ECHOES AND REFLECTIONS: A DISCUSSION OF BEST PRACTICES IN INUIT MENTAL HEALTH

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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

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TABLE OF CONTENTS

List of Figures

INTRODUCTION

The Nunavut Mental Health Task Force of the Centre of Excellence for Children & Adolescents with Special Needs in Rural, Remote, and Northern Canada requested this paper. The request included 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. To fulfil their mandate, the authors created an index of keywords to establish the boundaries of the search. 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. This assignment was enormous and required examination of more than 400 articles as well as other government documents and Web sites. Organizing this material was challenging. 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. What stands out in that document is the importance of community ownership of community-based mental health strategies. This also was a strong theme in our literature review. Although it was not our intention to exclude other methods of providing service, the authors of this report acknowledge the value of community-based strategies as best practices.

All Indigenous and Eurocentric mental health programs were examined in the review; however, the purpose of this paper was to focus on Inuit: boundaries of jurisdiction, intersectoral, and multidisciplinary; methods; program analysis and its challenges; and recommendations. What the paper is not is a defence of any one program for mental health; however, there is a clear endorsement of the support for community-based strategies evident in the literature.

The paper begins with a description of the parameters of best practices. There are three views: (a) literature support as theory, (b) definitions that are prescriptive, and (c) successful outcomes. Each view is elaborated and shows the lack of clarity in one singular definition of the concept of best practices. Hopefully, this clarification will allow readers to draw their own conclusions about what the concept of best practices means to them. At the very least, it will certainly provide the readers with an organized inventory of programs considered best practices in the literature.

The Inungni Sapujjijiit Task Force document (2003) served as the outline of this literature review to ensure a focus on Inuit with. The headings integrated the literature review with the recommendations voiced by the Nunavummuit in *Our Words Must Come Back to Us*: Let's Speak Out; Pride in Ourselves; Finding Our Foundations; Changing the Term "Imminiirniq"; Our Youth; Retrieving Our Skills; Programs, Services, and Facilities; and Concluding Remarks: Taking Ownership. The title of this report, *Echoes and Reflections*, embraces the echo of *Our Words Must Come Back to Us*, as noted in the literature and the authors' reflections about it.

Intent

The authors focused on Inuit and reflected upon the principles and values of Inuit traditional knowledge that are uniquely different from other Indigenous groups. The literature on mental health, however, spans the knowledge of all Indigenous peoples as well as the knowledge commonplace to the Eurocentric paradigm. The emphasis on Inuit is to support the work of the Nunavut Mental Health Task Force.

The authors reviewed the literature within the boundaries of intersectoral institutional domains: schools, medical clinics, community centres, recreation centres, psychological services,

social services, and corrections agencies. Various professional and paraprofessional disciplines that work interdependently in mental health—medicine, nursing, social work, psychology, education, and corrections—also were included in this review. The literature published within these sectors and disciplines was gathered from international, national, provincial, and local contexts.

The method for the literature review encompassed such standard procedures as establishing a keyword search and then following the resultant leads. The electronic databases and search engines included ISI Knowledge and Web of Science, ERIC, EducationIndex, Social Science Index, PsycINFO, Social Work Abstracts, PubMed, Google, and government Web site search engines. All searches were followed up with special requests for papers and letters asking for internal documents that were unavailable in the public forum. The Endnote Reference software provided a way of organizing the data for analysis.

The analysis categorized the literature by themes, empirical results, patterns, and other notable features. Reporting the voluminous number of programs mentioned in the literature added little to our understanding of best practices. Programs that add to the recommendations of the Inungni Sapujjijiit Task Force (2003) and contribute to our understanding of best practices in mental health were included in this paper. All reviewed programs are included in a searchable database that supplements this document.

The challenges of this paper are worth mentioning for future consideration. The field of mental health is extensive, and the literature is variable in quality. Furthermore, there is a lack of empirical standard. The findings are reported differently, making it difficult to compare and contrast. Reviewing the Eurocentric and Indigenous literature was grounded in worldviews that are not comparable. The authors of this report acknowledged the distinction of these two

worldviews, which was contextualized, and the patterns where best practices flourish within these domains. As well, the authors made suggestions to support the recommendations of the Inungni Sapujjijiit Task Force (2003). Finally, they highlighted some notable features about best practices as reflections for consideration.

Best Practices

For the purposes of this paper, there are three ways to consider best practices:

1. Literature support for a theory of best practices.

2. Literature support for definitions that are prescriptive.

3. Literature support for successful outcomes.

All three of these can be examined as a "product" or a "process." The first is theory. Some of the literature attempted to distinguish best practices following the standards of theory building. For example, best practices are activities or procedures that produce an outstanding result, are replicable, and are acknowledged by peers. They establish a standard of excellence.

The second is definition. The literature provided a prescription to follow in achieving best practices. The definition is usually situated in the Eurocentric paradigm, and it is sequential. It only requires a leader and a few participants to unite around accomplishing the goal. If implemented in order, the methods will guide the participants to a successful end. It is deductive, and the outcome is achieved by following a schedule of "what to do when." A definition is like a cookbook: It guides people and allows them to be part of the stages of implementation, whether they believe it or not, without committing to the process.

The third is successful outcome. The process is the most important factor in achieving a successful outcome. It requires ownership and a process that engages people in creating best practices. This view is the least understood. Process is inductive and experiential. To view

process from a distance, it is messy and incoherent. However, to the participants who own it and engage in the process, it is anything but messy; rather, it is crystal clear. It can change them and the community.

From a review of this literature, it became evident to the authors that "best practices" is a catchall phrase for a variety of meanings. There is a clear distinction between best practices that are community based and those that are transferred from elsewhere. Community-based best practices emphasize process, require ownership, and engage the entire community. These best practices are commonplace in the Indigenous literature. Programs that have been defined as best practices are like products that can be packaged and implemented anywhere. Some government funding criteria are predicated on these prepackaged best practices. However, it can go both ways. A well-established process at the community level can adapt prepackaged best practices successfully. Also, well-developed best practices can mobilize a successful process in a community. There is considerable support for the community-based approach for sustainability of best practices. Whatever the approach, it is obvious that best practices are "in the eye of the beholder."

LET'S SPEAK OUT

"Let's speak out" implies that communication is inherent to the human condition and that we freely communicate our thoughts and feelings. There is an assumption that if we freely communicate, we will be understood. Through the recent past, many barriers have impeded communication among the peoples of predominately oral cultures. The rapid changes of modernization have contributed to communication barriers between the generations. In dealing with rapid change, more and more people feel isolated; consequently, problems occur. One significant problem is isolation within families and communities. The helping professions have attempted to deal with the problems that have resulted from this, only to uncover more complex problems. There is an assumption in the helping professions that communication occurs spontaneously and without an understanding of the cross-cultural relationships necessary to deal with these problems. Furthermore, debate continues on the quality of communication and the commitment to develop depth and understanding about meaning, particularly in cross-cultural contexts.

Without this understanding and commitment of time to relationship building, caring professionals will always encounter hindrances to helping people with mental health problems. The illness itself is a barrier to communication for those afflicted. In addition, the professional model of helping, which was designed in a Eurocentric context, has been applied and adapted for use with Aboriginal cultures. This model has been successfully implemented to varying degrees. However, the reviewed literature suggests the need for new ways of speaking out to address mental health issues.

People with mental health difficulties struggle to be understood within their communities by family members and professionals. Moreover, the inability to communicate their needs is not

limited to these individuals. Communities must develop mechanisms for better communication, and they also must increase their capacity to communicate with other communities, intersectoral groups, and governments. "Let's speak out" in this context shifts the burden of responsibility from the individuals with mental health needs, along with the professionals who serve them, to entire communities.

The current analysis of literature pertaining to intersectoral and multidisciplinary best practices in mental health promotion has found that a paucity of communication mechanisms and strategies remains on all levels. This is not a new conclusion, nor is it limited to the field of mental health. It is, nevertheless, disconcerting because there has been little real action to correct this deficiency.

As already mentioned, the true nature of "lived experience" is a challenge to communicate cross culturally. For example, Inuktitut does not have a word for mental illness. Kirmayer, Fletcher, Corin, and Boothroyd (1994a) studied Inuit concepts of mental health in northern Quebec. They found that Inuktitut uses Isumaluttuq or Isumaqanngituq, "thinking too much" or "having no mind," instead of a general term for mental illness. Those interviewed were not familiar with the Eurocentric mental health terms employed in the study. Rather, what the participants described the most often as mental health problems were alcohol abuse, drug abuse, family violence and abuse, and suicidal behaviour. For the participants, the cause was usually attributed to childhood abuse and/or neglect. Kirmayer et al. found that identifying mental health problems in Inuit communities in northern Quebec is difficult due to a misinterpretation of the symptoms.

Language could also be considered a barrier. For example, an incident of suicide usually came as a surprise to even close family members, even though the person behaved "withdrawn,

isolated, depressed, having heavy thoughts, low self-esteem or hating themselves" (Kirmayer et al., 1994a, p. 5). Moreover, Inuit further defined the cause of mental health problems as physical and environmental, psychological or emotional, demon or spirit possession, cultural change or social disadvantage. The ability of the Inuit to take care of their own cannot be underestimated because they tend to "label behaviors or states of mind rather than individuals"[1] (Kirmayer et al., p. 6). Talking or speaking out was identified as a "good way" to address mental health problems. The researchers concluded that communication is the foundation for building strategies that shifts the responsibility for mental health from the individual to the community.

In looking at mental illness that results in suicide attempts and completions, Howard-Pitney, LaFromboise, Basil, September, and Johnson (1992) determined that the ability to talk to someone when in emotional pain is not easy. Of 84 Zuni adolescents in New Mexico who participated in Howard-Pitney et al.'s study, one third of them reported not telling anyone about their suicide attempts. People who are grieving because someone close to them has taken his/her own life are unable to share their own suicidal thoughts and grief. Although this is considered a communication issue and calls for the integration of communication skills training into all mental health promotion and intervention programs, it remains a bigger issue.

Most Indigenous peoples hold beliefs about the connectedness of people's spirits. Some Elders fear "that if you talk of one who has committed suicide, his/her spirit will continue to linger and may influence others to take their lives" (Devlin, 2001, p. 17). These beliefs may contribute to the lack of communication around mental illness. However, the dramatic increase in suicide among Aboriginal young people has motivated some Elders to put aside those fears in

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[1] Caution must be exercised here because the separation of behaviors from the individual could lead to the diminishing of the seriousness of the mental illness.

order to assist their communities' youth. A study of the understanding of mental health issues in Arviat, Nunavut, found that the community members acknowledged the presence of individuals (usually Elders) willing to talk with them and provide support (Harckham, 2002). Similarly, a group of 70 Elders provided counselling services in Igloolik to youth and their parents using traditional values (Henderson, 2003). In many forms of interaction, confiding in others has been identified as an important tool in helping those with mental illness (Borowsky, Resnick, Ireland, & Blum, 1999; Kirmayer et al., 1994a; Kral, 2003). The value of communication supported the creation of the Kamatsiaqtut (Inuktitut - Baffin Crisis Line) in 1990 (Kirmayer, Boothroyd, Laliberte, & Laronde Simpson, 1999). These studies found that communities can employ communication strategies and create programs to successfully address mental health issues at the community level. However, the process of opening up communication in regard to mental health concerns is slow and is further hampered at the policy level by the complex relationships of intersectoral and multidisciplinary cooperation.

Indigenous peoples, Inuit in particular, experience the social environment as much more than just a physical place. The place where one is born, one's name, and family relations contribute significantly to an individual's mental health. A sense of connectedness includes the land, animals, and a complex network of social support and extended family. Conversely, the lack of connectedness to these aspects of community life is directly related to emotional and behavioural problems (Garnefski & Diekstra, 1996). A community may accept a person exhibiting emotional and behavioural difficulties; however, the person may be unprepared to talk about them (Kirmayer et al., 1994a). They further observed that a high level of acceptance experienced by an individual usually promotes a lower level of emotional and behavioural

problems. Finally, the willingness of Inuit to "characterize problems in terms of the immediate situation and the corresponding reluctance to label individuals with traits" (Kirmayer et al., p. 97) informs a paradigm shift for creating community-based strategies to deal with mental illness.

On the other hand, some of the barriers to people with mental illness being prepared to share their stories might be fear of public scrutiny and loss of confidentiality. No level of community acceptance can dull the pain of vulnerability that occurs when people share their stories for the first time. Through a social action facilitation process with migrant women in Aotearoa, New Zealand, Williams, Labonte, and O'Brien (2003) found that when these women shared their stories, the emphasis was on the emotions expressed rather than becoming a critique of the storytellers. Williams et al. highlighted the importance of considering various methods of communication in the creation of mental health strategies that address the whole person, not just the illness.

Numerous prevention strategies focusing on the medicine wheel have been designed for First Nations and American Indians. However, not all Indigenous groups have embraced these teachings (Gardiner & Gaida, 2002). For Inuit youth, it is important to incorporate Inuit guiding principles and values into the design of clinical and community programs (Kirmayer et al., 1994a). Inuit have reclaimed these values and principles, making them part of the communication strategies between Elders and youth. These principles are referred to as Inuit Qaujimajatuqangit (IQ), which represents the "Inuit ways of knowing, ways of being, and worldview—past, present, and future" ("Interview: Janet McGrath on IQ," 2003, p. 6). IQ is a concept that bridges Inuit traditional teachings within a Eurocentric paradigm. The Government of Nunavut, although Euro-Canadian in design, has been including IQ, especially in the areas of

education, health, and social services. In their 2001 report, *The State of Inuit Well-Being in Nunavut*, Anielski and Pollock (2002) presented IQ as a chain of interlocking circles (see Figure 1)*.*

Inuit Quality of Life Values and Principles
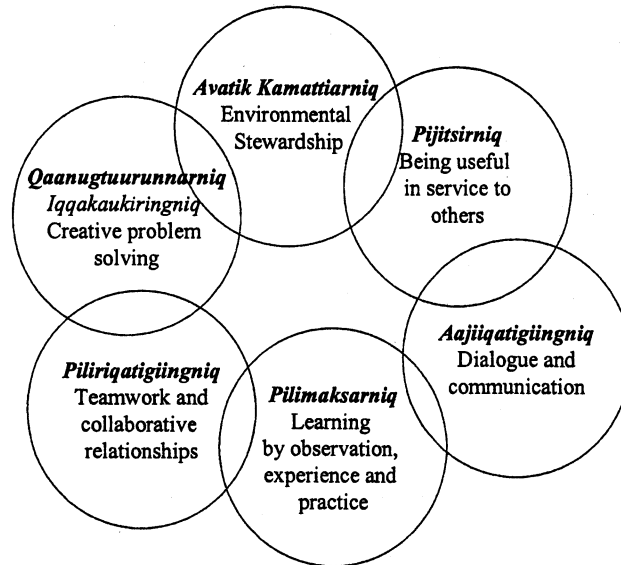
Figure 1. Inuit quality of life values and principles. (Adapted from Anielski & Pollock, 2002, p. 11)

Although the question, "What is IQ?," can never be fully answered, it is, by one interpretation, "really about healthy, sustainable communities regaining their rights to a say in the governance of their lives using principles and values they regard as integral to who and what they are" (Arnakak, 2001, n.p.). These principles could be considered as the Inuit ingredients for well-being in mental health. Elder Jacko Peterloosie stated, "We dealt with family problems before Western ways were introduced into our communities" (personal communication, May 19, 1996).

Although some traditional Inuit ways may have been foreign to Western ways of helping, they reflect the cultural reality. Part of the traditional value system is the belief that one should not interfere in the life of another. If, however, there is a true understanding of the symptoms and the consequences of untreated mental illness on family and community life, it will be easier for Inuit to intervene with less fear of interference (Kirmayer et al., 1994a). There is an implicit assumption, nevertheless, that Eurocentric diagnostics and methods of treatment will work well with Inuit. Regardless, policy shifts in health, wellness, and social services continue to feature IQ (Kral, 2003). Another feature of IQ is the importance of learning through personal responsibility, such as observing others and engaging in continual practice. Within rural, remote communities, these values and practices lay the foundation for self-help and social support services when professional services are unavailable (Government of Nunavut, 2002).

The integration of culturally appropriate belief systems and practices into Inuit mental health initiatives is heralded by many (Flaherty, 1997). It has been similar for many other Indigenous groups in Australia, United States and New Zealand, to name a few. Historically, there has been a great misconception that all Indigenous cultures are alike and that research findings, clinical instruments, and resulting prevention strategies are applicable to all communities. However, there are considerable differences within Inuit and First Nations groups and communities, and there are no uniform measures of mental health and prevention strategies that are likely to work everywhere (Kirmayer et al., 1994b; Power, 2003). Furthermore, governments have begun to transfer the responsibility for dealing with mental health issues from themselves to Aboriginal groups without the necessary financial, policy, and program supports so that "each community or group is obliged to create its own structures independently of others"

(Kirmayer et al., p. 52). This type of policy shift leaves communities isolated, unaware, and unlikely to easily benefit from the experiences of other communities.

