Culturally Competent Evaluation

Clinical Considerations for Rating the Child and Adolescent Functional Assessment Scale (CAFAS®) with Aboriginal Children and Youth

Melanie A. Barwick, Ph.D.,C.Psych.
The Hospital for Sick Children, Toronto, Ontario
University of Toronto, Toronto, Ontario

John Schmidt, B.A., S.S.W.
Consultant, Mental Health Programming
Lecturer, Confederation College, Thunder Bay

Kay Hodges, Ph.D., ABPP
Eastern Michigan University, Ann Arbour, Michigan

To cherish Knowledge
is to know Wisdom

Correspondence regarding this document can be addressed to:

Dr. Melanie Barwick
Community Health Systems Resource Group
The Hospital for Sick Children
555 University Avenue
Toronto, Ontario, M5G 1X8

Telephone: 416-813-1085
Fax: 416-813-7258
Email: melanie.barwick@sickkids.ca

Recommended citation:

Barwick, M. A., Schmidt, J., & Hodges, K. (2004). Culturally competent evaluation: Clinical considerations for rating the Child and Adolescent Functional Assessment Scale (CAFAS®) with Aboriginal children and youth. Toronto, ON: The Hospital for Sick Children.

Additional copies of this report are available on the internet:

www.CAFASinontario.ca

Publication of this document was made possible by a grant from
The Ontario Mental Health Foundation

TABLE OF CONTENTS

About the Authors 1
Acknowledgements 2
Glossary 3
Chapter 1 – About This Guide 7
Purpose 7
Development 7
A Work in Progress 8
The Ontario Context 8
Format of this Document 9

Chapter 2 – Cultural Competence 13
The Canadian Cultural Picture 13
Cultural Competence 13
Culturally Competent Mental Health Care for Children and Youth 15
Developing Cultural Competence 16
Achieving Cultural Competence 17

Chapter 3 – Overview of Aboriginal Peoples in Canada 21
Aboriginal History in Canada 22
Attempts to Legislate Aboriginals 23
The Indian Register 23
Prevalence of Mental Illness among Canada's Aboriginal Peoples 24
Residential Schools 25
Family Violence 26
Substance Abuse 27
Suicide 27
Education 28
Regeneration 29
Culturally Appropriate Mental Health Services 29

Chapter 4 – Clinical Considerations for Rating the CAFAS® for Aboriginal Clients 33
School / Work Performance 34
Home Performance 35
Community / Role Performance 37
Behavior Towards Others 38
Moods / Emotions 39
Self-Harmful Behaviors 40
Substance Use 41
Thinking 41
Caregiver Material Needs 42
Caregiver Social Support 43

Chapter 5 – CAFAS Vignettes® of Aboriginal Clients 47
Tara 47
Fred 50
Jeremy 54

References 59
Feedback Form 61
Contact Us 62

To know Love is to know Peace

ABOUT THE AUTHORS

Melanie Barwick is a Registered Psychologist and Health Systems Scientist in the Community Health Systems Resource Group at The Hospital for Sick Children (HSC). She is an Associate Scientist in the hospital's Research Institute, and Assistant Professor in the Departments of Psychiatry and Public Health Sciences at the University of Toronto. She received her doctorate in Educational Psychology at McGill University and did consecutive post-doctoral fellowships in developmental psychopathology and infant mental health at the Hincks Institute in Toronto. Before joining HSC in 2001, she was Director of Research at The George Hull Centre for Children and Families. Together with Dr. Bruce Ferguson, Director of the Community Health Systems Resource Group at HSC, Dr. Barwick leads the training and implementation of the province's outcome measurement initiative which involves the use of the Child and Adolescent Functional Assessment Scale as a province-wide mental health outcome measure. Her program of research includes work in the areas of knowledge translation and organizational change, particularly the transfer of evidence-based interventions and research to practice, and she has published in the areas of language impairment, psychopathology, and infant attachment.

John Schmidt is former Regional Director for North of Superior Programs, a multi-service agency serving children and adults with mental health and addictions concerns in the District of Thunder Bay, Ontario. John was Manager of the Mental Health Intake and Assessment Program at Dilico Ojibway Child and Family Services. John's educational background is in business management. He has worked extensively in the field of mental health and addictions, primarily with Aboriginal children and adults and now teaches at Confederation College, Thunder Bay.

Kay Hodges is a Professor of Psychology at Eastern Michigan University (EMU) and Associate Director of the Applied Research Unit at the Institute for the Study of Children, Family, and Communities at EMU. Before joining EMU in September 1989, she was an Associate Professor in the Division of Medical Psychology at Duke University Medical Center. Previously at the University of Missouri Medical School, she directed the Mid-Missouri Psychology Internship Consortium and directed the child and adolescent outpatient unit at the Community Mental Health Center. She received her doctorate in clinical psychology at the University of Maryland and did her internship training at the Children's National Medical Center in Washington, D.C. She has also received post-doctoral training at Washington University School of Medicine and the Menninger Foundation. She is a fellow of the American Psychological Association and has been active in several APA Divisions, including her role as secretary for the Division of Child, Youth, and Family. Her numerous publications are in the areas of treatment outcome, assessment of children and adolescents, childhood depression, and psychosomatic illness. Before developing the Child and Adolescent Functional Assessment Scale (CAFAS)®, which is a multi-dimensional measure of level of functioning, she authored the Child Assessment Schedule (CAS), a semi-structured diagnostic interview for children and adolescents that has been widely used in research.

GLOSSARY

Aboriginal Peoples

A term that came into common usage in the 1970s to replace the word "Indian," which many people found offensive. Although the term Aboriginal is widely used in Canada, no legal definition of it exists. Among its uses, the term "Aboriginal peoples" refers to the descendants of the original inhabitants of North America. The Constitution of Canada recognizes three groups of Aboriginal peoples – Indians, Métis people, and Inuit. These three separate peoples have unique heritages, languages, cultural practices, and spiritual beliefs.

Band

A group of Aboriginal people for whom lands have been set apart and money is held by the Crown. Each band has its own governing band council, usually consisting of one or more chiefs and several councilors. Community members choose the chief and councilors by election, or sometimes through traditional custom. The members of a band generally share common values, traditions, and practices rooted in their ancestral heritage. Today, many bands prefer to be known as Aboriginals.

First Nation

A term that came into common usage in Canada in the 1970s to replace the word 'Indian,' which many people found offensive. Although the term 'First Nation' is widely used in Canada, no legal definition of it exists. Among its uses, the term 'First Nations peoples' refers to the Indian people in Canada, both Status and Non-status. Many Indian people have also adopted the term 'First Nation' to replace the word 'Band' in the name of their community.

Indian

A term that describes all the Aboriginal people of Canada who are neither Inuit nor Métis. Indian peoples are one of three groups of people recognized as Aboriginal in the Constitution Act, 1982. The act specifies that Aboriginal people in Canada consist of Indians, Inuit, and Métis people. In addition, there are three legal definitions that apply to Indians in Canada: Status Indians, Non-Status Indians, and Treaty Indians.

Indian Act

This is the Canadian Federal legislation, first passed in 1876, that sets out certain Federal government obligations, and regulates the management of Indian reserve lands. The act has been amended several times, most recently in 1985. Among its many provisions, the act requires the Minister of Indian Affairs and Northern Development to manage certain moneys belonging to Aboriginals and Indian lands, and to approve or disallow Aboriginal by-laws.

Indian Status	An individual's legal status as an Indian, as defined by the Indian Act.
Inuit	An Aboriginal people in northern Canada who live above the tree line in Nunavut, the Northwest Territories, Northern Québec and Labrador. The word means 'people' in Inuktitut, the Inuit language. In other parts of the world, these people are referred to as Eskimo.
Métis	People of mixed Aboriginal and European ancestry who identify themselves as Métis people, as distinct from Aboriginal people, Inuit, or non-Aboriginal people. The Métis have a unique culture that draws on their diverse ancestral origins, such as Scottish, French, Ojibway, and Cree.
Non-Status Indian	An Indian person who is not registered as an Indian under the Indian Act. This may be because his or her ancestors were never registered, or because he or she lost Indian status under former provisions of the Indian Act.
Off-Reserve	A term used to describe people, services or objects that are not part of a reserve (reservation) but that relate to a First Nation.
Reserve	Land set aside by the federal government for the use and occupancy of an Indian group or band.
Status (Registered) Indian	An Indian person who is registered under the Indian Act. The Act sets out requirements for determining who is a Status Indian.
Tribal Council	A regional group of First Nations members that delivers common services to a group of First Nations.

Sources: Indian and Northern Affairs Definitions (http://www.ainc-inac.gc.ca/pr/info/info101e.pdf)

To honour all of the creation is to have Respect

ABOUT THIS GUIDE

Purpose

This guide was developed as a clinical resource to support the reliable and valid use of the Child and Adolescent Functional Assessment Scale® (Hodges, 2000a; CAFAS®) with Aboriginal children and youth. It serves as an adjunct to the CAFAS® Scale and training manuals developed by Dr. Kay Hodges. Rating of the CAFAS® requires training for inter-rater reliability and is supported by manuals and other documents developed by Dr. Hodges. To become a reliable rater requires establishing inter-rater reliability with the CAFAS® Self Training Manual. In Canada, those interested in CAFAS® reliability training can contact the CAFAS® in Ontario office at 416-813-7258. All other reliability training inquiries are directed to Kay Hodges, Ph.D., 2140 Old Earhart Road, Ann Arbor, MI, 48105, USA (Ph. 734-769-9725, FAX. 734-769-1434, email hodges@provide.net).

In addition to providing clinical rating considerations, this document is intended to provide mental health practitioners with an overview of Canadian Aboriginal history, mental health of Aboriginal children, and culturally competent mental health service delivery. One section describes important considerations for rating Aboriginal clients, organized around the CAFAS® subscales and the specific items within each. Another section provides case examples or CAFAS VIGNETTES which are intended to support the proper rating and interpretation of the CAFAS® for Aboriginal children and youth. The client CAFAS VIGNETTES® are included as models and do not replace the CAFAS® Self-Training Manual CAFAS VIGNETTES® which are used for establishing inter-rater reliability.

We hope this guide will encourage mental health practitioners to listen to the stories of their Aboriginal clients with a more enlightened ear, to involve Aboriginal families and communities in the treatment process, and to avail themselves of supports from Aboriginal organizations in providing service to Aboriginal children and youth. Life for Aboriginal persons in Canada presents many challenges that are important to consider when providing mental health service to Aboriginal children and families, and we hope this guide will provide practical assistance for those striving to improve the lives of our First Peoples.

Development

The need for clinical considerations grew out of the perceptions and experiences of the CAFAS in Ontario team and the practitioners at Dilico Ojibway Child and Family Services, a mental health service provider serving Aboriginal children, youth, and families in Northern Ontario. As Dilico staff began to use the CAFAS® they became aware of the need for further clarification or explanation regarding several CAFAS® items. Concern arose as it appeared that some items could be rated improperly by clinicians with insufficient knowledge of Aboriginal cultures and norms.

The guide was developed in a step wise process. First, a list of all CAFAS® items was distributed by survey to our mental health contacts in approximately 30 children's mental health agencies across Ontario, with written permission of the author to extract portions from the copyrighted CAFAS® assessment tool. The 30 organizations represented those known to serve Aboriginal children and youth. Respondents were invited to describe concerns regarding the rating of any CAFAS® item for Aboriginal clients. Respondents' comments were then reviewed by John Schmidt, Melanie Barwick, and CAFAS® Trainers Kirsten Madsen and Denice Basnett, and provided the basis for the item considerations included in this document.

A Work in Progress

This document is to be regarded as a work in progress. It represents a first attempt at capturing important clinical considerations regarding the application of the CAFAS® as a global measure of mental health outcomes for Aboriginal children and youth. It cannot be overstated that we welcome feedback from practitioners and Aboriginal communities regarding issues we may have missed, misrepresentations or incorrect information, the overall usefulness of the guide, or other interpretations or issues not captured in this version. A form at the back of this guide can be used by those wishing to provide feedback. Please keep in mind that this guide was developed on the basis of the Aboriginal experience in Ontario, Canada and may or may not be applicable to Aboriginal peoples in other parts of North America and beyond. We hope future versions will encompass a more universal Aboriginal experience.

