs the risk of over diagnosis, discrimination and stigma, and an undermining of self-efficacy and motivation.*[16(p7)]

Whereas the authors claim 'an increased focus on the classification of strengths as well as deficits' is in line with current conceptions of recovery in mental disorder (including the preservation and development of hope and fulfilment, regardless of symptom status).[16(p7)]

It is important that mental health practitioners guard against the potential to further pathologise Aboriginal people in the assessment and diagnostic process. This can be avoided by adopting a culturally aware and safe approach to assessment practices in which the DSM-5 and other diagnostic tools are applied as part of a holistic assessment process.

Incorporating Culture in Assessment

Importantly, the newly revised DSM-5 diagnostic classification system provides opportunities to take into account transgenerational trauma from genocide and ongoing discrimination, as well as culturally related symptoms. The APA offers the core *Cultural Formulation Interview* (CFI) and *Informant Version* (IV) and eight supplementary modules to the core CFI for further research and clinical evaluation.[13] They should be used in clinical settings as potentially useful tools to enhance clinical understanding and decision-making and not as the sole basis for making a clinical diagnosis. Additional information can be found in DSM-5 in the Section III chapter 'Cultural Formulation.'[13]

Establishing a Cultural Definition of the Problem

The DSM-5 outlines a number of questions for practitioners to take into account the cultural perceptions of the cause, context and support, as well as possible stressors for someone experiencing mental health issues. Practitioners are asked to consider issues around cultural identity, including psychosocial stressors, religion and spirituality, as well as issues for the specific ages and gender—older adults, children and adolescents, women—when undertaking an assessment. Importantly, practitioners are asked to take account of whether their client believes their condition is worsening as a result of discrimination due to race/ethnicity or sexual orientation.

Cultural Factors Affecting Self-coping and Help Seeking Behaviours

The CFI questions recognise that clients may seek help from a range of sources, including medical care, mental health treatment, support groups, work-based counselling, folk healing, religious or spiritual counselling, and traditional or alternative healing. Practitioners are encouraged to clarify the client's experience and regard for previous help through religion and spirituality, older adults, caregivers; and any barriers, including psychosocial stressors, to current coping and help seeking. This is particularly important and reaffirming given the recognised value that traditional healers and Ngangakaris still play for many Aboriginal people.

Practitioner–Client Relationship

Practitioners are encouraged to elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers or cultural differences that may

undermine goodwill, communication or care delivery. The DSM-5 recognises the potential for intercultural miscommunication—the possibility for clinicians and clients to misunderstand each other because they come from different cultural backgrounds, or have different expectations. It is important for practitioners to ask clients if they have any concerns about this and if there is anything that can be done to address this issue.

These questions or prompts acknowledge the importance of the client's perspective of their condition, which may be relevant for clinical care. The client may identify multiple causes, depending on the issue or problem they are considering. The DSM-5 CFI recommends that practitioners also take into account the view of the client's social or family network, which may be diverse and vary from the views of the client, by asking questions such as:

- Are there any aspects of your background or identity that are causing other concerns or difficulties for you?

- Why do you think this is happening to you?

- What do you think are the causes of your [PROBLEM]?

- Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes.

Guidelines for Implementing the CFI Supplementary Modules

There are also guidelines for implementing the Core CFI which are designed to help clinicians conduct a more comprehensive cultural assessment. The first eight supplementary modules explore the domains of the core CFI in greater depth. The modules are intended to guide cultural assessment and should be used flexibly to maintain a natural flow of the interview and rapport with the individual. In situations where the individual cannot answer these questions (e.g. due to cognitive impairment or severe psychosis), questions can be administered to the identified caregiver. The caregiver's own perspective can also be ascertained using the module for caregivers. The DSM-5 Section III, chapter 'Cultural Formulation,' section 'Outline for Cultural Formulation,' provides additional suggestions regarding this type of interview.[13] These measures are only to be used to enhance clinical decision-making and not as the sole basis for making a clinical diagnosis. They also need to be interpreted with regard to the additional guidelines and principles outlined in this chapter specific to diverse Aboriginal and Torres Strait Islander contexts.

National Guidelines for Assessment

There are several national guidelines for assessment and for standards of practice in assessment.