Communities are willing to take ownership of their mental health problems and solutions. Innovation and culturally defined programs at the community level have been compared to Western methods, often to their disadvantage, thus marginalizing these initiatives. In most cases, governments and policy makers have not listened (Inungni Sapujjijiit Task Force, 2003). Moreover, there is considerable disarray among supporters who promote mental health for Indigenous groups. Hence, a strong and dominant voice is lacking to inform governments, be they territorial, provincial, or federal (Tanney, 1995).

A serious gap exists between the specific nature of mental illness in each community and the policies created to meet the needs of the public as a whole. This is problematic, given that "public policy is potentially the most powerful tool there is to foster preventative services for children" (Ripple & Zigler, 2003, p. 483). By studying the details of what is affecting a community at a certain time, policy-based prevention would need to move beyond a problem-centred approach to one that offers comprehensive primary prevention services (Ripple & Zigler). Many studies of the Inuit and First Nations have found that the communities already possess critical knowledge to meet their collective needs (Devlin, 2001; Kirmayer et al., 1994a; Zamparo & Seburn, in press). Without a vision in policy creation, communities are unable to utilize their knowledge and understanding of mental health issues and create appropriate programs to deal with them.

Speaking out about the prevalence of mental health issues in a community can serve the entire community. Establishing mental health as a community issue removes the stigma and changes a negative focus to one that is positive. Such an approach would better inform decision

makers and guide allocated resources to such areas as prevention programs (Biglan, Mrazek,

Carnine, & Flay, 2003). However, prevention programs need innovations that reflect the cultural

environment without losing appropriate treatment programs. Designating funding for

community-based solutions gives communities a better chance of addressing all facets of mental

health. Without a positive strategy to deal with mental illness and suicide, people who have these

difficulties are marginalized. Community leadership is essential to improving the current

practices in dealing with mental illness.

Unfortunately, years of colonization have meant that Inuit and other Indigenous groups

must once again try to re-establish the foundations of their values and principles. Many

communities operate dual systems of helping, namely, one that is culturally grounded and one

that is Eurocentric. The integration of a self-reliant, supportive network within communities that

blends the best of both worlds will take considerable time and must be done in the face of

outside, dominant social influences. Williams et al. (2003) suggested that empowerment through

storytelling and reviving traditional knowledge has once again become a method by which

people and communities can begin to challenge dominant policies. The collective narrative will

better represent the whole and be more efficient in making outsiders (i.e., governments,

researchers, etc.) appreciate the communities' needs and concerns.

For communities to begin organizing their own strategies, they must not only understand

their collective need but also the true nature of mental illness. In general, Inuit, as well as other

Indigenous groups, have "received little education specifically addressed to understanding

mental illness" (Kirmayer, Fletcher, & Boothroyd, 1997, p. 85). This education is within the

Euro-Canadian paradigm: People from outside the community and the culture have delivered

most professional services. However, Inuit have shown a growing interest to pursue education in

these areas and incorporate traditional values, principles, and practices. To the extent that the education system in Nunavut continues to advance IQ in the curriculum, a fully integrated education program may become a reality in the near future. To be able to attract Inuit who want to work in the health and mental health fields, continuing education programs need to fully integrate IQ. Communities will then be better able to create community-based strategies and develop models of mental health together with these trained Inuit. These "grassroots" models will be the most sensitive to the true needs and wants of each community (Smye & Mussell, 2001). A community-based approach that uniquely reflects Inuit principles and values of mental health will engender "pride in themselves" to create a dynamic future for the new territory of Nunavut, its communities, and its people.

PRIDE IN OURSELVES

The previous section took us from a focus on individuals suffering from mental illness telling their stories to accepting communities that are willing to take responsibility for communicating the mental health agenda for all of its people. Building and communicating community-based strategies fosters pride in being able to find solutions to complex, community mental health problems. This section defines the concept of pride in oneself, in one's community, and in one's culture as intricately necessary for the success of community-based mental health strategies.

When communities take responsibility for mental health strategies, they strengthen a sense of pride and well-being, and they increase the overall mental health of the community (Kirmayer, Brass, & Tait, 2000). Program responses designed at the community level are integrated into the community's structure. A successful best practice program can provide a model for communities to redesign or create their own best practices. Therefore, a community-based approach maintains continuity and esteem to facilitate communities' ability to adapt to rapid social change (Kirmayer, Boothroyd, & Hodgins, 1998).

Figure 2 is a visual representation of the overlapping relationship of the three components of pride envisioned in a community-based approach. An emphasis on pride is a Euro-Canadian value; however, in the context of Inuit society, it is in reference to collective pride and a sense of well-being. The three themes of pride in oneself, pride in community, and pride in culture will organize the literature in this area.
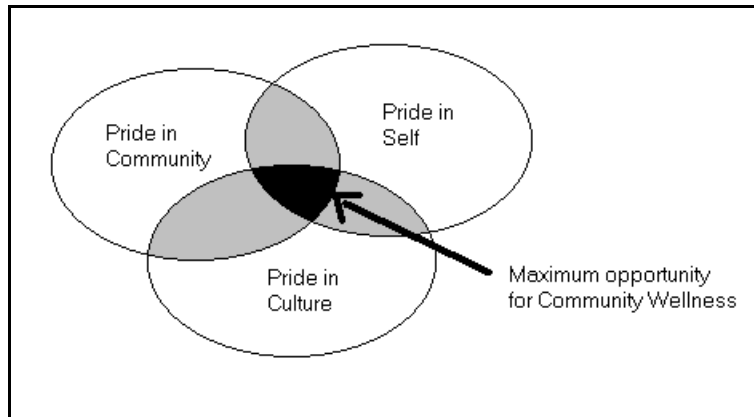
Figure 2. Components of pride.

Pride in Culture

Pride in one's culture involves knowing who you are, where you come from, who you are connected to, and where you belong. Pride is frowned upon in Inuit culture because it can appear boastful, thereby affecting community norms. However, the intersection of these three facets represents the collective identity of Inuit and, therefore, their pride. Other facets of culture become apparent in creating a community-based mental health strategy. For example, suicide and mental illness are not considered the Inuit way. Eurocentric symptoms and diagnosis of suicide ideation and mental illness may be misinterpreted both within and across Aboriginal cultures. These can vary between and among communities, so no particular strategy at the community level can be uniformly applied across that culture or any other culture. This inconsistency demands leadership and responsibility by each community in understanding mental health.

The powerful influence of culture was demonstrated by Novins, Beals, Roberts, and Manson (1999), who reviewed prevention programs and determined that what works for one community may not necessarily be transferable to another. Similarly, screening programs

designed to target and identify at-risk youth may misinterpret the differences among cultures, youth groups, or communities. Treatment and prevention programs that emphasize the medicine wheel to promote healing have been recommended for use by Aboriginal peoples. On further investigation, researchers have come to realize that because the medicine wheel is unknown by some Aboriginal groups, it is not understood how it can promote mental health (Minore & Hopkins, 2003; Zamparo & Seburn, in press). Cultural instruments of healing must be compatible with the values and belief systems.

Middlebrook, LeMaster, Beals, Novins, and Manson (2001) reviewed suicide prevention programs for American Indian and Alaska Native communities. They identified two major themes that acknowledge culture and community. The first theme emphasized that culturally relevant programs need to be developed; the second theme promoted community involvement for the success of programs. In another study that identified specific factors associated with individual communities, but did not emphasize culture, Manson (2000) stated that there is "a need for community-based, diagnostically rigorous psychiatric epidemiologic studies" (p. 626). Finding the balance between culture and Euro-Canadian diagnostic and epidemiologic instruments is critical to cultural pride in community-based approaches to mental health.

Kirmayer et al. (2001) reported on an ethnographic study about Aboriginal men in a Quebec halfway house and treatment centre. They reported that the blend of spirituality and Eurocentric psychotherapy in the treatment program was meaningful for a number of participants in creating pride in an Aboriginal identity. However, Inuit participants who were unfamiliar with the spiritual traditions and beliefs presented in the "Indian things" (Kirmayer et al., p. 14) reported expressions of strangeness. For people with strong traditions and beliefs, the

psychological aspects of healing were culturally inappropriate and disrespectful, thus undermining their identity and sense of pride.

For Inuit and other Indigenous groups, the act of blending traditional lifestyles and time on the land has created feelings of comfort and harmony (Kirmayer et al., 1994a). In a community survey, Inuit youth reported a desire to participate in the more traditional activities of hunting, camping, cooking, and sewing (Malus, Kirmayer, & Boothroyd, 1994). Most of these youth reported wanting to participate in more traditional activities, and the opportunities existed for them. However, there remains a discrepancy between the desire to participate in traditional activities and the capacity. Even though there is a "romantic notion" of returning to the land as part of Inuit identity, culture, and pride, those wanting to reclaim this part of their heritage lack the resources, the skills, and the connection to Elders to teach them.

Incorporating these limitations may well be the key to developing appropriate mental health interventions for youth, which should also include language, the use of symbols, and the promotion of cultural pride in organized activities (Malus et al., 1994). These efforts to enhance pride in one's culture and identity are strategic in reducing drug and alcohol abuse, often a symptom of negative feelings of self and suicide ideation among youth (Dorpat, 1994). Spirituality and traditional beliefs and practices are significant aspects of culture: They make a community what it is. Culture in all of its manifestations must be part of any community-based mental health strategy.

The health of a community and its ability to adapt to outside stressors cause variable rates of suicide ideation and incidences of mental illness (Kirmayer et al., 2000). Another study supported this observation when considering different Aboriginal communities. Gardiner and Gaida (2002) suggested that one mental health community strategy is inappropriate for all. For

the success of any intervention, the community, not the program, is the priority. Burns and Patton (2000) stated that "the setting for which an intervention has been designed, the target population and details of the intervention, specifically the intensity and duration" (p. 390) must complement the community. In the creation of community-based interventions, we cannot ignore the integral relationship between culture and a community's health. These studies revealed that culture is inseparable from the community in an Aboriginal context.

<div align="center">Pride in Community</div>

The section on cultural pride unites culture and community in creating an environment that allows pride and identity to flourish. The authors made the case for community-based strategies that recognize culture as an integral part of any mental health strategy for Aboriginal people. This section features the leadership responsibility of the community in reinforcing the connection between culture and self. Community provides the conduit for strengthening culture, community, and self as one identity.

Building development community fosters responsibility and community pride. Gardiner and Gaida (2002) reviewed the literature for the Alberta Mental Health Board and summarized the goals of community development as follows:

1. *Strengthen the ability* of communities to respond effectively to their social, economic, and health needs.

2. *Increase self-reliance* and decision-making power of a community.

3. *Increase self-esteem*, *self-confidence*, social contact, and mutual support among community members.

4. *Improve the level of skills* and knowledge of community members.

5. *Improve social health* and community cohesion.

6.   Build a sense of community *belonging*.

7.   Support a sense of *cultural continuity*. (p. 9 [italics added])

The goals of community development presented in this list mirror the principles and values of

IQ. For Inuit, however, the process includes reclaiming their heritage and acknowledging the

contributions of Elders to community life. Aboriginals believe that every person is a gift and has

gifts to share (Lindsay, 2003). The maturation process is about coming into one's own and

realizing these gifts. The strengths perspective is a Eurocentric construct of the same belief

(Heinonen & Spearman, 2001).

Community development from a strengths perspective utilizes the potential and expertise

of all individuals in the development of strategies. The objective of "community development as

a process" (Forbes, 1994, p. 242) reduces self-destructive behaviour as it builds strengths. In his

national overview of suicide progress and problems, Tanney (1995) noted that utilizing the skills

and expertise of all members is a foundation of community development. Small communities

need the strengths and participation of all members in sharing resources, building capacity, and

organizing around a vision of a healthy community. Everyone possesses some form of

knowledge based on their lived experiences of mental health.

Community strengths include natural helpers who can expand the capacity of any

community and provide mentoring to youth (Vance, 2002). Elders have a strong investment in

the development of children and youth, and this is one way to engage them in fostering

leadership (Fantuzzo, Coolahan, & Weiss, 1995). This level of community capacity

complements the professional infrastructure of community partners: researchers, specialists,

practitioners, officials, and caregivers (Power, 2003). This may occur in several ways: a

strengths-oriented mode of delivery, prevention programs, links between research and practice,

and maintenance of the appropriate boundaries between natural helpers and professionals in all service agreements. These agreements could be established with educational institutions, giving local people the opportunity to receive training in their natural helping roles as well as in all areas of mental health promotion (Zamparo & Seburn, in press). Therefore, training should not be limited to specific areas of mental health; rather, it should incorporate the broader determinants of health that address the whole person in his/her environment.

Beyond the development of natural helpers and professionals, all current health and mental health care workers should receive training and information specific to mental illness, suicide, and mental health promotion in a culturally relevant context (Garland & Zigler, 1993). In an Alaskan study, Forbes (1994) found that Indigenous paraprofessionals working in suicide prevention programs for youth reported having mixed success. Although Forbes did not explain why in his study, the authors of this report acknowledged that Indigenous people may have conflictual dual relationships. Without appropriate professional support and adequate resources to deal with the reality that suicide prevention programs require, the reason for the mixed reviews of success becomes clearer.

For the most part, however, a core group of Indigenous, community mental health workers greatly enhance any mental health intervention strategy. These workers are uniquely equipped with skill sets pertaining to "individual and family counselling, social network intervention and community development" (Malus et al., 1994, p. 58). Natural helpers and paraprofessionals have also expanded this core. Wassef, Mason, Collins, O'Boyle, and Ingham (1996) found that natural helpers have the potential of being successful when working with youth in school-based support groups

Recommendations by the participants in the 1993 Pauktuutit[2] workshop in mental health recognized that "there is a substantial need for recruiting and training of more Inuit healthcare workers" (Flaherty, 1997, p. 106). The community must take the leadership in its community-based strategy to ensure that it has adequate funding to build on its strengths and develop its own people. Governments and other funding partners ought to support community leadership and capacity building by establishing funding strategies that are organized so that communities have the freedom to design and implement programs that meet their needs. Community-based suicide prevention programs, such as those administered by the State of Alaska, provide financial support (maximum basic award is $20,000 US); training; and an information network to small communities intent on implementing local projects that will "reduce self-destructive behavior and promote community and individual wellness" (State of Alaska, 2003, n. p.). The structure and success of these programs and others are discussed later in the section that reviews best practice programs.

The Advisory Group on Suicide Prevention (2003) in Canada concluded that the manageability of smaller population sizes, combined with the need expressed by the increasing prevalence of suicide attempts in Aboriginal communities, makes a community-based mental health strategy a good fit. This approach reduces marginalization within the community by incorporating the members in the development of the community as a whole. Developing community-based strategies contributes to the reduction of power imbalances for Aboriginal people (Advisory Group on Suicide Prevention). Acknowledging community strengths enhances community pride.

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[2] Pauktuutit is a national, non-profit association that represents all Inuit women in Canada. For more information: http://www.pauktuutit.on.ca

Community wellness strategies have been identified as having the best chance of success (reference to report from Health Canada [2002], as cited in the Centre for Suicide Prevention, 2003). The development of such a strategy should include:

- Locally initiated, owned and accountable programs.

- Suicide prevention should be the responsibility of the entire community.

- Focus on behavioural patterns of children and young people is crucial. This requires involvement of the family and community.

- Problem of suicide must be addressed from many perspectives: biological, psychological, sociocultural, and spiritual.

- Develop both long-term and crisis response programs.

- Evaluation of strategies needed. (p. 1)

Addressing community problems at the community level serves to promote empowerment, gives people a feeling of control over their own lives, and encourages community pride (Kirmayer et al., 1994b; Malus et al., 1994). The act of community problem solving empowers individuals to reclaim their strengths and build upon them, thus creating many positive benefits. A community empowerment approach allows people to take care of each other from within the community (Kral, 2003). Some of these many benefits are increased capacity and community pride by being an influential model of a healthy community for other communities. In reality, community development is a nurturing growth process for the community as a whole and for individuals within it. There is a correlation between the community's capacity to develop its strengths and the "reduction of self-destructive behaviors" (Forbes, 1994, p. 242). Community problem solving and leadership, empowerment, and capacity building within a nurturing growth process ought to be part of any community-based mental health strategy.

