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Choosing Life

SPECIAL REPORT ON SUICIDE AMONG ABORIGINAL PEOPLE

Royal Commission on Aboriginal Peoples

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Royal Commission on Aboriginal Peoples

Canadian Cataloguing in Publication Data

Main entry under title:
Choosing life: special report on suicide among Aboriginal people

Issued also in French under the title: *Choisir la vie*.
Includes bibliographical references.

ISBN 0-660-15801-9
Cat. no. Z1-1991/1-41-4E

1. Native peoples – Canada – Suicidal behavior.
2. Native peoples – Canada – Social conditions.
I. Canada. Royal Commission on Aboriginal Peoples.
II. Title: Special report on suicide among Aboriginal people.

E78.C2C46 1994 971'.00497 C95-980008-5

© Minister of Supply and Services Canada 1995

Available in Canada through
your local bookseller
or by mail from
Canada Communication Group – Publishing
Ottawa, Canada K1A 0S9

Cat. no. Z1-1991/1-41-4E
ISBN 0-660-15801-9

Canada	Groupe
Communication	Communication
Group	Canada
Publishing	Édition

Royal Commission on Aboriginal Peoples

Commission royale sur les peuples autochtones

To His Excellency
the Governor General in Council

May It Please Your Excellency

We have the honour to submit to you, pursuant to paragraph 9 of Order in Council P.C. 1991-1597, dated August 26, 1991, the Report of the Royal Commission on Aboriginal Peoples on suicide among Aboriginal people in Canada.

Respectfully submitted,

René Dussault, j.c.a.
Co-Chair

Georges Erasmus
Co-Chair

Paul L.A.H. Chartrand
Commissioner
(Minority View)

J. Peter Meekison
Commissioner

Viola Robinson
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Mary Sillett
Commissioner

Bertha Wilson
Commissioner

January 1995
Ottawa, Canada

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Viola Marie Robinson
Commissioner

Mary Sillett
Commissioner

Bertha Wilson
Commissioner

It seems that every time the government is in a bind, it sends out Royal Commissions. It sends out people that study our people – more studies, more studies. While in reality we live [in despair], our people die, they commit suicide, they hang themselves, they die from overdoses, we see them splattered all over the highway sometimes. It's a slow death, this, what Canada has done to us.

Charles Joseph Bernard, Jr.
Whycocomagh First Nation
*Eskasoni, Nova Scotia, 5 June 1992**

On September 18, 1992, Abraham committed suicide by hanging. He was found in his locked bedroom by his uncle and brother-in-law who forced open the door. Abraham was on his bed in a semi-sitting position with a chain around his neck.... [He] was 16 1/2 years old.

Donna Roundhead, Nishnawbe-Aski Nation
Director, Nodin Counselling Services
Sioux Lookout Zone Hospital
Sioux Lookout, Ontario, 1 December 1992

[People] think, "Oh, I can't do anything about it, why should I try." That is the wrong attitude. They should provide children with examples of doing the right things. Teach kids how to live, not [how] to die.

Dennis Peters, Long Plains First Nation
Grade 11 student, Crocus Plains Secondary School
Brandon, Manitoba, 12 October 1992

[O]ur people have to start believing in themselves. [We] can't look outside to heal what is bothering the people inside the communities. The government's role is to provide adequate resources.... But our people have ... their own ways of dealing with issues like suicide, and that has to be respected.

Ruth Norton
Native Women's Association of Canada
Special Consultation on Suicide Prevention
Ottawa, Ontario, 7 June 1993

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* Unless otherwise noted, locations and dates refer to the public hearings of the Royal Commission on Aboriginal Peoples. Full transcripts of testimony given at the hearings are available.

Preface

Why Write a Special Report on Suicide Among Aboriginal People?

The Royal Commission on Aboriginal Peoples has been charged with a formidable undertaking: to investigate, explain and make recommendations on a mandate that covers all aspects of Aboriginal life in Canada and seeks fundamental reform of the relations of power between Aboriginal and non-Aboriginal people within our borders. For this work to make a lasting difference in Aboriginal lives, the Commission must focus its attention on long-term goals: self-government, self-sufficiency, healing. But if we fail to address urgent problems, Aboriginal people will have no reason to believe that the future can be different from the past.

Suicide is clearly one of the most urgent problems. Too many Aboriginal youth and young adults are pointing shotguns at their heads, putting ropes around their necks, destroying their powers of reason with the fumes of gasoline and glue. Even one such death or serious injury would be too many. It is hard to imagine a public responsibility more pressing than to stop them.