National Practice Standards for the Mental Health Workforce 2013

In accord with the *practice standards* to achieve culturally secure practice, all mental health practitioners need to undertake recognised cultural competence, awareness or sensitivity training in the context of Aboriginal mental health and SEWB.[17, 18] Both the *practice standards* and respective individual discipline guidelines acknowledge the need for practitioners to ensure the cultural safety of clients through the assessment process. Providing a culturally safe environment is fundamental to the practice of cultural competence and involving Aboriginal Mental Health Workers (AMHWs) in assessments of Aboriginal clients is an example of cultural safety.[19]

The Australian Psychological Society Guidelines

The APS has developed a set of guidelines which outline a series of principles to inform ethical practice in the assessment and treatment of culturally diverse groups: *Guidelines for the Provision of Psychological Services for, and the Conduct of, Psychological Research with Australian and Torres Strait Islander People of Australia, 2003*.[17] Psychologists working with Aboriginal people have a professional responsibility to obtain knowledge of Aboriginal peoples, their psychological functioning and personal needs, and the cultural and other social factors that underlie those needs. Alternatively, they need to refer Aboriginal clients to psychologists considered to be culturally competent to provide the services required.

The Aboriginal Indigenous Psychology Association Framework for Assessment

The Aboriginal Indigenous Psychology Association (AIPA) offers another useful framework for assessment.[18] They also emphasise the need for practitioners to understand:

- the potential impact of adverse life events on serious psychological distress and SEWB;
- the factors that protect against the development of serious psychological distress following adverse life events;
- the consequences of high and prolonged levels of psychological distress on Aboriginal health and mental health; and
- detection of individuals and groups who are at high risk of mental ill health due to high and prolonged levels of psychological distress.

As Kelly et al. (2009) notes, assessment tools:

> *... aiming to provide a universal measure of psychological characteristics will require close examination for cultural bias, particularly with the diversity of cultures, peoples and regional variations found among Aboriginal and Torres Strait Islander communities.*[20(p7)]

The Royal Australian and New Zealand College of Psychiatrists' Guidelines

The Royal Australian and New Zealand College of Psychiatrists' (RANZCP) Indigenous Mental Health Group identifies some of the issues, gaps in knowledge and solutions to be considered across the physical, psychological, social, cultural and spiritual dimensions in the *'Dance of Life'* matrix (Table 16.1).[21] All these elements must be explored and understood as part of the assessment process. The matrix was devised as a way of exploring Aboriginal values, experiences and understandings in a systematic and culturally appropriate way, consistent with the Aboriginal terms of reference (ATR). As the assessment unfolds, the practitioner moves backwards and forwards through these dimensions in pursuit of a detailed and comprehensive understanding of the client's context. This may also involve extensive consultation with family and other respected community members.

A crucial aspect of the assessment focuses on the most appropriate ways of doing things. This includes discussion of alternative or traditional healing practices; intervention such as medication; and therapeutic interventions such as counselling. The framework provides an opportunity to integrate and understand the complex interplay of cultural imperatives and practices that may impact on the understanding of the mental health issues being assessed.

Table 16.1: Understanding the Dance of Life

Traditional	Historical	Contemporary	Gaps in Knowledge	Solutions
Physical Dimensions				
• Earth as 'Mother', Nature as family • Connection to country, source of renewal • Traditional medicine • Traditional diet and activity, 'healthy specimens'	• Physical genocide • Dispossession, 'uprooted' • Environmental degradation • Rapid change in diet • Incarceration, institutionalisation • Forced labour • Ill-health, exposure to disease	• Population changes • Present morbidity, burden of chronic illness • Burden of care on children • Land-rights and treaty • Holistic view • Urban, rural and remote differences • Exclusion from health	• Stress, immunity and chronic disease • Grief and mortality • Transgenerational trauma and physical health • Chronic illness and mental health • Complimentary healing practices	• Sovereignty and Native Title • Equity and access • Accountability • Traditional diet, medicines and healers • Connection to country • Holistic medicine • Best start to life • Basic requirements
Psychological Dimensions				
• Different concepts, beliefs and meaning • Sense of self; external attributions; site of distress • Shared learning, cognitive development • Identity and role • Autonomy and relatedness • Life continuum, belonging • Birth and bereavement	• Psychological genocide • Profound trauma • Abuse • Loss and grief • Extreme powerlessness • Misdiagnosis, mislabelling, re-traumatisation	• Place in society • Present trauma, loss, grief • Future uncertainty • Psychological morbidity, illness • Identity issues • Psychological strengths • Apology • International perspective • Exclusion from humanity	• Appropriate diagnostic systems • Treatment options • Culturally valid tools • Appropriate outcomes • Accountability measures • Impact of racism and discrimination • Cultural and spiritual phenomenology • Culture bound syndromes	• Truth in history • National 'Sorry Day' • Human rights, safe development, future assurance • Inclusiveness • Pride, positive images • Professional development • Indigenous therapies, grief and trauma • Addressing 'stress' • Identifying and tackling racism
Social Dimensions				
• Community centred • Kinship system • Attachment and child rearing • Early autonomy • Country as home, kin • Collective vs Individual • Obligation and reciprocity • Two-way sharing	• Social genocide • Stolen Generations • Racism and apartheid • Slave labour	• Changing role of family especially men • Role models • Family disruption, isolation • Loss of buffering • Removal of children, adults • Paternity • Present disadvantage, impoverishment • Reconciliation • Exclusion from society	• Family therapies • Children's needs vs Family • Community outcomes • Systemic barriers	• Social justice • Social determinants • Generational view, long term commitment • Whole of life concept • Tracing family, restoring kinship • Recording oral histories • Narrative therapies • Empowerment • Representative body
Spiritual Dimensions				
• Origins of life • Dreaming • Belonging, connectivity • Philosophical views • Beliefs, experiences, healing	• Spiritual genocide • Impact of mission life • Imposition of Christianity	• Value of wisdom • Intolerance, understanding difference • Exclusion from existence	• Spirituality and health • Existential despair	• Central to health of Australia • Healing • Understanding, tolerance, respect • Purpose and future hope