White Stone is an example of a prevention program that is part of a community-based strategy using community pride to address mental health issues for Aboriginal youth (Suicide Prevention Training Program [SPTP], n.d.). This initiative, jointly developed by the RCMP (Aboriginal Policing) and SPTPs in Alberta, provides training to youth participants as peer support for other youth in their own communities. The unique feature of this program is its design for youth who have been identified as potential leaders and who have not been seen as at risk of suicidal behaviour. This program is discussed in more detail in the best practices section of this report. A caution for this program and similar ones is that youth must be involved in the design, selection, and implementation (Forbes, 1994). This program is usually administered in a larger community, and the youth from smaller ones attend for training. They then return to their own communities to implement the program. Community-based strategies could be weakened when centralized programs with specialized training are implemented without the full commitment of the community. However, if the community sets out a strategy that incorporates a centralized program, involves youth in the development, and has the infrastructure support to nurture these young people who receive training, it can only be a win-win for the community.

As the report from the Inungni Sapujjijiit Task Force (2003) indicated, community wellness is a high priority. To achieve this wellness, communities must have long-term goals. However, "success" has a different meaning within Inuit and Aboriginal cultures. The Eurocentric measures of evaluation set out rigorous standards of achievement that misrepresent the good things that support the values and principles of a community's achievement. With this discrepancy between measures, how can a community show, with some precision, how effective its strategy is in preventing mental health difficulties? Biglan et al. (2003) suggested "a system for monitoring child and adolescent well-being" (p. 434). They saw this system as similar to ones

used to monitor economic activity. The compatibility of monitoring systems that can measure child and adolescent well-being alongside economic activity is hopeful. Children and youth with good mental and physical health contribute to the economic health of the society rather than act as a drain on its resources. In the initial stages of the design of a community-based strategy for long-term success, each community needs to consider a method of tracking achievement, including attainable goals that incorporate all aspects of community health and well-being.

When attempting to promote pride in the community while simultaneously serving as a motivator, it is imperative that community-based strategies focus on at-risk youth, parents, families, and others associated with the youth (Boothroyd, Kirmayer, Spreng, Malus, & Hodgins, 2001). In small communities, this may very well encompass the majority of the population. The factors that have placed youth at risk, such as rapid culture change and marginalization, have also impacted others in the community. The whole community needs to be healed and must be engaged in any change process. The beauty of a community-based mental health strategy is simply this: The process of engaging people to take leadership roles in creating a mental health strategy develops responsibility, builds capacity, and creates a sense of community pride as people begin to articulate what matters to them.

Pride in Self

Cultural genocide is a term used to describe the effects of colonization (Tatz, 1999). The education system played a significant role by removing children from communities and placing them in residential schools, where they were taught Eurocentric ways, forced to speak English, and denied their traditions. When these children returned home, their parents did not recognize them. The communication barrier grew between parents and children. Today, generational communication barriers are prevalent.

This educational process of acculturation disassociated young people from their parents, who embodied their culture. The Euro-Canadian system rejected this culture, thus breaking the bonds of cultural pride between parents and children. Inuit youth are today confronted with individualistic values of a consumer-oriented society portrayed through the media (Kirmayer et al., 1998). Three generations later, this has translated into dissonance in values and principles that has led to communication difficulties between Elders and youth. Elders share a sense of collectivity and a mutual vision of community life, whereas youth strive to individually achieve the rewards glamourized in Euro-Canadian society. Consequently, the transfer of knowledge and cultural pride is impaired between the generations.

As mentioned, colonization has significantly damaged the Aboriginal sense of identity and pride. Aboriginal youth are frustrated with the limited options available to them in remote, rural communities in achieving the Euro-Canadian dream of material success. This disappointment may extend to a distorted sense of self that may precipitate mental illness that has the potential to culminate in suicide (Kirmayer et al., 1998). At the very least, this disappointment, combined with the lack of connection to cultural roots with an established sense of pride, leaves young people and adults vulnerable to other influences.

A lack of pride and a low self-esteem among Aboriginal peoples is frequently manifested by the abuse of such substances as alcohol, drugs, and solvents (Haggarty, Cernovsky, Kermeen, & Merskey, 2000). The influence of chemical toxins and alcohol has been reported to greatly enhance the impulsivity of suicide attempts by youth (Allen, 2001; Howard-Pitney et al., 1992; White & Jodoin, 2003). Bechtold (1994) predicted that the restriction of these substances or the limitation of access "might also be expected to prevent youth suicide in certain cases" (p. 76).

However, in restricted and controlled communities, bootlegging and the black market sale of these substances continue, and these products remain available at exorbitant costs.

It is accepted that alcohol and drug abuse can induce a depressive state. In their study of an Arctic community, Haggarty et al. (2000) stated that "depression in Native peoples can be a precursor to alcohol and drug abuse" (p. 357). In their secondary analysis of a 1992 Santé Québec community survey of 203 Inuit youth, Kirmayer et al. (1998) found that significant risk factors for suicide attempt in the last year included serious illness and alcohol abuse, substance use, and the number of life events. Both of these studies highlighted the relationship among substance abuse, depression, and suicide attempts and completion.

To facilitate the design of successful intervention/prevention strategies, it is necessary to understand the relationship between depression and substance abuse (Kelder et al., 2001), particularly in Indigenous youth. Malus et al. (1994) suggested that mental health interventions, especially those for suicide, must "develop and improve access to treatment programs for alcohol and substance abuse" (p. 58) for Aboriginal peoples. Studies that have correlated substance abuse with mood changes and suicidal behaviour support the descriptions Inuit have provided in their definition of mental health problems (Kirmayer et al., 1994a). Addressing this issue within the cultural context of individual behaviour will re-establish self-pride.

Another important facet in considering self-pride is the influence of vulnerability as a weakness introduced by colonization. Inuit society's values of collectivity and connectedness would never lead to this conclusion. Therefore, within a Euro-Canadian paradigm, admitting to needing help, being unwell physically or mentally, or having suicidal thoughts is not easy; for some, the constraints of their environment may make it impossible. Admitting to these things may be interpreted as being weak and not in control of oneself. To assist community members

struggling with these burdens, it is imperative that communities do not label their strategies in such a way that will impede a willingness to get help.

Moreover, direct efforts to confront certain problems, such as suicide ideation, often incite concerns that they will only exacerbate the problem. For example, a suicide prevention program may induce youth into thinking about suicide (Silverman & Felner, 1995). The labelling of such strategies may very well interfere with their efficacy and must be considered when still in the development phase. However, attempting to establish roles in a mental health strategy for all members of the community creates an increased level of acceptance. The environment is then more conducive to attracting those needing help. Culture identity and pride engendered by connectedness must be integral to community-based mental health strategies.

FINDING OUR FOUNDATION

Our Words Must Come Back to Us (Inungni Sapujjijiit Task Force, 2003) is a document created by Inuit to establish their position on mental health strategies and address the issue of suicide. This document stresses the importance of establishing a foundation, setting down a point of reference, and making a commitment to doing things differently. There are several tenets to establishing a foundation: (a) having the ability to speak out about problems facing the community, (b) instilling pride in the community's wellness, and (c) regenerating the ability of the culture to take care of its own.

One primary focus of this literature review was to determine the frequency and function of interagency collaboration in the area of mental health. To what extent are strategies focused on interagency collaboration, and do these strategies make a difference? Interagency collaboration is another aspect of developing a community-based mental health strategy whose purpose would be to ensure that a coordinated effort by multiple service providers forms a community network to address ongoing and emergency mental health issues. In itself, the goals of interagency communication and coordination include the following:

- Clarify the roles and responsibilities of various service agencies within a community.
- Increase awareness of range of community services available.
- Increase accessibility for those youth who are at-risk or vulnerable and their families.
- Increase coordination between agencies, thereby decreasing service duplication, confusion, and inappropriate referrals.
- Facilitate open communication among agencies.

- Provide client-related information in a timely manner while preserving confidentiality.

- Identify gaps in services, and act quickly to fill the identified gap.

(Adapted from White & Jodoin, 2003, p. 64)

Although this list highlights the necessary criteria of any interagency collaboration plan, it fails to emphasize the communication function. Communication and ongoing dialogue are critical to any community-based mental health strategy, and "they are the glue that holds it together." Communication and collaboration between the individuals and the service providers within a community will lay the foundation to revitalize community wellness, stimulate a sense of community pride, and motivate the community to care for one another in a way that restores cultural traditions.

Another important ingredient of establishing a community-based mental health strategy is a working definition. There is a plethora of terms, definitions, and understandings of *mental health*. Some definitions can be organized in a process continuum and show that there is no right or wrong way to define mental health. Consequently, a community can construct its own interpretation of mental health that reflects its cultural identity. In her study of mental health in Arviat, Nunavut, Harckham (2002) found that the community members described the meaning of mental health to include the following:

- Mental health is broad: It encompasses the totality of life.

- Definite relationships exist [among] physical, mental, emotional, and spiritual health.

- Mental health is intimately related to the health of the family.

- Mental health is intimately related to traditional knowledge.

- Mental health is exhibited in healthy interactions with other people.

(pp. 12-13)

These meanings of mental health illustrate the interdependence of health and well-being in finding one's foundations. Her study (2002) included a methodology that allowed community members to describe their own meanings. However, it fell short of building a process that situates this meaning within a working definition that the entire community can understand and support.

Engaging the community in discussing what mental health means to them allows a vision of community health and wellness to emerge in the process. Moving beyond a methodology introduced by outsiders and motivating community members to take on the responsibility of creating community-based initiatives that reflect their definitions of mental health is paramount. Someone from outside the community who carries out this role is ineffectual in the long term. As the authors have already noted, there is no right or wrong definition of mental health; therefore, it is important for communities to create and support their own commitment and generate the initiatives to reflect it. Clarifying the meaning of mental health is an important and necessary first step. Part of forming a strong foundation for a community-based mental health strategy is the establishment of "clear and non-ambivalent moral proscriptions against suicide" (Bechtold, 1994, p. 77). With this foundation, there is no doubt that the act of suicide is an unacceptable solution to problems within the community. This is easy for Inuit because Elders have been clear in their revival of values and principles that "suicide is not our way" (Uluadluak, 2002).

Kirmayer (1997) aptly described the essential issues that must be addressed in the beginning stage of developing a community-based model. The themes of his discussion included scale and remoteness, anonymity, resources, professional training, language, culture, and rapidity

of culture change. For the purposes of this report, the authors listed appropriate questions based on the themes to assist community groups in assessing their situation in the Appendix.

Renewing the foundations of a community's ability to care for its own involves the process of community capacity-building. This process enhances individuals' capabilities to define and address mental health issues, resulting in breaking down barriers and improving the quality of the community's life (Labonte, Woodard, Chad, & Laverack, 2002). Ultimately, the process of creating a community-based mental health strategy contributes to building capacity within the community as well as benefitting the overall well-being beyond the development of programs designed for that purpose. Labonte et al. pointed out that there is seldom funding available specifically for building community capacity. However, there may be funds available to improve mental health standards within a community. Community capacity building could be an outcome of that process that is known to increase a sense of pride and well-being.

Once communities complete the process of defining their community-based initiatives, they may find it necessary to enlarge their "circle of care." Some communities may extend invitations to external partners for their particular expertise (Cross, Earle, Echo-Hawk Solie, & Manness, 2000). Communities that undertake a community-based mental health strategy are better equipped to invite partners who will engage in a respectful way that does not undermine the integrity of their leadership process (Raphael, 2000). Partners in the communities include existing services, schools, churches, and others who can provide an infrastructure of support that strengthens the communities' leadership role rather than weaken it. Respecting the integrity of the process to build a foundation that includes a commitment to the culture is the first step in establishing an environment that allows a shared partnership to grow between people with expertise from inside and outside the communities. Their partnership agreement can generate

shared goals that bring to bear the expertise of each partner. One community's experience can be shared with others to illustrate the process and the outcome of building a foundation based on finding the roots of the culture in everything related to the mental health strategy.

Under years of duress and distress, Aboriginal communities have survived the severe consequences of colonization. Their members have found the strength to go on and to dig deep into their roots to restore the foundation of their culture in the design of a mental health strategy and the ensuing programs. Aboriginal peoples ought to be celebrated and encouraged for their resilience in the way they define and attend to the contributory factors of mental illness in their communities (Oblin, 1997). Finding their foundation and defining these factors within this context are necessary steps in the healing process, and they go beyond to build community capacity, pride, and solutions. The outcome becomes a design and vision of a healthy community that members strive for and contribute to in caring for one another. The negative aspects of mental illness are dealt with by focussing on the positive.

Equally important to finding their foundation for adults is the example that is set by young people. Featuring young people who are doing well and who can provide peer support or an example for other young people who are having mental health difficulties can make all the difference (C. M. Mitchell & Beals, 1997). However, it must be situated within the cultural context rather than the Eurocentric paradigm to refrain from the stigma and judgment that are so damaging to young people in trouble. The use of models and peer support of Elders, adults, and young people is about reclaiming the values and principles of the culture. Aboriginal and Inuit demonstrate care for one another and build healthy communities through positive regard for the contributions of all.

One of the threats to a successful mental health strategy is the risk associated with staff burnout and staff shortages, combined with "practicing beyond competence" (Delaney & Brownlee, 1995), that occurs in rural, remote communities. In Nunavut, there exist serious staff shortages, inadequate training of those working on the front line, and little or no supervision or leadership. These overwhelming challenges prevent agencies from collaborating and working together to deal with these issues (Government of Nunavut, 2002).

The Inungni Sapujjijiit Task Force (2003) considered this a major concern that must be addressed as part of the strategy to revive the communities' foundations. From a survey of community needs, Zamparo and Seburn (in press) observed that individuals providing services in Nunavut communities have not resided in the north for long and may be particularly susceptible to workplace stress caused by cultural dissonance. Workplace stress also results from the other factors identified by the Inungni Sapujjijiit Task Force. Staff turnover is the result. Communities must support and care for their caregivers to help reduce stress and the resulting high staff turnover (Inungni Sapujjijiit Task Force). Training people who live in the communities and encouraging them to get professionally trained and become supervisors are goals sought by all. This human resource strategy has the potential to create a sustainable workforce that understands the nuances of rural, remote community life while respecting the culture. The extended support network of family and kinship will contribute to the well-being of these employees as they strive to work with the communities to implement the mental health strategies.

A well-designed mental health strategy sets out a process that is built on a firm foundation of cultural integrity and positive regard for all who are part of the communities. Based on this foundation, the process will evolve naturally (Tanney, 1995). Positive regard for all community members allows for the inclusion of everyone's gifts and talents in making the

strategy work. While doing so, the well-being of all is enhanced, and the capacity of the communities grows as people gain more skills in a safe and nourishing environment. The well-being of all becomes the goal of a healthy community mental health strategy. The Nunavut Government's Department of Health and Social Services accredits Nunavummiut with having "a strong tradition of helping their family and community in times of need" (as cited in Government of Nunavut, 2002, p. 10). Years of adapting have prepared Nunavummiut and "the spirit of the community is tremendous as traditionally the ability for a group to survive is heavily based on the collective strengths of its members" (Government of Nunavut, p. 10). This statement reflects the values and principles of Inuit society and is one of the first building blocks for finding their foundation.

Another building block in finding their foundation is balancing traditional and modern ways. The consequences of modernity and colonization on community life are evident in Aboriginal communities. For those who are sceptical about cultural survival, Inuit provide an excellent example of resilience: They have preserved their traditions and are reclaiming their cultural foundations. How people have successfully adapted to rapid change without losing their cultural roots uncovers their strengths. A wellness plan and a long-term vision for healthy communities ought to include these strengths. Limiting subsistence activities such as hunting in lieu of a cash economy has served to marginalize Aboriginal males (Kirmayer et al., 1994a).

Revealing the adaptive skills of Aboriginal people is the juncture where traditional and modern ways can become the focus for positive social and economic change for communities. The potential for economic sustainability in rural, remote communities is at the heart of a mental health strategy. The concept of "sustainable livelihoods" might be more compatible with Aboriginal and Inuit cultures. "Sustainable livelihoods" incorporates traditional and modern

economic indicators as measures of sustainability of a community's economic health. Similarly, a community's mental health includes the belief systems and values of Aboriginals and Inuit. Many cultural groups, including Inuit, have preserved their belief system and cosmology, which have sustained them in adapting to change (Kirmayer et al., 1994a). No community-based strategy can survive without integrating traditional with modern; otherwise, some people will be left out.

Hypotheses have linked the absence of cultural traditions and suicide attempts by youth in First Nations communities (Chandler & Lalonde, 1998; Leslie & Story, 2002). The upside of what these researchers have reported is that communities that engage in restoring their cultural foundations and building and maintaining their cultural traditions may have fewer suicide attempts. The blending of the traditional and the modern across the generations ought to include country food in the dietary needs of the community. Some believe that the consumption of traditional country foods has positive effects to ward off symptoms of depression, headaches, and sadness. Kirmayer et al. (1994a) cited separate (1991) studies by Borré and Fletcher in which Inuit indicated that eating seal meat and beluga can rejuvenate their blood, body, and mind. The treatment of mental health issues, without acknowledging what is considered to be an integral part of wellness within the Inuit culture, may hinder success, particularly in those with strong traditional beliefs.