In the view of Commissioners, responsibility for reducing suicide belongs to everyone: to Aboriginal people in their communities, to Aboriginal leaders and governments, to Canadian leaders and governments, and to Canadians one and all. We are resolved to help by placing suicide at the forefront of issues competing for time and attention on the agenda of change for Aboriginal people, and by making recommendations in this special report for immediate and continuing remedial action.

Suicide is a Special Issue

We believe that suicide is a special issue. It is first and foremost a matter of life and death for that minority of Aboriginal people whose inner despair threatens daily to overwhelm them. But, like other forms of violence and self-destructive behaviour in Aboriginal communities, it is also the expression of a kind of collective anguish – part grief, part anger – tearing at the minds and hearts of many people. This anguish is the cumulative effect of 300 years of colonial history: lands occupied, resources seized, beliefs and cultures ridiculed, children taken away, power concentrated in distant capitals, hopes for honourable co-existence dashed over and over again.

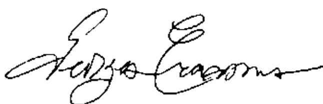
The death of one adolescent boy who lies down on the white line of a two-lane highway in the dark of the night and waits for a transport truck to make the darkness permanent is a symbol of that history, that anguish. The damage must be acknowledged before it can be healed. For that boy – and for all of us who must yet find ways to share the land in fairness and mutual understanding – the Royal Commission has decided to publish this special report on suicide among Aboriginal people in advance of our full and final report on Aboriginal affairs.

Thanks to the People Who Spoke With Us

Commissioners were deeply moved by the testimony of those who came to our hearings and other meetings to tell us how suicide has grieved them and, in some cases, tormented their communities.[1] We know these are not easy matters to discuss in public. Our particular appreciation goes to those who participated in two special consultations on suicide prevention, convened jointly with the Assembly of First Nations, the Native Women's Association of Canada, the Native Council of Canada (now the Congress of Aboriginal Peoples), the Inuit Tapirisat of Canada, Pauktuutit (Inuit Women's Association), and the Metis National Council, in the spring of 1993.

Inside the Commission, some of us ourselves have been saddened by the self-inflicted death of someone close. No matter what our personal experience, we were all affected in heart and mind by what we learned about suicide and its effects on Aboriginal people. We respect the courage and resolve of those who shared their sorrow and their ideas for change with us. By speaking out, each of you has done a great service for Aboriginal and non-Aboriginal people alike. You have offered Canada another chance to understand its own history. You have made a powerful case that high rates of self-inflicted death and injuries are the final, undeniable evidence that the conditions of Aboriginal life must change.

René Dussault, j.c.a.
Co-Chair



Georges Erasmus
Co-Chair

1

Suicide Among Aboriginal People: The Crisis and the Hope

> It is time for all of us, including our leaders, to take the problem of suicide seriously.... Suicide is as important as the Constitution.
>
> *Joey Hamelin, Métis National Council*
> *Special Consultation on Suicide Prevention*
> *Ottawa, Ontario, 7 June 1993*

In 172 days of public hearings held in 96 communities across Canada, the Royal Commission heard few issues discussed with such pain – and such determination to make change – as suicide. Commissioners are left in no doubt that the harrowing stories of shootings, hangings, drug overdoses and teen death-pacts recounted in the national media are only a shadow of the full problem of self-destructive behaviour among Aboriginal people. We are convinced that current high rates of attempted and completed suicide among the First Nations, Métis and Inuit peoples – and the threat of new episodes – constitute an immediate crisis in human and public policy terms.

Of all that we have learned, we are especially troubled by these facts:

- The rate of suicide among Aboriginal people in Canada for all age groups is **2 to 3 times higher** than the rate among non-Aboriginal people. It is **5 to 6 times higher** among Aboriginal youth than among their non-Aboriginal peers.
- Death is not all that is at issue. Frontline health and youth workers agree that **suicide attempts** are many times more frequent.[2]
- High rates of self-inflicted injury and death **have persisted over many years,** despite past reports and studies documenting the warning signs and countless cries for help from Aboriginal communities.

- Statistical analysis predicts a **coming increase** in the number of suicides by Aboriginal youth as the 'population bulge' of children now under the age of 15 enters the vulnerable years of young adulthood.
- There is a wide and demoralizing **ripple effect** from almost every Aboriginal suicide through a chain of interconnected families and communities. Some people in the chain are vulnerable to copycat suicides and other self-destructive responses in their turn.
- There is a **blunt and shocking message** to Canada in so many suicides: a significant number of Aboriginal people in this country believe they have more reasons to die than to live.

Yet, if these facts were all we had learned, the Commission might not now be publishing a special report on suicide among Aboriginal people. As a temporary agency created to nourish reform, the Commission's intent is to do more than parade dispiriting statistics and lament a tragic situation. Our intent is to offer support to struggling communities by making concrete proposals to governments and communities for action to reduce the incidence and address the causes of self-inflicted death and injury.