Continued . . . .

Table 16.1: Understanding the Dance of Life (continued)

Traditional	Historical	Contemporary	Gaps in Knowledge	Solutions
Cultural Dimensions				
• Lore/Law • Language • Ceremony • Healing beliefs, expression, experiences	• Cultural genocide • Misinterpretation • Tokenism • Sacrilege	• Cultural clash, two worlds • Cultural mix • Cultural practices, age, gender • Endurance and resilience, strengths • Cultural knowledge • Cultural grief • Exclusion from custom and consciousness	• Continuum of cultural identity • Diversity of practice and experience • Models of care	• Acceptance • National identity • Compensation • Cultural renaissance • Self determination (Indigenous rights) • Indigenous governance • Cultural security • Cultural Respect Framework • Education, training • Shared learning, collaboration

Source: Royal Australian and New Zealand College of Psychiatrists, Indigenous Mental Health.

RATIONALE FOR CULTURALLY COMPETENT ASSESSMENT

Cultural competence is fundamental to good assessment practice. Along with the processes outlined above, culturally competent assessment involves a commitment by the practitioner to self-exploration, critical self-reflection and recognition of the implications of the power differentials inherent in the role of clinicians and clients. Chapter 12 (Walker, Schultz and Sonn) outlines the tools and techniques for critical reflection and competence as well as the elements for engaging with Aboriginal clients and communities as culturally competent practitioners. These techniques involve both a commitment to ATR and a critical examination of 'whiteness'. Both promote decolonising practice. The incorporation of ATR provides a sound and coherent framework for assessment practice—a complete picture of the experiences and circumstances of the person being assessed. It serves as a guide to culturally competent practice, an analytic and reflective frame for understanding Aboriginal experiences of mental illness. It is consistent with culturally appropriate models for assessment recommended by the DSM-5's standards for incorporating cultural concepts in the DSM-5 and the mental health-related cultural competencies described by Westerman[6] and Garvey.[5]

This 'dual lens' is an essential component of the processes of deconstructing colonising practices that underpins cultural competence. Both strive to move the practitioner towards cultural competence as a necessary foundation to working with Aboriginal people—see Chapter 12 for a more comprehensive discussion of these issues.

Culturally Appropriate Assessment

The DSM-5 CFI schedule is consistent with the approach to assessment in cross-cultural contexts proposed by Ponterotto et al. (2001) outlining a framework which involves:

- an exploration of the client's worldview and understanding of his or her problems;
- an understanding of the client's family background;
- cultural explanations of illness for the individual;
- cultural elements of the client–practitioner relationship that reflect a clear understanding of the practitioner's insight into their own positioning.[9]

Professional Practice – Four Stages of Culturally Appropriate Assessment

Acevido-Polakovich et al. (2007) also outline four stages of professional practice in the assessment process.

