Mental Health Task Force: Government of Nunavut

The Feasibility and Applicability of the Australian (WASC-Y) Model of Suicide Prevention/Intervention for Use in Nunavut

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Centre of Excellence for Children & Adolescents with Special Needs

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Background

Within the Centre for Excellence for Children and Adolescents with Special Needs is a Mental Health Task Force sponsored by the Government of Nunavut. The focus of the task force has been research on youth suicide prevention in Nunavut. Death by suicide continues to undermine the well-being of Nunavummiut. Communities and families are bereft with the sense of loss. The Nunavut of vision, planning, and hard work struggles with depression, anger, and a socioeconomic deficit. What has gone wrong? Why are youth unable to see opportunity? Isolation, suicide ideation, and issues have replaced identity, intimacy, and ideals. Initially, a summary of initiatives on the issue of death by suicide in Nunavut was prepared by the task force to provide baseline data for Nunavut and a synthesis of available Nunavut-specific information.

Despite prevention programs, healing sessions, preaching, interviews, surveys, and statistics on the topic, the number of deaths by suicide in Nunavut continues to soar. From the formation of Nunavut in 1999 until March 2004, 143 deaths by suicide were recorded. In 2003, there were 37 deaths by suicide in Nunavut, an increase of 61% over the 2002 total of 23.[1] Also in 2003, many attempts were made to determine what was happening in Nunavut and what could be done about it. Events included the Best Practices in Suicide Prevention Workshop, Iqaluit; the Rankin Inlet Youth and Elder Conference on Suicide; the Innuqatigiisiaqniq Forum for Elders and Youth; the Power of Storytelling Youth Engagement Conference; the Canadian Association for Suicide Prevention Conference; the National Inuit Youth Conference on Suicide; and Inungni Sapujjijiit, the Nunavut Task Force on Suicide Prevention and Community Healing. Linked to these events were other community projects such as consultations and interviews that spawned a series of reports.

The reviewed reports were grouped by type, and their purposes were outlined. They were then examined for their references to at-risk indicators for suicide. Insights derived from the findings were discussed, and theories about the significance of the findings were included in the summation (see Appendix A).

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[1] Nunavut Suicide Statistics Report (2003).

Event-based reports, reviews of literature and best practices, and focused research were summarized as part of this project. The event-based reports were factual accounts of what happened during particular broad-spectrum events. The reports dealt only with risk indicators for suicide; the indicators are embedded in the work. The reports also included recommendations that communities might consider utilizing to improve the current conditions and lower the incidence of death by suicide. The presence of risk indicators was both stated and implied in each report. There was a recurring theme or understanding that the at-risk indicators for suicide are experienced by large numbers of youth. Underlying that theme was the assumption that specific conditions linked to risk indicators for suicide and youth who demonstrate warning signs for suicide are widely evident in the communities of Nunavut.

To determine what should be done about the high rate of youth suicide in Nunavut, the following guiding questions were frequently raised:

- What used to work before contact with Western European culture?
- What is working well in our communities?
- What assistance do we need to get on with our lives?
- Who can assist us?
- What are Inuit, other than those in Nunavut, doing about suicide?

The reviewed documents were an overview of what has happened and what is currently happening around the topic of death by suicide in Nunavut. Except for the National Inuit Youth Suicide Prevention Framework, the reviewed documents do not make recommendations. The research papers were more specific in that each focused on a specific aspect of death by suicide. They include the results of a long-term study on conversations with Nunavummiut in Igloolik about the feasibility of conducting what is referred to as a “psychological autopsy” interview of Nunavummiut, a comparative analysis of suicide response plans, an examination of information presently available to frontline workers, and perceptions of the usefulness of this information.

Links between the Reports and Risk Indicators for Death by Suicide

To avoid confusion about terminology, the risk indicators and the warning signs were defined by the task force. There was evidence in the research that these terms were used interchangeably. Further, there was ongoing debate over what constitutes a risk indicator. Research based in Canada clearly included gender and race as precipitating factors, and it accepted that suicide is largely the consequence of a mental disorder. However, Tatz (2001)

stated, “The personification of the very existence of people themselves as at ‘suicide risk’ must cease: you don’t suicide because you are Inuit, or Maori” (p. 14). If one embraces the medical approach to suicide indicators, *depression* can become the catchall term for a variety of behaviours. So, too, might *loss* become the catchall phrase from an anthropological approach. In this report, it is understood that statistics clearly confirmed the prevalence of suicide among young male Inuit in Nunavut, so the focus was on other indicators.

At-risk indicators for suicide identified in the reviewed documents included:

- Previous suicide attempt(s).
- Loss related to culture - food, language, tradition, skills, respect, culture, clear role identification, kinship, alienation.
- Loss of person - romantic partner, friend to suicide, divorce of parents, health.
- Family dysfunction - fighting and/or violence between parents and/or between children and parents, financial stressors, child neglect.
- Substance Abuse - drugs and alcohol, suicide attempts in family.
- Abuse - sexual, physical, emotional, mental.
- Depression to the point of hopelessness.
- Impending court date(s).
- Poor communications/social skills - isolation.
- Low self-esteem.
- Poor coping and solution-seeking skills.
- Pressure to succeed.

Alternatively, warning signs related more to the thoughts, feelings, behaviours, and appearance presented by a person who may be at-risk for suicide. Warning signs for attempting death by suicide include:

- Thoughts - guilt, loneliness, escapism, sacrificing, scattered, worthlessness, planning (for suicide).
- Feelings - sadness, lethargy, apathy, distress, anger, hopelessness, helplessness, worthlessness.

- Behaviours - crying, withdrawal, quitting, alcohol or drug abuse, recklessness, fighting and law breaking, “tidying-up” or giving away personal belongings as gifts (preparing for death).
- Physicality - no appetite, disturbed sleep, loss of interest in appearance, loss of interest in sex, lack of physical energy, withdrawal.

A comparison grid of at-risk indicators for suicide based on those referenced in the reviewed documents was prepared (see Table 1). Kirmayer, Malus, and Boothroyd’s (1996) study on indicators for suicide among Inuit youth in one community in Nunavik has been used frequently as a guide for this kind of research; however, Nunavut 2004 is vastly different from Nunavik 1996. Although it may be cogent to believe that the at-risk indicators for suicide are globally similar, it is prudent to ascertain any indicators specific to Inuit in Nunavut, should they exist, because therein may lie the key to more efficacious interventions. In the prologue of his paper, Tatz (1999) argued that culture and history play a significant role in understanding youth suicide among Aboriginals. A comparison of youth from different cultures such as Maori and Inuit may not hold true, but it may be applicable to both cultures. Tatz commented, “To understand Aboriginal suicide one has to understand Aboriginal history: their way of life has been destroyed, resulting in a loss of structure, cohesion, and meaning” (p. 8).

It is important to acknowledge the complexity and the many causes of youth suicide while attempting to isolate the factors that may explain the increasing rate of suicide in Nunavut communities. Consequently, a chart was developed to describe at-risk indicators for suicide identified in the documents. Mention of at-risk indicators was largely embedded in the discussions. Ongoing work in this area includes the determination of an emergent pattern of at-risk indicators for suicide that are mainstream and those that are Nunavut specific, as well as their frequency of mention.

Table 1

Comparison Grid of Indicators Mentioned per Report

Documents in Chronological Order	Previous attempt	Loss of culture	Loss of Relationship	Family dysfunction	Substance abuse	Abused	Low self-esteem	Weak communications skills	Depression	Pressure of court date	Weak coping skills	Pressure to succeed
Unikaartuit		√	√	√	√	√	√			√		
Feasibility of Psychological Autopsies		√	√		√	√	√		√	√		
Arctic Best Practices Workshop	√	√	√	√	√	√	√	√	√	√	√	
Innuqatigiisiaqniq Forum		√	√	√	√	√	√	√	√	√	√	
Piguninga Unipkaat: Youth Engagement Conference	√	√	√	√	√	√	√	√	√	√	√	
Inungi Sapujjijiit Task Force		√	√	√	√	√	√	√	√	√	√	
National Inuit Youth Framework		√	√	√	√	√	√	√	√		√	
Suicide and Community Wellness		√	√	√	√	√	√	√	√	√	√	
We're Trying to Keep Up		√	√	√	√	√	√	√	√		√	
Suicide Response Plans Comparative Analysis	√	√	√		√	√	√	√	√			

Insights

Despite the number and diversity of reports (i.e., event-based reports, reviews, and research), there was consistency in the repeated reference to perceived at-risk indicators for suicide. The event-based reports most consistently mentioned at-risk indicators for suicide. The *previous suicide attempt* indicator was mentioned rarely, and the *pressure to succeed* indicator was not mentioned at all.