The Ontario Context

The Child and Adolescent Functional Assessment Scale (CAFAS®) was developed by and is the intellectual property of Dr. Kay Hodges (2002a). The CAFAS® has been mandated for use in the province of Ontario by the two ministries responsible for children's mental health: the Ministry of Community, Family, and Children's Services (MCFCS) and the Ministry of Health and Long-Term Care (MOH-LTC). The province's mental health measurement initiative seeks to measure functional outcomes for children ages 6 through 17 years who have received mental health services in the 108 participating organizations. A team of clinicians and health systems scientists based at the Hospital for Sick Children is responsible for undertaking the training and implementation support for the CAFAS® in Ontario under the leadership of Dr. H. Bruce Ferguson, Director, Community Health Systems Resource Group, and Dr. Melanie Barwick. The team works under contract with the Ministry of Community, Family, and Children's Services and in partnership with a Steering Committee comprised of service provider representatives. Additional information about this initiative and use of the CAFAS® in Ontario can be found on our web site at www.cafasinontario.ca and/or by contacting Melanie Barwick (Ph. 416-813-1085 Email melanie.barwick@sickkids.ca).

Format of This Document

This document begins with definitions of relevant Canadian terminology to orient the reader. This is followed by an overview of cultural competence. Also included is a brief overview of Canadian Aboriginal history and the social issues faced by Aboriginal peoples in Canada. These first sections serve an educational purpose, to introduce readers to the complexities of treating Aboriginal children and youth in a mental health setting.

Two sections follow that are intended to assist clinicians in rating and interpreting the CAFAS® appropriately for this population. We provide a section that describes specific CAFAS® items requiring special consideration when rated for an Aboriginal child or youth. Also, three CAFAS VIGNETTES® are included to provide case examples of CAFAS® ratings for Aboriginal children.

Bravery is to face the foe with Integrity

CULTURAL COMPETENCE

What is culture? Culture has been defined as "…the learned values, beliefs, norms and way of life that influence an individual's thinking, decisions, and actions in certain ways" (College of Nurses of Ontario, 1999). Others have characterized culture as "…a way of life, a way of viewing things and how one communicates…it provides an individual with a way of viewing the world, as a starting point for interacting with others…all encompassing and reflects the assumptions individuals make in every day life (Registered Nurses Association of Nova Scotia, 1995).

Developing awareness of culture is important in the provision of mental health care. "Culture is individual, learned, and shared. It varies across groups and over time" (Nursing Now, 2000). Over the past 15 years, the changing face of culture in Canada has created a significant challenge for the mental health practitioner. Canadians have a larger range of ethnicity, language, and country-of-origin than ever before.

A number of factors hinder the development of a mental health system that is sensitive to culture. Lack of experience and lack of knowledge are two significant barriers. Students in mental health programs are rarely exposed to ethnocultural content in their curricula, and attitudinal factors such as fear, ethnocentricity, cultural blindness, racism, and discrimination can also keep practitioners from being sensitive to the culture of others. We hope this guide will help to address some of these deficiencies for Aboriginal children and youth.

The Canadian Cultural Picture

According to recent census information, immigration to Canada increased by 15 per cent in the five years leading up to 1996. This is three times higher than the growth of the Canadian-born population. In 1996, 42 per cent of Toronto's population was comprised of immigrants, mostly coming from Asia, the Middle East, Central and South America, the Caribbean, and Africa.

The Canadian picture regarding ethnic origin and visible minorities, also based on 1996 census data, portrays a country in which visible minorities represent 11.2 per cent (3.2 million) of the Canadian population. People of Aboriginal ancestry comprise 1.1 million people (about 3 per cent) (i.e., Indian, Métis or Inuit). These data show Ontario, British Columbia, and Manitoba with the highest numbers of Aboriginal people, with the highest concentration evident in the north where Aboriginal people make up 62 per cent of the population of the North West Territories (including Nunavut) and 20 per cent of the Yukon Territories. About one quarter live in major urban centres.

Cultural Competence

Cultural competence is the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population. It involves the use of a systems

perspective which values differences and is responsive to diversity at all levels of an organization, i.e., policy, governance, administrative, workforce, provider, and consumer/client. Cultural competence is developmental and community focused, and family oriented. In particular, it is the promotion of quality services to underserved, racial/ethnic groups through the valuing of differences, the integration of cultural attitudes, beliefs, and practices into diagnostic and treatment methods, and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions, and system practices among providers and staff to ensure that services are delivered in a culturally competent manner (CEO Services, 1999).

Cultural Knowledge: Familiarization with selected cultural characteristics, history, values, belief systems, and behaviours of the members of another ethnic group (Adams, 1995).

Cultural Awareness: Developing sensitivity and understanding of an ethnic group. This usually involves internal changes in terms of attitudes and values. Awareness and sensitivity also refer to the qualities of openness and flexibility that people develop in relation to others. Cultural awareness must be supplemented with cultural knowledge (Adams, 1995).

Cultural sensitivity refers to one's understanding and responsiveness to the cultural needs of clients and families that leads to holistic and responsive care (Cerny, 1997). It involves knowing that cultural differences as well as similarities exist, without ascribing values, i.e., better or worse, right or wrong, to those cultural differences (National Maternal and Child Health Center on Cultural Competence, 1997).

Cultural competence is a term that describes a process in which practitioners develop cultural awareness, knowledge, and skill in encounters with people of other cultures (Campinha-Bacote, 1994). It is a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations (Cross, Bazron, Dennis, & Isaacs, 1989). Cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of health and mental health care; thereby producing better health and mental health outcomes (Cross et al, 1989).

Transcultural competence describes the skills of the mental health practitioner in providing care. Transcultural care includes cultural assessment, respect for the individual, and incorporation of cultural values into care. Cultural awareness and sensitivity are essential to the provision of transcultural care, (Cooper, 1996).

Culturally Competent Mental Health Care for Children and Youth

Culturally competent mental health service providers and the agencies that employ them are specially trained in specific behaviours, attitudes, and policies that recognize, respect, and value the uniqueness of individuals and groups whose cultures are different from those associated with mainstream (North American) culture. These populations are frequently identified as being made up of people of colour, such as Canadians of African, Caribbean, Middle Eastern, Asian, and Aboriginal descent. Cultural competence as a service delivery approach can be applied to systems that serve all persons, because everyone in the society has a culture and is part of several subcultures, including those related to gender, age, income level, geographic region, neighborhood, sexual orientation, religion, and physical disability (Cross et al., 1989).

Culturally competent service providers are aware and respectful of the importance of the values, beliefs, traditions, customs, and parenting styles of the people they serve. They are also aware of the impact of their own culture on the therapeutic relationship and take all of these factors into account when planning and delivering services for children and youth with mental health problems and their families (Cross et al., 1989).

Culturally competent programs can be established by following these nine principles (Cross et al., 1989):

1. The family, however defined, is the consumer and usually the focus of treatment and services.
2. North Americans with diverse racial/ethnic backgrounds are often bicultural or multicultural. As a result, they may have a unique set of mental health issues that must be recognized and addressed.
3. Families make choices based on their cultural backgrounds. Service providers must respect and build upon their own cultural knowledge as well as family strengths.
4. Cross-cultural relationships between providers and consumers may include major differences in world views. These differences must be acknowledged and addressed.
5. Cultural knowledge and sensitivity must be incorporated into program policymaking, administration, and services.
6. Natural helping networks such as neighbourhood organizations, community leaders, and natural healers can be a vital source of support to consumers. These support systems should be respected and, when appropriate, included in the treatment plan.
7. In culturally competent systems of care, the community as well as the family determine direction and goals.
8. Programs must do more than offer equal, nondiscriminatory services; they must tailor services to their consumer populations.

9. When boards and programs include staff members who share the cultural background of their consumers, the programs tend to be more effective.

Ideally, culturally competent programs include multilingual, multicultural staff and involve community outreach. Types of services should be culturally appropriate; for example, extended family members may be involved in service approaches, when appropriate. Programs may display culturally relevant artwork and magazines to show respect and increase consumer comfort with services. Office hours should not conflict with holidays or work schedules of the consumers.

Developing Cultural Competence

Canadian service providers have much progress to make toward cultural competence. Increased opportunities must be provided for ongoing staff development and for employing multicultural staff. Improved culturally valid tools are needed. More research will be useful in determining the effectiveness of programs that serve children and families from a variety of cultural backgrounds. This document and subsequent efforts to understand the level of functioning of Aboriginal children and youth in Ontario represent the beginning of a much needed effort.

For many programs, cultural competence represents a new way of thinking about the philosophy, content, and delivery of mental health services. Becoming culturally competent is a dynamic process that requires cultural knowledge and skill development at all service levels, including policymaking, administration, and practice. Even the concept of a mental disorder may reflect a western culture medical model.

At the policymaking level, programs that are culturally competent (Cross et al., 1989):

- Appoint board members from the community so that voices from all groups of people within the community participate in decisions;
- Actively recruit multiethnic and multiracial staff;
- Provide ongoing staff training and support developing cultural competence;
- Develop, mandate, and promote standards for culturally competent services;
- Insist on evidence of cultural competence when contracting for services;
- Nurture and support new community-based multicultural programs and engage in or support research on cultural competence;
- Support the inclusion of cultural competence on provider licensure and certification examinations; and
- Support the development of culturally appropriate assessment instruments, psychological tests, and interview guides.

At the administrative level, culturally competent administrators:

- Include cultural competency requirements in staff job descriptions and discuss the importance of cultural awareness and competency with potential employees;
- Ensure that all staff participate in regular, inservice cultural competency training;
- Promote programs that respect and incorporate cultural differences; and
- Consider whether the facility's location, hours, and staffing are accessible and whether its physical appearance is respectful of different cultural groups.

At the service level, practitioners who are culturally competent:

- Learn as much as they can about an individual's or family's culture, while recognizing the influence of their own background on their responses to cultural differences;
- Include neighbourhood and community outreach efforts and involve community cultural leaders if possible;
- Work within each person's family structure, which may include grandparents, other relatives, and friends;
- Recognize, accept, and, when appropriate, incorporate the role of natural helpers (such as shamans);
- Understand the different expectations people may have about the way services are offered (for example, sharing a meal may be an essential feature of home-based mental health services; a period of social conversation may be necessary before each contact with a person; or access to a family may be gained only through an elder);
- Know that, for many people, additional tangible services – such as assistance in obtaining housing, clothing, and transportation, or resolving a problem with a child's school – are expected, and work with other community agencies to make sure these services are provided; and
- Adhere to traditions relating to gender and age that may play a part in certain cultures (for example, in many racial and ethnic groups, elders are highly respected). With an awareness of how different groups show respect, providers can properly interpret the various ways people communicate.

Achieving Cultural Competence

To become culturally competent, programs may need to:

- Assess their current level of cultural competence;
- Develop support for change throughout the organization and community;
- Identify the leadership and resources needed to change;
- Devise a comprehensive cultural competence plan with specific action steps and deadlines for achievement; and
- Commit to an ongoing evaluation of progress and a willingness to respond to change.

Those interested in a self-assessment checklist of cultural competence for personnel providing services and supports to children with special health needs and their families are directed to: www.georgetown.edu/research/gucdc/nccc

Honesty in facing a situation is to be Brave

OVERVIEW OF ABORIGINAL PEOPLES IN CANADA

Aboriginal peoples in Canada comprise four main groups: status Indians registered under the Indian Act of Canada; non-status Indians; Métis, and Inuit. The demography of the Aboriginal population is distinct from that of the general Canadian population in several important respects (Kirmayer, Gill, Fletcher, et al., 1994). First, a greater proportion of the Aboriginal population are young (Norris, 1990). The rate of growth of the Aboriginal population is currently decelerating, but the birth rate remains at about twice that of the general population. Aboriginal peoples have significantly higher mortality levels, with a life expectancy of about 10 years shorter than that of the average non-Aboriginal Canadian. Census data from 1986 indicated that 37% of all Status Indians had less than a grade 9 education, more than twice the total non-Aboriginal Canadian rate of 17% (Frideres, 2001).