Four Stages of Culturally Appropriate Assessment

Stage 1:	***Proactive steps before the assessment*** require that practitioners receive and maintain formal training in culturally appropriate assessment.
Stage 2:	***The outset of assessment*** requires that practitioners undertake a comprehensive interview with their client before deciding on the assessment processes and use of any formal testing (if that seems appropriate). They recommend an exploration of cultural history, contact with other cultural groups, acculturation status and stress, some assessment of language and language skill. This may include using an interpreter and/or the translation of material. A crucial element of this stage is to explain fully and document the limitations of any testing protocol that may be used.
Stage 3:	***The assessment process*** requires that practitioners recognise and document the impact of language and non-verbal communication. Proactive training should alert the assessor to the potential impact of culturally relevant international variables.
Stage 4:	***The interpretation and reporting of results*** requires that practitioners incorporate cultural explanations and avoid labelling in the final stage when interpreting the results.[22(p376)]

Stage 1: Pre-assessment

The pre-assessment phase requires practitioners to consider aspects of initial engagement and access. Westerman[6] and Garvey[5] identify a number of elements of good practice which are consistent with the DSM-5 CFI including:

Appropriateness of Referral

Practitioners need to consider whether they are the most appropriate person (or agency) to conduct the assessment. The gender, age and cultural identity of the practitioner could all be relevant in the decision to accept or not accept a referral.

Introductions and Community Access

This may include:

- using cultural consultants. They are a valuable resource in facilitating access and building good relationships in the community;

- taking the time to become both known and familiar with the community. This is especially important in regional and remote communities;

- adhering to community protocols such as notifying and seeking permission from community councils, reporting to the community office on arrival, and seeking permission to move around the community. These are all signs of respect, courtesy and cultural competence;[5]

- contacting the community. Other valuable information will often arise such as finding out about issues relating to the health service program and local issues of service delivery and in reference to the regional health services.[19]

The Site for Assessment

With respect to the site where the assessment takes place, it is important to:

- recognise the risk of misunderstanding that may arise when assessment is conducted away from country, family or community, such as prison and hospitals or other sites that may cause distress.[6]

- assess a client in their natural environment where they feel most comfortable—it is always preferable as the information gathered is much more informative and accurate.

Stage 2: Negotiating the Process of Assessment

Assessment in Perspective: 'Bringing it all Together'

The fundamental aspects of assessment of Aboriginal mental health have been discussed throughout this chapter. For accuracy, appropriateness and effectiveness of assessment there are a number of issues to consider:

- Be patient and take the time to engage with the client. Remember, this is the most important part of the process;

- Identify your own attitudes, values and beliefs;

- Respect community protocols;

- Find out who is the right person to speak with in the community;

- Involve an AMHW;

- Traditional and non-traditional healing practices should be considered when deciding on appropriate intervention, i.e. Elders, community healers;

- Are the assessment tools appropriate and what factors do you need to consider when interpreting the data?

- Have you considered engaging a cultural consultant? If so, is this consultant appropriate to engage, i.e. relationship to client, gender?

- Is this person's behaviour within cultural context?

- Is it appropriate for you to see this client?

In summary, the key elements of culturally competent practice and assessment are:

- cultural respect;

- acknowledgment;

- empathy;

- understanding; and

- continuous consultation with family, Elders and community.

These principles of assessment serve as a guide for clinicians to employ best practice methods which have been documented by Aboriginal clinicians such as Westerman, Milroy and Hunter and others such as Mark Sheldon. Importantly, at the time of writing, the revised *practice standards* are expected to incorporate principles consistent with those outlined in this chapter signalling real reform in this sector.

The most important elements of assessment include:

- being flexible throughout the process to have time to establish rapport with clients;

- taking the time to understand the community and family, to enhance engagement and build trust;

- negotiating the process of assessment such as the number of sessions required; and

- providing a clear explanation of any tests or assessment including the purpose, uses, limitations and benefits .

Once initial pre-assessment activities have been undertaken the actual assessment may commence.

Stage 3: The Assessment Process

Almost all forms of mental health assessment will include some form of mental state examination (MSE).

Mental State Examination

The MSE is a crucial tool for understanding the mental state of the client or patient at the time of assessment. There are numerous approaches to MSEs but most include an assessment of the cognitive, emotional and physical state of the client. Clearly, these parameters are subject to interpretation that may be culturally biased if not undertaken by culturally competent practitioners.[23]

Does the person have the knowledge required? For example, asking the person day, dates and times may be inappropriate. Sheldon identifies considerations for assessing Aboriginal people when conducting MSEs as detailed in Table 16.2.[19]