Kral et al.'s (2003) feelings-based research report did not refer to at-risk indicators for suicide as a topic of discussion during the interviews. Precipitated by the questions that were asked, the indicators emerged as the result of people describing how they experienced sadness. Losses were shown as two separate indicators on the chart; however, losses could be considerably expanded to identify their significant role in how people think about themselves. The use of the term *losses* is a more concrete way of thinking about trauma. Losses are compounded from one generation to the next, so based on the interviews conducted in this research, many Nunavummiut describe themselves as carrying an intergenerational loss (trauma) load.

According to the documentation reviewed, there appear to be two at-risk indicators for suicide, namely, *a previous suicide attempt* and *pressure to succeed*. Significant importance has not been ascribed to either attempt. Although research on at-risk indicators for suicide in other countries has found similarities in Nunavut, no research-based evidence in the reviewed documentation determined cultural differences specific to Nunavut. As Tatz (2001) claimed, to understand youth suicide, one must first understand the history of their culture. "Aboriginal peoples in Canada have faced cultural oppression through policies of forced assimilation on the part of Euro-Canadian institutions since the earliest periods of contact" (Tatz, p. 8).

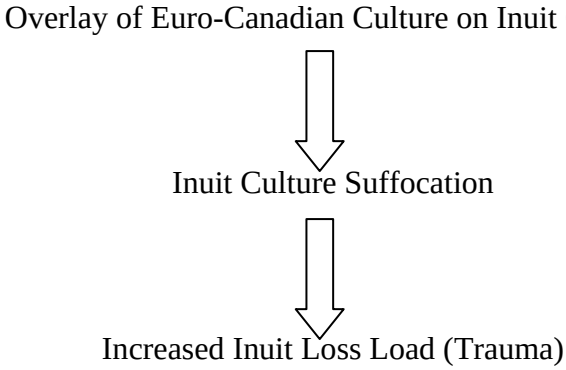
There is a deep sense of loss around identity and roles clarification, especially for young males in Nunavut. Isolation may exacerbate that sense of loss. The losses increase as communities experience more deaths by suicide. Losses from suicide are accompanied by losses of cultural ways and affiliations. As each generation bears its children, the losses are passed on and are potentially experienced as a new norm.

Culture-based traditions began to erode after contact with European culture, so a related theory is that European colonization has been a strong causal link in Inuit feeling badly about

themselves (Kirmayer, Malus, & Delage, 1993). The impact of the residential school experience and forced relocation (Brody, 1975; Marcus, 1995; Minor, 1992; Tester & Kulchyski, 1994) into communities has been deleterious for Inuit individuals, families, and communities. The relocation policy of the federal government was based on a plan to assimilate Inuit into settlement life. To this day, Inuit speak of the deep sense of loss of their traditional lands, dogs, independence, extended families (families were not necessarily relocated to the same community), and traditional leadership affiliations.

> I saw the broken-down look of so many houses and the paucity of everyday goods and services. Many people told me about the confinement and inactivity that came with living in a settlement. They could not hunt or fish or trap without making a journey that was almost from town to country, from one way of life to another. In house after house, I saw the results of modern northern planning- low-cost housing, economies of administrative scale, reliance upon wage employment (and therefore the creation of unemployment), schooling, illnesses that come with settlement life, bottle-feeding of babies, a nursing station to meet the medical problems-- and from person after person, I heard quiet, understated dismay. (Brody, 2000, pp. 28-29)

There has not been a comprehensive approach to healing for Nunavummiut. Traditional Inuit values set out a pattern of everyday observance of culturally specific ways of being that supported Inuit for thousands of years in the most threatening environment: Inuit persevered, shared, and survived. The documents asserted that the more a culture is respected, restored, and honoured, the greater the chances of casting aside negative aspects of the cultural overlay of trauma.



The reports related to death by suicide in Nunavut were examined and perused in terms of at-risk indicators for suicide that are deemed relevant to Nunavut. For all of the effort in developing strategies to address suicide prevention in Nunavut, a decrease in the incidence of suicide among young Inuit has not materialized. At-risk indicators for suicide need to be

identified clearly so that they can be transformed into recommendations for the development of a more culture-specific suicide prevention program. For example, the at-risk indicator of *loss of a close person to suicide* could become *improved awareness of suicide survivor needs*. This may be a simplistic solution, but there is a need to build on positive strengths in the culture.

There is also a prevailing belief among Inuit that they have been overresearched, except in the case of suicide, which has admittedly not been discussed openly. There is social apprehension about the political and moral correctness of addressing death by suicide. The Nunavut Research Institute database confirms that little psychologically or sociologically based research has taken place. There is no central store of information on death by suicide in Nunavut communities. Useful research information is now being amassed by the Nunavut Research Institute, but information about suicide prevention programs and their effectiveness remains fractured.

The direction of the Nunavut inquiry into suicide and suicide-related issues must continue its shift to a grassroots community base. To assume otherwise is presumptuous: Death by suicide is a personal act dependent on a personal belief system cradled within a culture. When a young person is lost to death by suicide, the family, the community, and the culture are affected. The solutions lie within the culture itself. Steps that involve funding, infrastructure, policy changes that reflect tangible support to community-based strategies need to be taken.

Practices and/or policies that support the early detection of children who exhibit at-risk indicators for suicide should be advanced. The necessary research on suicide prevention in Nunavut will evolve if a culturally specific strategy is implemented. A prerequisite to the success of such an endeavour is a shift in perspective from product to process that would require a real level of trust and the relinquishment of control. Minor's (1992) description of a design for culture-specific helping includes a three-step approach: control and direction from within the culture; definition of culture specific; and provision of support, facilitation, and testing. It seems evident from the task force's review that a culturally specific support model targeting youth at risk for suicide is required.

Introduction

In Iqaluit in March 2003, the Department of Executive and Intergovernmental Affairs (EIA) hosted a circumpolar conference in suicide prevention best practices. One of the presenters was Tracy Westerman, whose work in Western Australia had garnered international attention.

Westerman's (2002) work has focused on culturally appropriate prevention, intervention, and postvention programs. Key is the Westerman Aboriginal Symptom Checklist for Youth (WASC-Y), a risk assessment tool that was developed and normed to be culturally appropriate. It has been successful in identifying youth at risk for suicide. Her research has included comprehensive intervention and training that is community-based and broad in application. Jack Hicks, co-chair of the conference, said, "Westerman's work has huge potential in Nunavut. What Tracy showed us is a vision of the future when we have Inuit mental health professionals doing things in the Inuit way" (*Nunatsiaq News,* March 21, 2003). Subsequently, in the EIA report to the Government of Nunavut (GN) departments, the following recommendation was made:

> Education and Health & Social Services should work with their partners in the Nunavut Suicide Prevention Council to explore the development of culturally informed assessment tools to enable early identification of children at risk – and develop intervention tools/training for persons significant to those children identified as being at risk. Conceptual model is the 'Westerman Aboriginal Symptom Checklist – Youth'(WASC-Y), a culturally validated measure of depression, suicidal behaviours, substance abuse, impulsivity, anxiety and cultural resilience developed by the Australian Aboriginal clinical psychologist Dr. Tracy Westerman. (Note: CHSRF, CIHR or other research funding should be brokered with the research community – little or no GN funding should be required.) Timeline: Initial Assessment by March 31, 2004.

In follow-up contact with Westerman about this work, it became clear that a feasibility study of her model for Nunavut would require the task force to access information at the source. Recognizing that the GN would not be able to fund this kind of study, the Mental Health Task Force of the Centre of Excellence for Children and Adolescents with Special Needs agreed to sponsor this research. This report will provide a descriptive analysis of the Westerman model and some initial responses regarding the applicability of the model for Nunavut.

Purpose of the Westerman Study

The purpose of Westerman's (2002) research was to improve the conceptual understanding of indigenous mental health and identify a framework for the enhancement of research and clinical practice. Westerman found a lack of appropriate research and culturally appropriate methodologies in the field of clinical psychology. Initially, she looked at the international body of indigenous epidemiological research. Recognizing the importance of using evidence-based research to inform practice, Westerman was concerned that the body of research available was not culturally appropriate for Aboriginal Australians. She identified methodological problems about the cultural validity of measures, which raised, in her mind, the

question of reliability. The measures constructed in mainstream cultures to define mental ill health are not necessarily applicable to indigenous cultures. Data collection techniques may be inappropriate, and there is always concern about cultural bias in testing and clinical judgment. This concern has been addressed with the creation of fair practices guidelines for assessment in Canada; however, these guidelines are often ignored in terms of their application to Aboriginal groups. Westerman identified a number of factors that can determine a conceptual understanding of test bias:

- Because the normative populations are mainstreamed, the norms may not be relevant to indigenous people.
- The tester is operating from a cultural perspective different from the testee, resulting in interpretation bias.
- The testee's emotional, spiritual, and behavioural presentation is not represented in the test.
- The representativeness of the test performance to everyday life, knowledge, and ability (cultural values).
- The language format and content may be in a second language.
- The suspiciousness of indigenous people about the whole testing process.

