

## **ABSTRACT**

Bias in the assessment of Aboriginal youth experiencing mental health problems has long been recognised in the literature (Davidson, 1995; J.J Goodnow, 1988; Kearins, 1981). The basis of this bias lies in the lack of culturally valid tests and clinical assessment processes for use with this population (Davidson, 1995; T.G. Westerman & Kowal, 2002b). This study has developed and validated two separate protocols for Aboriginal youth aged 13-17 years in Urban (Perth) and Rural (North West) locations in Western Australia including; (a) a unique self-report inventory, the Westerman Aboriginal Symptom Checklist – Youth (WASC-Y), and (b) a set of clinician guidelines for use with the WASC-Y. These guidelines address identified sources of practitioner and interpretation bias in the assessment of Aboriginal youth. They include four main components, which were developed through focus groups with Aboriginal parents, youth and mental health professionals. First, a culturally valid engagement process for Aboriginal youth was developed. Second, interpretation guidelines, to assess for potential cultural variants in symptoms reported by Aboriginal youth. Third, a model of cultural validation, which assesses for the role of culture in mental health presentation. Finally, a model to guide the resolution of culturally related mental health problems. Factor and reliability analysis on the WASC-Y resulted in a 53-item inventory including six subscales of depression, suicide, alcohol / drug usage, impulsivity, anxiety and cultural resilience. Factor Analysis (FA) demonstrated good factor structure, with single factors accounting for variances of 34% to 82%. Internal reliability was also sound with Cronbach's alphas ranging from .75 to .88. Validation of the Clinician Guidelines was also determined by interviewing youth identified as being at risk (N=111) with this protocol and assessing engagement. 97% of all youth interviewed demonstrated good engagement. The extent of agreement between the WASC-Y and cultural / clinical validation interviews was also determined to be excellent through calculation of the Kappa statistic ( $\kappa = 0.84$ ).

Results of large-scale screening of Aboriginal youth (N=183) indicated that whilst overall risk for disorder was moderate, a significant percentage of the sample reported risk at

high to very high levels across all subscales. Levels of cultural resilience were also characteristically low indicating a lack of protective factors against the development of disorder. Of particular note is that one-third of the sample reported high levels of risk across more than three subscales. This provides some initial evidence for the strong role of comorbidity of disorders for Aboriginal youth. ANOVA also failed to reveal any significant differences between genders or across geographical locations on any of the subscales. Correlations between subscales indicated significant relationships between impulsivity and suicide risk, depression and anxiety and depression and impulsivity. Correlational differences were found across geographical locations, including stronger relationships between suicide and impulsivity, suicide and anxiety, depression and suicide and depression and anxiety for Urban compared to Rural youth. Cultural resiliency also had moderately stronger negative relationships with suicide, depression and anxiety in Urban areas than Rural areas. This study provides evidence of a need for the continued development and refinement of culture-specific assessment processes to enhance diagnosis, prognosis and intervention with Aboriginal youth at risk of mental health problems.