Table 16.2: Implications and Considerations in Mental State Examinations

Appearance	Understand the person's 'usual' standard of self-care and appearance. Identify any changes that may indicate a mental health issue. Consider cultural influences and manifestations such as grief.
Behaviour	Have a good understanding of Aboriginal culture as it relates to a person's behaviour. Behaviours can be culture-specific.
Affect	Affect can take on cultural forms as not all human emotions are universal. Anxiety and depression for example, may be difficult to diagnose as the manifestation of these conditions could be vastly different to that of other people.
Mood	An Aboriginal person's mood may not be expressed in the same way as a non-Aboriginal person. Language may not have meaning for Aboriginal people and may need to be translated into meaningful terms.
Speech and thought form	Thought disorders may be difficult to detect if the client does not have good English. The clinician would then need to rely on the services of an AMHW.
Thought Content	Aboriginal spirituality may display as delusional or otherwise cultural. The clinician needs to ascertain whether the primary symptoms pre-date the culturally based retrospective attributions.
Perception	These may be pathologically or culturally based. It is advisable to seek advice from the AMHW. Auditory hallucinations are less commonly sited and may be indicative of a mental disorder.
Cognition	Assessing cognition is difficult due to the lack of culturally appropriate assessment tools— assessments of function and activities of daily living are not appropriate in remote communities where living in collective in nature. It is not uncommon for families to seek help as a last resort.

In particular, practitioners should avoid over-interpretation and culturally bound inferences. For example, in terms of behavioural presentation, posture, gesture, touch and eye contact, all have cultural interpretations that may differ from one setting to the next. Affective responses too, may be a function of cultural imperatives. Anger and resentment in Aboriginal people may be more historical than circumstantial, or indeed some combination of the two (an expression of suppressed grief—see Chapter 28, Wanganeen). Non-Aboriginal psychologists or psychiatrists conducting assessment are representatives of the dominant culture and may invoke anger and resentment that are substantially exacerbated in the context, particularly of involuntary review.

Language and speech may vary for reasons other than being solely a function of a person's mental state. Assessment of cognitive functioning and orientation in space and time should be carefully interpreted.

The common thread in all of these frameworks is that they are predicated to a greater or lesser extent on the dual lens discussed earlier—understanding and taking into account Aboriginal terms of reference and acknowledging and unmasking white privilege.

Stage 4: Post-assessment

Interpretation and Presentation of the Assessment

This should include a discussion of the cultural formulations developed during the assessment stage. The identification and implications of culture-bound syndromes will be crucial to this process.[5] Once again, the practitioner should consider the wider political implications of the assessment.

Intervention Strategies

This stage includes a contemplation of traditional healing practices as well as a thorough analysis of the appropriateness of traditional western approaches to intervention. Chapter 13 (Schultz and Walker and colleagues) outlines a range of relevant people including immediate family, extended family, Elders, community healers and relevant interdisciplinary care stakeholders who may need to be involved in the intervention. Sheldon suggests that intervention should be guided by the family's wishes.[19] There are some exceptions to this rule, where the client's situation presents risk factors, i.e. suicide—the clinician's involvement would significantly increase. Generally, family involvement is organised by a meeting and talking about the problems, then asking the family for some possible solutions. The AMHW is a key facilitator in this process.

Negotiating treatment intervention strategies is as equally important as the assessment process. Existing traditional healing methods practiced within communities should be offered in conjunction with clinical treatment, and even as the primary source of treatment. Community healing methods should be guided by an appropriate, identified person within the community. Failure to acknowledge and recognise this fundamental aspect promotes ongoing barriers for Aboriginal people to effectively access mental health services.[24, 25]

Follow-up, Disengagement and Closure

Most assessment processes are short term. However, the mental health practitioner has a responsibility to ensure that the outcomes of the assessment process are implemented and managed, and to evaluate the impact of their assessment on the client, their family and the community. This may take a variety of forms, including direct contact or liaison through a cultural consultant if one has been engaged. This form of empathetic engagement is welcomed by Aboriginal people and supports their cultural security.

The RANZCP Guidelines on diagnosis and management require practitioners to make sure an adequate explanation is given and treatment negotiated and planned appropriately with the patient and/or family. They stress the importance of follow-up as 'Aboriginal or Torres Strait Islander clients are often lost in the system due to geographical isolation, demarcation between service providers and failed communication'.[26]

Practitioner Reflection Post Assessment

The RANZCP Guidelines[26] suggest the following reflective questions:

- Has the team you are working with, or other providers working with your client, received cross-cultural education and do they understand the meaning of mental health for Aboriginal and Torres Strait Islander Australians? (See also Chapter 13)

- Has the presentation of illness been understood in the context of the patient's own culture and history?

- Has there been consideration of the impact of trauma, grief and loss?

- Is the treatment appropriate to the person's cultural belief system and does it include a broad based assessment of all needs?

- Have alternative treatments been considered or used in conjunction with mainstream practices?