Research has failed to address methodological factors. Of concern is the single test without any accompanying interviews or other means of validating the results. The second is the difference in the worldviews of tester and testee. There is also a need to follow a holistic assessment process. These tests are being used as diagnostic tools rather than one aspect of an overall assessment process.

Indigenous mental health has to be understood at the conceptual level in order to relate the relevance of specific indigenous risk factors and protective factors. Incorporating these risk and protective factors within assessment and intervention is best accomplished by understanding the indigenous conceptualization of mental ill health, the need for cultural competence in clinical practice, and an exploration of the relevance of culture-bound syndromes. Westerman (2002) asserted that protective factors have been shown to produce resilience to the development of psychological problems. Westerman was interested in exploring the psychological issues of Aboriginal ill health through the culturally appropriate lens of cultural resilience. For funding purposes, government agencies demand evidence-based research. However, the amount of

research carried out in Aboriginal communities and, more importantly, validated by Aboriginal communities, is almost nonexistent.

Because of the widespread lack of access to support services, particularly mental health services, in remote northern communities, contact with medical professions often occurs only after abnormal behaviour has escalated to a critical point. Culturally competent assessments may not be readily available. There is also a higher acceptance of abnormal behaviour in Aboriginal communities. Communities will try to care for the persons within the community until they have become extremely violent. Comorbid factors also are prevalent in Aboriginal populations. For example, substance and alcohol abuse are associated with Aboriginal suicide and are related to personal problems, education failure, and family arguments (Blum, Harmon, Harris, Bergeisen, & Resnick, 1992). Westerman (2002) identified family factors for Aboriginal youth as extreme neglect, family violence, parental psychopathology, physical illness in a parent, substance use, parental rejection and behaviours that model prompt and reinforce maladaptive coping styles. The prominence of violence, rape, and other forms of abuse among Aboriginal families is well documented in her work. A specific set of risk factors for these youth include:

- Social-historical context.
- Cultural identity, racism, and acculturation.
- Acculturative stress.
- Substance abuse.
- Social and cultural isolation.

The psychological impact of dispossession, racism, exclusion, extermination, denigration, and degradation strikes at one's sense of self and result in a disconnect from society (Westerman, 2002). Durkheim (1951) commented that there is a devaluation in the Aboriginal sense of community (i.e., the social solidarity essential to the concept of community) to the extent that their own norms and values are no longer relevant. Colonized indigenous cultures experience high rates of distress (Berry & Kim, 1988; Johnson, 1994). Indigenous peoples with high acculturation involvement and low participation in their original culture may experience acculturative stress and mental ill health, high rates of unemployment, substandard education, poor housing, high mortality rates, and negative coping strategies (McKendrick, Cutter, Mackenzie, & Chui, 1992). Tatz (1999) noted that in Aboriginal communities, high rates of mental ill health have become an acceptable norm compounded by a lack of appropriate coping

models. Environmental factors that reinforce maladaptive coping styles play a significant contributory role to rates of suicides and self-harm (Hunter, 1990, 1991, 1993). Significantly, paying attention to these environmental factors from a holistic perspective rather than a focus on maladaptive behaviours is critical to Aboriginal suicide prevention. By identifying the role of acculturative stress in mental health disorders, preventative efforts can be directed toward building coping or resiliency factors (Cuellar, 1998).

Why Choose Westerman?

Westerman (2002) contextualized her work as the need for a model for cultural difference rather than a cultural deficit approach. This important distinction has grounded all of Westerman's work. In terms of the design of the WASC-Y, great effort was made to identify and validate culturally specific risk variables and indicators of cultural resiliency. Operating on the premise that Aboriginal youth with a strong cultural identity are less likely to have mental ill health, Westerman set out to resystemize mental health assessment and service delivery in culturally supportive ways. The focus of her research has been the application of consistent processes across the culture of the youth rather than specific mental health interventions. The result has been a focus on the development of cultural resilience that promotes a suicide prevention context based on protective factors. Focus groups were engaged to define culturally appropriate concepts of wellness, character, and pathologies that specifically looked at the differences in manifestation between mainstream and Aboriginal groups. It was a process of cultural variation.

In the investigation of Aboriginal difference, Westerman (2002) found very little evidence-based data on the Australian Aboriginal population as a whole. Indicators of Aboriginal youth suicide had been identified as:

- Depression.
- Anxiety.
- Suicidal behaviour.
- Low self-concept and esteem.

Although there is almost no research on suicidal ideation related to Aboriginal people, the fact remains that the rates of Aboriginal suicides are rising disproportionately to those in the mainstream population, which are the focus of most research.

The WASC-Y was developed out of the need for an improved methodology and a nonbiased assessment process that is appropriate for Aboriginal youth and has a cultural resiliency perspective. The checklist focuses on identifying protective and risk factors implicated in anxiety, depression, and suicide. There is little known about resilience among Aboriginal children, including cognitive style, biological or genetic vulnerability, comorbidity, family factors, and previous episodes of mental health disorders (Zoccolillo, 1992).

What Is the WASC-Y?

The WASC-Y has two components. The first part is a self-report inventory for youth that is a paper-and-pencil symptom checklist based on a set of culturally normed assessment items. This assessment tool was not designed to be diagnostic in nature; rather, it is a screen for specific mental health risk factors for Aboriginal youth. The screen also looks at cultural resiliency, particularly the levels of protective factors. Administrators of this assessment must be trained and accredited by Indigenous Psychological Services (IPS). The self-administered report is accompanied by a clinical assessment based on guidelines that consider culturally appropriate methods of engagement. These guidelines also include interpretations that explain youth symptoms within the culture, a model of cultural validation to aid in the interpretation of youth self-report data against cultural views of their mental health functioning, and a model for the resolution of culture-bound disorders.

Both components were developed through a broad process of consultation with the Aboriginal community and the health service provider community. The WASC-Y provides an indication of risk, not diagnostic disorder. The consultation process focused on ensuring that the instrument was culturally safe and methodologically sound and that it would result in a relationship of mutual obligation to the communities and agencies that make up the three community partners involved: , the health provider, and research.

How Was the WASC-Y Developed?

By adopting a comprehensive planning process, the assessment tool was developed with the following considerations in mind:

- Test administration.
- Timing.
- Testing conditions.
- Linguistic factors.

- Ethological factors.

A specific process for the development of the WASC-Y involved extensive consultation over 9 months across Aboriginal communities in order to identify the indicators for the assessment tool. The focus groups for these consultations included Aboriginal health workers, Elders, key community stakeholders, parents, and youth. Together with community stakeholders, they worked through the development of a specific Aboriginal test to identify the need, the context for the assessment and building of community ownership, and partnerships of the process. The consultations addressed such questions as:

- What does unwellness or mental ill health look like? (i.e., How do you know that someone is depressed in this cultural milieu?)
- How do people cope with unwellness?
- Does it look different in remote communities from larger communities?
- What terminology is used to describe these conditions?
- What behaviours or behavioural changes characterize these conditions? (i.e., becoming culturally disrespectful)
- How does the person become impaired within the cultural context?

Focus groups comprised of Aboriginal stakeholders, service providers, parents, and youth participated in the development of the items to ensure that the tool was based on cultural integrity and practical experience. The questions were designed to guarantee the external validity of information, so the questions were constructed to be comparable both within a group and across groups. Test pools of symptoms and a qualitative presentation of mental health problems were identified. The youth determined the terminology (pigeon-type street language common to Aboriginal youth). Attention was paid to cultural inclusion. Questions for the focus groups that were developed to determine their content validity and relevance were based on factors reflective of indigenous risk as well as protective factors. They were designed on the assumption that resilience and building resilience are valid forms of treatment. The focus groups worked around the topics until a saturation point was reached and consensus was achieved. The groups were constructed to respect such cultural issues as gender and kinship ties.

The Process

- Posing a question to the group. Everyone was given a chance to respond. If someone did not respond, he/she was encouraged to offer information in an effort to reach consensus.
- At the end of discussion on a topic, a summary was prepared, and agreement was obtained to ensure that the summary was an accurate representation of the discussion.
- The groups identified symptoms of depression, suicide, anxiety, and self-esteem, as well as protective factors. In addition to this information, they incorporated risk factors such as drug use and impulsivity.
- The format for the assessment tool was also arrived at with the youth focus group. The result was an assessment tool that was highly visual and linguistically accessible (i.e., at an easy comprehension level). The process involved youth discussions and trials to determine if the format was suitable, accessible, and comprehensible. If a youth was unable to read the screen, he/she could have it delivered orally.
- Finally, they did a pilot to ensure the functional validity. They recruited participants from a variety of agencies, administered the tool, and had a feedback session to discuss potential ambiguities. As a result, some items were removed, and one item was reworded. The WASC-Y was now validated for school-based trials.