Aboriginal children and youth are the fastest growing segment of Canada's population. The 1996 Canadian census reported 491 Aboriginal children under the age of five years for every 1000 Aboriginal women of child bearing age. This ratio is approximately 70 percent higher than for the total Canadian population. Based on this growth rate, it is likely that more and more mental health services will be needed for Aboriginal children and youth in the near future.

There is substantial variation in the type and frequency of social problems faced by Aboriginal communities in Canada. Although most Aboriginal communities face similar problems of rapid cultural change, there is great cultural diversity among Aboriginal groups with some 596 bands located on 2284 reserves and Crown land, 10 different languages and more than 58 dialects (Frideres, 2001; Kirmayer et al., 1994). Communities vary in their distance from cities and are situated across a great diversity of geographical locations and coastal, mountain, prairie, arctic, and sub-arctic ecosystems (Kirmayer et al., 1994). Environments differ along dimensions of economy, subsistence patterns, educational opportunities, practice of traditional lifestyle, transmission of language and culture, and experience of minority status and discrimination.

To be truly effective, clinicians serving Aboriginal children, youth, families, and communities must appreciate their diversity and understand the historical and contemporary issues that continue to effect Aboriginal populations in Canada. This overview attempts to provide mental health practitioners with a better understanding of these issues so that they might rate and interpret the CAFAS more appropriately for this population. It is our intent to educate and raise awareness, not to label or generalize all Aboriginal children. We believe it is the responsibility of the clinician to explore the unique heritage, social, historical, and political reality together with their clients. It is important, as well, to emphasize that this overview does not attempt to capture all of the unique issues confronting Aboriginal people today. Issues can vary widely by community, and it is the responsibility of the mental health clinician to provide informed treatment that considers the cultural context of the client.

The overview begins with a brief history of Aboriginal people in Canada and the impact of colonization. Issues affecting Aboriginal children are briefly discussed, including substance abuse, suicide, poverty, racism, family violence, and residential school syndrome. The compounding effect of these crises on Aboriginal communities is reviewed, with particular attention on the impact on treatment planning and response. We discuss efforts to regenerate culture with individuals, families, communities, and Aboriginal social service agencies.

Aboriginal History in Canada

It is estimated that, prior to colonization in the early 1500's, there were over 18 million Aboriginal peoples in North America north of the Rio Grande. Currently, in Canada, there are fewer than 800,000 Status Indians. Colonization was the beginning of unprecedented and unforeseen changes for the traditional life of Aboriginal peoples in Canada. Europeans could not possibly have understood what the future held for Canadian immigrants. When Europeans began to settle in Canada they brought with them warfare, disease, alcohol, and Euro-Christian beliefs. All these things had a significant impact on Aboriginal peoples' social, cultural, and political lives. It was impossible to determine at that time that the impact on the Aboriginal way of life would be devastating. Modern historians have called it genocide. In the early 1600's the Jesuits came to Canada and began their attempt to "civilize" Indians through conversion to their beliefs. In the late 1600's and early 1700's the church and government began imposing their laws on Aboriginal peoples, taking away the traditional ways communities had for dealing with conflict. In 1763, the Royal Proclamation directed that all land for future development in British North America must first be cleared of Indian Title by Crown Purchase. Thus began massive negotiations for Indian land and the introduction of treaties. Aboriginal Title was recognized and continues to exist in law. It also continues to be central to much legal and political debate.

The First Reserve was created for the Mic Mac people in 1773, at which time it was stated: "They will be forced to settle down or starve." In the 1850's came the Robinson Treaties, covering as much land as in all previous surrenders. Subsequent treaties were numbered and encompassed the remainder of Aboriginal land in Canada. When discussing treaties it is important to note that by custom, the perception of Aboriginal peoples was that agreements were not permanent and they were not positioning themselves as subservient to any demeanor other than their own. Rather, they viewed treaties as a means by which they would be able to adapt to the demands of the contemporary world within the framework of their own traditions.

Attempts to Legislate Aboriginals

In 1867, at the time of confederation, the federal government enacted legislative authority over Indians and lands reserved for Indians in the British North America Act. The Indian Act was introduced in 1876 and to this day remains virtually unchanged. The Indian Act served to ban traditional ceremonies and gave the federal government the responsibility of educating Native children. This led to the destruction of Native culture and traditional lifestyle. It also paved the way for residential schools. It wasn't until an amendment was made in 1951 that Aboriginal peoples could once again practice their ceremonies, unfortunately by this time much abuse and devastation resulted through the cultural genocide imposed by government and church.

Aboriginals have always resisted government-imposed legislation. Regeneration of Aboriginal culture and the political organization of Aboriginal peoples came to the political forefront in 1969 as a response to the White Paper; a policy document authored by Jean Chrétien and introduced by then Prime Minister Pierre Elliott Trudeau. Its intent was to dissolve the Department of Indian Affairs and the Indian Act and to give all Indians the status of ordinary Canadian citizens. Of course, this lead to extreme opposition from Aboriginal peoples and was the catalyst for the formation of the National Indian Brotherhood. A strong united force against the White Paper lead to its ultimate withdrawal but it continues to influence negotiations between the Federal government and Aboriginal bodies. The Aboriginal historical experience is one of assimilation, marginalization, elimination, and assimilation. There continues to be much debate regarding the extent to which Aboriginal people have influenced Non-Aboriginal social political structures.

The Indian Register

The Indian Register is the official record identifying all Status Indians in Canada. Status Indians are those who are registered with the federal government as Indians according to the terms of the Indian Act. Status Indians are known as Registered Indians and have certain rights and benefits that are not available to Non-Status Indians or Métis people. These include on-reserve housing benefits and exemption from federal and provincial taxes in specific situations.

In 1985, the Federal government amended the Indian Act with the passage of Bill C-31. These amendments ended various forms of discrimination that had been ongoing since the 1860s. Many people over the decades had lost their Indian status because of unjust provisions in the Act. Since the passage of Bill C-31, the names of over 100,000 people who lost their status as a result of these provisions have been added to the Register. Until the passage of Bill C-31, there were several ways a person could lose his or her Indian status unfairly under the terms of the Indian Act. One of the ways was through the process of enfranchisement. Enfranchisement was a continuation of the old colonial government policy aimed at assimilating Aboriginals into mainstream society. Until 1960,

the only way Indians could vote in federal elections like other Canadian citizens was to give up their Indian status and become enfranchised. One of the most unjust provisions in the Indian Act affected Indian women. If an Indian woman married a non-Indian man, she automatically lost her Indian status. She was no longer considered to be an Indian within the meaning of the Indian Act. Nor were her children any longer considered to be Status Indians. Bill C-31 enabled people in these situations to apply to have their status restored, and their names included in the Indian Register. Bill C-31 also enabled certain people to be registered for the first time: Children of unmarried women with Indian status, whose registration had been successfully protested on the grounds that their fathers were not Status Indians; and children of people whose status is restored as a result of the new bill.

Prevalence of Mental Illness among Canada's Aboriginal Peoples

According to a report on mental health among Canadian Aboriginal Peoples (Kirmayer et al., 1994), only four community epidemiological studies of psychiatric prevalance rates among North American Aboriginal adults have been published, two of which represent Canadian Aboriginal populations (Roy et al., 1970; Shore et al., 1973; Sampath, 1974; Kinzie et al., 1992). Readers are directed to the Kirmayer report for more on adult psychopathology among Aboriginal Canadians. Mental health information about Aboriginal children is even more scarce. Opportunities to collect information have been lost because of the difficulties of preparing culturally appropriate instruments. For example, the Ontario Child Health Survey excluded Aboriginal communities because there was no standardization of measurement tools on these populations (Armstrong, 1993).

Research in both Canada and the United States suggests that compared with their majority culture counterparts, Aboriginal youth experience an elevated risk of academic failure (Armstrong et al., 1990; LaFromboise & Low, 1991), substance abuse (Oetting & Beauvais, 1990), and suicide (Garland & Zigler, 1993; Kirmayer, 1994). A small number of studies among Aboriginal children document high rates of both depression and conduct disorder as well as significant associations between psychpathology and compromised functioning (Armstrong, 1993; Sack et al., 1993). Many of these studies, however, are hampered by methodological shortcomings. Typically, studies have been based on samples limited in both size and cultural representativeness (Oneil, 1995), and few have attended to the problem that mental health measures developed for use with majority culture children may have limited cross-cultural applicability (Davis et al., 1990; Manson et al., 1990).

What research has been done suggests that Aboriginal adolescents have almost five times greater risk for emotional disorder than do their non-Aboriginal peers in the general population

(Beiser & Attneave, 1982; Beiser et al., 1993; Sack et al., 1987). In the Flower of Two Soils Reinterview Study (NCAIANMHR, 1991) conducted with the 251 Northern Plain children who took part in the earlier study and were now 11 to 18 years of age, data are available for 43% of the original sample. Fully 43% of the respondents received a diagnosis of at least one DSM-III-R disorder. The most frequent diagnoses were disruptive behavior disorders (22%, including Conduct Disorder 9.5%), substance use disorders (18.4%), anxiety disorders (17.4%), affective disorder (9.3%), and post-traumatic stress disorder (5%).

In a Brief submitted to the Royal Commission on Aboriginal Peoples, Peavy (1993) contends that Aboriginal peoples in Canada face many social, economic, cultural, and educational issues. Social issues of concern to Aboriginal peoples include, but are not limited to, poverty, unemployment and underemployment, access to health care and health concerns generally, alcohol and substance abuse, high suicide rates, child care, child welfare, and family violence. Economic issues of concern to Aboriginal peoples include unemployment, access to labour markets, and discrimination in employment. Cultural issues of concern to Aboriginal peoples include recognition by Canadian society and institutions of the intrinsic value of Aboriginal spirituality, Aboriginal family structures, and child care patterns. The situation of Aboriginal youth is also of concern, especially access to education, alcohol and substance abuse, suicide amongst youth, and means of promoting and enhancing a positive self-image in Aboriginal youth. Educational issues of concern to Aboriginal peoples include Aboriginal cultural identity in educational institutions, and the encouragement of Aboriginal children to complete post-secondary education.

Residential Schools

Characteristic in the Federal government's paternal approach to assimilate Aboriginal children was the belief that Aboriginal peoples should conform to the beliefs of the dominate culture. Thus began the era of the residential schools. The first residential school in Canada opened in 1874 and served to separate children from families in an effort to integrate them into mainstream society. Initially, the Federal government operated the residential school system with the support of various religious organizations. The majority of residential schools closed in the 1970's after the Federal government took full responsibility for the schools from the churches. The last residential school in Canada was located in Saskatchewan and did not close until 1996.

Hundreds of thousands of Aboriginal children were taken from their homes and communities and placed in the residential school system as young as the age of four. Most children remained at the residential school until they were between eighteen and twenty-one years old. While attending residential schools, many children survived physical and sexual abuse, as well as emotional neglect and loss of self-esteem, language, spirituality, identity, etc. The impacts of residential schools on the children and families that experienced them were extremely devastating and long lasting and

have had multi-generation repurcussions. These impacts can still be observed on many Aboriginal reserves and communities and must not be underestimated. Residential School Syndrome exists, and it is multi-generational in nature. The residential schools separated children from their families and communities in the name of education and religion, and in an attempt to "civilize" and streamline them into European society. The Aboriginal cultures and traditions were portrayed as "evil" and as something to be shunned by Aboriginal peoples. Children who grew up in the residential school system lost their personal family life as well as their language, culture, traditions, and in many cases, their communities. These children never had the opportunity to develop a sense of personal or cultural identity. When they finally returned home at the age of eighteen, they no longer knew their culture.