- Has a second opinion been sought from an AMHW or cultural consultant?

COMMUNICATION SKILLS FOR ASSESSMENT

An understanding of micro skills is increasingly required as part of acquiring cultural competence. See Chapter 12 (Walker, Schultz and Sonn). Guidelines for assessment include the following micro skills:

- Self-disclosure is one of the most important processes in establishing rapport with Aboriginal people. It is important for Aboriginal people to know who you are, and for you to know who they are, where they are from and who their family is. Take time to allow for this engagement process to occur. See Chapter 15 (Dudgeon and Ugle);

- Communication style includes verbal skills such as awareness of the client's use of language and language proficiency, using plain language without jargon, finding out the preferred and culturally appropriate forms of address.[27] The use of technical language can lead to misinterpretation—make use of visual aids such as pictures;

- Non-verbal skills are also very important and include the appropriate use of eye contact, posture and gesture.[27] A nod may not be an answer to the question you're asking but an acknowledgment of what you have asked. The clinician or practitioner needs to check if the client has understood what has been said;

- Use a conversational or yarning approach.[5] It is important to let the person tell their story— asking direct questions to obtain information for assessment tends to create inaccuracies;

- Knowing what questions can and can't be asked and the right person to talk to to ask is important. See Chapter 15 (Dudgeon and Ugle). Take time to get to know the client and their community to determine the right way of going about your assessment;

- Be aware of sensitive topics and obtain a client's permission when discussing issues such as bereavement, ceremonial business, sexuality and marital problems;

- Explore treatment options, including traditional healing methods, westernised models of treatment, or a combination of both. This is particularly important if a 'client has a strong connection with their Aboriginal belief system'. However this needs to be a facilitated process by an appropriate cultural consultant.[24(p223)]

Consideration of these factors takes time, yet it is by far the most effective way of obtaining information to make an accurate assessment, which is critical in determining the most appropriate treatment and level of service.

EFFECTIVE MODELS FOR ASSESSMENT

One effective model for assessment with Aboriginal people is the *Mental Health Stay Strong Care Plan*.[23] This comprehensive package of support materials provides a series of culturally appropriate stages of assessment and care planning options for supporting mental health in Aboriginal communities. The package incorporates an understanding of the holistic nature of Aboriginal health and mental health.[23] Their 'grow strong mental health tree' is an excellent example of combining the visual with the written word to explain mental health issues and provide a framework for exploring them in a cultural context. The power of visual representations is also evident in other effective programs and models, for example, as developed by Casey (Chapter 26) and Powell and colleagues (Chapter 27).

While there are shortcomings in many of the assessment tools for Aboriginal people, several of the chapters in this book highlight the need for practitioners to access valid tools and to be able to effectively measure specific areas. These include assessment for:

- Young people at risk of suicide – Chapter 9;

- Cognitive disabilities and ABI, ND through trauma – Chapter 18;

- Dementia – Chapter 18;

- Perinatal mental health and wellbeing – Chapter 19;

- Fetal Alcohol Syndrome Disorders – Chapter 20;

- Behavioural and emotional problems in young people – Chapter 22;

- Youth social and emotional wellbeing – Chapter 22; and

- Early development – DSM-5, Appendix 111 module.

The following table lists a number of culturally validated assessment tools and where further information can be found from the references or websites.

Table 16.3: A List of Culturally Validated Assessment Tools

Assessment Tool	Description	Further Sources of Information
WASC-Y, WASC-A	Youth 13-17 years, Adults aged 18 years and over. Identifies risk of anxiety, depression and suicidal behaviour whilst factoring in cultural resilience.	(1)
Kimberley Indigenous Cognitive Assessment tool (KICA)	Cognitive screening tool that assesses dementia in older Aboriginal Australians living in rural and remote areas.	(2)
Strong Souls	Assesses SEWB of Aboriginal youth. Measure for depression, anxiety, suicide risk, and resilience.	(3)
Negative Life Event Scale	Assessment of psychological wellbeing in Aboriginal Australians. Measures exposure to stress.	(4)
Kearins' Visual Spatial Memory test	Assessment based around research with Aboriginal children aged 6-17 years that focused on task behaviour.	(5)
Australian Aboriginal Version of the Harvard Trauma Questionnaire (AAVHTQ)	Culturally competent measure of specific traumatic stressors and trauma symptoms criteria for PTSD. This questionnaire includes specific cultural idioms of distress reactions that are relevant to Aboriginal people.	(6)
The K-5 measure of psychological distress	A subset of five questions adapted from the Kessler Psychological Distress Scale-10 (K-10) developed in 1992 by Kessler and Mroczek (ABS 2003).	(7)
The K-10	A non-specific psychological distress scale of 10 questions to measure levels of negative emotional states experienced in the 4 weeks prior to interview.	(8)
Kimberley Mum's Mood Scale	Currently in development as an adapted version of the EPDS and is currently being validated across the Kimberley in Western Australia. This tool screens for depression and anxiety.	(9)
Q Test	Cultural-fair, language-free assessment measure of cognitive functioning screening and trainability.	(10)