The Results

The WASC-Y (Westerman, 2002) comprises 53 assessments in six subscales that represent mental ill health and personality concepts:

- Depression.
- Suicidal behaviour.
- Substance abuse.
- Impulsivity, hyperactivity, and agitation.
- Anxiety.
- Cultural resilience.

In her work on the WASC-Y, Westerman identified the following risk factors for Aboriginal youth:

- Social-historical context.

- Cultural identity, racism, and acculturation.
- Acculturative stress.
- Substance abuse.
- Social and cultural isolation.

The WASC-Y also identified protective factors for Aboriginal youth:

- Individual temperament and coping skills

  This is characterized by the protective factors of having an easy early childhood temperament, high self-esteem, and an internal locus of control. Problem-solving or task-coping strategies tend to be more prevalent, whereas children who use emotion-focused coping strategies are not as successful. Emotion-focus strategies include daydreaming or suppressing anger; positive strategies include seeking of information, positive self-talk, diversion of attention, relaxation, and thought stopping.

- Family and external factors

  Significant is a strong relationship with a parent, positive attachment, and a high level of positive, external contact with peers.

- Culture

  A positive view of culture and being Aboriginal is associated with staying in school, positive self-esteem, and concept. Positive views of one's culture of origin and the dominant culture are critical to good mental health.

Data Collection

Westerman (2002) administered the WASC-Y initially in schools between June 2000 and July and August 2001. The school staff members were informed by the principal which students would be leaving their classes on particular days to take the test. Students were told at the beginning of the day that they would be taking this test. Literacy levels had been obtained from the teachers prior to the screening, and arrangements for oral testing were made for students with low literacy levels. The rural sample was obtained at three different screening times. The urban sample was collected at six different screenings.

Consent was obtained in the rural area quite readily, whereas the urban group wanted assurances that the rural youth who had already been tested had received support after taking the test. In the urban area, there was a deliberate slowing down of the process until documentation of

the posttest supports provided to rural youth had been seen and verified. Participants were assigned codes to maintain anonymity and confidentiality.

Data Analysis

An analysis of descriptive data obtained from the large-scale sampling of all Aboriginal youth screening with the WASC-Y (N = 183) using SPSS-11.5 helped to describe the rates of risk. The results provide information about the nature and extent of depression, suicidal behaviours, substance use, impulsivity, anxiety, and cultural resilience for Aboriginal youth in selected urban and rural locations of Western Australia. Descriptive data that had been calculated for the sample included (a) frequency distributions, including the mean responses of youth self-reports for each of the six subscales of the WASC-Y. This also included calculations of the frequency of youth responses to certain salient items (e.g., percentage of youth reporting thoughts of suicide); b) the correlations among subscales of the WASC-Y; and (c) calculations of comorbidity of risk among each of the subscales under examination.

Current Status of the WASC-Y

The test is made up of a series of Likert scales. Students were asked to mark the items that are the most descriptive of the way they usually feel. A statistical analysis of the results quantified the degree of uniformity or normality of the data. Based on this factor analysis, items that were considered statistically unreliable were removed. Factor Analysis (FA) identified which items should be included or excluded. Some testing assumptions formed the basis of the FA (e.g., minimum size is believed to be 5 study participants per variable). FA variables must be normally distributed. There must be a linearity of the data. FA is sensitive to outline cases, so these need to be identified, removed, or transformed. There must be factorability of the correlation matrix. This includes that the matrix has correlations in excess of .3 and that Bartlett's Test of Sphecipherity and the Kaiser-Meyer- Olkin are used to determine the factorability of the matrix (greater than .6).

There exists a correlation between the sample size and the power of the test to identify statistically significant relationships. A minimum sample of 100 participants is required. The WASC-Y had a participant-to-variable ratio of 3.3:1. Results of the FA for each subscale were 17:1 for depression, 18:1 for suicidal behaviour, 19:1 for substance abuse, 61:1 for impulsivity, 17:1 for self-esteem, and 20:1 for protective factors.

There were two kinds of response sets: social desirability and acquiescence. The latter was the tendency of the respondents to agree with the test items, no matter what the content. Social desirability was the tendency to respond positively in order to conform socially. Because a 5-point Likert scale was used, the respondents could pick the middle one, which is a neutral response. As part of the analysis, patterns of random responses were identified. These items were removed.

A detailed defense of the reliability of the assessment tool based on confirmatory factor analysis and exploratory factor analysis was undertaken. The reliability of the Depression subscale was tested using Cronbach's alpha. It is more thoroughly described in the WASC-Y training manual.

Findings

The results were analyzed by gender and geographical location of the participants. This approach provided a comparative analysis of the effect of these two variables on the degree of risk reported by youth in the sample. It was based on research indicating that these two variables may impact the extent of risk reported by youth. Relationships identified as statistically significant were reported by Westerman (2002). However, it is significant to note that the research looked for differences in urban and rural communities, the terminology that would be most familiar in the youth's context, and the most typical youth response behaviours that would have been exhibited in their specific contexts.

The research was exploratory in nature, resulting in valuable findings:

- There is enormous support for the development of an assessment test specific to the Aboriginal population (in Aboriginal and non-Aboriginal communities).
- There is sufficient empirical evidence that existing tests result in biased assessments of Aboriginal people.
- There is evidence of differences in symptom presentation between Aboriginal and mainstream diagnostic criteria.
- There is evidence that a unique, culture-specific set of disorders remain undetected by mainstream tests.
- There exist a number of important intervention processes within Aboriginal communities that must be incorporated into standard practice.
- The assessment process requires the following:

- *General Issues* - community consultation and agreements between researchers and community.
- *Information Systems* - development of practical and culturally acceptable mental health information systems.
- *Data Collection* - Instrument design
  - Use of appropriate language.
  - Inclusion of spiritual values and understanding.
  - Not using existing diagnostic categories.
- *Data Collection* - Methods
  - Culturally appropriate.
  - Informed consent at the individual and community levels.
  - Debriefing available for data collectors and respondents.
- *Data Collection* - Access, storage, use
  - Improved access to data through open consultation and common data standards and classifications.
  - Agreements governing data collection and use.
  - Facilities for communities to store their own data.
- *Training Issues*
  - Training for indigenous data collectors and researchers.
  - Training for indigenous health workers.

General Comments

WASC-Y, which had been developed from a very limited Australian research base, framed a mental health inventory unique to Aborigine youth (Westerman, 2002). In the past, the methodology utilizing existing measures to increase reliability and validity was flawed primarily because community consultation was not included in the process. The methodology must make sense to Aboriginal communities. Mental health in Aboriginal communities is holistic and should be considered in the context of social and emotional well-being. Constructs such as social cohesion, spirituality, sexual abuse, family violence, trauma, culture, racism, removal policies, unemployment, and exclusion from education must be considered. More research is required in all of these areas.

Researchers have also failed to address the problem of how data should be interpreted for Aboriginal people. The WASC-Y research developed a culturally appropriate engagement model and clinician guidelines in order to tackle issues of cultural disparity. The process of assessment has (a) increased levels of cultural competence among practitioners, (b) used cultural consultants in assessments, (c) used culturally appropriate counselling skills with a focus on engagement and therapeutic alliance, and (d) understood the effect of acculturation on the Aboriginal worldview and cultural beliefs. The purpose of using cultural consultants is to increase the cultural skills of non-Aboriginal practitioners (Westerman, 2002).

Mental Health Problems among Aboriginal Youth

The WASC-Y (Westerman, 2002) showed that 19.2% of the participants had a high to very high risk for symptoms of anxiety, 30.6% for depression; 32.2% for suicidal behaviours, 22.3% for alcohol and drug abuse, and 33% for impulsivity. Their protective factors stood at 23%. There were clinically significant levels of anxiety (higher in the males) and depression (in the females). As females progress into adolescence, they tend to base their self-esteem on their relationships with others (Chevron, Quinlan, & Blatt, 1978; Kaplan, 1986). Individuals' reliance upon others for approval puts them at risk. However, the suicide risk is higher for males. These patterns of gender predispositions in the mainstream are the same for the Aboriginal population. Clearly, it is important to recognize and establish norms for these patterns.