Using the resources of the communities' traditions brings to bear a credible realm of helping and healing possibilities as the cornerstone in the foundation of a promising mental health strategy. This approach enables each person, especially youth, to be considered "within the context of his/her family and community" (Cross et al., 2000, p. 16) in a manner consistent with the culture's worldview. This section reiterated and established a number of significant

factors that are integral to building a strong foundation for an effective, community-based mental health strategy. The most important aspect of finding their foundation is the commitment to a process for discovering it.

CHANGING THE TERM "IMMINIIRNIQ"

An appreciation of language as a medium to convey culture is another important aspect of engaging a community. Translation and interpretation services have always been available to communicate Eurocentric terms and concepts; however, the communication is one way. There is an assumption that Eurocentric terms convey the same meaning to Indigenous groups. For most Aboriginal groups and Inuit, this is inaccurate. What is missing is an understanding of Aboriginal and Inuit cultures as they are expressed through their language. For meaning to occur, there must be an ongoing dialogue based on respect of each culture's understanding and experience of meaning. When this happens, Eurocentric and Indigenous understanding is changed. Strict translation and interpretation of concepts from a Eurocentric paradigm do not allow for this understanding of meaning to occur. Many of these terms and concepts have no meaning and can be offensive (see Figure 3).
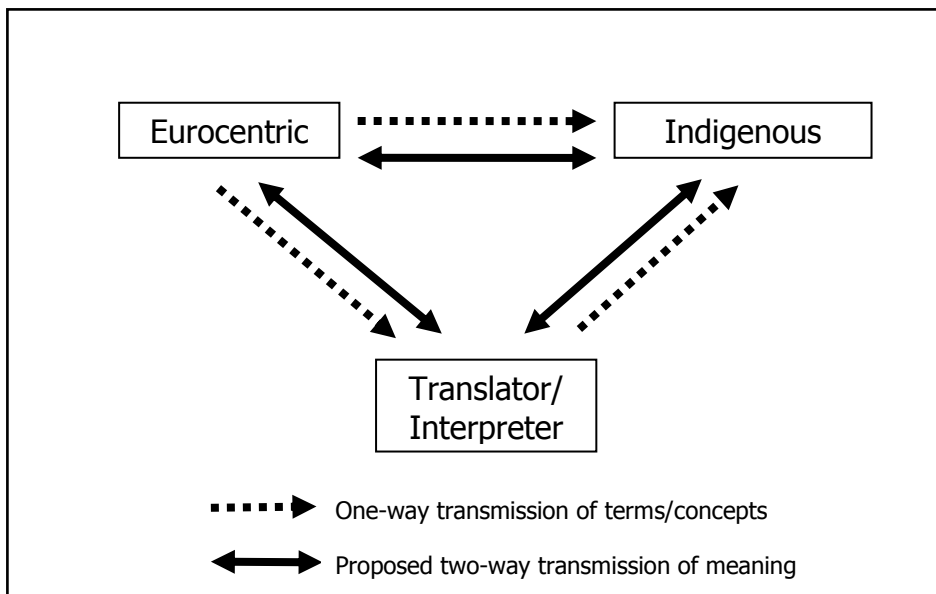
Figure 3. Translation and interpretation of terms and concepts.

When developing a community wellness strategy, reflecting on mental health terminology and its meaning is a necessary first step. Communication allows for the process of understanding and meaning to occur. Community members and professionals can engage in building agreement and comfort about the meaning of these terms. The term "suicide," or "imminiirniq," is considered "too direct and insensitive" (Inungni Sapujjijiit Task Force, 2003, p. 13) to Inuit, and some have expressed a need to use mental health terms that are more compatible with the Inuit way. Relatively isolated communities with a commitment to keeping their traditions strong find Eurocentric mental health terms offensive and inappropriate. Agreeing on what suicide is and communicating this understanding and meaning allow each community to engage in its own process of naming it and finding solutions. One community, for example, may comfortably use the words "killed oneself" (ingminik turkusartuq), whereas the phrase "did one's own action" (nangminik pijuq) may be preferable in another. The Inungni Sapujjijiit Task Force members reported that it was not their place to recommend a specific term for suicide. However, they did provide a list of various terms, such as the two already mentioned and others used by communities, as a guide for community processes. Communities may select the terms that meet their needs or develop their own. It is their choice.

It is questionable as to how much the term *suicide* is understood in any culture. Egel (1999) contended that the term suicide fails to take into account the cultural differences between "the observer and the person doing the self-killing" (p. 393). The Inungni Sapujjijiit Task Force (2003) understood this by refraining from defining suicide. Instead, it supported the definitions of some communities and suggested the terms as a guide while recommending that communities make their own decisions on the meaning of suicide.

Within some cultures, honour is defined in such a way that taking one's own life is the only option. Egel (1999) used as an example Japanese culture to illustrate this point. He noted that to a Japanese observer, a person who takes his/her life because of dishonour, or "loss of face," is not considered a suicide. To differentiate terms, Egel suggested a new one, namely, "sucism,"[3] to mean "self-killing that is not culturally normative" (p. 394). This new term is sensitive to cultural differences, yet it provides a term for general use. The clarification of terms across cultures within a Eurocentric paradigm must be a complement to the community process. The community must take responsibility for its own definitions and meaning of suicide and the way in which a community wellness strategy promotes good mental health.

Combined with the inappropriate use of the term suicide at the community level are unacceptable "medicalese" terms to describe suicidal events (Anawak, as cited in Henderson, 2003, p. 17). A community is disempowered and feels helpless when more than one suicide is described as a "contagion" or an "epidemic." The survivors are left with a loss of control and a sense of inadequacy, no matter what action they take as a community. Instead, the use of different terms, for example, "cluster," enables one to place the emphasis on multiple occurrences of suicide rather than portray the problem as unmanageable. Anawak also pointed out that using the phrases "successful suicide" and "completed suicide" affixes a higher value to the completion of the act (as cited in Henderson). Instead, she felt that the phrase "death by suicide" removes any value of success and, hence, is a more neutral term.

A dialogue about the meanings of words and their use in the process of any community-based mental health strategy starts at the beginning and is ongoing throughout the process. The

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[3] A literature search suggests that "suicism" may be the proper spelling, the Oxford dictionary indicates that suicism was at one time used to describe taking one's own life but it is now obsolete.

language that affords meaning to suicide that is representative and respectful of each

community's beliefs within the context of its culture is part of the foundation necessary for the

community to move ahead.

OUR YOUTH

Community-based mental health strategies are perceived as the best way of finding foundations; achieving meaning through ongoing communication that is respectful; and stimulating culture, community, and self-pride. Although any community-based wellness strategy will inherently involve and benefit all members of the community, this section highlights the ingredients for best practices in mental health promotion and prevention of suicide among youth. The Inungni Sapujjijiit Task Force (2003) noted that youth have "lost their identity" (p. 17) by living between two worlds. Therefore, youth are the main impetus for creating mental health best practices.

As a way of conceptualizing what is needed for mental health best practices for youth, the authors of this report addressed their unique needs separately. The risk factors for suicide and mental health difficulties among youth are the first priority. Although there are common themes across communities, the risk factors vary in intensity. The second priority is to provide opportunities for youth, adults, and Elders to communicate and grow in understanding each other's point of view improve the quality of life.

Building upon this second point, teaching youth their traditions, encouraging youth to teach each other these traditions, and supporting them throughout will build future leaders for the community. Unlike programs designed for youth but without youth involvement, a best practice would demand that youth are involved and that their voices are heard and implemented in the design of these programs (Forbes, 1994). The Inungni Sapujjijiit (2003) Task Force members recognized the importance of including youth in any wellness strategy; however, this approach conflicts with traditional Inuit teachings, namely, that youth are taught through observation and demonstration rather than being asked for their opinion. Having a voice is a postmodern

construct within the Eurocentric paradigm that must be balanced to protect youth who lack experience. Living between two worlds is a continuum of modern at one extreme and tradition at the other. The modern approach of teaching abandons youth to their discretion, whereas a traditional approach of teaching and mentoring is an obscure and lengthy process. Youth become impatient with either approach. Therefore, for their safety, a balance between both is critical because ongoing communication deepens understanding and acceptance.

In whatever way youth are prepared for leadership as peer mentors either in their communities or by visiting other ones, they must be guided and supported. This also applies to youth who return from treatment programs, other types of training, and education. Re-entry into the community after being away for a period of time always requires adjustment for everyone. Youth need to be carefully monitored as they learn to share their new knowledge and live their lives differently. Without the community's support and appreciation of the transition youth are going through, they are at risk.

As part of balancing between two worlds and retaining their traditions, the Inungni Sapujjijiit Task Force (2003) suggested that youth add traditional country food to their diet. Aboriginal and Inuit cultures have used the process of gathering, preparing, and eating traditional country food as part of healing and reclaiming identity. At the very least, it is about healthy eating and overall well-being.

Finally, youth need a gathering place. Some communities have youth centres; others make available existing facilities, such as school gymnasiums or community halls, for youth to gather during specific times. These places allow youth to nurture a positive closeness and create opportunities for peer support in resolving the confusion of living "two very different lifestyles" (Inungni Sapujjijiit Task Force, 2003, p. 17) between two cultural worlds. Subsequent sections

elaborate how these ingredients can form the foundation for best practices in implementing a community-based mental health strategy.

Risk Factors

A common practice with many Eurocentric research studies is to generalize risk factors across cultures. However, this section presents a cluster of risk factors for youth and highlights those risk factors that are unique to Aboriginal and Inuit youth. Risk factor identification is the first priority of a community-based mental health strategy for youth.

A (1992) survey of 100 Inuit youth aged 14 to 25 years from one community on the Hudson Bay coast in Northern Quebec found a cluster of risk factors to be the most prevalent and somewhat predictable (as cited in Malus et al., 1994). The factors that were identified in the survey include being male; being the first-born child in the family; doing poorly in school; having a poor attendance record at school; attending church infrequently; living in overcrowded accommodations; and experiencing parental substance abuse, personal solvent use, and inappropriate use of over-the-counter medicines. Although these risk factors may appear significant, the methodology must be examined for this degree of predictability in the results.

Malus et al. (1994) adapted the survey instrument from the self-reporting (1988) Adolescent Health Survey of the Indian Public Health Service in the United States. They redesigned the survey from a questionnaire to interview format and translated it into Inuktitut. Although instruments are adapted frequently from one use to another, Malus et al. pointed out that there were idiosyncratic dialectic variations in understanding particular to the Hudson Bay coast region in the survey. In addition, the original survey was designed for a completely different cultural group than Inuit. The unique characteristics of this Inuit community on the Hudson Bay coast of Northern Quebec were not a priority in the adaptation of this survey.

Consequently, even though the risk factors may be predictable when generalized to the larger population, careful consideration must be given to the uniqueness of this or any other Inuit community in Canada.

Bechtold (1994) identified culturally sensitive risk factors by examining the clinical and developmental considerations of American Indians This study generated a list of risk factors for youth in general and specifically applicable to this cultural group. Bechtold's list included the following risk factors: male; over 12 years old; precocity in adolescents (12-14 years); acceptance of death by suicide; overexposure to suicide; vulnerability to substance abuse, depression, antisocial behaviour; previous suicide attempts; living between two worlds; suicide threats by parents; family disruption and dysfunction; and, easy access to firearms. Bechtold made an effort to caution the reader that although these risk factors could occur, their significance would vary in importance within a community or between and among communities. Bechtold's approach recognized the interplay between risk factors and culture, as well as community and environment, as necessary in determining priorities in mental health strategies for youth.

Healing and Learning Facilities

Risk factors can be considered in another context. In this section, the authors present at-risk behaviours and offer programs and solutions to target specific behaviours and engage youth in community life. The emphasis in this section is on removing the label of "at-risk" from youth and including them in programs with their families, adult mentors, and Elders.

Mazza and Eggert (2001) found that adolescents who were at risk of suicidal behaviour spent proportionally more time alone and that youth who spent more time with their peers and families exhibited fewer risk factors and appeared healthier. Furthermore, they found that

adolescents in general tend to spend more time with their families on the weekends, but at-risk adolescents spend less time in family activities during the weekdays. Consequently, Mazza and Eggert contended that family support and involvement in weekday activities should be considered in any mental health strategy and suicide prevention program. Although the quality of social interaction was suspect in Mazza and Eggert's study, at-risk youth for both suicidal behaviour and school leaving tended to have higher levels of social activity than typical youth. These researchers qualified that they collected data from self-report questionnaires without specifying the amount of time spent on activities. The degree of social activity as a risk factor for mental health requires a community-based strategy to ensure that both the level and the quality of youth activities are appropriate. Rather than designing activities and programs targeted only for at-risk youth, having all community members, especially Elders, participate would enhance the benefits of programs and activity centres.

Community activity centres are potentially a viable place of healing and learning, and the authors of this report suggest that they be considered as part of a community-based mental health strategy or suicide prevention program. Activity centres can be inexpensive, and an unoccupied and available space may already exist in a community. Community leaders can shift the emphasis away from a focus on government initiatives, which are preoccupied with establishing a building and assessing the related costs, to activities and the participants themselves. Designing these centres for the entire community, with a special emphasis on mentoring youth and engaging them in other community activities, may reduce the risk of suicide attempts (Kirmayer et al., 1998). Gathering community members to engage in certain activities (e.g., storytelling sessions, playing games, having tea, etc.) is an important element in creating a facility for community healing and learning.

The traditional skills of a culture can be lost without a concerted effort to pass on this knowledge to young people. As noted with other Aboriginal cultures, social activities and events that transfer knowledge are very important, and without them, youth are unable to develop and maintain these skills (LaFromboise & Howard-Pitney, 1994). Efforts to include traditional skills for personal and social coping in school curricula and youth at-risk programs must complement this knowledge transfer with repetitive opportunities that occur in a social context that is enjoyable. A variety of opportunities for traditional skill development and knowledge transfer can improve the adaptability of youth.

<div align="center">Teaching the Youth</div>

Transferring traditional knowledge and teaching young people are also balanced with knowledge and information that can keep them safe. Even though brief suicide awareness classes offered in or out of school may have little impact on youth who are suicidal, it may raise the awareness of their peers. These classes can inform youth about at-risk behaviours and appropriate strategies so that they can deal with problems exhibited by their classmates and peers (Kalafat & Elias, 1994). Classes that teach coping mechanisms for dealing with depression, substance abuse, anger, and relationship problems, as well as provide problem-solving techniques, can better equip Indigenous youth for a healthier future (Malus et al., 1994). This information can have a negative as well as a positive impact on youth. Therefore, promoting a balance among traditional teaching, mentoring, and engaging youth in community activities is essential in reducing at-risk experimental behaviours.

Prevention/intervention programs may miss the mark in the prevention of suicide within Indigenous communities. Chandler and Lalonde (1998) found that communities actively involved in rebuilding and maintaining their cultural traditions are less likely to have incidents of

suicide among their youth. Engaging Indigenous youth in community efforts to reclaim their traditions and move toward self-determination and self-governance contributes significantly to their mental health (Kirmayer et al., 1999; Leslie & Story, 2002).

Using knowledge and experience across the generations can contribute greatly to a community's ability to create healing opportunities for its youth (Cross et al., 2000). However, it is notable that the healing goes both ways. Having Elders share traditions of language and life skills with youth contributes significantly to a healthy community; more than that, it entrusts these youth with the responsibility of passing on these traditions to the next generation (Kirmayer et al., 1994b; Malus et al., 1994; "Prevention Through Connection," 2002). Elders may have only some of the answers for youth because they, too, have experienced extreme societal change throughout their lifetimes (Westerman, as cited in Henderson, 2003). Relationships developed through this sharing are the most important.

A participatory action research project in two communities, Igloolik and Qikiqtarjuaq, reported that these interactions and relationship building are appreciated by both Inuit Elders and youth (Kral, 2003). Recognizing, rediscovering, and supporting family and kinship relations are great resources in building and strengthening bonds, community and cultural pride, and positive self-identity and self-esteem for all ages. Although it may seem trivial to bring Elders and youth together, in communities where generations have been separated by language, modernity, outside influences, and colonization, the difference in age is unlikely to pose the only barrier. As Kral stated, "Elders and youth appear to be waiting for each other" (p. 1). Finding ways to bring these two generations together by establishing mentoring programs and social events and by teaching traditional skills can act as the impetus for forging multigenerational, supportive networks.