Sadly, when the children of residential schools became parents themselves, they did not know how to parent their children and families. This has lead to tremendous hardships in families and communities. The repercussions continue to the present day and have contributed to the multiple challenges faced by Aboriginal peoples. In order for a therapeutic relationship to develop between client and clinician, it is critical that the multi-generational impact of residential school syndrome be thoroughly understood.

Family Violence

The causes of Aboriginal family violence are rooted in the colonization of Aboriginals and the social, economic, political, and spiritual disruptions which accompanied colonization (Peavy, 1993). Aboriginal peoples have experienced enormous losses; loss of loved ones through violent deaths, loss of communities, loss of tradition, of family and kinship, and loss of cultural identity. Some family violence problems such as child sexual abuse, wife assault, and adult survivors of sexual abuse are receiving increasing attention. However, addressing the phenomenon of family violence is much more complex than just removing dysfunctional behaviour and the healing of individuals. Additionally, issues of community control over programs and policies, building of healthy relationships within families and communities, and the development of culturally appropriate educational, social, and treatment programs are all factors linked to the diminution of Aboriginal family violence. It is important to understand that family violence is not a part of Aboriginal traditional life, but derives from colonization practices. Actions taken to "assimilate" Aboriginal peoples into mainstream society include establishment of reserves, enactment of the Indian Act, placement of Aboriginal people in different categories with differing rights, "scooping of children" (child welfare practices), establishment of residential schools, creation of Band Councils, banning of Potlatches, and erosion of traditional economics (Frank, 1992). The combined effect of these colonization practices has been to promote family violence, crime, poverty, substance abuse, suicide, and bring about the worst socioeconomic conditions for any group of people living in the country (Agenda for Aboriginals and Inuit Mental Health, 1991).

Substance Abuse

The negative impact of substance abuse on Aboriginal peoples must be understood in both social and multi-generational terms. It is estimated that 75% of all Aboriginal deaths are alcohol related. There is a myriad of reasons for this, but to quote an elder from Pic Mobert reserve in North-Western Ontario, "The heart of any addiction is pain." This pain derives from many things: the loss of traditional culture, poverty, unemployment, inadequate housing, abuse, and so forth. The need to escape this pain is real and, unfortunately, the means is often abuse of substances. The resulting impacts of substance abuse allow for a continuation of the pain resulting in a cyclical continuum.

Children and youth living in remote fly-in communities are at further risk as they often resort to abuse of solvents due to the lack of available substances. It is well documented that solvent abuse is a very high-risk and dangerous activity that can result in permanent mental and physical impairment, and death. When interviewing an Aboriginal child, it is important to explore the possibility that observed impairments in behavior and/or cognitive functioning may be related to solvent abuse. It is also important to look at family and historical substance abuse as it provides an important context for the multi-generational cycle of abuse. Clinicians should also explore the possibility that behavioral and/or cognitive impairments may be related to Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effect (FAE). A FAS Toolkit has been developed by the Canadian Centre for Substance Abuse in collaboration with the Breaking the Cycle Program and funded by Health Canada and the Office of Learning Technologist, HRDC. It is available as an online resource at: http://www.ccsa.ca/toolkit/introduction.htm.

Although the incidence of substance abuse by Aboriginal peoples is of great concern, there is hope. The community of Alkoli Lake in Northern British Columbia at one time had an alcoholism rate of 99% among its adult population. Yet, a small group of people in that community achieved sobriety and worked to address the issues in their community. Over the course of several years, band members attended treatment, began to reclaim their culture and language, and the community eventually became economically self-sufficient. As a result, the rate of addiction among adults dropped from 99% to 5%. Many Aboriginal individuals and communities have overcome the effects of substance abuse, and for many, this is an ongoing issue of great importance. Substance abuse programs and initiatives are rampant in virtually every Aboriginal in Canada; they must been viewed as an important resource.

Suicide

The rate of suicide and self-inflicted injuries among Aboriginal youth is six times higher (15 to 24 age group) than the national average. Suicide and self-injury were the leading causes of death for youth and adults up to age 44 (Frideres & Gadacz, 2001). One of the northern communities

in Ontario has the highest suicide rate in the world. Again, the reasons are many and complex, but many agree that they stem from a sense of hopelessness and lack of choice and potential among Aboriginal youth. Suicide ideation is contributed to by poverty, lack of adequate housing, substance abuse, lack of community resources, isolation, shame, culture oppression, among other factors. As a clinician, it is important to explore this with your client and to be aware that there may be a multitude of issues impacting on a client's risk for suicide. Another important consideration is that when a youth commits suicide in an Aboriginal community, there is an increased likelihood that another youth may also make an attempt. When an Aboriginal individual goes in to crisis, so does the community. The clinician must seek to understand these dynamics within the community.

Education

Formal education brings multiple issues to light for Aboriginal children. An Aboriginal child attending a mainstream school is likely to be the victim of racism, discrimination, and/or bullying. Often, systematic discrimination occurs through instruction of Canadian history that is most times incorrect and can be extremely demeaning for the Aboriginal child. Limited attempts to present less biased and more accurate accounts do exist, but they still fall seriously short of the accurate history of Aboriginal people in this county. Aboriginal professionals refer to this as creating cultural confusion. These burdens can result in poor academic performance, absenteeism or truancy, and acting out behaviors. Clinicians need to investigate the possible role of cultural confusion and the effects of victimization when rating CAFAS and working with an Aboriginal child.

In Ontario, several communities have schools on reserve for children up to grade eight. These schools are funded Federally and do not fall under the Education Act. Historically, it has been difficult to find quality teachers to staff these schools and there is a large amount of turnover – hence, instability. As well, Aboriginal schools are not funded to the same degree as mainstream schools. This has resulted in a trend for Aboriginal children to leave the reserve school system performing below their potential. This is not reflective of intelligence or effort, but a result of a less than supportive environment.

Another area to consider in regards to education is what occurs after grade eight. Only a handful of communities offer secondary school education on reserves. Where there are none available, children have to be bused long distances to mainstream schools, or in the case of northern communities, relocated to a major urban center during the school year. For instance, this means that a fourteen-year-old from a small, fly-in community in Northern Ontario must leave her family and attend school in Thunder Bay. She must live with boarding parents, learn to live in a city, and will probably have to struggle to upgrade academically, all without the support and comfort of her family and community. Obviously, this is problematic for a young girl struggling with adolescence. Clinicians are encouraged to explore these issues when working with an Aboriginal child.

Regeneration

There has, in the recent past, been a regeneration of traditional culture among Aboriginal individuals and communities, despite the continued systematic discrimination that remains on many levels. This has, and continues to have a positive impact on Aboriginal people.

Regeneration includes becoming re-acquainted with ceremonies, language, and traditional teachings. As well, rebuilding of political, social, educational frameworks is occurring at a very rapid rate. Opposition exists within the mainstream culture and often results in a heightened struggle for Aboriginal people to regain control of their lives. For clinicians and service providers, more broadly, it is important to make culturally based programming available for Aboriginal clients in addition to mainstream approaches. For instance, Dilico Child and Family Services has adopted a holistic approach that embraces the teachings of the medicine wheel and the Seven Sacred Teachings; these teachings can be found throughout the section headings of this document and again on the back cover. As an Aboriginal social service agency Dilico embraces the values and beliefs as Anishinabek[1] in all aspects of the organization. The agency provides services in the areas of child protection, treatment, and health to the Anishinabek who reside in the city and district of Thunder Bay, an area that encompasses 70,000 square kilometers. More and more Aboriginal agencies are forming to address the needs of Aboriginal peoples in a manner that is both appropriate and respectful to their culture and history.

Culturally Appropriate Mental Health Service

Currently, it is not established what forms of mental health service are most appropriate for Aboriginal peoples. What does seem clear from experience and research, however, is that it is not sensible to expect that Euro-Canadian models of mental health treatment which have been developed for mainstream, non-Aboriginal people can be simply imposed upon, or grafted wholesale onto Aboriginal lifestyles and cultural situations (Peavy, 1993).

Peavy (1993) lists some of the values and skills which appear sensible within Aboriginal counseling:

- Conveying a world-view that is holistic and harmonious with nature
- Respecting an ethic of non-interference
- Cooperative interaction, respect for the family and the conscious submission of the individual to the welfare of the community
- Respect for Elders and traditional practices
- Emotional restraint
- Sharing
- Learning by being shown (modeling) rather than being told (verbal instruction)
- Organization by space rather than by time

1 The original people

- Present focus; and
- Knowledge of, and sensitivity toward, nuances of culture-specific communication practices

Some of the faulty assumptions that arise when attempts are made to impose EuroCanadian counseling ideas and practices in the provision of mental health care to Aboriginals are (Peavy, 1993):

- Misconception of what is normal. What is considered normal behaviour varies according to cultural context. Standards of normalcy which are rooted in middle-class white society often are inadequate for judging what is normal and what is not in other cultural contexts.
- Emphasis on individualism. In EuroCanadian conexts, counseling attempts to underscore the value of the individual over the welfare of society by emphasizing such goals as self-determination, self-fulfillment, and self-discovery. This can be in direct contradiction to a culture where priority is given to family, community, and nature.
- Fragmentation. Mainstream mental health providers often undergo training that focuses on separate fields of knowledge, such as psychology, sociology, education. As such, they learn to view behaviour from the narrowly defined perspectives of these disciplines rather than from an integrated, holistic perspective. Fragmentation is an especially serious drawback in a culture which emphasizes holistic world-views.
- Neglect of client's support system. In non-Aboriginal counseling, great emphasis is placed on self-sufficiency and reduction of dependence. One of the major problems faced by Aboriginal clients, especially in contexts such as attending off-reserve schools, is social and cultural isolation. The building and maintaining of support-systems and networks is much more important to many Aboriginal clients than gaining individual autonomy.
- Neglect of history. Many Aboriginal clients have experienced years of racism, abuse, discrimination, poverty and exploitation. Personal and cultural history is much more important to understanding and helping these clients than it is for clients who have lead a mainstream life. There is a great deal of pain, shame, and hostility in the lives of many Aboriginals stemming from their treatment during childhood and adolescence by dysfunctional parents, social service officials, school personnel, and many other members of mainstream Canadian society. For many clients, healing of old pain and hurts must be very much a part of the counseling process, no matter what other objectives may be implied by the treatment approach.

Humility is to Know Yourself as a sacred part of creation

CLINICAL CONSIDERATIONS FOR RATING CAFAS WITH ABORIGINAL CLIENTS

School/Work[1]

Level		Item	Consideration
Severe	001	Out of school or job due to behavior that occurred at school or on job during the rating period (e.g., asked to leave or refuses to attend).	Score this item regardless of the reason the client is out of school. When you have completed the rating and need to interpret the meaning of the CAFAS score, it will be useful to provide a context for why the client is out of school in developing a formulation and treatment plan.
	005	Unable to meet minimum requirements for behavior in classroom (either in specialized classroom or regular classroom with specialized services in public school or equivalent) without special accommodations.	The issue of note here is that clients may have varying levels of success / difficulty depending on whether they are attending a reserve school or a non-reserve school. Again, rate the client according to the observed behavior, regardless of the type of school. State on the CAFAS report which school environment you believe would be most effective for this client and why. Moving the client to a particular school or type of school could be listed as a goal for treatment.
	006	Chronic truancy resulting in negative consequences (e.g., loss of course credit, failing courses or tests, parents notified).	Truancy is defined as purposefully avoiding school in order to do something the client feels is more pleasurable, and is rated in this item. Other reasons for not getting to school are rated in the next item (007). Do not rate the child as impaired if they are being formally home schooled or participating in a family (cultural) activity, such as hunting or sweat lodge.
	007	Chronic absences, other than truancy, resulting in negative consequences (e.g., loss of course credit, failing courses or tests, parents notified).	This is where you rate absences that occur for reasons besides truancy. These reasons might include: (1) transportation problems, (2) sleeping in late, (3) being kept home from school by family members, (4) parent(s) are drinking, (5) client is needed to care for siblings, or (6) parent(s) do not make client attend school. No matter what the reason and regardless of the perception that this might be common or ordinary behavior in the client's community, rate the child as impaired if s/he has absences. Any concerns, which you may have about issues explaining the absenteeism (e.g., discrimination at school makes the youth reluctant to attend) should be mentioned in your report. You can also endorse "Exception" in this column and write your concerns under "Explanation" to bring attention to them.
	009	Failing all or most classes.	Here you are rating the client as impaired if they are failing all or most of their classes no matter what the possible reason(s). If you think the reason is due to factors other than "lack of effort," comment under Explanation and in your report. Do not rate if due to physical or mental ability (see items 032 through 035).