The WASC-Y (Westerman, 2002) research was limited in its applicability to Aboriginal cultures outside of the areas it was designed for. Because the youth who were sampled were screened in schools, they may be representative only of a high-functioning group. Because Westerman is Aboriginal, the participants also may have been more willing to speak to her. The fact that she is female may have resulted in an increase in the number of girls who were willing to self-report rather than the number of boys. There remains a need to improve on the knowledge base to ensure there is ongoing validation and refinement of the outcomes from the WASC-Y.

Next Steps for the WASC-Y

- Validation of the symptoms.
- Prioritization of particular symptoms, specifically with the acting-out rather than the acting-in phenomenon.
- Assessment for prevalence of bipolar disorder in terms of symptoms of anxiety and agitation.

- Piloting and possible rewording of some of the test items.
- The strength of the relationship between impulsivity and risk for suicide was significant and requires further exploration. There may be an association between impulsivity in terms of death by external causes such as driving too fast and suicidal behaviour.
- Exploration of protective factors to inform early intervention programs.
- Refinement and validation of the WASC-Y so that it can be used for all Aboriginal youth in Australia. This will require population specific norms.
- Articulation of a full support process that encompasses:
    - The need for cultural validation.
    - Supports through culturally appropriate counselling skills.
    - Resolution of culturally related mental health problems.
    - Awareness of the hierarchical process of traditional interventions.
    - Recognition of the impact of acculturation and acculturated stress.
    - The use of cultural competence continuums by practitioners.
    - The phenomenology of mental ill health for Aboriginal people.

What Is Currently Happening?

Four major projects are underway to determine the validity of the WASC-Y (Westerman, 2002). The clinician guidelines are being used by the Department of Education in Western Australia (WA) to screen Aboriginal youth at regular intervals and collect normative data. The WASC-Y and the clinician guidelines are being investigated by James Cook University in Queensland to determine their validity outside of WA. The WASC-A, an adult version of the WASC-Y, is in the pilot stages. The WASC-Y is being further validated for use as an outcome measure in an indigenous youth intervention program.

The Clinician Guidelines

Cognizant of the need to identify bias in the assessment process and provide intervention services to youth identified by the WASC-Y as high risk, Westerman (2002) also established clinician guidelines to identify culturally appropriate models and assessment processes for youth engagement and intervention. The guidelines were developed through another focus group consultation process that raised the following issues:

- The use of culturally appropriate methods of engaging youth in testing and assessment and concern about:
    - Non-Aboriginal cultural divide between testers and testees.
    - Clinician familiarity with tribal groups, boundaries, and connections to the land and relationships.
    - Issues for Aboriginal practitioners around community dynamics.
    - Trust issues between practitioners and clients.
    - Conducting of assessments outside the cultural context. Testing in unfamiliar environments may result in inaccurate measures.
    - Cultural disparity between practitioners and youth, and the need to recognize cultural difference rather than deficit.
    - Inappropriate use of cultural consultants (e.g., cultural consultant of the wrong gender, one who had an avoidance relationship with the client, or one who is from a different linguistic or tribal group).
    - Gender difference between youth and practitioner.
    - Direct questioning and other culturally inappropriate strategies.
    - The cultural competence of practitioners and the level of cultural competence needed to incorporate demonstrated cultural knowledge, underlying beliefs about Aboriginal people, flexibility in practice, and personal involvement in the Aboriginal community.
    - Understanding the effect of acculturation and acculturated stress and the impact of the Aboriginal worldview on client perceptions.
    - An understanding of culture-bound syndromes and their impact on behaviours in the community setting.
- The clinician guidelines provide specific information on culture-bound disorders that are imperative to understand in the clinical context. In the Australian context, culture-bound disorders are identified as:
    - Payback as a mechanism for conflict resolution.
    - Being sung or having the bone - cursing (Both are cultural forms of retribution/threat).

    - External attribution belief system that attributes a disorder to an external cause.
    - Avoidance relationships.
    - Running from the traditional law.
    - Longing for country and the relationship need to reconnect with the land.
    - Sorry time (grief).
    - Pathological grief and hysteria.
    - Psychosis.
    - Self-harm.
    - Ritualistic and obsessional behaviours.
- Replication would require a process to identify culture-bound disorders for Inuit and norm these across Inuit populations.

Once they were developed, the clinician guidelines also underwent a validation process to ensure cultural safety and confidentiality as well as confirm culturally appropriate questioning. The following criteria are the result of this validation process:

- Validation has to occur at the individual community and cultural levels.
- Cultural consultants should be engaged in this process.
- Practitioners need to assess the cultural origins of Aboriginal problems based on the guidelines.
- Mental health norms need to be established for Aboriginal culture.
- There needs to be a match between mainstream and Aboriginal worldviews in the diagnostic process.
- Practitioners need to demonstrate cultural competence.

Using these clinician guidelines, all youth who participated in the WASC-Y (Westerman, 2002) also participated in follow-up clinical interviews to support at-risk youth and increase the validation of the assessment screen. However, the validation process requires that the clinical assessments be culturally fair. To this end, it is necessary to validate the cultural competence of the clinical team. Later in this report is a description of Westerman's work in the area of assessment of cultural competencies.

Potential for Replication

The process for developing the WASC-Y assessment tool (Westerman, 2002) was extensive. Replicating this for Nunavut will require the services of psychological assessors who are accepted by the cultural community and have an in-depth understanding of the cultural issues that Inuit face in this context. As a result of this investigation into the work and the initial results that the IPS is achieving in WA, the task force believes there is merit in pursuing this approach for the Inuit youth population. In terms of the financial cost and societal gravity of the issue for the Inuit population, an appropriate approach would be to secure national funding to develop an Inuit WASC-Y assessment tool for use across Canada. Given the high rates of youth suicide in every Canadian Inuit jurisdiction, there should be interest in this kind of partnership between the federal government and pan-Canadian Inuit associations.

It is recommended that potential partners, including research and funding partners for this work, be identified as quickly as possible by the GN through the Senior Officials Healthy Lifestyle Committee. It may be appropriate to seek funding through CHSRF or CIHR with a consortium of partners. Key in this collaboration will be Inuit organizations. It is further recommended that a process for identifying focus group participants from the various stakeholder communities be identified and that a lead organization be tasked with developing a proposal for an effective risk assessment tool based on the Westerman (2002) WASC-Y model for Inuit youth populations. The lead organization best placed for this work may be Inuit Tapiriit Kanatami, or the Inuit Circumpolar Youth Council. For the assessment tool to be valid for pan-Canadian Inuit populations, input must be received from all jurisdictions.

The development of clinician guidelines requires the collaboration of Inuit Elders and personnel with expertise in conducting research. This phase of the project should be identified as part of the initial proposal, but it should run as a parallel research project involving another team of experts. Both teams should communicate their findings throughout the process to shorten the time lines for the completion of this project and the delivery of an assessment tool.

Training Forums for Intervention

These forums, which ascribe to a holistic model of community intervention approach, are conducted with three stakeholder groups: youth, community, service providers. A series of three training forums are delivered at 3- to 6-month intervals that allow for knowledge uptake and application. The sessions are delivered consecutively, with up to 2 days for each stakeholder

group for each of the forums. All participants take pre- and postassessment tests at each training forum that facilitate the monitoring of the program's effectiveness and provide evaluation data. At the end of the training, a process of community consultation begins so that communities can begin to develop strategic plans for ongoing program delivery.

The forums focus on developing culturally appropriate program content and delivery that are hands-on and clinically sound training and intervention strategies. They involve all stakeholders and validate the important roles that these people play in providing crisis support. Essential is a community development focus that recognizes the importance of Aboriginal young people in the intervention; understands that youth in crisis go to other youth; acknowledges that Aboriginal youth are at risk; and utilize the WASC-Y, a culturally validated assessment tool. The forums engage youth with the intention of having them help themselves.

Because many communities have limited access to grassroots services, and because there are cultural and language differences in service delivery, the forums enable communities to fill service gaps through capacity building and the training of cultural consultants. The forums:

- Increase the skills of service providers.
- Increase the knowledge about depression and suicidal behaviours of all three groups.
- Increase the ability of community stakeholders and youth to recognize signs of mental ill health.
- Increase the likelihood of community stakeholders and youth to provide assistance and intervention.
- Develop a network of local community responders.

The training process involves four phases:

- **Phase 1** is an intensive consultative period when communities develop their own needs profile to ensure that the forums are locally relevant.
- **Phase 2** involves the preskills assessment for all participants, the introductory training, and the postassessment. It targets such areas as:
    - Cultural and community beliefs about suicide.
    - Myths about suicide.
    - Causes of Aboriginal suicide.
    - Cultural and community factors in Aboriginal depression.
    - Role of depression in suicide.