Youth Teaching Themselves

The values and the principles of helping one another are strong in Inuit communities, particularly among youth. However, Elders and adults must mentor youth so that the ability to "be there" for their peers does not put them at risk. Troubled youth and those suffering with mental illness may negatively influence their friends. Examples of this occur when one troubled youth persuades others to commit suicide with him/her as a pact or bond of their friendship or love. These events can be prevented through mentoring programs and the careful monitoring of youth. Kugluktuk had the highest rates of suicide in Nunavut; in response to this dilemma, the youth joined together to create peer counselling support as a prevention. They were supported and mentored by professionals and other adults. Youth are a valuable resource for showing support and sharing with others. For example, members of the Iqaluit Youth group, which is funded by the Qikiqtani Inuit Association, developed a video on what life means to them (Inungni Sapujjijiit Task Force, 2003). From that video, the youth formed a band and designed workshops. Now, they are travelling to Nunavut communities to share their experiences and encourage other youth.

In May 2003, youth and Elders representing each of the 26 Nunavut communities participated in a youth engagement conference in Iqaluit (Loponen et al., 2004). The purpose of this conference was to expand the dialogue between Elders and youth and instill a commitment to suicide prevention that they would take back to their home communities. As a result of their time together, the youth developed a number of projects: Web site development, open radio talk shows, ad campaigns, peer mentoring, music videos, and establishment of youth centres. All projects were designed to engage youth in positive activities.

Elders and adult mentors are encouraging youth to continue to support one another. By teaching each other, they are also learning and communicating healthy ways of living. Because 50% of the population is under the age of 15, communities are reaching out to youth.

<div style="text-align:center">Peer Closeness</div>

In the document *Our Words Must Come Back to Us*, the Inungni Sapujjijiit Task Force (2003) acknowledged that youth are better able to share their feelings with their peers. Inuit youth who have attempted suicide more often share this event with their friends or family rather than medical personnel or social workers (Malus et al., 1994). Other youth who fear family members' anger, frustration, and misunderstanding are unable to share this information. The Inungni Sapujjijiit Task Force was adamant in its report that this must change; support for their position is unanimous in all the communities of Nunavut.

Parents, teachers, Elders, and adult mentors need to be open to accepting youth and all of their issues. Youth need to be able to approach them without fear. An opportunity for the generations to get together and participate in community activities facilitates communication and removes barriers, yet more is needed. Programs that improve communication skills between parents and their children can overcome some of the hurts of the past. Adults who were children of residential schools need to learn how to be parents. These programs will assist them.

It is encouraging that some youth discuss their suicidal thoughts with their peers. Often, however, these peers are ill equipped to handle the situation (Kalafat & Gagliano, 1996). Teaching youth how to handle these situations and being available to them as support are part of the mentoring role of adults and Elders. White and Jodoin (2003) examined best practices for peer helpers and found that providing both training and professional resources for referral and support is necessary for their success. Similarly, adults need the same training, along with the

ability to recognize when their own children and other youth in the community are in distress. While acknowledging that youth may be closer to their peers than parents and adults, it is unacceptable to place the onus for the well-being of other youth on their shoulders. Mental health is a community problem, and it should have community solutions.

<div style="text-align:center">Ensuring the Voice of the Youth</div>

Another aspect of engaging youth is listening to them. Youth often describe feeling left out of decisions that affect them (Loponen et al., 2004). At a public forum held in Iqaluit in the spring of 2003, Kirmayer (as cited in Henderson, 2003) recommended that youth be represened in community planning because it provides them with a sense of direction, belonging, and purpose. Engaging youth teaches them new skills and contributes to reducing feelings of helplessness and lack of control in their lives. All youth can benefit from this activity because so often, youth who act out seem to get all the attention. Youth who "have it all together" are often burdened with pressures to succeed and seldom get the recognition they deserve for being good. Youth forums and opportunities to share their feelings with each other and the community provide an opportunity for greater understanding between those who are leaders and those who are experiencing life's challenges differently.

In addition, these forms of dialogue allow the community to identify its potential leaders. Youth can practice these skills by visiting other communities and sharing views on mental health. The messages can also be presented through multimedia. Greenlandic rock band Chilly Friday is another example of communicating the message. This band produced a video that spoke to the issue of suicide and urged youth to avoid it as a way of dealing with their problems (Henderson, 2003). Young people, with the support of Elders, their parents, and adult mentors in the community, can expand their communication skills. Using the media, these young people can

convey their mental health needs and desires for a better future to government departments and politicians at the territorial and federal levels.

Coming Back to the Community

From the moment they are born, Inuit travel a lot and have to visit other communities for special services. Youth who have left their communities for treatment, detention, or schooling have variable difficulty in adjusting when they return home. Therefore, special attention must be given to their adjustment needs upon arrival and welcoming. The Inungni Sapujjijiit Task Force (2003) recommended that any youth returning to their home communities should be welcomed back, supported, and monitored to ensure their well-being. Family and extended kinship networks of support can be employed to create the safety net for these youth. Safety nets that rely on family and kinship strengthen community cohesiveness and create a mechanism of support that extends beyond the family to benefit all community members. This supportive mechanism can be integral to a community-based mental health strategy and can serve multiple purposes.

Feeding the Youth

The previous sections have talked about feeding youth's mind, spirit, and sense of interconnectedness. This section actually talks about diet. Eating traditional country food is often a "better predicator of a healthy cultural life" (Westerman, as cited in Henderson, 2003, p. 30). In discussions of Inuit health issues, traditional country food is a major theme (Kral, 2003). There is a close relationship between mental health and traditional country food among Inuit that is missing in the Eurocentric paradigm, where body and mind are treated separately (Kirmayer et al., 1994a). Elders hold a strong association between well-being and traditional country food that is critical to the culture and must be passed on. However, Elders will not direct the eating habits of youth (Borré, 1991). Elders believe that this is unnecessary if babies and children are

nourished in their early years on traditional country food. Ultimately, they will crave traditional country foods and will recognize its importance to Inuit identity.

The government of Nunavut recognized the importance of traditional country foods to the health and well-being of Nunavummiut when they promoted the Nunavut Food Guide and included such traditional country foods as caribou, seal, beluga, fish bones, and seaweed (Rideout, 2002). This initiative supports the nutritional and economic benefits of Nunavummiut and respects their traditional beliefs.

<div align="center">Youth Living Two Lives</div>

Living between two worlds is another expression to portray youth living two lives, one Eurocentric and the other Inuit. Youth accept this duality as reality. At the same time, they are acutely aware of its challenges. The media glamorize individualistic and consumption-based values of Eurocentric society, a lifestyle that is unattainable to Inuit youth (Kirmayer et al., 1998). Youth mental health is aligned with the achievements of Eurocentric society's values (Forbes, 1994). The duality that Inuit live serves to complicate the identification of risk factors and the design of appropriate solutions to prevent and treat mental illness.

The dualism experienced by Inuit youth has not gone unnoticed by community Elders and adult mentors, who have expressed concern for youth "stuck in two worlds [and] stuck in between" (Kral, 2003, p. 21). These Elders and adults are committed to building bridges between these two worlds to save their young people. These bridges are predicated on communication, pride, foundations, and the preservation of language and culture. Youth have captured the imagination and attention of Elders and adults in an effort to find a place that bridges both worlds. Elders and adults are reaching out to build these bridges in an effort to save their young people and as a result are saving everything that is important to them.

RETRIEVING OUR SKILLS

"Retrieving our skills" is a term that has a deeper meaning in Aboriginal and Inuit cultures. It combines finding their foundations and reclaiming the role of meaning in the way young people are prepared for the future. Colonization disturbed a sense of pride and ability to speak out about their cultural roots and what is important to them. The traditional teachings were lost among the generations during that period of influence. Aboriginal people worldwide have begun to claim their identity and tell their stories. Combined with traditional healing and other programs to address the impact of colonization, a new hope has emerged about the future. Land claim agreements and the creation of new territories such as Nunavut have contributed to this new hope. Living between two worlds, young people see the opportunities available in the Eurocentric at the same time they are Aboriginal or Inuit. The Inungni Sapujjijiit Task Force (2003) identified the need to retrieve their former skills as a first step in bridging the two worlds.

Need to Improve Existing Services

No one would question the adequacy of mental health service for Indigenous peoples. In Nunavut, for example, a recent document presenting an addictions and mental health framework declared the inadequacy of services for individuals with addictions and mental illness (Government of Nunavut, 2002). Services are often transported from the south without adjustment to the unique needs of Inuit. Southern professionals often provide these services, and Inuit hired to provide these services are untrained by southern standards and are overwhelmed. In addition, many complementary services and specialized ones are unavailable. The Advisory Group on Suicide Prevention (2003) contended that medication is the first line of intervention because of the lack of appropriate services, such as counselling. Although medication treats acute symptoms, it fails to deal with the underlying problems. These issues have been well

documented, but nothing has changed. The Inungni Sapujjijiit Task Force (2003) recognized and encouraged communities to take care of their own by retrieving former skills in finding solutions to improve existing services.

Mental health services must be integrated into each community in a way that supports rather than takes away from existing services and resources (Raphael, 2000). This is particularly true of specialist support and consultancy on cyclical rotations to the community. Even though it is necessary to provide support to these professionals, the community's health care staff ought to be mentored and trained while providing this support. The rhythm of the community and its services should be maintained while these professionals are visiting. Specialized services can be integrated to meet the mental health needs of the community only after the community has taken a leadership role in defining an appropriate mental health strategy that provides for human resources.

Traditional knowledge and skills are very important in setting out a mental health strategy. Policies regarding mental health that are initiated at the federal level tend to be problem oriented. This generic approach has failed to recognize the specific needs of each community (Ripple & Zigler, 2003). Rather than being helpful at the community level, these policy recommendations thwart the benefits of traditional knowledge and skills, which tend to focus on building strengths.

<div align="center">Ensuring Our Health Before Helping Others</div>

"Walking the talk" is a fundamental belief of Aboriginal people. Healers must engage in their own healing. Some believe that healers can only heal to their own level of health, mentally or physically (Fleming, 1994). A community wellness committee is responsible for monitoring the overall health of a community and implementing the needed programs and services.

Although some people in the community may be healthy, if the overall health of the community is impaired, the healthy ones have little impact. It is essential that communities strive for a comprehensive approach to mental health (Middlebrook et al., 2001). Each community must make a commitment to be healthy.

The majority of rural, remote and northern communities are small enough to obtain input from everyone. Uncovering solutions to mental health is possible with the community's commitment to a healthy lifestyle. One way to do this is by enlisting; educating; and empowering natural helpers (e.g., caregivers, community members, teenage youth) to assist in providing services (Power, 2003). Natural helpers would have a larger investment in the community and its youth and would be able to provide culturally appropriate services. Indigenous close-knit relationships provide an informal infrastructure of social support for transferring traditional knowledge and skills. Conversely, without a commitment to a healthy lifestyle, these close-knit relationships can be breeding grounds for ill health.

A cohesive network of service providers, including informal or alternative ones, will determine the success of any community-based mental health strategy. The successful impact necessitates action in each of the three major areas in youths' lives: community, school, and youth/family (White & Jodoin, 2003). Professional services, the RCMP, and Telehealth are considered part of an informal, allied system of support often overlooked in conventional mental health delivery plans, according to a survey of 48 service providers across Nunavut (Zamparo & Seburn, in press). The blending of these informal systems will be compulsory if small communities are going to manage their own mental health issues.

Models of mental health strategies should be designed and implemented by each community. Mental health solutions must be broader than one suicide prevention strategy

(Potter, Powell, & Kachur, 1995). It is wise for communities to integrate more than one specific suicide prevention strategy within their community-based wellness strategies. Instead of transferring models used with other populations, Aboriginal people should encourage a broad spectrum of interventions (Strode, 2003). Small communities do not mean small problems. In fact, they are often a microcosm of the same issues in larger centres. Therefore, specialized programs within small communities ought to reflect their uniqueness in dealing with mental health issues.

Return of the Formerly Incarcerated

Returning to the community can be more complicated for people who have left for serious problems. Life events that result in legal problems, charges, admission to treatment centres, trouble with police, and incarceration can increase the risk of suicide (Beautrais, Joyce, & Mulder, 1997). Removing offenders and community members who are seriously ill gives the community a reprieve during their absence. Without addressing the impact of their leaving on the community, welcoming the persons back may be a challenge. However, welcoming them with acceptance and the necessary support for their transition is the only way to prevent depression, suicide, and other unfortunate consequences. This is especially true in smaller communities, where most members are likely to be related, in some way, to the persons who are returning.

A community-based mental health strategy anticipates all the needs of the community while adjusting for events as they occur. The incident of people being removed from the community for mental illness or problems with the law requires special interventions for community healing. Communication between those who leave and those who remain is important to ensure that the support is appropriate and meets their needs. This process, which is

the same for people leaving for treatment, school, and specialized training, conveys the message that everyone is valuable.

Supporting Each Other

As a valuable member of the community, you can expect support and encouragement with whatever challenging life event confronts you. Suicide and related mental illnesses are more than an individual's problems; rather, they are problems that impact the community (Malus et al., 1994). This awareness must be central in any community-based mental health strategy. It is often the case that a sense of community is developed in response to a tragedy, particularly in communities that are small (Allen, 2001). Even though it can be strengthened and mobilized to respond to unfortunate situations, a strong sense of community and all that goes with it must be part of daily life within small communities. The commitment to and the process of creating a community-based mental health strategy serves to promote a sense of community and provide support for all. It is necessary for the community to compensate for any negative effects because there are an increasing proportion of youth being raised in "impoverished and disrupted family environments" (Wassef et al., 1996). Furthermore, many suicidal youth and the problems that they experience are inseparable from the problems faced by the family and the community surrounding that youth (Malus et al.).

The process of "retrieving our skills" includes parenting and family life. The absence of traditional roles in modern Inuit lifestyles may contribute to the increased occurrence of mental illness (Malus et al., 1994). Specifically, rapid cultural change in Inuit society has displaced the males' role as subsistence providers. Nonetheless, males are expected to provide for families in a cash economy that they are unskilled to participate in. There is more meaning to a traditional way of life. Traditions contribute more than just subsistence to the Inuit people; they also are a

means of attaining "total health of person and community" (Kirmayer et al., 1994b, p. 59). They include religious, moral, and psychosocial practices that are an inherent part of the traditional ways. All aspects of traditional ways of life must be retrieved so that Aboriginal people can adapt to rapid social change in their communities.

No one is proposing solutions that takes Inuit back in time; however; the Inungni Sapujjijiit Task Force (2003) suggested that those skills of the past and the values embedded in them be brought forth to inform the modern ways of community life. Reminding people of the consequences of a loss of tradition and the problems that remain unsolved usually leads to a strong commitment by all to engage in a process of revival. A number of programs (listed in the database) that emerged in response to engaging communities in a recovery of their traditions and the healing process that ensues are presented as examples of best practices for bridging two worlds.

Without serious dialogue and attempts to deal with these issues one way or another, the problems become normalized in the community. One fear is that suicide is becoming acceptable as a method of dealing with one's problems (Tanney, 1995). Governments lack the leadership to challenge this malaise. At the community level, however, most people have been touched by suicide and mental illness, and they are caught between the malaise of accepting it as part of life and it being a numbing paralysis. The motivation must come from the community members themselves to mobilize strategies for healing and interventions within their community as well as the broader macro-level of government.

<div align="center">Discipline and not Rushing into Adulthood</div>

Two final issues raised by the Inungni Sapujjijiit Task Force (2003) under the heading of "Retrieving Our Skills" was that youth must be raised with discipline and that they must refrain

from rushing into adulthood. As pointed out by the task force, there is less emphasis on disciplinary actions within the modern family unit, which contrasts the traditional Inuit way. Discipline is about survival and respect, and youth need both to prepare for adulthood. To be respectful of the land and the people who inhabit it is one of the core principles and values of the society (Uluadluak, 2002). Parents, although unprepared for their parenting roles because of a variety of school-related issues, are reluctant to try for fear of losing their children altogether. Fear and doubt of being bad parents underlie their feelings of inadequacy. However, youth need structure, and they must be taught life skills with appropriate limitations if they are to come to understand what is expected of them in the future.

For the community, youth who are out of control become public nuisances, and their behaviour provides negative role models for younger children. A community that wants to convey a positive regard for all members is caught in a difficult position. Some youth may take discipline personally and, ultimately, become depressed and at risk of suicide and other mental illnesses. On the other hand, youth who experience appropriate discipline and appropriate limitations within the family unit have a certain degree of personal control that mitigates depression levels and suicide risk behaviours (Thompson, Eggert, & Herting, 2000). A mental health strategy must incorporate the boundaries between parenting roles within the family and mentoring roles for youth best available in the community from adult mentors and Elders. Without a clearer distinction of role responsibilities, the messages get confused for young people who are being parented by the community when this role has been abandoned by their families.