[1] *The CAFAS® items and scale scores are extracted and used by permission from the copyrighted works of Kay Hodges, Ph.D.*

School/Work (continued)

Level		Item	Consideration
Moderate	012	Non-compliant behavior which results in persistent or repeated disruption of group functioning or becomes known to authority figures other than classroom teacher (e.g., principal) because of severity and/or chronicity.	Consider that other authority figures include (1) community nurse, (2) counselors
	014	Frequently truant (i.e., approximately once every two weeks or for several consecutive days).	There is a difference between being "truant" and "not getting to school' (see Guideline for #006).
	015	Frequent absences from school (i.e., approximately once every two weeks or for several consecutive days) due to impairing behavior and excluding truancy and physical illness.	This is where you rate absences that occur for whatever reason (as outlined in 014). The exception would be that a client is absent from school because (1) they were participating in a culturally sanctioned activity (see comments for item 007).
	017	Disruptive behavior, including poor attention or high activity level, resulting in individualized program or specialized treatment being needed or implemented.	It is noted that in certain areas of Northern Ontario, schools may not recommend or provide special services for Aboriginal children/youth. The trend seems to be toward suspensions. You can indicate that an individualized program has been recommended even if it is not being provided.
	019	Grade average is lower than "C" and is not due to lack of ability or any physical disabilities.	Rate what you know to be the case for the client regardless of whether you believe the type of school (reserve, off-reserve) is a factor. By all means, add a note in the CAFAS report that you believe the client's grades would be better in a particular setting. Also, base your rating on the client's actual grades, regardless of whether you believe the client is doing poorly in school because they are shy, victimized, etc. Your interpretation of this item can be described in the CAFAS report and a comment made under "Explanation" on the CAFAS form.
	020	Failing at least half of courses and this is not due to lack of ability or any physical disabilities.	Lack of effort, not lack of physical or mental ability.
Mild	022	Non-compliant behavior results in teacher or immediate supervisor bringing attention to problems or structuring youth's activities so as to avoid predictable difficulties, more than other youths.	Rate what you observe and/or are told, but comment later if you believe that the teacher misinterprets the clients behavior as non-compliant.
Minimal or No Impairment	028	Reasonably comfortable and competent in relevant roles.	This item asks: "Is the client generally functioning well in school?"

School/Work (continued)

Level		Item	Consideration
	032	Schoolwork is commensurate with ability and youth is mentally retarded.	The term "mentally retarded" continues to be used in the United States. In Canada, the appropriate term is "developmentally delayed."
	035	Schoolwork is commensurate with ability and youth has a learning impairment due to maternal alcohol or drug use.	Rate this if the client is known to have Fetal Alcohol Syndrome. Rate this in the Exception box if you only suspect FAS or FAE. For a description of typical FAE / FAS features and characteristics, see http://www.ccsa.ca/toolkit/introduction.htm
Exemption	039		This could be for a client who is trying, but due to insufficient teaching in the elementary reserve school, they have fallen behind academically.

General Comment: Issues related to language (ESL), racism, geography, stress, victimization are important considerations for Aboriginal clients. Note, however, that you are asked to rate behavior as it has been observed and/or reported. Important issues that place these behaviors in context can and should be elaborated upon in the CAFAS or client assessment report.

Home

Level		Item	Consideration
Severe	044	Repeated acts of intimidation toward household members.	Threatening household members even without the use of physical force is still considered intimidation, so rate this behavior as severe.
	046	Behavior and activities are beyond caregiver's influence almost all of the time (i.e., serious and repeated violations of expectations and rules, such as curfew).	Sibling rivalry may or may not be rated as "severe" – use your best judgment. Must be dangerous enough to require constant monitoring.
Moderate	052	Frequent use of profane, vulgar, or curse words to household members.	The question is whether you should rate this type of behavior if it happens to be the family norm. Consider that if this type of behavior is the norm in the family, than the parent (your main informant, usually) will not report that their child does not comply with rules to this extent. If the parent reports this for the client but says it's okay (not considered an issue in the family), then do not rate. If the parent reports this for the client and says it is true for all his/her children, then you should rate it as problematic. The associated goal would be that the client becomes more compliant in the home context.
	053	Repeated irresponsible behavior in the home is potentially dangerous (e.g., leaves stove on).	See comment on children with "special needs " at bottom of page 36.

Home (continued)

Level		Item	Consideration
Mild	057	Frequently fails to comply with reasonable rules and expectations within the home.	See comment on children with "special needs" at bottom of page.
	058	Has to be "watched" or prodded in order to get him / her to do chores or comply with requests.	See comment on children with "special needs" at bottom of page.
	059	Frequently "balks" or resists routines, chores, or following instructions, but will comply if caregiver insists.	See comment on children with "special needs" at bottom of page.
	060	Frequently engages in behaviors which are intentionally frustrating or annoying to caregiver (e.g., taunting siblings, purposeful dawdling).	See comment on children with "special needs" at bottom of page.
Minimal or No Impairment	062	Typically complies with reasonable rules and expectations within the home.	The question is how to rate if there are no rules or expectations in the home. Again, it depends on whether the parent (informant) reports this to be a problem or not. If the client is unruly, s/he would have been rated earlier on item #045, for instance.

In Canada, "special needs" refers to a designation used in the Education sector for children with identified special learning needs, including the gifted. For purposes of CAFAS rating, rate these items for children with Autism and Pervasive Developmental Delay (PDD). Do not rate these items for children with learning disabilities or developmental delay unless behavioral problems accompany them, and only if the behavior problems are more than typical for youths with these disorders. When rating a CAFAS you do not rate behaviors attributed solely to a learning disability of developmental delay (mental retardation). However, if a child is learning or developmentally disabled and displays impaired behaviors not due solely to these diagnoses, the behavior is rated. Autism and PDD are psychiatric disorders and, therefore, behaviors in children with these conditions are rated on the CAFAS.

General Comment: If a client is hoarding food, you need to consider the reason why. If there is very little food in the home relative to the number of people who live there, then that would be rated in the caregiver material needs section. Remember, you are not "blaming" the parent(s) for not providing enough food, rather stating that this is a problem that requires attention. If the client is stealing food when there is food available, rate this in item # 051.

If the client's behavior in the home is related to family issues, such as domestic abuse, alcohol use, remember that you are being asked to rate the client's behavior, regardless of underlying causes. If you believe the client's home behavior would improve in another living environment, you can speak to this in the report.

Community Role Performance

Level		Item	Consideration
Severe	066	Confined related to behavior which seriously violated the law (e.g., stealing involving confrontation of a victim, auto theft, robbery, mugging, purse snatching, fraud, dealing or carrying drugs, break-ins, rape, murder, drive-by shooting, prostitution).	If the client is confined related to "assault", rate this as severe.
	067	Substantial evidence of, or convicted of, serious violation of the law (e.g., stealing involving confrontation of a victim, auto theft, robbery, mugging, purse snatching, fraud, dealing or carrying drugs, break-ins, rape, murder, drive-by shooting, prostitution).	The client does not have to be in jail or convicted yet, and you would still rate this as severe.
	071	Deliberate firesetting with malicious intent	Malicious intent means intentionally harming someone or their property.
Moderate	074	On probation or under court supervision for an offense which occurred during the last 3 months.	This also includes charges of school truancy if the client is on probation/court supervision for it. Also includes running away, if the client is on probation/court supervision for it.
	075	On probation or under court supervision for an offense which occurred prior to the most recent 3 month period.	This also includes charges of school truancy if the client is on probation/court supervision for it. Also includes running away, if the client is on probation/court supervision for it.

General Comment: Clients presenting as socially withdrawn or disenfranchised - an issue for many Aboriginal clients –relate to causal mechanisms and should be discussed in the report.

Behavior Towards Others

Level		Item	Consideration
Severe	088	Behavior is consistently bizarre or extremely odd.	Behaviors that are consistently bizarre or extremely odd do not include those behaviors that may be cultural in nature. If you are not certain, consult with someone more knowledgeable about Aboriginal peoples or review the introduction of this guide. Bizarre behaviors include things like eating non-food items, exposing oneself in public, as well as behaviors related to some mental disorders such as Tourette Syndrome (ticks, if they are bizarre). You are trying to identify bizarre behaviors that interfere with other people relating to the client or wanting to.
	091	Deliberately and severely cruel to animals.	Hurting or killing an animal or animals as participation in a satanic ritual is generally regarded as dysfunctional and is not accepted as appropriate behavior in the mainstream culture. Hunting for sport or for food is not rated as impaired functioning.
Moderate	098	Frequently mean to other people or animals.	This includes kicking animals.
Mild	103	Unusually quarrelsome, argumentative, or annoying to others.	The question is how to rate a client who may be culturally encouraged to be independent, which might be interpreted as unusually quarrelsome, argumentative, or annoying to others. Again, rate the behavior not the perceived cause(s). Note that inappropriate behavior towards others is not specific to Aboriginals or other cultural groups, but rather a learned behavior.
	104	Poor judgment or impulsive behavior that is age-inappropriate and causes inconvenience to others.	The concern is that these behaviors may be seen in clients who have experienced loss and are grieving. Still, rate the behavior and provide the context and suggested directions or treatment plan goals in the report.
	105	Upset (e.g., temper tantrum) if cannot have or do something immediately, if frustrated, or if criticized.	
	106	Easily annoyed by others and responds more strongly than other children; quick-tempered.	
	108	Difficulties in peer interactions or in making friends due to negative behavior (e.g., teasing, ridiculing, picking on others).	
	109	Immature behavior leads to poor relations with same-age peers or to having friends who are predominantly younger.	

Behavior Towards Others (continued)

Level		Item	Consideration
	107	Does not engage in typical peer recreational activities because of tendency to be ignored or rejected by peers.	The concern is that Native people are often excluded due to racism/prejudice, and teasing is prominent. Also cultural differences could be a factor. This is a valid concern. Rate the behavior and speak to underlying factors in the report. Capture what is going on in the rating, and discuss why and what can be done about it in the report.

General Comment: Lack of social skills seems to account for many problems experienced with peer relationships. Children and youth from Aboriginal communities sometimes do not know how to interact with the larger mainstream society to which they may have had limited or no exposure. It is important that you capture this in the treatment plan, and refer to social skill goals that can be set.

Moods/Emotions

Level		Item	Consideration
Severe	116	Viewed as odd or strange because emotional responses are incongruous (unreasonable, excessive) most of the time.	Incongruous means "unreasonable." In other words, the emotional reaction does not "match" the situation to a gross degree.
	117	Fears, worries, or anxieties result in poor attendance at school (i.e., absent for at least one day per week on average) or marked social withdrawal (will not leave home to visit with friends).	Rate the behavior, not the suspected cause of the anxiety.
	118	Depression is associated with academic incapacitation (i.e., absent at least one day a week on average, or if made to attend school, does not do work) or social incapacitation (i.e., isolates self from friends).	Rate this behavior as severe even if the depression is due to loss/grief or other legitimate causes.
Moderate	126	Emotional blunting (i.e., no or few signs of emotional expression; emotional expression is markedly flat).	The concern is that lack of emotional expressiveness common to Aboriginal people will be viewed as emotional blunting. If the behavior is reflective of a cultural norm in emotion expression, do not rate as emotional blunting.
Mild	130	Very self-critical, low self-esteem, feelings of worthlessness.	Although it is true that low self-esteem is related to suicide risk, we are capturing less severe low self-esteem in this item.