- Signs to look for.
- Self-harm and the role of culture.
- Prediction and assessment of suicide risk.
- WASC-Y.
- Conducting of risk assessments in Aboriginal communities.
- Responsiveness.
- Dealing with culturally related suicide behaviours.
- Role of culture in suicide and depression.
- Basic culturally appropriate counselling techniques.
- Postvention.
- Prevention of copycat suicides.
- Looking after self as part of the community.

In addition, young people's forums include a psychoeducational package aimed at enhancing coping skills and developing strategies for high-risk situations. These include:

- Building of cultural resiliency.
- Building of cultural identity.
- Discussion of acculturation and acculturative stress.

To ensure the safety of the youth participants, if clinical interviews and clinical interventions are required, the youth are linked with local supports. At the completion of each forum, IPS staff provide debriefing, counselling, support, and advocacy services for community members.

- **Phase 3** involves skills consolidation training.
- **Phase 4** involves process and impact evaluations.

Results to Date

Following are the key implications arising from the results:

- Overall, the youth rated their level of knowledge and understanding of depression and suicide as substantially greater after having participated in the Skills Consolidation (SC) workshop.
- They also cited an increase in their knowledge of ways to manage feelings of stress. This finding is of particular importance, given the role of chronic stress as a risk factor in the development of depression and suicidal ideation.

- Youth felt that their capacity to identify the signs and symptoms of depression in others improved as the result of attending the SC workshop. Youth also reported that the workshop had made them feel more confident in determining if someone experiencing depression were also at risk of suicide. These results represent important gains at the level of existing peer support networks, which can often be critical in suicide prevention.
- Perhaps most importantly, the youth reported a significant increase in the likelihood that they would help someone whom they identified as being at risk of depression.
- As in previous workshops, service providers reported an increase in their knowledge of depression and suicide in Aboriginal populations as the result of having attended the SC workshop.
- Pre- and postevaluations also indicated an increase in the service providers' comfort level of referring at-risk Aboriginal clients to local services.
- There was also a postworkshop increase in the level of comfort that service providers felt in regard to professional support available to them.

Providing booster-type workshops has the prospect of increasing knowledge within the service provider group. Reinforcement of training content increases the participants' ability to tune in to or attend to the information presented (within the context of the training program).

Although comprehensive interforum analyses are not included in this report (they will be the focus of a forthcoming document), it is worth noting that the gains in knowledge about depression and suicide reported by the participants in this forum were greater than the gains recorded at the previous introductory and follow-up forums conducted at Community X.[2] This finding suggested a number of conclusions:

- Gains in knowledge made between the introductory and follow-up forums were maintained over the 12 months between the follow-up and the SC forums.
- The increased gains in the SC workshop suggest a ratchet-type effect in which previous gains build from workshop to workshop.

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[2]The name of the community will remain confidential.

- A similar picture emerged with confidence in referring suicidal clients to relevant services. That is, gains were maintained across workshops and were built upon in the SC phase.
- A slight decrease was found between posttest follow-up and pretest SC data, suggesting a small decline in the amount of information retained over the intervening 12 months between workshops. This decline may be due in part to the more specific nature of the content being evaluated. Again, the effect of the SC training on the workshop participants was clearly much greater than at follow-up. Service providers rated themselves as more knowledgeable about depression and suicide after the SC forum than they did after the follow-up forum.

Potential for Replication of Training Model

Initially, these training sessions were designed to provide intervention support across the community for those youth who were identified as at risk in the WASC-Y (Westerman, 2002). Essentially, this training builds capacity across a community and supports intervention, but it also builds preventive protective strengths by making community connections that might otherwise not be made. These training workshops can be delivered in every Nunavut community as part of a training cycle, that is, a strategic investment that will reduce long-term care costs by building community-based capacity, connectedness and, care networks. Although the WASC-Y and the clinical assessments target a specific at-risk population, with research now indicating that 40% of Inuit youth consider suicide, the delivery of broad, community-based training should be a priority for all youth.

The need for this training is significant. The training should be developed and delivered as a priority in all communities, regardless of the state of development of the at-risk assessment tool itself. Once the youth risk assessment tool does become available, however, it will become a valuable component of the intervention process. It is further recommended that in the course of designing this approach, linking the training to a community wraparound model will lead to better uptake, sustainability, and community ownership.

This is an initiative that could be designed by GN departments such as Education, Culture, Language, Elders & Youth (CLEY) or Health & Social Services (H&SS), or it could be tasked to Nunavut's Promise for Children and Youth. Ultimately, the training delivery could be contracted to Nunavut's Embrace Life Council or a similar nongovernmental organization as the

training delivery agent. The Embrace Life Council is well placed with youth committees already established in communities.

What Is the Cultural Competency Continuum?

The clinician guidelines were framed on the prerequisite that the person providing the WASC-Y (Westerman, 2002) assessment must have proficient cultural competency. It became necessary to formalize this requirement through the development of an instrument to measure cultural competence for both Aboriginal and non-Aboriginal service providers, and to link this to cultural consultants, cultural specialist, and training modules to ensure that the professional services recognize the differences between mainstream and Aboriginal strengths and needs.

Cultural competence refers to the ability of mental health care providers and organizations to understand and respond effectively to the cultural needs brought by Aboriginal clients to practitioners within their organizations. This means appreciating how culture-specific illnesses may manifest emotionally, physically, mentally, or spiritually in Aboriginal clients, as well as understanding how these manifestations differ from the mainstream constructs of mental ill health. Cultural competence must be shown at the levels of (1) identification, (2) culturally valid assessment, and (3) culturally appropriate intervention through evidence-based models of traditional and Westernized treatments from which Aboriginal clients may select.

The purposes of this assessment tool are to:

- Identify areas of personal strength and limitations.
- Assess the cultural competency of the organization as a whole in terms of its service delivery policies and practices to aboriginal clients.
- Have aboriginal staff rate their organization in its cultural effectiveness.
- Link the results from client and staff surveys to align the perceptions of the effectiveness of cultural service provision.
- Identify professional development with measurable outcomes to improve the cultural competence of individual staff and the organization as a whole.

Based on personal and organizational assessments, competency training can move the individual and organization along the cultural competency continuum. Results from the surveys included:

- Issues around trust.
- Concern from Aboriginal workers who practice in a non-Aboriginal paradigm.

- Lack of Aboriginal-specific approaches and strategies.
- Impartiality.
- Communication.
- Systems of reciprocity between Aboriginal and non-Aboriginal staff.

Based on the surveys done by the client groups and the service provider groups, 15 recommendations were offered:

- Formalize a cultural induction process for the organization that is ongoing, phased, and mandatory.
- Provide cultural advisors for non-Aboriginal staff.
- Provide cultural supervision.
- Provide community consultation.
- Incorporate cultural competencies into job descriptions, performance indicators, and duty statements.
- Initiate mutual learning contracts between Aboriginal and non-Aboriginal staff.
- Identify staff-team approaches.
- Monitor and evaluate systemically every 6 months.
- Develop a training strategy in culturally appropriate assessment protocols.
- Establish memorandums of understanding with local communities to embed culturally specific treatment approaches as standard practice.
- Develop Aboriginal-specific resources.
- Encourage staff to participate in the community.
- Provide mentorship between new and experienced Aboriginal staff.
- Develop individual worker support plans (IWSPs).
- Provide training in management, policy, and human resources for Aboriginal staff.

Implementation of these 15 recommendations is expected to promote staff self-reflection, help staff to become aware of the larger social structures affecting clients, and help them to promote client empowerment and control over their mental health issues.

Cultural Competency Structured Questionnaire

Emerging from these recommendations was the development of the Cultural Competency Structured Questionnaire. It was administered to individuals within organizations interested in

identifying their cultural competency. Resulting from this process were individual cultural competency profiles and an organizational cultural competency profile, both of which were assessed on a 5-item rubric of cultural descriptors of attitudes, beliefs, behaviours, and perspectives. The questionnaire assessed 45 items in five domains:

- Knowledge of the cultural background of the clientele.
- Skills/Abilities, which include culturally informed counselling approaches.
- Beliefs/Attitudes, which relate to the openness of the service provider to other worldviews and beliefs.
- Resources/Linkages, which relate to how aggressively and respectfully service-providers have undertaken professional development in terms of learning about the culture both from key stakeholders in the community (community consultants) and from resources that are available.
- Organizational/System level cultural competencies, which relate to how well the organization promotes and encourages the development of cultural competence.

How Was It Developed?