The Inungni Sapujjijiit Task Force (2003) believed that today's youth are rushing into adulthood. With weak parenting skills in many families, many youth are unprepared for the reality of what it means to be an adult. Youth are confronted with many personal problems that

are beyond their years. These problems often are intensified by the fact that parents, friends, and community may be experiencing the same difficulties. Here is where a community-based mental health strategy becomes selective. Youth may need a reprieve from dealing with the complications of some problems because they are ill-prepared emotionally to deal with them in a meaningful manner. The community maintains its commitment to dealing with the problems while only engaging those who are the best equipped to implement the solutions. Doing so is in keeping with the traditional Inuit way: Children and younger adults did not experience the full brunt of community problems and seldom knew about them. Instead, children and youth would be assigned tasks and would be included in solutions without feeling alone with the responsibility, as youth do today. The involvement of youth and children was more about skill development that was appropriate for their age. A re-emphasis on traditional ways redistributes the responsibility to the family and the community and relieves youth from the burden of rushing into adulthood without excluding them. Otherwise, a mental health plan is being undermined by dysfunctional behaviours that are left unchallenged.

PROGRAMS, SERVICES, AND FACILITIES

Off the Beaten Path

"Programs, Services and Facilities" is the heading of this section. A series of themes further organizes the information and sets up the context for best practices. The authors utilized some of the same themes of the Inungni Sapujjijiit Task Force (2003) report to organize the literature. As well, this section goes beyond the limits of the Inungni Sapujjijiit Task Force categories to arrange a larger resource of information from the relevant literature. A complementary database accompanies this paper and provides more in-depth examples of the best practices under these themes.

To present a cohesive package of mental health and suicide prevention best practices for children and adolescents, the authors emphasize a community-based approach. Also, the community-based approach echoes the messages of the Inungni Sapujjijiit Task Force (2003) report. To complement the community-based approach as a foundational part of any best practice, the authors presented the concept of culturally appropriate assessment, along with an example of an assessment process, for Australian Aboriginal children. To arrange the other themes, the concept of a Eurocentric approach counterbalances a culturally appropriate one. Within the Eurocentric category are several themes that can be adapted and utilized.

To be effective, programs and strategies following these themes require a community-based and culturally appropriate orientation. The Wraparound Process, which is one such theme, is an overarching concept that bodes well with the interdisciplinary and intersectoral models of service. As a point of origin, school and family-centred services are two other themes. Environmental control is another theme with programs designed to promote a safer environment for the person and the community dealing with mental illness. Telehealth is cutting-edge

technology with the potential to offer a wide range of services from information sharing to complex interventions in mental health where limited or no services currently exist. In this final section, the authors discuss various issues and findings that have come to light about programs, services, and facilities when addressing mental health issues for northern rural and remote communities.

Program Themes

A number of programs that have been recorded in the database, for the most part, fall under one or another theme. Overall, these themes are described in detail in the literature to varying degrees. However, in this report, the authors chose to integrate these themes to suggest what is necessary for successful programs and best practices in rural, remote communities. The key themes for mental health programs are presented with their references in the following table.

THEME	EXAMPLE REFERENCES
Community responsibility y	Kirmayer et al., 1999; Government of Nunavut, 2002
Community development and empowerment	Gardiner & Gaida, 2003; Power, 2003; Waring, Hazell, Hazell, & Adams, 2000
Locally initiated, owned, and accountable	Government of Nunavut; Kirmayer et al., 1999; Power
Interdisciplinary approach with multiple perspectives and comprehensive	Greenberg et al., 2003; Kirmayer et al.; Raphael, 2000; Silverman & Felner, 1995
Integrated and coordinated services	Silverman & Felner
Geographically accessible services	Government of Nunavut; Raphael
Maximum participation of multiple stakeholders	Kirmayer et al.; Power; Raphael
Engage and train natural helpers (e.g., caregivers, community members, youth)	Fantuzzo, 1995; Power
Well-trained paraprofessional and professional staff with opportunities for continued support	Kirmayer et al.; Nation et al., 2003; Waring et al.
Appropriate policy development	Greenberg et al.; Silverman & Felner; Waring et al.
Ongoing evaluation of programs and processes	Burns & Patton, 2000; Capp, Deane, & Lambert, 2001; Kirmayer et al.; Nation et al.
Involvement of family and community in all youth programs	Government of Nunavut; Raphael
High standards for cultural awareness and usage	Kirmayer et al.; Nation et al.; Power; Raphael
Systemwide protocols (intergovernmental and interagency agreements)	Gardiner & Gaida; Government of Nunavut; Raphael; Silverman & Felner
Gatekeeper training (e.g., school, community, physicians)	Berman & Jobes, 1995; Burns & Patton; Capp et al.; Gardiner & Gaida; Potter et al., 1995
Public education (i.e., awareness and information about mental health and suicide)	Berman & Jobes; Burns & Patton; Gardiner & Gaida; Potter et al.; Waring et al.
Early identification and intervention	Raphael; Silverman & Felner

Screening procedures and protocols	Berman & Jobes; Gardiner & Gaida; Potter et al.
Treatment	Gardiner & Gaida; Raphael
Support mechanisms for peers and family	Berman & Jobes; Gardiner & Gaida; Potter et al.; Raphael
Health promotion for positive relationships with adults, peers, community	Government of Nunavut; Nation et al.
Skill building for life skills coping mechanism	Gardiner & Gaida; Waring et al.
Media education	Burns & Patton; Gardiner & Gaida
Positive school climate	Gardiner & Gaida; Greenberg et al.; Raphael
Accessible crisis centres and hotlines	Berman & Jobes; Burns & Patton; Potter et al.
Strategies for means restriction (limited access to handguns, drugs, etc.)	Berman & Jobes; Burns & Patton; Gardiner & Gaida; Potter et al.
Cluster prevention strategies to prevent multiple tragedies	Berman & Jobes; Government of Nunavut; Potter et al.
Adequate and flexible funding	Government of Nunavut
Family interventions for cohesion, conflict resolution, and parenting	Burns & Patton; Government of Nunavut
School-based interventions promoting resilience	Burns & Patton; Raphael

Program Database

The goal of this report was to present a comprehensive literature review of the programs

and services used in the promotion of mental health and suicide prevention best practices. The

Inungni Sapujjijiit Task Force (2003) report emphasized a community- based approach.

Therefore, in keeping with this approach, the authors' preliminary review of this literature led to

the creation of a searchable database of resources that might be useful for communities. Once the

authors made this decision, it seemed unnecessary to explain every program and service

available. However, a description of themes and examples is available to guide people to find the

information in the database. It offers a supplement to this report and contains program details.

The database includes information from two summaries of mental health practices

released in the fall of 2003: (a) *Aboriginal Youth: A Manual of Promising Suicide Prevention*

Strategies by White and Jodoin (2003). This summary of prevention programs for Canadian

Aboriginal populations is a guide for those wanting to develop and implement suicide prevention

programs, and (b) *A Summary of Best and Promising Mental Health Practices for Select*

Populations includes a *Literature Review and Resource Guide for Evidence-Based Best and Promising Mental Health Practices* by Strode (2003). These companion documents are a "compilation of literature reviews and resource guides for evidence-based mental health practices for specific sub-populations" (Strode, p. 2). Another document by Devlin (2001), *First Nations & Inuit Suicide Intervention Training Best Practice*, was added to these two supplements. Devlin reviewed 15 suicide intervention training programs designed specifically for the First Nations population. These three publications are an excellent database of programs. Although the three documents serve as an extensive compilation of sources, the authors of this report added other material to the database from articles and references found in the literature review.

Community-Based Mental Health Strategies

Throughout this report are several references to the importance of a community-based mental health strategy. A review of the program literature has positioned community-based initiatives as an empowering process that is strategically important to the success of a best practice program. However, there are capacity-building impediments to a community-based approach. One such barrier was identified by the First Nations and Inuit Health Branch (FNIHB, 2003), which pointed out that "many First Nations communities do not have the structure nor resources to undertake major proposal writing" (n. p.).

Another hurdle to a well-developed community-based approach is the availability of well-trained staff (Inungni Sapujjijiit Task Force, 2003). Technology and Telehealth methods may fast-track the build-up of available human resources in the community. Aboriginal people have been known to learn quickly all aspects of the computer and Internet use (Loponen et al., 2004). An Inuit Elder said that "technology does not define our culture but rather it helps us be

more efficient in what we do" (personal communication, May 19, 1996). Therefore, culturally sensitive approaches are complementary to community-based interventions.

The program database, however, provides excellent examples of communities breaking through these barriers and many others to develop successful, community-based mental health strategies. Some of them are best practices. Two unusual examples are a statewide program in Alaska (Aquino, as cited in Henderson, 2003; Forbes, 1994; State of Alaska, 1990, 2003), and another, whereby nongovernmental funding supported a community initiative in North Queensland, Australia (Devlin, 2001; P. Mitchell, 2000). The funding formula for the Alaskan program was unique. Annually for 3 consecutive years, approximately 60 communities received funding and showed positive results in their programs. This example illustrates the effectiveness of flexible funding, which has been identified as a necessary component of mental health programs and strategies.

Sometimes, public funding has criteria that implicitly or explicitly predetermine a community strategy. One community in Australia stayed true to their process and did not utilize the National Youth Suicide Prevention Strategy funding. The community of Yarrabah designed its program to address the community's risk factors rather than focus on at-risk individuals. This set the stage for an ongoing process that re-evaluated the community's needs and tackled severe problems by focusing on the positive aspects of life in the Family Life Promotion Program. Even though the themes provide direction on how to proceed, community-based approaches to mental health uncover the resilience of communities and their capacity to solve their own problems.

Culturally Appropriate Assessments

Some communities are geographically, linguistically, and culturally unique. A successful best practice program incorporates these aspects into their community-based mental health

strategies. This does not preclude the use of pre-existing assessment and treatment modalities that are Eurocentric; however, these methods must be examined closely within the community context. Assessment is an important part of the mental health process. In determining the cause of undesirable behaviour, people are assessed, and based on the results, treatments are implemented. The literature in this area is quite extensive and reports various strategies for conducting assessments (Cawthorpe, 2001; Haggarty et al., 2000; Mackesy-Amiti, Fendrich, Libby, Hirsch, & Grossman, 1996) and implementing treatments (Beautrais, 2000; Miranda et al., 2003; Thompson & Eggert, 1999; Thompson, Eggert, Randell, & Pike, 2001).

Often, behavioural assessments are designed using pre-exiting instruments, and they are adjusted to target idiosyncratic symptoms manifested by the client in the initial stages. The adaptation of instruments and the creation of new ones frequently focus on the illness rather than the client's unique characteristics. Mental health professionals interpret client behaviour according to uniform criteria established in these instruments, and they overlook the clients' culture, lifestyle, and beliefs. Misinterpretations and errors occur continually when these instruments are employed indiscriminately with Indigenous people.

Several aspects of Indigenous lives conflict with Eurocentric assessment processes. Time is regarded differently. Although Judeo-Christian culture perceives time as linear in nature, with a past, a present, and a future, some Indigenous cultures perceive time to be more cyclical, and the present is the most important element (Janca & Bullen, 2003). The saying "all of my relations" used by First Nations people joins the wisdom of the past and the future into the present moment. The Eurocentric interpretation of time is embedded in all mental health systems and, in particular, in the first stage of assessment.

Time reflects the rhythm and understanding of life and influences the way in which daily routines and events are communicated to mental health professionals. Most often, psychiatric/behavioural assessments involve an interview process whereby the client is prompted to provide information about his/her present, past, and personal and family history in a chronological fashion (Janca & Bullen, 2003). Recounting the events of a period of time in response to linear questions, Aboriginal people will do so in a way that tells a story in context rather than one that systematically isolates events. Aboriginal people will answer the questions, but they have reported that in many cases, the questions are the wrong ones to arrive at the answers that address their needs (Peterloosie, personal communication, May 19, 1996). Communication between mental health professionals and Indigenous clients may be in conflict, and the meanings may be misunderstood and misinterpreted. Aboriginal people seldom question the way assessments are done. Instead, they detach from their ways in order to receive mental health services that are, by and large, scarce in their communities.

Assessments are generally biased within the Eurocentric paradigm. Janca and Bullen (2003) recommended that a culturally appropriate assessment needs to be conducted with Aboriginal clients' understanding of "contextualized time." They suggested that this process should engage Indigenous people on their own terms. However, this is seldom the case. Professionals are in control of time and manage it when visiting several people in a community in a very short period of time.

Time is also influenced by the few hours allotted to clients who leave their communities and are expected to adjust to larger urban centres while adapting to the bureaucratic environments where many assessments take place. To respect Aboriginal peoples on their own terms requires another step in the assessment and clinical intervention processes. This

intervening step allows the clients and the professionals to interact as people first and to begin to feel comfortable with each other. The emphasis is less on the assessment and diagnostic process and more on the comfort level and needs of the clients to find a common rhythm and pace. Once a comfort level is established, clients and mental health professionals can engage more effectively in the assessment and diagnostic process.

Assessment tools typically involve the completion of prescribed questions within a predetermined time line; however, both the questions and the time line may be out of context for Aboriginal clients. Literacy is another factor for consideration in prescribed tools that are question driven. Typical measurement scales of numerical or categorical gradations may not have meaning for Aboriginal people. Some Aboriginal cultures value thought and observation first as a way of gaining understanding (Strachan, 1988). Using methods that are closer to the Aboriginal ways of communicating and gaining understanding will remove the limitations for those lacking literacy skills (Janca & Bullen, 2003). Finding neutral ways of communicating, such as using pictures, can reduce the stress and engage clients more fully in the assessment process.

Although it appears reasonable to consider these cultural factors in the development of behavioural assessments, a paucity of culturally appropriate measures was reported in the literature. Furthermore, these assessment tools, when constructed appropriately, have the potential of serving a community as a screening tool to assist in providing early intervention and creating proactive strategies. Integrating assessment tools into a community-based mental health strategy is critical to its successful implementation. The authors listed these assessment tools, along with culturally appropriate programs, in the database.

Westerman Aboriginal Symptom Checklist for Youth

The Westerman Aboriginal Symptom Checklist for Youth (WASC-Y) is one example of a culturally appropriate assessment tool (Westerman, 2000). This psychological instrument, which was first developed specifically for use with Australian Aboriginal youth rather than acting as a modification of a Eurocentric assessment, was culturally validated to ensure the appropriate measure of depression, suicidal behaviour, substance use, anxiety, and cultural resilience. The instrument avoids bias and the problems commonly associated with adapting instruments for Aboriginals and, in particular, youth. The use of images is one way in which the 53-item self-report inventory was adapted to indicate categorical scales (Westerman, 2003).

The WASC-Y is available for approximately $660 (Australian dollars) through Indigenous Psychological Services (IPS), a Western Australian company founded by Westerman in 1999. To guarantee the appropriate use of the assessment tool, the WASC-Y package can be purchased only by those who have completed the training program provided by IPS. This may be disappointing to non-Australian Indigenous groups, but it is a responsible approach to prevent those seeking a quick solution to obtaining culturally appropriate screening techniques.

By being cautious about circulating her assessment instrument, Westerman recognized the importance of administering a culturally situated assessment tool. Her approach challenges communities to be responsible and to know what they are doing when engaging in the assessment process. Culturally appropriate techniques for one group, community, individual, and so on, may be unsuitable for another. Therefore, even though Westerman's checklist serves the Australian Aboriginal youth population appropriately, it might be an inappropriate choice for Inuit of Nunavut, for example. Whether one adapts a Eurocentric instrument for a cultural group or designs a new instrument, it will be ineffective without a responsible process of dialogue

within a community-based mental health strategy. The WASC-Y is an excellent example of how each Aboriginal cultural group can create an assessment instrument to reflect its uniqueness. Inuit can engage in a community process that allows them to design their own instrument to assess the mental health needs of their communities.

Eurocentric Dominance

The literature on mental health is dominated by the Eurocentric worldview, which has been assimilated into all institutions of governance and policy making in Canada. This national view has been transferred to the provinces and territories, which are primarily responsibility for the delivery of education, health, and social services. Eurocentric values and norms are embedded in many programs and services, and people who have a different worldview tend to be left out if they are unable to integrate themselves. For those who are unable to adapt, the result can be mental illness and other coping problems. Programs and services have been created to deal with their specific problems, some of which might address their unique needs.

The Canadian government created a multiculturalism strategy and attached a funding envelope to it. Bilingualism was another government strategy to address the unique needs of the francophone population. The Aboriginal Healing Foundation is another example of a financial commitment to programs and services to meet a specific problem. However, most problems are more complex and remain unsolved. For example, the Eurocentric worldview perpetuated intergenerational colonization and programs that were designed to assimilate Aboriginal people, but failed to do so.