General Comment: Because these communities are relatively small and close knit, community suicides should be considered in rating the client's moods and emotions. Suicide is highly "contagious" and has a different impact severity in Aboriginal communities. Consider rating item #119 for youth if they have sadness or depression and if they are judged to be in jeopardy of committing suicide because of suicide contagion.

Self-Harmful Behaviors

Level		Item	Consideration
Severe	142	Non-accidental self-destructive behavior has resulted in or could result in serious self-injury or self-harm (e.g., suicide attempt with intent to die, self-starvation).	Can include abuse of inhalants, or sniffing gas. Normally, this would not be rated here, but rather as Severe under Substance Use item 151 because of physical health problems. However, if inquiry about sniffing (or any other potentially self-destruction behavior) reveals self-harmful feelings (e.g., Why should I care about myself – no one else does?"), then you could rate on this scale. If the youth said this and was sniffing gas, rate as Severe here. If the youth were doing less lethal behaviors, rate as moderate.
Moderate	146	Non-accidental self-harm, mutilation, or injury which is not life-threatening but not trivial (e.g., suicidal gestures or behavior without intent to die, superficial razor cuts).	The concern is how to rate behavior that is indicative of group affiliation, such as burning oneself with a cigarette, or behavior that is ceremonial, such as fasting. If you believe the behavior is not a suicidal or self-harming gesture, than do not rate it. You may still need to refer to it in the report (i.e., cigarette burning). Gang-like behavior done to express belonging to a group is not rated here.
	147	Talks or repeatedly thinks about harming self, killing self, or wanting to die.	Although talking about harming oneself, killing oneself or wanting to die is a common coping strategy in reserve communities, it does not reflect good functioning. Rate this as moderate impairment.

General Comment: Suicide attempts in the community or the client's family can be considered as a "severe" impairment if the rater judges there to be a risk of contagion (the client is more likely to act upon suicide ideation). Rate this as severe using the "Exception" category. Note that any youth who talks about suicide can be rated at the moderate level (item 147) regardless of the reason.

Substance Use

Level		Item	Consideration
Severe	155	Dependent on continuing use to maintain functioning (e.g., likely to experience withdrawal symptoms such as feeling sick, headaches, nausea, vomiting, shaking, etc.)	If the client is abusing substances for the control of pain, rate as severe substance use. If medications are prescribed for pain – and the client is not abusing the prescription, do not rate as impaired here.
	159	Use of substances is associated with serious negative consequences (e.g., injured in accident, doing illegal acts, failing classes, experiencing physical health problems).	Rate gas and glue sniffing and other solvent inhalants here because of the possibility of permanent brain damage and death.
Moderate	168	Friendships change to mostly substance users.	Within the rating period (last month), client's friends may have been mostly substance users.
	170	For 12 years or younger, occasional use without intoxication and without becoming obviously high.	If the client is abusing solvents, even occasional use should be rated as severe because of the risk involved (i.e., sudden sniffing death).
Mild	174	For 12 years or younger, has used substances more than once.	As above (#170), if the client is abusing solvents, more than once should be rated as severe.
Minimal or No Impairment	178	Has only "tried" them; does not use them.	Tried substances, or experimented with substance is rated here.

Thinking

Level		Item	Consideration
Severe	182	Communications which are impossible or extremely difficult to understand due to incoherent thought or language (e.g., loosening of associations, flight of ideas).	Flight of ideas refers to having a stream of thoughts, one after the other.
	183	Speech or nonverbal behavior is extremely odd and is non-communicative (e.g., echolalia, idiosyncratic language).	Idiosyncratic language refers to words that are not appropriate to their real meaning.
Moderate	188	Frequent distortion of thinking (obsessions, suspicions).	See the section on cultural beliefs in the CAFAS Self-Training Guide.
Mild	193	Eccentric or odd speech (e.g., impoverished, digressive, vague).	This item does not refer to dialect, Aboriginal or otherwise.

General Comment: In Ojibway culture, grief reaction is often associated with seeing visions/hearing things. Recognize that in some Aboriginal communities, "hallucinations" reflect life experiences, practices, ceremonies, superstitions, and are passed down from parents and are not "psychotic" in nature. As long as the "hallucination" reported is culturally consistent with the circumstances, then it would not be rated. However, if there is some doubt about this, the behavior could be rated as "Mild Impairment" under item 196 so that the youth might get care if the behavior is not culturally consistent and persists.

Caregiver/Material Needs

Level		Item	Consideration
Severe	201	Youth's needs for food, clothing, housing, medical attention, or neighborhood safety are not being met such that severe risk to health or welfare of youth is likely.	Problems with housing, mold, etc are very real issues in many Aboriginal communities and are not the responsibility of individual families but rather a Federal (advocacy) issue. Still, to capture the extent of this problem, you need to rate it. Be honest about capturing aspects of material needs that are not political because it is important to capture events that could be addressed in treatment or by another service.
Moderate	203	Frequent negative impact on youth's functioning OR a major disruption in the youth's functioning due to youth's needs for food, housing, clothing, medical attention, or neighborhood safety not being met.	See response to 201 above.
Mild	205	Occasional negative impact on the youth's functioning due to the youth's needs for food, housing, clothing, medical attention, and neighborhood safety not being met.	The concern here is that Aboriginal families are often low income families who live in potentially dangerous neighbourhoods and may run out of food. Some medications are not paid for by the province and situations can be outside of parental control. Rate what is happening and then note why in your report/ formulation.
Minimal or No Impairment	208	Able to use community resources as needed.	The level of community resources is very low in many communities. Rate what is happening and provide a context in your formulation/report.

Caregiver/Family Social Support

Level		Item	Consideration
Severe	211	Socio-familial setting is potentially dangerous to the youth due to lack of family resources required to meet the youth's needs/demands.	If this is the case because the family lives in a very remote area, rate it as you see it then add the context later.
	214	Youth is subjected to sexual abuse in the home by a caregiver.	Here, sexual abuse may be by another family member living in the home (due to housing shortage). Rate it nevertheless.
	215	Youth is subjected to physical abuse or neglect in the home by a caregiver.	Encouraging independence (e.g., Ojibway adolescent rights of passage) is not the same thing as neglect; keep them separate conceptually.
	218	Failure of caregivers to provide an environment safe from possible abuse to a youth previously abused or traumatized.	If the client lives on a reserve with 75 people this presents a shortage of options and limits the family's ability to provide a safe environment. Rate it and provide context in the formulation/report.
Moderate	222	Youth's developmental needs cannot be adequately met because youth's needs/developmental demands exceed family resources.	Same as #218.
	223	Marked impairment in parental judgment or functioning (may be related to emotional instability, psychiatric illness, substance use, physical illness, criminal activities, or other impairing condition).	Rate even though you recognize that many parents have experienced the residential school system and have not been parented, nor have they learned to parent. This should be addressed in treatment with the family.
	227	Failure of caregiver to provide emotional support to youth who has been traumatized or abused.	The concern here is that the caregiver may not be able to provide emotional support because of distance. Note that this item pertains to a situation in which the parent is physically able to provide support, but does not. Even parents who cannot be physically close to their child can continue to be emotionally supportive.
Mild	230	Family not able to provide adequate warmth, security, or sensitivity relative to the youth's needs. Support from other sources outside the immediate family is unable to compensate for this inadequacy.	The concern here is that clinicians may perceive an Aboriginal family as "cold" because of their manner of expression. The key here is the warmth, security, or sensitivity relative to the youth's needs. If the youth and parent(s) report that they feel adequately supported emotionally, then rate that as having no impairment.

Truth is to know all these things

CAFAS VIGNETTES OF ABORIGINAL CLIENTS

Tara

Tara is a 14-year-old girl who is presently in the 9th grade. She lives with her foster parents and two older foster siblings. Her biological mother has recently remarried and has weekly visits with Tara. Tara disclosed past sexual abuse by family friends three months ago. Each of her biological siblings has been in counseling for various reasons.

CHILD FUNCTIONING

School

Tara recently returned to community school and has disciplinary problems in the classroom. She has been suspended for absenteeism and verbal aggression with staff and peers.

006: Chronic truancy resulting in negative consequences (e.g., loss of course credit, failing courses or tests, parents notified.

Home

Her foster parent reports that Tara has missed curfew on numerous occasions. She has been reported missing on three occasions (usually on the weekend but returning home on the Sunday night). Tara's behaviors continue to worsen. The foster parent feels that Tara will have to be moved to another home if her behaviors are not stabilized. Tara took an overdose of prescription medication during one of her runs and was hospitalized briefly for this.

048: Run away from home overnight more than once, or once for an extended time, and whereabouts unknown to caregiver.

Community

Tara has charges pending for shoplifting. Her foster mother reports that Tara has come home with new clothing on two occasions. Tara denies stealing them. The police have brought Tara home twice for running away.

073: Serious and/or repeated delinquent behavior (e.g., stealing without confronting a victim as in shoplifting, vandalism, defacing property, taking a car for a joyride.

Behavior Toward Others

Foster parents report that Tara is very impressionable and that she has begun to hang around with older teens who are not a good influence on her. She is quarrelsome at home but seems to get along with her biological family.

103: Unusually quarrelsome, argumentative, or annoying to others.

Moods/Emotions

Tara is always irritable at home. She presents with drastic mood swings (very high to extreme lows where she will isolate herself from others). Tara has trouble sleeping at night and has a poor appetite.

122: Depressed mood or sadness is persistent (i.e., at least half of the time), with disturbance in functioning in at least one of the following areas: sleeping, eating, concentration, energy level, or normal activities. If only irritability or anhedonia (i.e., marked diminished interest or pleasure in typical activities) is present, there should be disturbance in two or more areas.

Self-Harmful Behaviors

Tara was taken to the hospital for an apparent overdose of sleeping pills. Although at first, Tara stated that she did not want to die, when asked about her overdose and the other things she does that expose her to dangerous situations, she described feelings of hopelessness. She said that she does not care about herself and others do not care for her either. She admitted hoping at times that something would happen to her.

142: Non-accidental self-destructive behavior has resulted in or could result in serious, self-injury or self-harm (e.g, suicidal gestures or behavior with intent to die, self-starvation).

Substance Use

Foster parents think that Tara uses alcohol and drugs, especially on the weekends. Tara disclosed that although she does not drink, she does "smoke up" on occasion to relax with her friends.

167: Behavior potentially endangering self or others is related to usage (e.g., vulnerable to injury or date rape).

Thinking

Foster parents reported that Tina has complained about hearing voices at night when she was alone in her room.

196: Unusual perceptual experiences not qualifying as pathological hallucinations.

SURROGATE CAREGIVER RESOURCES

Material Needs

All material needs are satisfactorily met as she is in foster care.

207: Basic material needs are arranged for or adequately met so that there is no disruption in the youth's functioning.

Family/Social Support

Tara's foster parents have recently reconciled after a 6-month separation. Tara's biological family

continue to be involved with Protection Unit services because of alcohol abuse, legal problems, and inappropriate parenting during access visits. Tara's foster parents feel that it is hard to supervise her since she continuously disobeys rules. They have tried to monitor and supervise her. Tara states that she wants to return to her mother's care but her mother has been unable and unwilling to take on this responsibility. Although they find her challenging, they want to keep her, and assistance from the community will help them do this.

237: Even though there are temporary problems in providing adequate support to the youth, there is compensation from the wider social support system.

CAFAS SCORING SUMMARY

Scale Scores for Youth's Functioning

Role Performance
- School /Work 30
- Home 30
- Community 20

Behavior Toward Others 10

Moods/Self Harm
- Moods/Emotions 20
- Self-Harmful Behavior 30

Substance Use 20

Thinking 10

Total for Youth based on 8 scales: **170**

Scale Scores for Caregiver Resources

Material Needs 0

Family/Social Support. 0

Key Points for Consideration

There is no information here about the youth's cultural background or experiences. Clinicians should ask about a youth and family's cultural beliefs and traditions and to what extent they are practiced. This can be a means of identifying strengths and can provide a framework for understanding how a client views their experiences. It is also important to ask what community a family is from. Clinicians should get to know the different communities in their area as this information is helpful in understanding a family's experience and beliefs. For example, some Northern Ontario communities can follow very traditional ways while others emphasize different religious beliefs and still others may have their own folklore or "superstitious" beliefs. Hearing voices can be interpreted as a supernatural experience in some communities rather than as a

hallucination or trauma response. This needs to be explored further for this client.
It is unclear why no information was captured by the clinician regarding the biological parent(s) in this case. When dealing with multiple caregivers, it is important to capture information on all of them.