Cross's (1989) initial work on a culturally competency system of care outlined seven levels of competence. This research was the basis of the development of a framework for competencies appropriate to the WA context. Again, focus groups developed the areas identified in the framework. All work was based on parameters of cultural sensitivity and security, and models of cultural support and supervision. The initial purpose was to improve levels of service support for at-risk clients in communities where the assessments were taking place. However, this continuum has broad applications in diverse contexts. It is especially useful in terms of informing practice, ensuring good hiring practices, and providing direction for effective professional development.

Current Status of the Cultural Competency Continuum

Individual Worker Support Plan

Upon completion of the questionnaire, an analysis established each practitioner's place along the continuum. Based on the responses, IWSPs were generated that identified learning modules that practitioners can pick up to move along the continuum. The IWSPs are self-directed learning modules designed to help move service practitioners progressively along a rubric of skills, attitudes, knowledge, and beliefs. Culturally competent practitioners look inward

and are aware of their own cultural and sociopolitical influences (Dudgeon, Pickett, & Sanson, 2000). This self-reflection is an ongoing process, and the practitioners are aware of personal underlying assumptions about other cultural groups. In addition, such practitioners are cognizant of how these attitudes may influence client interactions positively or negatively. Practitioners who are culturally competent understand and appreciate the cultural strengths and resources available to clients; in this way, clients are viewed from a strength rather than a deficit perspective (U.S. Dept. of Health and Human Services, n.d.).

Organizational Cultural Competence

Organizations are coming to IPS asking to have the cultural competence of their workforces assessed. IPS is developing a computer program that combines the individual responses into an organizational report with recommendations. Organizational standards can be identified to give a baseline upon which to build. As the organization moves along the continuum, changes in policies and practices as well as the status quo can occur. Success requires a real commitment to restructuring the organization. A starting place is to build cultural competencies and expectations into job descriptions. There is also the need to establish a workplace environment where certain principles are fundamental:

- Reciprocal and culturally appropriate information sharing between the department and communities/individuals.
- Flexible integration and delivery of department-related services.
- Cultural sensitivity and inclusiveness in evolving the department's organizational structure.
- Critical mass makes a difference. Where there is critical mass, one can expect to see change.

Survey Findings and Recommendations for the Domains

- **Cultural Knowledge**

Service users across all regions expressed a desire to see increased levels of cultural knowledge among non-Aboriginal department staff members. A great many clients felt that department staff would benefit from knowing more about Aboriginal family structures, kin relationships, and associated systems of reciprocity. They recommended that this kind of knowledge might best be gained through increased contact between Aboriginal people and department staff.

Recommendations

- Formulate links with key Aboriginal organizations to develop an induction process.
- Work these in phases.
- Make them mandatory.
- Be specific to the location.
- Explore opportunities to engage in cultural supervision specific to their statement of duties.
- Consult with the indigenous community during the development and writing phase of the processes.

- **Skills/Abilities**

Service users demonstrated a clear appreciation for the skills and attributes that many non-Aboriginal staff members bring to their work at the department. There is a general feeling that service users valued the direct communication style adopted by many staff. There were also a number of comments referring to the inherent familial impartiality of non-Aboriginal service providers as being a notable asset. Service users emphasized the need for augmenting the current skills and expertise of departmental staff members by increasing awareness and cultural sensitivity, reflecting a desire to see increased interpersonal skills in terms of frontline staff-client interactions as well as the application of culturally informed counselling approaches.

Recommendations

- The department commits to a long-term strategy of developing specific cultural competencies for its workforce.
- The department prioritizes the training and development of Aboriginal staff members, particularly in remote and highly populated regions.
- A core group of Aboriginal and non-Aboriginal staff members are identified across each location to engage in culturally specific mental health and counselling training.
- Consider the development of mutual learning contracts between Aboriginal and non-Aboriginal staff members in such a way that a transfer of clinical and cultural knowledge occurs.

- Success of these strategies is determined via the ongoing monitoring of cultural competencies.

- **Beliefs/Attitudes**

Service users often raised the view that beliefs and attitudes tend to flow from knowledge and understanding. Respect for Aboriginal people is a function of how intimately non-Aboriginal people understand the culture. They reiterated that understanding can only come from improved communication channels between Aboriginal people and department staff members at the community level.

Recommendations

- The department commits to the development of specific case-planning and treatment processes for Aboriginal clients.
- Aboriginal caseworkers have a particular and required role to assist in the cultural elements of treatment and the development of culture-specific case plans.
- Specific supervision and support must be provided to Aboriginal staff from each region to develop and consolidate appropriate case-planning methodologies for use with Aboriginal clients.
- The department commits to a long-term strategy of training staff members in culturally appropriate assessment protocols.
- The department commits to the development of memoranda of understanding with local community Elders, traditional healers, and the like, for the purpose of embedding culture-specific treatment approaches into standard practice within the department.

- **Resources/Linkages**

A number of respondents offered positive feedback on existing departmental programs. There was, however, a unanimous call from service users across all sites for greater targeting of resources according to the identified needs of specific groups. In particular, most respondents felt that there are not enough resources aimed at young men, the elderly, single mothers, and children with behavioural and mental health problems. Regarding linkages, one of the most recurrent themes emerging from the service user data was the belief among Aboriginal clients that community-based forums are one of the best means of improving the delivery of departmental services.

Recommendations

- The department commits to the ongoing development of Aboriginal-specific resources to promote the department to communities.
- The department commits to having their staff members attend important cultural events such as Journey of Healing Days.
- The department commits to working within a cultural consultant model of service delivery by embedding it within policy. This requires that non-Aboriginal staff members work in direct partnership with Aboriginal colleagues. Non-Aboriginal staff members must commit to working in outreach to communities and that this not be viewed solely as the role of Aboriginal staff.

- **Organizational/System level cultural competencies**

Service users wanted more Aboriginal people employed at all levels of the department. In particular, a number of those surveyed suggested that more Aboriginal males should be employed in an effort to promote a more culturally sensitive environment in which Aboriginal males have a choice of whom they wish to liaise with. Service users also wanted Aboriginal staff to receive more support for professional development.

Recommendations

- Increase the number of Aboriginal employees.
- Improve the recruitment of Aboriginal employees.
- Provide supervisors with training in the supervision of Aboriginal staff members.
- Define cultural competencies for staff members at the management level.
- Provide confidential exit interviews.
- Have effective mentoring systems where new indigenous staff members are teamed with existing indigenous staff.
- Implement individual training and pathway plans.
- Give Aboriginal workers priority to high-quality training on a variety of topics, including management strategies, policy development, and the like.
- Recruitment of more indigenous workers into the human resources department.

Is This Suitable for Nunavut?

The development of an assessment tool for determining the cultural competence of government employees, especially service delivery employees, is extremely interesting to

consider, particularly in the context of both the mandate for *Inuit Qaujimajatuqangit* (IQ) and for the Inuit Employment Plan. In fact, this approach could establish a way of providing pre- and in-service support to all GN employees, particularly around IQ. It would also create a common framework for professional development and training across departments. This approach could lend credence to the GN's commitment to implement IQ in the workplace. The dual focus on personal and organizational cultural competence would facilitate the implementation of a department review process into this evaluation.

Implementing a process to assess cultural competence is important particularly for the governmental departments of education and health & social services because the service providers in both of these departments are core in communities. However, the development of this continuum, the process, and the implementation also require the involvement of the departments of culture, language, elders and youth, and human resources. The use of a continuum of cultural competence for the GN should be considered a proactive way of implementing IQ across the government.

What Would It Take to Develop and Implement in Nunavut?

There has been considerable documentation about IQ and culturally appropriate practice to date. Much of this information resides in a variety of government departments and Inuit organizations. The information can be gathered and summarized as a set of key cultural indicators that can form the basis of the continuum. Once these indicators are developed, a set of protocols need to be identified to establish the performance level of the employees against the indicators. The questionnaire would need to be field tested and normed. Training modules could be developed to meet deficit areas identified through the continuum. Finally, a data entry process needs to be set up so that questionnaire data, once analyzed, can produce reports with recommended areas for professional development.

This work would optimally be contracted to a research and development team with the skills and background to develop culturally appropriate indicators and the expertise to develop modules for professional development.