A community-based approach can make the best use of a Eurocentric worldview in dealing with the unique needs of Aboriginals. Some programs have been successful in doing so under community leadership. *RespectED*, a national program of the Canadian Red Cross, has

been adapted by the Nunavut Department of Education for culturally appropriate use in Arviat

(Posavec, 2003). This particular program, like *Walking the Prevention Circle for Aboriginals*,

targets community risk factors rather than undesirable, individual behaviour.

As well, the community-based approach can depart from existing programs and services

and create new ones that stand out as models of best practices. The Family Life Promotion

Program, envisioned by the community of Yarrabah, Australia, is an excellent example of

community ownership that symbolizes a community-based best practice (P. Mitchell, 2000).

Fundamental to the success of these programs and others is the shift from the individual with the

problem to the community with the solution. Other such programs that revive cultural

foundations and traditional skills provide exceptional examples of community mobilization for

the promotion of mental health. Community empowerment and resilience have gone beyond

anyone's expectations, especially in communities that have implemented some of the programs

listed in the database.

The paradox of a best practice is that it follows neither a Eurocentric nor an Aboriginal

worldview for the promotion of mental health. The process engaged in a community-based

approach mobilizes community ownership; brings together people with different worldviews;

and, through the process, establishes its own worldview. It allows the imagination of all

members to draw from any worldview in establishing a mental health strategy. Therefore, the

following program themes can be situated within a community-based approach.

School-Based Programs

Schools provide an environment where programs can be implemented for both

individualized interventions for youth as well as programs and services that address

communitywide risk factors. Aptly stated by Metha and Webb (1996), "Prevention of the

needless death of so many young people is the responsibility of the entire community, [*sic*] it is without question that the schools must assume a major role in the suicide prevention efforts of the community" (p. 4). Some communities have learned important lessons, such as "a single school-based strategy implemented in isolation will not have a large effect" (Greenberg et al., 2003, p. 470).

The focus should be less on the question of which program works but rather on what combination of programs works (Greenberg et al.). An excellent example of a "whole" school-based strategy within the Australian educational system is "Mind Matters" (Wyn, Cahill, Holdsworth, Rowling, & Carson, 2000). This program is unique in the way that mental health is viewed as a complex and integrated issue. A number of programs have been devised to engage all students and staff in various ways, raise awareness, build skills, and create an atmosphere that encourages young people to care for one another. This program and others like it are listed in the database.

<center>*Family Programs*</center>

Policies and programs created to address the needs of families are frequently designed to deal with specific problems. Seldom are there programs that support healthy families and recognize the efforts of parents and other family members as models of care. Strong families and parents who strive to teach their children and youth have prevented serious problems from getting out of hand. Furthermore, parenting and family intervention programs are empirically effective in mitigating problems among youth (Kumpfer & Alvarado, 2003). This is a "best kept secret," and more attention must be placed on applauding the success of family-based programs, which provide a microcosm view of the successful characteristics of community-based programs.

As such, these programs have the same impact as a best practice for the entire community. In other words, family is community, and community is family.

The family is the lifeblood of the community. Among Aboriginal cultures, even though families may have abandoned their parenting roles, they are still regarded as very important. For example, family-based treatment programs, combined with other treatment interventions with youth, have been more effective than those without the family-based component (Brent & Perper, 1995). Especially important is the valuable resource and natural helping role of the family and extended kinship networks in a crisis. There are many examples of this in rural, remote communities.

Many culturally and linguistically strong programs have taken advantage of this natural resource when engaging communities in problem solving (Range et al., 1999). An example is the Family Group Decision-Making process, which has replicated a Maori program from New Zealand in Newfoundland and Labrador (Pennell, 1997). The Family Group Decision-Making process engages professionals, family members, and other community supports in the design and implementation of family conferences to solve problems of family violence and abuse. This model, which has been applied in other settings to address other types of social issues, includes sentencing circles, suicide prevention strategies, and community problem-solving processes on mental health.

Environmental Control Programs

More intrusive types of programs have been developed to limit the world of the person needing help. In addition, communities have made a commitment to be dry (i.e., alcohol free) or controlled as a way of preventing violence and other community problems stemming from substance abuse. This strategy attempts to control the environment to ensure prevention by

eliminating the opportunity to do harm to self or others. For example, on careful review, the

World Health Organization's report on suicide prevention (as cited in Bertolote, 1993) generated

a list of six steps to prevent suicide. In all but one, the focus is on controlling the environment

and removing the appeal of suicide (Leenaars et al., 2000). This approach is effective, but it

removes the onus for well-being from the individual. Behavioural modification strategies, which

are often used in mental health programs, reinforce a permissiveness that undermines the

community members' capacity to care for one another. This intervention places an inordinate

amount of responsibility on the community to foresee the consequences of an individual's

actions.

Another example of communities organizing around issues is "means restriction," which

is employed to deal with high rates of suicide. In Nunavut and New Zealand, youth frequently

choose hanging as a means to commit suicide (Beautrais, 2001; Kral, 2003). To prevent and

reduce suicide, the community has removed closet rods and locks from bedroom doors in

Qikiqtarjuaq, Nunavut, as a symbol that suicide is unacceptable (Bell, 2003; Kral). In other

countries and communities, there are numerous places and means for hanging and committing

suicide (Beautrais; Cantor & Neulinger, 2000). There are severe limitations to any program

designed to prevent suicide. Therefore, a comprehensive, community-based approach to problem

solving teaches responsibility and has the greatest potential to maximize the caring capacity of

community members for one another.

Wraparound

A recent contribution to the treatment of youth has been the implementation of the

Wraparound process. Strode (2003), Cross (2003), and Cross et al. (2000) provided excellent

summaries of the Wraparound process. In a survey of community needs, Wraparound was

suggested as a comprehensive strategy for Nunavut (Zamparo & Seburn, in press). This section features aspects of these reports.

Wraparound is a process rather than a prescribed model or way of providing services. An integrative and collaborative philosophy is at the core of a wraparound system of care for youth and families in need. Rather than having one institutional designation, the Wraparound process is community based and relies on an intricate network of professionals and community members who become part of an assessment and treatment team to provide support. This highly individualized initiative is flexible and can adjust to cultural and geographic needs. The optimum goal is to provide the needed supports in the community and organize them so that youth can remain at home with their loved ones during the course of treatment.

Integrated Services for Northern Children (ISNC) is an interministerial program commitment of health, mental health, and education services for children living in rural, remote areas of northern Ontario (see Ministry of Children and Youth Services, Government of Ontario Web site). The ministries united in this commitment are the Ministry of Children and Youth Services, the Ministry of Health and Long-Term Care, the Ministry of Education, and the Ministry of Northern Development and Mines. Interdisciplinary teams are based in six major centres, and these professionals provide assessment, consultation, and treatment services to children and their families. All services, which are offered in the home community or close by, are linguistically and culturally appropriate.

Case managers provide a single entry point and coordinate the specialized services and the plan of care. The child/youth-centred service plan created for each child is based on the needs of that child, as opposed to only the available services. The Wraparound process provides the opportunity to focus on the child in all life domains: family, living situation, financial,

educational/vocational, social/recreational, behavioural/emotional, psychological, health, legal, cultural, and safety. This practice is a process rather than a program model. It is highly adaptable and can be employed anywhere.

Other programs that integrate the wraparound philosophy and approach are services that emphasize strengths-based community empowerment (e.g., Sacred Child [Cross et al., 2000; Strode, 2003]) and are youth and family centred (e.g., Mno Bmaadzid Endaad [Strode]).

The Wraparound process provides the best opportunity for community empowerment when combined with a community-based mental health strategy. The philosophical basis of the Wraparound approach is constructed from an important set of elements:

- Treatment must be based within the child's/youth's community.

- Individualized treatment must meet the needs of the child/youth and family.

- Treatment plan must maximize the available service systems.

- Parents are a central component whose active participation is important to the success of the process.

- Funding must be flexible and follow the child's/youth's plan of care.

- Interagency collaboration must respect community ownership of the process.

- Service plan must be flexible and adaptable to change.

- Outcomes must be measured. (Adapted from Strode, 2003, pp. 38-41).

More details regarding Wraparound is provided in the separate program database in Strode, Cross et al. (2000), and the Center for Effective Collaboration and Practice – Wraparound Planning at http://cecp.air.org/wraparound/default.htm.

Telehealth

Telehealth has several applications in Canada and other countries. In Canada, a comprehensive review of Telehealth services in every province and territory was done as recently as 2000 (Picot & Cradduck, 2000). Telehealth has been touted as the answer to health and mental health services for geographically distant, low-population density communities in rural, remote areas (Lessing & Blignault, 2001; Zamparo & Seburn, in press). Although the literature reported several applications for Telehealth, many of them are developmental and are on a continuum ranging from information sharing to assessment and interventions. Several issues of accountability, such as access (Lessing & Blignault); cost effectiveness (Hailey, Bulger, Stayberg, & Urness, 2002); frequency (Jennett et al., 2003); and sustainability (Cradduck, 2002), are emerging in the early stages of implementation. Considering issues of accountability in the development stage is misguided: A certain amount of time must pass before the investment can be evaluated for its utility. Telehealth is more than an alternative: It is a necessary part of providing specialized mental health services to remote areas. For the purpose of this report, the authors selected Telehealth's mental health services that focus on information sharing, assessment, and treatment interventions.

Building the infrastructure, training personnel, and building capacity for using Telehealth has been a long and challenging process. Prior to 1997, Telehealth consisted of mainly demonstrations of techniques for staff (Stamm & Perednia, 2000). Now, the technology facilitates service delivery, education, and administrative activities through Telehealth. These services have expanded in spite of the lack of efficacy of Telehealth delivery systems (Jennett et al., 2003). Investment in building a technology infrastructure for Telehealth has been as much an economic development strategy for rural, remote communities as a service delivery system.

Stamm (1998) noted the research literature about Telehealth usage is increasing rapidly. However, the quality of such research is untested and inconsistent.

The case for implementing Telehealth to promote the mental health of children and adolescents is encouraging. In the United States, mental health applications ranked first as the most common use of Telehealth services in 1997 (Stamm, 1998). Part of this may be because of the relative ease with which mental health communication can occur via the technology utilized in Telehealth. Furthermore, using Telehealth to promote the mental health of children and adolescents is reasonable because of their natural fascination with technology (Stamm). Children and adolescents are eager to make use of technology, such as computers and the Internet. Privacy issues are less complex. Telehealth is effective in allowing interdisciplinary and multiple modes of interventions to occur simultaneously.

In 1997, the Joint Working Group on Telemedicine in the United States created the Interdisciplinary Telehealth Standards Working Group (Reed, McLaughlin, & Milholland, 2000). Reed et al. identified some caution, and propose that Telehealth can restrict access. The restrictions, which have been mainly financial, are influenced by commercial markets. To counter this, Reed et al. identified five reasons why the practice and development of Telehealth should be an interdisciplinary activity:

1. To protect clients who may be recipients of Telehealth services.

2. To promote a unified voice of health care professionals to increase meaningful participation and improve the quality of Telehealth policy.

3. To mitigate the effects of the pace of technological development and change on the nature of the services provided.

4. To prepare, guide, and support all health care professionals to incorporate emerging Telehealth technologies into their practices.

5. To be cautious in allowing technology to be the driving force in the development of telemedicine. (pp. 171-172)

The Alberta Mental Health Board engaged local stakeholders in the development of their telemedicine mental health service in the beginning stages. This consultative process was designed to ensure approval and input from local health care professionals and four regional health authorities. The Alberta Mental Health Board conducted assessments of the telemedicine mental health services in Alberta and concluded that telepsychiatry is "acceptable and sustainable at a realistic cost" (as cited in Hailey et al., 2002, p. 24). Engaging stakeholders and interdisciplinary health care providers, who focus on clients, has strengthened the Alberta project into a viable option for mental health treatment in the province.

Cultural Appropriateness

Telehealth services have considerable potential in providing culturally appropriate mental health support. Training Inuit to use Telehealth is a way of blending southern professional knowledge with IQ. Simply put, it engages people online who can ensure that the cultural norms are considered in any mental health assessment and intervention processes (Jennett et al., 2003). Telehealth can provide much needed services to anyone, including Indigenous people; however, these services must be respectful of their language, traditional values, and norms. Furthermore, programs and services must take into account the uniqueness of geography for the recipients.

Rural, Remote Services

Rural, remote communities can access all sorts of mental health services: assessment, intervention, treatment, public education, consultation, training and support. For some rural,

remote communities, Telehealth may be the only feasible method providing mental health services, given the constraints of staffing, cost, time, and travel (Jennett et al., 2003). According to Jennett et al.'s socioeconomic analysis of all Telehealth programs, "telephone-based applications, such as triage, telecare, or patient monitoring, can improve access, quality of care, and reduce travel and cost" (p. 316). The results would be similar for mental health services. Telehealth services might be the best way to offer culturally and linguistically appropriate services, with well-trained people providing the services and conveying the information to communities. Potentially, they can be designed and delivered with less intrusion.

Several Telehealth services have been established worldwide to provide services in rural communities, with little research dedicated to the sustainability of these programs. Observable indicators of successful Telehealth mental health programs that are working effectively include:

- Telehealth is a service absorbed into a comprehensive health program.

- The number of Telehealth sites is increasing.

- Telehealth has adequate capacity to respond to demands.

- Telehealth requires an ongoing investment.

- Telehealth is a core budget line item.

- Policies to support Telehealth services are part of a mental health strategy.

(Cradduck, 2002)

If Telehealth programs in Nova Scotia and Alberta are examples, both needed approximately 4 years before they matured to the level of being integrated into the health care delivery system (Cradduck). However, in Canada, it is often the case that funding is available to initiate an innovative plan, yet the time line frequently sunsets before programs reach that level of maturity.

Program evaluations can enhance a Telehealth system in rural, remote communities, particularly for programs in mental health. It can best do so by engaging people with a vested interest in the success of the program to monitor and feedback their observations. Program evaluations can also shift the focus toward clients and away from technology and its value by recognizing the importance of developing programs that address their special needs (Stamm & Perednia, 2000). The Australian New Zealand Telehealth Committee (2000) joined forces with the Commonwealth Department of Health and Aged Care to prepare *A Methodology for Telehealth Evaluation in Australia*. Mental health was among the issues addressed in the report. Templates and support for staff, funders, and stakeholders are available to evaluate the cost and utility of Telehealth programs. Because Australia is comparable to Canada in the vastness of its rural, remote communities, this document is an excellent resource.

First Nations and Inuit Telehealth

FNIHB (2003) has facilitated information-sharing sessions on the benefits of Telehealth for Indigenous communities in Canada. Some communities have experienced better access to health services, less patient isolation, improved response times, community empowerment, and reduced travel and transportation costs (FNIHB). The FNIHB identified the lack of connectivity in rural, remote communities as a problem that is exacerbated by the lack of community capacity to obtain the financial resources to build a suitable infrastructure.

In October 2000, FNIHB sponsored the National Information Sharing and Feedback Session on the Potential Future of Telehealth in First Nations and Inuit Communities in conjunction with the Assembly of First Nations and Inuit Tapirisat of Canada. The final report of this consultation process served to clarify the possibilities of current technology and Telehealth in a First Nations and Inuit context. This report summarizes the challenges, lessons learned, and

evaluations of other Telehealth projects. This document also provides a comprehensive summary

of Telehealth activity in Canada and included a blueprint for Telehealth planning.

Examples

Because Telehealth was implemented to provide a range of services, the examples that

the authors included in this section feature some provincial responses (i.e., Alberta, Nova Scotia,

Nunavut), as well as one from Australia, to mental health issues that are worth noting. As well,

each example has a Web site with other valuable resources.

Alberta

Alberta has developed a relatively large Telehealth program that has grown quickly

(Cradduck, 2002). By the end of June 2003, the number of Telehealth sites had risen to 236.

Even though continuing education and administration account for most of the system's use,

mental health activities occupy most of the clinical volume. Individual health regions initiated

this program, and they collectively planned and developed the mental health Telehealth program.

The Alberta Wellnet Telehealth Web site (http://www.albertawellnet.org/Telehealth) provides an

organized list of Telehealth links for further information.

Nova Scotia

Nova Scotia was the first province in Canada to establish a provincewide Telehealth

network, beginning with a pilot project in 1996 (Nova Scotia, 2003). Currently, the Telehealth

network in Nova Scotia comprises approximately 42 sites. This is comparable, on a per capita

basis, to Alberta's Telehealth network. Similarly, the heaviest Telehealth usage is the result of

continuing education. In terms of clinical programs, in 2001-2002, the TeleMental Health

Program for adults and paediatric psychiatric consultation had the highest percentage of

transactions (487/1499 [32.5%]). The Nova Scotia government Web site, in addition to providing

a significant amount of information about the program, links to other Telehealth programs. It is a

valuable resource to any group contemplating Telehealth as a viable option

(http://www.gov.ns.ca/health/Telehealth/links.htm).