Fred

Fred is an 11-year-old Aboriginal boy who was referred to the Family Counseling Program to address issues relating to truancy from school, anger management, and family conflict.

CHILD FUNCTIONING

School

Mrs. Rains, Fred's 4th grade teacher, has expressed concern that he has missed school for 30 days of a possible 60 days. On days he has attended, he has arrived late to class approximately 10 times. When he is at school, Fred's interactions with peers often require re-direction. He tends to play roughly at recess and play fights often escalate into actual fights. Initially, he was much more withdrawn in his peer interactions, choosing to spend time alone in the courtyard. His friendships are with other children from Northern reserves who tend to display aggressive tendencies.

His academic work is below that of his same-age peers. He has difficulty participating in classroom discussions and does not attempt to answer questions. He has to be re-directed to maintain focus on his school work. Homework is seldom completed and he has not completed any projects that have been assigned. He is oppositional with authority figures.

Fred is now participating in a "Safe Arrival" program at school that requires the school to contact Fred's home if he should fail to arrive. This has been unsuccessful because the family does not have a telephone. Fred's mother, Sharon, has presented as very quiet yet compliant with the school's concerns. She has not raised any concerns of her own.

006: Chronic truancy resulting in negative consequences (e.g., loss of course credit, failing courses or tests, parents notified).

Home

Fred's family is new to Thunder Bay, having recently relocated from Kingfisher Lake at the beginning of August 2001. The family's move was precipitated by Sharon's need for medical treatment for her diabetes. Sharon is a single parent who is raising Fred and two older siblings. Fred's father has been out of the home for approximately two years. Prior to the separation there were incidents of physical abuse by the father towards Sharon and her children. Sharon stated

that the violence was the reason for the separation. There is also a multi-generational history of alcoholism in both the maternal and paternal families.

Sharon has reported that she has difficulty applying structure at home. Fred argues a great deal with his siblings.

060: Frequently engages in behaviors which are intentionally frustrating or annoying to caregivers (e.g., taunting siblings, purposeful dawdling).

Community

Fred does not participate in any community activities. His siblings have had trouble with shoplifting and gang-related activities. Fred seems to have difficulty interacting positively with his same-age peers. He has not had contact with police or the justice system.

084: Youth does not negatively impact on the community.

Behavior Toward Others

Fred tends to isolate himself from his peers and has difficulty initiating contact with others. He is very withdrawn from children outside his ancestry. He argues a great deal with his siblings. Fred is oppositional with authority figures.

093: Behavior frequently / typically inappropriate and causes problems for self or others (e.g., fighting, belligerence, promiscuity).

Moods/Emotions

Fred has expressed anxiety about attending school. He seems to become anxious when he is in larger settings, i.e., when out in the community. He does work well on a one-to-one basis. Fred reports experiencing difficulty falling asleep and frequently does not fall asleep until at least 1 am. Sharon has attempted several medications, with little success. Fred has not expressed any feelings regarding the separation and move from his father and his community of origin.

117: Fears, worries, or anxieties result in poor attendance at school (i.e., absent for at least one day per week on average) or marked social withdrawal (will not leave the home to visit friends).

NOTE: He scored a 117 because there is also evidence of chronic truancy and this is believed to be due to the high levels of anxiety.

Self-Harmful Behavior

It is noted that, at times, Fred will bang his head when disciplined, i.e., when in "time-out" in his room. He does not do this hard enough or on hard enough surfaces to hurt himself.

149: Repeated non-accidental behavior suggesting self-harm, yet the behavior is unlikely to cause any serious injury (e.g., repeated pinching self or scratching skin with a dull object).

NOTE: In younger children, consider rating head banging as a 30 because of the potential for brain damage; sometimes, children are hospitalized for this behavior. In this case, the clinician did not feel that Fred's head banging behavior was serious enough (in frequency and intensity) to cause damage. Rate as mild if no bruising or swelling.

Substance Use

There are no problems in this area.

176: No use of substances.

Thinking

There are no problems in this area.

198: Thought, as reflected by communication, is not disordered or eccentric.

PRIMARY CAREGIVER RESOURCES

Material Needs

Fred's father does not provide any financial support to the family at this time. Sharon is supporting her family on Ontario Works Assistance. Presently, the family of four is living in a 2-bedroom apartment. There appears to be supply of food in the home at all times, however, there is no money left over for extras.

206: EXCEPTION – The clinician attempted to capture a housing issue that is typical in Aboriginal communities - the lack of adequate space (e.g., a 2- bedroom apartment for 4 people). This problem can have a negative impact on Fred's functioning.

Family/Social Support

Fred's father has only sporadic contact with the children. Sharon reports that the two older boys bully Fred at times. She seems to be accepting of professional support but does not initiate contact. Sharon has been referred for counseling for her bouts of depression, but she does not consistently attend. Due to their recent move from Kingfisher Lake, there is no natural support system available to the family at this time.

233: Family not able to provide adequate supervision, firmness, or consistency in care over time relative to the youth's needs: no other supports compensate for this deficit.

CAFAS SCORING SUMMARY

Scale Scores for Youth's Functioning

Role Performance
- School /Work 30
- Home 10
- Community 0

Behavior Toward Others 20

Moods/Self Harm
- Moods/Emotions 30
- Self-Harmful Behavior 10

Substance Use 0

Thinking 0

Total for Youth based on 8 scales: **100**

Scale Scores for Caregiver Resources

Material Needs 10

Family/Social Support. 10

Key Points for Consideration

It is not clear whether the clinician could have captured more information about Fred's behavior at home. Often, parents are reticent to talk about the child's behavior at home; if that is the case, it should be stated in order to support the rating.

Particular attention should be paid to the academic histories of family members. Mom appears to dismiss or minimize Fred's attendance, possibly due to her own residential school experience or those of Fred's grandparents and/or great-grandparents. There may be a history of passivity with school, and academic achievement may not be valued in this family.

It is also noteworthy that this family moved to an urban centre from a remote community where traditional knowledge (e.g., hunting, fishing, forest) is more valuable and practical for their way of life. The urban centre may be a transitional stop with future plans to returning to a more traditional lifestyle.

Community values of his home reserve may affect Fred's social/interpersonal skills. Whereas some behaviors may raise concern here (e.g., passivity, shyness, aggressive play), these behaviors fit with the values of his reserve community.

Multi-generational experiences with residential schooling may also account for the concerns regarding parental limit setting and enforcing structure. The residential school system has been attributed with breaking down the natural Aboriginal parenting model.

Fred's behaviors may be perpetuating a strong familial value structure that is widely perceived in his own community as acceptable. Although these behaviors are acknowledged and addressed within a non-traditional environment, interventions may not be supported within the home environment. Mom may participate in consultations with professionals, yet not value these issues. As a result, she may not address these issues or apply recommendations in the home setting. Due to a traditional attitude, Mom may not express her non-commitment directly. Issues are traditionally addressed with non-confrontational methods such as humour and the telling of stories or legends.

Jeremy

Jeremy is a 9-year-old boy originally from an isolated Northern reserve community. He is not fluent in Ojibway but does understand some words. He has a younger sister (3 years) and an older brother (15 years). His parents struggle with alcohol abuse and there has been involvement with child welfare. Jeremy has been in foster care once in the past and has also frequently been left in the care of extended family for periods ranging from a few days to a few months. Jeremy presents with more behavior problems than do his siblings. Relatives in his home community have struggled to care for him. Jeremy arrived in this urban centre two years ago to live with his aunt and uncle who he knows quite well. His siblings remain in their home community with his parents. Jeremy's aunt and uncle are sober and provide a relatively stable influence in his life. They have two teenage children of their own. Jeremy visited his parents and siblings last summer and has occasional phone contact with them. He is described as oppositional and aggressive. School officials are concerned about the potential for self-harm.

School

Jeremy reports that he hates school because he feels different from the other children and thinks that they and the teachers do not like him. He says that some of the white boys have called him a "dirty Indian" and this makes him angry.

He usually attends school but will often arrive late or leave school property without permission. When at school, Jeremy is often oppositional and defiant with teaching staff, refuses to do school work, and regularly bothers other students during class time. He is often sent to the principal's office. During recess and transition time he has been observed bullying other children and being physically aggressive with both younger and same-age peers. Recently, he threw a rock at another

student hitting him in the head. Teachers have also observed scratch marks on Jeremy's arm and he was once observed trying to carve into his arm with a box cutter.

Jeremy is failing all subjects and his teacher reports that he is functioning well below grade level. There has been no learning assessment and Jeremy has not been identified for special education through an IPRC (Individualized Program Review Committee).

009: Failing all or most classes.

Home

Jeremy's aunt and uncle report that they enjoy having Jeremy in their care. They note that he listens well and has only shown anger a few times, when he did not get his own way. Each time, he has lost control and punched holes in the walls. His aunt says that he leaves the house and comes back more calm about a half an hour later. Jeremy's aunt and uncle report that they discipline him by explaining right from wrong and by taking away privileges, i.e., Nintendo. Jeremy helps out around the house but there are no set chores or schedules. He has no set bed time and often goes to bed late. Jeremy has trouble waking up in the morning.

055: Deliberate damage to the home.

Community

The police have come to the home three times following complaints that Jeremy was seen vandalizing property with other children in the neighbourhood. There is also concern that Jeremy may be associating with a group of older boys who call themselves the "East End Warriors." Jeremy does sometimes use gang talk and has been drawing gang symbols at school. Jeremy's aunt and uncle encourage him to follow the traditional path and regularly take him to pow wows and other cultural events in the community.

073: Serious and/or repeated delinquent behavior (e.g., stealing without confronting a victim as in shoplifting, vandalism, defacing property, taking a car for a joyride).

Behavior Toward Others

At school, Jeremy can be very rude and argumentative. He has physically attacked students and has engaged in power struggles with teachers. Although he has no friends at school and children there are afraid of him, he has many friends in his neighbourhood, all of whom are Aboriginal. Jeremy is reportedly well-behaved when attending community cultural events. His aunt and uncle emphasize the importance of respecting elders, and they note that he is increasingly respectful when relatives, particularly elders, visit the home.

089: Behavior so disruptive or dangerous that harm to others is likely (e.g., hurts or tries to hurt others, such as hitting, biting, throwing things at others, using or threatening to use a weapon or dangerous object).

Moods/Emotions

Jeremy is generally happy in the home. He gets very angry when he does not get his own way and then, afterwards, seems sad and anxious. He needs to be reassured that he can still stay with his aunt and uncle, and asks them repeatedly not to send him away. He worries when his aunt and uncle are away from home for a few hours and regularly asks where they are going and when they will return. He sometimes becomes sad after phone conversations with his parents and tends to talk angrily about his siblings who are still with his parents.

At school, Jeremy looks angry most of the time. Teachers note that he does not seem to know how to have fun or play like other children. They have asked him if he feels sad, but he refused to talk to them.

124: Fears, worries, or anxieties result in the youth expressing marked distress upon being away from home or parent figures; however, the youth is able to go to school and engage in some social activities.

Self-Harmful Behavior

Family and school first noticed scratch marks on Jeremy's arm about a month ago. He says that he scratches himself with something sharp to take away angry feelings. He sometimes talks about being better off dead, usually when he is missing his family up North or after he gets angry at home. He has known people, including relatives that have committed suicide in his home community.

146: Non-accidental self-harm, mutilation, or injury which is not life-threatening but not trivial (e.g., suicidal gestures or behavior without intent to die, superficial razor cuts).