Initial Recommendations to the GN

The research team feels that there is much to recommend Westerman's (2002) work. There are definite advantages for Nunavut to pursue the replication of her WASC-Y assessment

tool in ways that are culturally appropriate for Inuit. To this end, the following recommendations are offered:

- The GN should consider the development and delivery of broad, community-based training programs in suicide prevention that are culturally appropriate and responsive. Presently, we are spending money to train employees in southern programs that may not be effective or appropriate for our communities. A phased-in training program like that offered by IPS would ensure that all Nunavut communities have access to basic suicide prevention training and information. Training delivery could be contracted to Embrace Life or another Nunavut nongovernmental organization.
- The GN should seek partners to pursue the development of a developmental/risk assessment tool similar to the WASC-Y for use in Inuit jurisdictions. This work should be done at the federal level, and the tool should be available to all Inuit jurisdictions. Once available, community service delivery personnel should be trained in the use of the tool as well as the use of wraparound as an appropriate intervention system. It may be worth exploring the possibility of this tool being implemented as part of a developmental continuum of assessment that begins with Ages ’n’ Stages at the early childhood level.
- The GN should invite a presentation on the cultural competency continuum so that key departments may consider the potential and implications for the GN. The model should be considered in terms of the applicability for implementing IQ across the government as well as the possible impact on the Inuit Employment Plan.
- It is further recommended that this report be shared with the Senior Management Suicide Prevention Council and that this group be tasked with the development of a GN response plan for these recommendations.

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APPENDIX A

Publications

Event-Based Reports

Henderson, A. (2003, March). Best Practices in Suicide Prevention and the Evaluation of Suicide Prevention Programs in the Arctic.

This report evolved out of a weekend workshop attended by approximately 40 delegates from Alaska, Australia, Greenland, Nunavik, and Nunavut who were invited to listen to, share, and discuss recent developments in the area of effective suicide prevention programming in the circumpolar world. Among the several speakers from each region was Mr. Chris Aquino, who described an Alaska program strategy that focuses on the empowerment of local communities. Dr. Laurence Kirmayer from Montreal, while speaking about at-risk indicators for suicide, mentioned depoliticizing the issue of suicide while engaging youth in political processes in order to create a self-direction that might aid in suicide reduction. Dr. Tracy Westerman described her Aboriginal-specific research in Western Australia that has resulted in the development of an at-risk for suicide early screening tool for Aboriginal children. There were many speakers; the workshop agenda was full. The report from this event is 71 pages long and includes actionable recommendations and guidelines for moving forward on the issue of suicide prevention.

Brackenbury, J. J. (2003, May). Innuqatigiisiaqniq Forum Report: Government of Nunavut.

The purpose of the Innuqatigiisiaqniq forum was to focus youth and Elders on an Inuit discussion about suicide. The report shared the actual events of the forum with those who did not attend in a manner that depicted the feeling of the event. Twenty-six Elders and 26 youth representing all of the communities in Nunavut gathered to discuss death by suicide from their perspective. There was an opportunity for Elders to talk with other Elders, and youth to discuss with youth, as well as the intergenerational discussion groups. The sounds, sights, and stories, as well as the teachings of the forum, were outlined to challenge the reader to think about the next step in preventing suicide – the action step. During discussions, at-risk indicators for suicide were cited when delegates listed what and why something was working in their communities.

Tagalik, S., et al. (2003, May). Piguninga Unipkaat: The Power of Storytelling: Youth Engagement Conference. Centre of Excellence for Children & Adolescents with Special Needs.

This conference was designed to engage youth in learning more about themselves, each other, and wellness activities related to suicide prevention. Through the power of telling a personal story, one realizes the significance of living one's entire life journey. Self-esteem and sense of purpose are strengthened through the storytelling process. Youth and Elders participated in exercises and discussion together; through this process, suicide indicators were listed. Youth initiated concrete plans to assist in suicide prevention in home communities. There is a section of recommendations from Elders.

Sivummut: Moving Forward (CASP): Canadian Association for Suicide Prevention. May 2003.

Although no formal report of this event is available, the purpose of this annual CASP conference was to bring together national and international speakers to present on a variety of issues around the topic of death by suicide. In May 2003, the conference was held in Iqaluit, Nunavut's capital. Many speakers participated in this huge and *hugely* successful gathering. Inuit and non-Inuit presenters spoke to some 700 delegates. Consequently, the information gleaned from the conference was carried far and wide. The CASP conference reflected a sense of national and international caring about the numbers of deaths by suicide in Nunavut. One of a host of keynote speakers was Dr. Colin Tatz from New Zealand.

Inungni Sapujjijiit: Task Force on Suicide and Community Healing: Our Words Must Come Back to Us. Government of Nunavut: Health & Social Services, October 2003.

The Nunavut Task Force visited 7 Nunavut communities. Task force members participated on local radio to answer questions and listen to community members, they visited Elders, and they held open community meetings. These efforts focused on hearing more about suicide from the community perspective. The very comprehensive report makes 34 recommendations based on a set of 8 themes, and in that process, identifies many at-risk indicators for suicide.

Reviews

Stevenson, L., & Ellsworth, Q. (2003, March). National Inuit Youth Suicide Prevention Framework: Qikiqtani Inuit Association.

Because youth are the segment of the Nunavut population who are the most at risk for suicide, the National Inuit Youth Suicide Prevention Framework reviewed what was happening in terms of programs, reports, and conferences on suicide among Inuit, and it consequently created a specific list of actionable tasks directed to Inuit youth and organizations.

As examples:

- from the Findings section comes the conclusion: There is not enough knowledge of specific risk factors and there is a need for a culturally specific risk assessment tool.

- from the Quality of Life section comes this recommendation: All stakeholders, including youth, adults, elders, governments, organizations must change their emphasis from "the avoidance of death" to "the promotion of life and well-being"; instead of focusing on problems, they must focus on building strong communities.

Henderson, A. (2003, July). Suicide and Community Wellness in Nunavut.

Commissioned by the GN's Department of Health and Social Services, the purpose of this report was to review current material and provide information on death by suicide to the Nunavut Task Force on Suicide Prevention and Community Healing prior to their departure. It provides a clear summation of information as of July, 2003. This comprehensive report examined what is known about suicide in Nunavut and what can be inferred from information about similar populations in the circumpolar world.

Research

Kral, M., et al. (2003, February). Unikaartuit: Meanings of Well-Being, Sadness, Suicide, and Change in Two Inuit Communities.

This feelings-related research paper recounts interviews with Inuit of Igloolik and Qikiqtarjuak, Nunavut, about how they experience sadness, happiness, and suicide. Because the feelings include sadness, there are many references to what causes sadness; hence, the indicator of loss related to suicide is frequently cited. This type of research is rare in that an interview team or an individual must get to the core of others' feelings and opinions. It is a delicate and

time-consuming process. The purpose of such research is that it provides greater insight into how Inuit might relate feelings and death by suicide.

Davidee, E., Grier, E., Wenczler, J., & Stevenson, L. (2003, March). On the Feasibility of Conducting 'Psychological Autopsies' in Nunavut Communities: A Research Report For GN Evaluation and Statistics: Government of Nunavut.

The purpose of this work was to determine the feasibility of conducting psychological autopsies in Nunavut. A psychological autopsy involves interviewing persons who were close to the deceased to gather information about risk indicators for death by suicide and increase knowledge about protective factors against suicide. The report cited a lack of data on the underlying factors as justification for this process and supported this approach if the research *"is done in a way that is culturally sensitive and that the interviewees receive adequate psychological support."*

Minore, B., & Hopkins, H. (2003, April). Suicide Response Plans: A Comparative Cross-Jurisdictional Analysis. Centre of Excellence for Children & Adolescents with Special Needs.

This research report produced a comprehensive policy document that supports and supplements debate around suicide response planning specific to children and youth. It examined the response plans in each province and territory of Canada, and the activities linked to establishing a nationwide plan (for suicide response in Canada) are explored.

Zamparo, J., & Spraggon, D. (2005, March). Echoes and Reflections: A Discussion of Best Practices in Inuit Mental Health: A Comparative Cross-Jurisdictional Analysis of the Literature on Services, Program Models, and Best Practices in Mental Health, With a Focus on Interdisciplinary, Intersectoral Approaches Emphasizing Inuit Youth. Centre of Excellence for Children & Adolescents with Special Needs.

This paper provided a thorough literature review and analysis of services, program models, and best practices on mental health for children and youth. The emphasis was on cross-jurisdictional, interdisciplinary, and intersectoral approaches. It included a consideration of some of the mental health issues that have been addressed in various forms: policies, programs,

models, services, and best practices. The framework of the Inungni Sapujjijiit Task Force (2003) document *Our Words Must Come Back to Us* provided a comprehensive structure that allowed the various themes of the literature to be organized to complement their recommendations in the document.

Zamparo, J., et al. (2005, August). We're Trying to Keep Up: A Report on the Availability and Accessibility of Information on Mental Health and Suicide Prevention Issues in Nunavut. Centre of Excellence for Children & Adolescents with Special Needs.

This research paper utilized a survey to assess what is known about and the ease of access to information related to mental health and suicide prevention in Nunavut. Two key issues were emphasized by the data: (a) the need for more culturally specific resources, and (b) information sharing in Nunavut. Collaboration and technology expansion that ensure the availability of current information in Inuktitut and increased service provider confidence are elements of this report.