Sources of Information:

(1) http://www.indigenouspsychservices.com.au/staticpage.php?static_id=13
(2) http://www.wacha.org.au/kica.html
(3) http://www.ncbi.nlm.nih.gov/pubmed/20073566
(4) http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2203968/
(5) http://online.santarosa.edu/homepage/jkremer/kearinsvisualspatialmemory.pdf
(6) http://www.wealli.com.au
(7) http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/84330C2EDC3DB940CA2579D50015D74E?opendocument
(8) http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/84330C2EDC3DB940CA2579D50015D74E?opendocument
(9) Kimberley Mum's Mood Scale is an adaptation of the Edinburgh Postnatal Depression Scale (EPDS)
(10) VEQ Pty Ltd and G E Kearney. http://www.VEQ.com.au

PART 4

CONCLUSION

Assessment remains an important, yet problematic area to help address the magnitude and nature of issues being faced by Aboriginal individuals, families and communities. The low levels of confidence among practitioners in using many existing assessment tools for Aboriginal clients means that fewer assessments are undertaken than within the wider population. There are concerns regarding under-diagnosis of Post Traumatic Stress Disorder (PTSD) and other mental health issues. The potential cultural bias and monoculturalism, lack of understanding of Aboriginal culture, pervasive transgenerational impacts of colonisation upon Aboriginal children, and more holistic conceptions of mental health and SEWB among Aboriginal families and communities, creates real challenges for both mental health practitioners and services.

A number of tools have been developed/adapted to assess a range of mental illnesses. We discussed a range of principles and models of assessment and care to ensure cultural security in assessment. Mental health assessment is the gatekeeping process to mental health service provision, including alternative healing programs and services. Thus, the challenge remains to develop processes and tools to assist in appropriate and accurate diagnosis of mental illnesses, as well as processes for appropriate culturally secure engagement of individuals and communities to promote mental health and wellbeing.

In summary, culturally competent assessment is a decolonising practice that requires practitioners to simultaneously acknowledge the importance of Aboriginal terms of reference and the impacts of white privilege to overcome marginalisation and alienation. Culturally competent assessment promises to be transformative in its intention and practice for both individuals and the wider Aboriginal community. Practitioners require increased knowledge and abilities and culturally appropriate assessment tools to assess and treat Aboriginal people. Culturally competent assessment offers the promise of a shift from 'discourses of distress' to 'discourses of hope'.[28]

REFLECTIVE EXERCISES

1. Review the assessment protocols in your agency or agencies you are familiar with. Does the protocol systematically address all the elements for culturally appropriate assessment outlined in this chapter? If not, how could you revise the protocols?

2. If you employ psychological or other tests, review each of them using the issues raised in this chapter as a critical lens. Are the tests culture-fair? culture-free? Aboriginalised? In each case reflect on how you have used, interpreted and reported the results in your practice. Have you honoured the principles of culturally competent assessment practice? How could you do things differently in the future?

3. What are some of the processes that need to be considered when consulting Aboriginal communities and key stakeholders to undertake an assessment?

4. How do you determine your level of cultural competency before undertaking an Aboriginal mental health assessment?

5. Reflect on the limitations of mental health assessment, both past and present, and discuss how we move forward to improve mental health assessment for Aboriginal and Torres Strait Islander peoples.

REFERENCES

1. National Practice Standards for the Mental Health Workforce. Victorian Government, Melbourne (forthcoming) 2013.

2. Drew N, Adams Y, Walker R. Issues in Mental Health Assessment with Indigenous Australians. In: Purdie N, Dudgeon P, Walker R, editors. Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. Canberra: Commonwealth of Australia; 2010.

3. Davidson G. Insight 12: Further reflections on emergent narratives in Indigenous Australian psychologies. In: Garvey D, editor. Indigenous identity in contemporary psychology: Dilemmas, developments, direction. Melbourne: Thomson; 2007. p. 131-34.

4. Dingwall K, Cairney S. Psychological and Cognitive Assessment of Indigenous Australians. New Zealand Journal of Psychiatry. 2010; 44(1):20-30.