Substance Use

Jeremy sniffed gas three times when he was 7 years old and living in Fort Hope (2 years ago). He has not tried alcohol or other drugs.

176: No use of substances.

NOTE: His behavior at age 7 is not within the time period being rated.

Thinking

No impairing thought disturbances are noted.

198: Thought, as reflected by communication, is not disordered or eccentric.

SURROGATE CAREGIVER RESOURCES

Material Needs

The family lives below the poverty line but basic needs are being met. Transportation is a big issue as they do not have a car and cannot regularly afford to take the bus.

283: Occasional negative impact on the youth's functioning due to the youth's needs for food, housing, clothing, medical attention, or neighborhood safety not being met.

NOTE: this captures the issue around lack of transportation.

Family/Social Support

Jeremy's aunt and uncle report that they had problems with alcohol and argued frequently when they were younger. They have been sober for 10 years and report that they have a good relationship with each other and with their children. They are very patient and have a high tolerance for negative behavior. They say they understand that Jeremy is hurting inside because of all of the losses he has experienced. They also understand what it is like to grow up with alcoholic parents. They found help by living the traditional Native way and they feel strongly that this will work for Jeremy. They encourage him to smudge every morning and attend cultural events and ceremonies. Jeremy's uncle has taken him to the bush to fish and trap in the traditional way. They have lots of support through extended family members who are also sober.

313: Family is sufficiently warm, secure, and sensitive to the youth's major needs.

NON-CUSTODIAL CAREGIVER RESOURCES

Material Needs

His parents struggle with alcohol abuse and there has been involvement with child welfare. Jeremy has been in foster care once in the past and has also frequently been left in the care of extended family for periods ranging from a few days to a few months.

Insufficient information for rating.

Social Support

He sometimes becomes sad after phone conversations with his parents and tends to talk angrily about his siblings who are still with his parents. His parents struggle with alcohol abuse and there has been involvement with child welfare. Jeremy has been in foster care once in the past and has also frequently been left in the care of extended family for periods ranging from a few days to a few months.

251: Gross impairment in parental judgment or functioning (may be related to psychosis, substance abuse, severe personality disorder, mental retardation).

CAFAS SCORING SUMMARY

Scale Scores for Youth's Functioning

Role Performance
- School/Work 30
- Home 20
- Community 20

Behavior Toward Others 30

Moods/Self Harm
- Moods/Emotions 20
- Self-Harmful Behavior 20

Substance Use 0

Thinking 0

Total for Youth based on 8 scales: **140**

Scale Scores for Caregiver Resources - Surrogate Family (Aunt and Uncle)

Material Needs 10

Family/Social Support. 0

Scale Scores for Caregiver Resources – Non-custodial Family (Biological)

Material Needs . . . . . no rating

Family/Social Support. 30

Key Points for Consideration

Note that in Aboriginal communities, traditional living and cultural ceremonies and practices are important to one's sense of identity, healing, and personal wellness. Families should regularly be asked about their particular traditions and beliefs so that this can be acknowledged, incorporated, and /or built in to the intervention plan.

Many members of Aboriginal communities adopt a parenting style that is non-directive, allowing children to learn from experience. With each family, it is important that the assessment process include understanding the family's belief system, traditions, and history so that current practices and behaviors can be understood.

Education standards differ on Northern reserves, and it is not uncommon for youth to be achieving below grade level compared to other youth in less remote and more populated centres.

REFERENCES

Adams, D. L. (Ed.). (1995). *Health issues for women of colour: A cultural diversity perspective.* Thousand Oaks: SAGE Publications.

Agenda for Aboriginals and Inuit Mental Health: Report. (1991). Report of the steering committee.

Armstrong, H. (1993). Depression in Canadian Native Indians. In P. Cappaliez, and R. J. Flynn (Eds.), *Depression and the social environment: research and intervention with neglected populations,* pp. 218-234. Kingston, Canada: Queen's University Press.

Beiser, M., & Attneave, C. L. (1982). Mental disorders among Native American children: Rates and risk periods for entering treatment. *American Journal of Psychiatry,* 139, 193-198.

Beiser, M., Lancee, W., Gotowiec, A., Sack, W., & Redshirt, R. (1993). Measuring self-perceived role competence among First Nations and non-Native children. *Canadian Journal of Psychiatry,* 38(6), 412-419.

Campinha-Bacote, J. (1994). *The process of cultural competence in health care: a cultural competence mode of care* (2nd Edition). Wyoming: Transcultural Care C.A.R.E Associates, p.7.

Cerny, L. (1997). *Cultural sensitivity study.* Masters thesis, Department of Sociology, McMaster University, Hamilton, Ontario, Canada.

CEO Services. (n.d). *Cultural competence online.* www.culturalcomptence2.com.

College of Nurses of Ontario. (1999). *Guide to nurses for providing culturally sensitive care.* Toronto, ON: Author.

Cooper, T. (1996). Culturally appropriate care: Optional or imperative? *Advanced Practice Nursing Quarterly,* 2(2), 1-6.

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). Towards a culturally competent system of care, Volume I. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Davis, G. L., Hoffman, R. G., & Nelson, K. S. (1990). Differences between Native Americans and whites on the California Personality Inventory. *Psychological Assessment,* 2, 238-242.

Dion, R. (1998). Depression and conduct disorder in native and non-native children. *Journal of the American Academy of Child and Adolescent Psychiatry,* 37, 736-742.

Frank, S. (1992). Family violence in Aboriginal communities: A First Nations report. British Columbia: B.C. Ministry of Women's Equality.

Frideres, J. S. & Gadacz, R. .R. (2001). Aboriginal peoples in Canada: Contemporary conflicts, 6th Edition. Scarborough, ON: Prentice Hall Allyn and Bacon Canada.

Garland, A. F., & Zigler, E. (1993). Adolescent suicide prevention: current research and social policy implications. *American Psychologist,* 48, 169-182.

Hodges, K. (2000a, 2nd revision). Child and Adolescent Functional Assessment Scale. Ypsalanti, MI: Eastern Michigan University.

Kinzie J. D., Leung P. K., Boehnlein J., Matsunaga D., Johnson R., Manson S., (1992). Psychiatric epidemiology of an Indian village: A 19-year replication study. *Journal of Nervous Mental Disorders,* 180(1), 33–9.

Kirmayer, L. J. (1994). Suicide among Canadian Aboriginal peoples. *Transcultural Psychiatry Review,* 31, 3-58.

Kirmayer, L. J., Gill, K., Fletcher, C., Ternar, Y., Quesney, C., Smith, A., Ferrara, N., & Hayton, B. C. (1993). *Emerging trends in research on mental health among Canadian Aboriginal peoples* (Report for the Royal Commission on Aboriginal Peoples/Working Paper 2): Culture & Mental Health Research Unit, Department of Psychiatry, Sir Mortimer B. Davis – Jewish General Hospital.

LaFromboise, T. D., & Low, K. G. (1991). American Indian children and adolescents. In J. T. Gibbs and L. N. Huang (Eds.), *Children of color: psychological interventions with minority youth,* pp. 114-147. San Francisco, CA: Jossey-Bass.

Manson, S. M., Ackerson, L. M., Dick, R. W., & Baron, A. E. (1990). Depressive symptoms among American Indian adolescents: psychometric characteristics of the Centre for Epidemiological Studies Depression Scale (CES-D). *Psychological Assessment,* 2, 231-237.

Nursing Now Issues and Trends in Canadian Nursing, Cultural Diversity: Changes and challenges (Issue 7, February 2000). Ottawa: Policy, Regulation, and Research Division, Canadian Nurses Association.

Oetting, E. R., & Beauvais, F. (1990). Adolescent drug use: findings of national and local surveys. *Journal of Consulting and Clinical Psychology,* 5, 385-394.

Oneil, J. D. (1995). Issues in health-policy for indigenous peoples in Canada. Australian *Journal of Public Health,* 19, 559-566.

Peavy, R. V. (1993). Development of Aboriginal counseling: A brief submitted to the Royal Commission on Aboriginal peoples. www.bced.gov.bc.ca/abed/reports/subroyalcom.htm.

Registered Nurses Association of Nova Scotia. (1995). *Multicultural health education for registered nurses: A community perspective.* Halifax, NS: Author.

Roy, C. Choudhuri, A., & Irvine, D. (1970). The prevalence of mental disorders among Saskatchewan Indians. *Journal of Cross-Cultural Psychology,* 1(4), 383-392.

Sack, W. H., Beiser, M., Phillips, N., & Baker-Brown, G. (1993). Co-morbid symptoms of depression and conduct disorder in First Nations children: some findings from the Flower of Two Soils project. *Culture Medicine and Psychiatry,* 16, 471-486.

Sampath H. M. (1974). Prevalence of psychiatric disorders in a Southern Baffin Island Eskimo settlement. *Canadian Psychiatric Association Journal,* 19, 363–367.

Shore JH, Kinzie JD, Hampson JL, Mansell E. (1973). Psychiatric epidemiology of an Indian village. *Psychiatry* 36(1),70–81.

Statistics Canada. (1998). *The daily. 1996 census: immigration and Citizenship.* www.statscan.ca/Daily/English/971104/d971104.htm.

Statistics Canada. (1998). *The daily. 1996 census: Aboriginal Data.* www.statscan.ca/Daily/English/980113/d980113.htm.

Texas Department of Health, National Maternal and Child Health Resource Center on Cultural Competency. (1997). *Journey towards cultural competency: Lessons learned.* Vienna, VA: Maternal and Children's Health Bureau Clearinghouse.

FEEDBACK FORM

PLEASE TELL US WHO YOU ARE

Name:
Organization:
Address:

Province / State:
Postal code / Zip code:

Telephone Number:
Fax Number:

Email:
Organization Web Site:

PLEASE COMMENT ON YOUR IMPRESSIONS OF THIS DOCUMENT

	Disagree Strongly (1)	Disagree (2)	Undecided (3)	Agree (4)	Agree Strongly (5)
You feel comfortable applying these considerations in your practice with Aboriginal children and youth.					
You will distribute this document to other clinicians for whom it could be relevant.					
You gained new knowledge about Aboriginal children and youth from this document.					
This document will improve the reliability and validity of CAFAS for Aboriginal children and youth.					
You believe these guidelines require revision.					

PLEASE SHARE YOUR CONTENT RECOMMENDATIONS

We invite you to share your thoughts and suggestions for rating CAFAS with Aboriginal children and youth. Alternatively, feel free to contact us by email at melanie.barwick@sickkids.ca.

WITH RESPECT TO CAFAS:

Are you CAFAS Trained / Reliable? [ ] yes [ ] no
Have you experience in rating CAFAS with Aboriginal children/youth? [ ] yes [ ] no

Return to: Dr. Melanie Barwick, CAFAS in Ontario, Community Health Systems Resource Group,
The Hospital for Sick Children, 555 University Avenue, Toronto, Ontario, M5G 1X8
Fax: 416-813-6011

CONTACT US

For information about this document and/or the use of CAFAS in Canada:

Dr. Melanie Barwick
Psychologist, Associate Scientist
Community Health Systems Resource Group
The Hospital for Sick Children
555 University Avenue
Toronto, Ontario
M5G 1X8
Telephone: 416-813-1085
Fax: 416-813-6011
Email: melanie.barwick@sickkids.ca

For information relating to CAFAS reliability training in Canada:

Karen Fennell, Administrative Coordinator
CAFAS in Ontario
Toll free: 1-866-515-1574
http://www.cafasinontario.ca

For information about CAFAS:

Dr. Kay Hodges
Functional Assessment Systems
2140 Old Earhart Road
Ann Arbor, MI 48105
Telephone: 734-769-9725
Fax: 734-769-1434
http://www.cafas.com

To cherish Knowledge is to know Wisdom

To know Love is to know Peace

To honour all of the creation is to have Respect

Bravery is to face the foe with Integrity

Honesty in facing a situation is to be Brave

Humility is to Know Yourself as a sacred part of creation

Truth is to know all these things