Nunavut

The Nunavut Department of Health and Social Services is responsible for the

development and support of the Ikajuruti Inungnik Ungasiktumi[4] (IIU) Telehealth Project. As of

June 2003, when this program was launched, 15 Nunavut communities had Telehealth sites.[5] It is

also expected that by the end of the 2005 fiscal year, 25 communities will have operational

Telehealth services. Each of these has community members trained as site technicians

(Government of Nunavut, 2003). As with most Telehealth projects, IIU provides improved

access and delivery of health, social services and health education. This project has great

potential for Nunavut to offer specialized mental health programs to remote and isolated

communities. IIU also serves a community development function and provides a mechanism for

intercommunity communication, thus enabling communities to benefit from each other's

experience.

Australia

Lessing and Blignault (2001) noted that psychiatric and mental health activities account

for approximately one third of Australia's Telehealth activity. The first trial mental health

service, which was delivered by teleconference in 1993 between the Royal Adelaide Hospital

and the Whyalla Hospital in South Australia, soon led to the establishment of a permanent

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[4] Ikajuruti Inungnik Ungasiktumi translates from Inuktitut to English as "a tool to help people that are far away" (http://www.gov.nu.ca/hsssite/Telehealth.shtml)
[5] E-mail correspondence (April 17, 2004) with Tina McKinnon, manager of Telehealth services, indicated that a final report on Nunavut's Telehealth implementation process is currently being drafted and will be published after approval by the appropriate figures.

program. In 1999, Lessing and Blignault conducted a national survey of 25 mental health

telemedicine programs. With information garnered from 23 programs, Lessing and Blignault

found that state government funds 16 of these programs and that the Commonwealth government

supports 4. The majority of these programs (14) provide services for adults only, and only 3 sites

concentrate on services for children and adolescents. Furthermore, the average distance to a

mental health service is 518 km for those programs operating in nonmetropolitan areas. None of

these operate as stand-alone projects; rather, they are part of mental health services. All involve

interdisciplinary stakeholders in development and execution. Of immediate interest is that

approximately 7% of users are Australian Aboriginals or Torres Strait Islanders, as compared to

the Australian population average of 2%.[6]

One specific example of Telehealth services in Australia is the *Bringing Child and*

Adolescent Mental Health Services to Rural Communities. The Rural Health Support, Education,

and Training Program (RHSET) Telehealth Project funds this program and the evaluation of its

services. The three aims of the project for children and adolescents are "to improve accessibility

to services, to establish Telehealth networks and to evaluate the effectiveness of Telehealth"

(J. Mitchell, 2000, p. 3) in such rural communities in Australia as Darwin, Alice Springs, Roxby

Downs, and Coober Pedy.

This evaluation by J. Mitchell of the project in its early stages has concluded that the

project extends the technology used by previous Telehealth projects. Firstly, the established

network is extremely complex because it spans state and territory borders, and different health

departments, with a maximum distance of 3,000 km from Adelaide, the home base of the project,

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[6] Lessing and Blignault (2001) stated that this is likely an underestimate because client data were unavailable from some programs servicing regions with large Indigenous populations.

to Darwin, the northernmost site. Secondly, the network makes use of subnetworks for professional development from metropolitan to rural centres. Thirdly, the use of media other than videoconferencing, such as the World Wide Web, videotapes, and print, offers a large array of possibilities in a Telehealth setting. Lastly, and also a prime indication of the sustainability of the project, is that the Telehealth provision is a fully absorbed and integrated process in the Children and Adolescent Mental Health Services at the Division of Mental Health, Women's and Children's Hospital in Adelaide, Australia. Through this integration, the Telehealth program for youth has secured a modest budget and a notably high degree of satisfaction by its users. The results verified the indicators set out by Cradduck (2002) as criteria for the creation of best practices for sustainability of a mental health program in Telehealth. It is not surprising that Telehealth is significant interest, with worldwide interest in the variety of health services that it can provide. Mental health services and their easy adaptability to online Telehealth show great promise for meeting national and regional needs in rural, remote communities.

REFLECTIONS: TAKING OWNERSHIP

This complex literature review, represented well by its theme of a cross-jurisdictional analysis of the literature on services, program models, and best practices in mental health, with a focus on interdisciplinary, intersectoral approaches, is somewhat unorthodox. There are three reasons for this. The authors based their report on a document entitled, *Our Words Must Come Back to Us*, which unites the voices of Nunavummuit in their pursuit of solutions to suicide in their communities. The Inungni Sapujjijiit Task Force on Suicide Prevention and Community Healing (2003) set out detailed recommendations to accomplish this mission. The Minister of Health and Social Services stated, "The need for support structures to be in place at the community level to ensure that community-based prevention, action, and healing can take place" (Picco, as cited in Inungni Sapujjijiit Task Force, p. 2). Clearly, the government recognizes the value of this report. Therefore, this *Echoes and Reflections* report reverberates the intent of the Inungni Sapujjijiit Task Force.

Although this literature review is framed to complement an Inuit document, it reflects Eurocentric and Indigenous worldviews from an interdisciplinary and cross-jurisdictional viewpoint. Because the document is intended to be user friendly and a useful resource to anyone, the concluding remarks serve a dual purpose of reinforcing the conclusions in the Inungni Sapujjijiit Task Force (2003) report about community-based ownership of the mental health process and suggesting critical reflections that add to these findings.

Taking Ownership

Throughout the report, the authors stressed community ownership as a central theme for best practices in mental health. The Inungni Sapujjijiit Task Force (2003) was very clear that Inuit want to take responsibility by caring for the welfare of each other. This message was

reinforced in other documents, such as the *Nunavut Addictions and Mental Health Framework* (Government of Nunavut, 2002) and in the Inuit principles and values endorsed by the Nunavut government (Uluadluak, 2002). A community-based mental health initiative mobilizes Inuit to action in regaining their foundations, retrieving their skills, and building a strong community of resources capable of caring for their own.

For Inuit and other Indigenous peoples, empowerment is about process, and it takes time. As the authors pointed out previously, time is regarded differently. Allen (2001) contended that in Igloolik, for example, the Inuit "described finding a confident place from which it is possible to take action" (p. 142) and exemplified the collective nature of these people for problem solving. Even though all communities congregate around tragedies to care for one another, a community-based mental health strategy unites everyone around a vision of wellness.

Confidentiality Issues

Confidentiality issues in mental health promotion are mostly challenged by cultural diversity. Many rural, remote communities have professional services delivered by people with different cultural roots and values. These professionals are also strangers to the community and lack history, relationship networks, and a knowledge of the people who live there (Inungni Sapujjijiit Task Force, 2003). An important recommendation of the task force was that "all caregivers [including outside professionals] with access to personal information need to be trained to respect it" (p. 23). Therefore, a community-based mental health strategy ought to engage the community in a process that establishes a consistent protocol for dealing with confidential matters that inspires trust and confidence. This standard of respect allows people to feel safe in seeking help (Cross et al., 2000; Dobson & Darling, 2003). When this occurs, secrets

have no power. Consequently, more people, not only the select few who benefitted from services in the past, are less isolated as they move closer to achieving wellness.

Tension Between Communities and Government

Communities need agreement among the various levels of government to be able take ownership of their wellness initiatives. The ongoing territorial debates among federal, provincial, and regional jurisdictions do little to assist the development of successful mental health programs for Aboriginal and Inuit communities (Smye & Mussell, 2001; Tanney, 1995). The lines between government authority at the federal, territorial, and community levels are blurred and lead to confusion and inertia rather than action. This is particularly true in the areas of health, mental health, and social services, where there are large numbers of programs and overlapping jurisdictions. In fact, Smye and Mussell pointed out that such debates act as a "major barrier to service provision" (p. 3). Change is slow with many of these programs; therefore, governments are less enthusiastic to support mental health causes (Tanney). However, the community-based strategy is proactive in addressing the root causes of mental health issues. It is all about results.

The historical inflexibility of governments has hampered many communities in their intention to incorporate wellness strategies. Flaherty (1997) argued that communities are handicapped by the lack of information, control, and resources to make change. Their situation is exacerbated when governments download service delivery to unsuspecting communities (Kirmayer et al., 1994b). Some resources have accompanied this responsibility, but the criteria for access hinder community ownership of a mental health strategy (Ripple & Zigler, 2003). This phenomenon is a cross-national and cross-jurisdictional issue.

Some communities that struggle to deal with suicide have compromised their community plans and have implemented prescribed programs when funding is available. For these

communities, access to programs is about politics and competition (Leslie & Story, 2002).

Communities that take ownership of a community-based mental health strategy have the best of

both worlds. These communities know clearly what they want, and they have local support to

pursue their goals. Funding agencies are quick to support a thoroughly planned mental health

program strategy, yet these communities are also able to create their own revenue. Mental health

strategies are an integrated system of bringing people and resources together. The provision of

competitive funding opportunities shows a lack of respect to communities that engage in

community-based, problem-solving processes. The Inungni Sapujjijiit Task Force (2003)

suggested that governments must change to meet the needs of Nunavummiut so that

communities can take ownership of their mental health strategies.

Feedback for Capacity Building

Communities know best who can represent them, benefit from training, and bring the

information back for the benefit of all. The Inungni Sapujjijiit Task Force (2003) reiterated a

need for leadership in deciding who is sent for training to share with their communities. Each

community has its own process, and under the rubric of a mental health strategy, a selection

process can target young people who are potential leaders. This same mental health strategy can

establish accountability protocols for knowledge transfer. Instilling a sense of responsibility and

ownership reduces the possibility that the people selected to attend training may misinterpret the

opportunity as a holiday.

Other ways to strengthen community-based mental health strategies is to bring the

training to the community. This method engages the entire community in the learning experience

and allows for a wider transfer of knowledge. It also has other benefits, such as economic

development and the opportunity to recharge and refocus the community's energy and resources

in a positive manner. Flaherty (1997) was very deliberate in showing the mental health benefits

of training in local communities:

> A series of workshops should be held in Inuit communities to address mental
> health issues with the clear intention of informing the communities as to how
> social problems could be dealt with at the community level and how general
> mental health can be improved. (p. 105)

The rationale for sending representatives to attend either regional or national training sessions

has been cost efficiency and the inability of rural, remote communities to provide the

infrastructure.

It is easy to articulate all of the reasons why this approach is unmanageable. However,

mobilizing a sense of well-being that arouses the imagination of the people to support it has more

benefits over the long run than short-sighted associated costs and other barriers. The authors of

this report made a strong argument for Telehealth as an effective means of sharing information

and providing mental health services. Telehealth, combined with online consultations, Web sites,

and prepackaged training materials, can bring training and development to a local community or

a group of communities on their own terms.

Any training opportunity must respect the collective nature of Inuit society and allow the

decision-making process to be centred within the community. Building up capacity for mental

health programs and services creates models of best practices that can be shared with other

communities. These best practices can exemplify the recovery of foundations and the retrieval of

skills while engendering a sense of pride that other communities can emulate. Intercommunity

communication and sharing of experiences generate a feedback mechanism that rejuvenates

community imagination for problem solving.

Misunderstanding Between Two Worldviews

Mental health converges two worldviews. Professional support to rural, remote communities brings to bear a Eurocentric worldview, whereas the community has a worldview that is interconnected and interdependent. A major part of a community's ownership that permits the foundations, values, and strengths to flourish is about community pride, which demands respect from others. In most cases, outside service providers are ill-equipped in matters of traditions, values, and cultural beliefs, especially in the treatment of Aboriginal groups (Smye & Mussell, 2001). Culturally appropriate mental health interventions are more effective in treating families (Malus et al., 1994; Middlebrook et al., 2001; Power, 2003). To achieve a better rapport between these two worldviews, communication is critical. Every effort must be made to bridge language and cultural barriers with respect to the knowledge ingrained in the traditions of the community. Expanding a community's capacity to provide its own services is the solution to overcoming the tensions between two worldviews.

Meanwhile, those individuals providing services to any cultural groups should be trained in appropriate techniques to make their services more successful (Gardiner & Gaida, 2002). An understanding of the impact of colonialism must be integrated into any training programs for non-Aboriginal professionals who may have little respect for Aboriginals and their concept of time, values, and traditions, as well as the distinct features of each community in their approach to providing services (Kirmayer et al., 1994b, 2000). For Inuit communities specifically, non-Inuit service providers should be required to complete training that clearly explains Inuit culture, traditions, and values (Flaherty, 1997). It might be considered excessive to expect non-Aboriginal professionals to undergo such extensive training, but it is necessary to counterbalance the Eurocentric paradigm that is an integral part of all mental health professional training.

Our Data Belong to Us

A disturbing aspect of research and consultative activities is the lack of respect for the "participants" and the lack of feedback. Research processes must be respectful of people's culture and traditions (Robinson, 1997). Bringing the community's words back in the form of completed research allows community members to benefit from their own contributions and knowledge. The Inungni Sapujjijiit Task Force (2003) encapsulated this notion in the title of its report, *Our Words Must Come Back to Us*.

Having access to an Aboriginal community is a privilege. This is due, in part, to the wariness of Aboriginal leadership caused by the "historical misrepresentation of 'behavioral studies of native communities' " (Cross et al., 2000, p. 93). The lines of communication between community and researcher must remain open to create a feedback loop that benefits both.

One benefit to communities is the opportunity to train local researchers afforded through participatory action research projects. his method collects data while initiating and guiding social processes (Chalmers & Bramadat, 1996; Flaherty, 1997; Robinson, 1997; Tanney, 1995). Ideally, action research projects will be entwined with community-based mental health strategies so that even after the research projects are completed, communities will be able to continue to negotiate successful paths to wellness for their community members.

Cultural centres located in rural, remote communities often provide a "warehouse" for traditional knowledge and other data on wellness, well-being, and mental health that can be retrieved for future research and teaching. A clearinghouse for culturally appropriate mental health promotion and suicide prevention information and research accessible through the World Wide Web would enhance communities' databanks. Having such a valuable resource has been recommended by the Advisory Group on Suicide Prevention (2003), commissioned by the

Assembly of First Nations and Health Canada as one of its long-term goals. The Advisory Group

recommended that the Institute for Aboriginal Peoples' Health and the National Aboriginal

Health Organization:

> Create a national clearinghouse and website for information on best practice
> models and culturally sensitive methods of health research and evaluation in
> Aboriginal communities and populations. This should be linked to similar groups
> and sites working in U.S., Australia, New Zealand and other countries to address
> mental health issues with Aboriginal peoples. (p. 10)

Sadly, many of these insightful recommendations have not been implemented. Implementing a

successful community-based mental health strategy necessitates the collaboration of two

worldviews and eliminates the separation between research and program delivery.

Healing Our Youth at Home

The ultimate goal of many Aboriginal communities is to preserve their communities and

keep their families together. Youth in need of help who are sent out of their communities for

treatment suffer greatly from a loss of cultural identity while away and the confusion of

reintegration upon their return. Communities mirror the same loss and disruption to their support

networks and families. The authors of this report presented examples of and offered suggestions

to enhance community-based ownership of mental health strategies. There is little doubt that this

is the right path for Inuit and other Aboriginal people. In retrospect, it is the right path for

everyone.

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APPENDIX

Questionnaire to Establish a Community-Based Model for Mental Health Strategies

The following questions can be used to assess the community's capacity to develop a community-based model for mental health strategies. This list is adapted from the themes developed by Kirmayer (1997).

1.   Scale and remoteness.

        a.   How large is the community?

        b.   What are the demographics?

        c.   How far away from major urban centres is the community?

        d.   What are the statistics on mental health difficulties in this community?

2. Anonymity.

        a.   Can anonymity be preserved in this community?

        b.   What safeguards are needed to preserve anonymity in this community?

        c.   How will breaches in anonymity be handled?

3. Resources.

        a.   What resources does the community have?

        b.   How can these resources be enhanced?

        c.   Where can funding be sought?

        d.   Are there communities within the area with whom a reciprocal agreement can be developed?

4. Professional Training.

        a.   What are the professional training options that are viable for this community?

       i.   Is there someone in the community who can do the training?

      ii.   Can professional trainers be brought in to train our people?

     iii.   Should our people go to the trainers?

  b. How does the community benefit the most from the professional training option?

5. Language.

  a. What languages are appropriate for programs in the community?

  b. What options can be provided for those not able to read/write/speak/hear?

6. Culture.

  a. What about our culture will enhance our mental health strategy?

  b. What about our culture will inhibit our mental health strategy?

  c. How best can our culture be used to promote mental health?

  d. Who is the best equipped to use our culture as a tool?

7. Rapidity of culture change.

  a. How can we address the change in culture from our past to our present and future?