5. Garvey D. Indigenous identity in contemporary psychology: Dilemmas, developments, direction. Melbourne: Thomson. 2007.

6. Westerman T. Guest editorial: Engagement of Indigenous clients in mental health services: What role do cultural differences play? Australian e-Journal for the Advancement of Mental Health. 2004; 3:1-8.

7. Westerman T. The value of unique service provision for Aboriginal Australians: The benefits of starting from scratch. [Internet]. 2007. Available from: www.indigenouspsychservices.com.au.

8. Social Health Reference Group (SHRG). National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004-2009. Australian Department of Health and Ageing. Canberra; 2004.

9. Ponterotto J, Gretchen D, Chauhan R. Cultural identity and multicultural assessment. In: Suzuki L, Ponterotto J, Meller P, editors. Handbook of multicultural assessment (2nd ed). San Francisco: Jossey-Bass; 2001. p. 67-69.

10. Brown R. Australian Indigenous mental health. The Australian and New Zealand Journal of Mental Health Nursing. 2001; 10(1):33-41.

11. Davidson G. Ethnicity and cognitive assessment: Australian perspectives. Darwin: DIT Press; 1998.

12. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).

13. Lewis-Fernandez R. and Diaz N. Psychiatric Quarterly. 2002. 73(4): 271-95

14. Aboriginal Disability Network of New South Wales Inc. Telling it like it is report Aboriginal Network of New South Wales Inc. 2007.

15. World Health Organization. The ICD-10 Classification of Mental and Behavioural Disorders. Geneva: World Health Organization; 1993

16. Crowe S, Littlefield L. A Submission to the American Psychiatric Association by the Australian Psychological Society on DSM-5 Draft Criteria [Internet]. 15 June. Available from: http://www.psychology.org.au/Assets/Files/APS-DSM-5-submission.pdf. 2012.

17. Australian Psychological Society (APS). Guidelines for the Provision of Psychological Services for and the Conduct of Psychological Research with Australian and Torres Strait Islander People of Australia, 2003.

18. The Australian Indigenous Psychologists Association (AIPA). [Internet]. [cited June 2013]. Available from: http://www.indigenouspsychology.com.au/.

19. Sheldon M. Reviewing Psychiatric Assessment in Remote Aboriginal Communities. In: Purdie N, Dudgeon P, Walker R, editors. Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. Canberra: Commonwealth of Australia; 2010.

20. Kelly K, Dudgeon P, Gee G, Glaskin B. Cooperative Research Centre for Aboriginal Health. Living on the edge: social and emotional wellbeing and risk and protective factors for serious psychological distress among Aboriginal and Torres Strait Islander people. Discussion paper No 10. [Internet]. 2009. Available from: http://www.indigenouspsychology.com.au/Assets/Files/AIPA-Living-on-the-Edge-web.pdf .

21. Dance of Life [Internet]. [cited June 2013]. Available from: http://indigenous.ranzcp.org/index.php?option=com_content&task=view&id=27&Itemid=.

22. Acevido-Polakovich ID, Reynaga-Abiko G, Garriot P, Derefinko K, Wimsatt M, Gudonis L, et al. Beyond instrument selection: Cultural considerations in the psychological assessment of US. Latinas/os. Professional Psychology: Research and Practice. 2007; 38(4):375-84.

23. Nagel T, Thompson C. Mental health stay strong care plan package: AIMHi NT. Northern Territory: Menzies School of Health Research. 2006.

24. Westerman T. Engaging Australian Aboriginal Youth Mental health Services. Australian psychologist. 2010; 45(3):212-222.

25. Garvey D. A review of the social and emotional wellbeing of Indigenous Australian peoples: Considerations, challenges and opportunities. [Internet]. 2008 [cited March 2009]. Available from: www.healthinfonet.ecu.edu.au/sewb.

26. The Royal Australian and New Zealand College of Psychiatrists. Statements and Guidelines, Resources for psychiatrists and other mental health professionals. [Internet]. [cited June 2013]. Available from: http://indigenous.ranzcp.org/content/view/11/12/.

27. Westerman TG. Frameworks of working with Aboriginal communities. Psychologically Speaking. [Internet]. 1997. Available from: http://www.mcsp.org.au/resources/Frameworks_of_Working_with_Aboriginal_People_v1_8.11.10.pdf.

28. Gone JP. "We never was happy living like a Whiteman": mental health disparities and the postcolonial predicament in American Indian communities. American journal of community psychology. 2007; 40(3-4):290-300.