To make useful proposals, we must understand what suicide among Aboriginal people, in all its complexity, really is: *not just a problem in itself, but the symptom of deeper problems.*

The Commission's Approach

After extensive consultation and study, Commissioners have concluded that high rates of suicide and self-injury among Aboriginal people are the result of a complex mix of social, cultural, economic and psychological dislocations that flow from the past into the present. The root causes of these dislocations lie in the history of colonial relations between Aboriginal peoples and the authorities and settlers who went on to establish 'Canada', and in the distortion of Aboriginal lives that resulted from that history.[3]

We have also concluded that suicide is one of a group of symptoms, ranging from truancy and law breaking to alcohol and drug abuse and family violence, that are in large part *interchangeable* as expressions of the burden of loss, grief and anger experienced by Aboriginal people in Canadian society.

On both grounds, we are convinced that an adequate response to the crisis of suicide among Aboriginal people cannot be limited – either to crisis services in the absence of long-term family and community supports, or to narrowly focused suicide prevention programs without reference to the web of related social problems in which communities may be caught. An adequate response to suicide must entail an overall *healing strategy*. It must speak to the many forms taken by self-destructive behaviour in Aboriginal communities and to its underlying causes. It is not enough to treat desperate individuals and the immediate sources of their

despair – although such treatment must be the starting point of a comprehensive suicide prevention strategy. As well, Aboriginal people must gain the means to address long-standing needs of families and communities and to redress the imbalance of power between themselves and other Canadians from which so much distress flows.

It is the work of the Royal Commission to make recommendations on the critical issues of social justice, land entitlement, economic opportunity and self-determination that reflect the relative powerlessness of Aboriginal people in Canada. We believe that progress on these matters will, ultimately, give more Aboriginal people the reasons they now lack to choose life over death.

In the meantime, however, suicide attempts show no sign of abating. Indeed, some researchers and frontline workers believe they may increase. Attention to Aboriginal suicide *cannot wait* until the foundations of a renewed relationship between Aboriginal and non-Aboriginal people in Canada are in place. Commissioners are persuaded that before that is achieved, action is needed. The collective resources of Aboriginal communities and organizations, as well as Canadian people and governments, must be gathered together now, and focused on a response that is immediate, comprehensive and sustained until positive results are achieved.

In this special report, the Commission develops the rationale and recommends the means for a Canada-wide response to the facts of suicide among Aboriginal people, encompassing

- the establishment of crisis services;
- resources for community development; and
- support for self-determination.

The Basis for Hope

Suicide is a persistent feature of human societies. We cannot expect it to yield easily to remedy. But in the Commission's work so far, we have found grounds for hope and ideas for change. Both spring from the activities of Aboriginal people themselves – activities undertaken to change the conditions that depress and oppress them. Commissioners have seen much evidence that Aboriginal people are, in the words of one national leader, "rising above the psychology of grievance"[4] – shifting their energies from decrying problems to solving them.

Sometimes community initiatives to counteract the threat of suicide take the form of direct prevention programming – but often they do not. Often they range far afield into programs to promote child welfare, programs to restore traditional spirituality, recreation programs for youth, and so on. Their variety should not be surprising. It reflects the variety of reasons people may have to choose life over death. Whatever their focus, those programs that promote strong, secure personal

and collective identities for Aboriginal people, as well as extending the opportunities for personal and collective self-determination, are in fact suicide prevention programs.

For the most troubled Aboriginal communities, the struggle to end suicide and other kinds of self-destructive behaviour may be a long one. But if those communities that are strong carry through with their plans – some needing the help of governments or Canadians generally, others entirely independent – and if others catch the spirit and learn from their successes, we believe that rates of suicide among Aboriginal people will slowly but surely go down.

Contents of the Special Report

This report sets out what Commissioners have learned about suicide among Aboriginal people and how we think its incidence and effects can be reduced. In the report we discuss

- how suicide among Aboriginal people is similar to suicide among all people, and how it is different;
- who is most at risk and why;
- what is already being done to help, and what more could be done;
- key elements in the strategies that work; and
- recommendations for immediate and long-term reduction of the problem.

The report depends as much on the views and life stories of Aboriginal people as on the insights of research to arrive at an understanding of the problem of suicide and its solutions. Inevitably, some of the stories are grim. But most are full of hope, pointing the way forward.

Our purposes in publishing this report are, first, to increase the understanding of Canadians in general; second, to share the ideas for change we have heard from Aboriginal communities; and third, to make recommendations to all responsible authorities for action to alleviate an intolerable situation.

> How do we stop suicide? Again, the answers are many, but I believe the foundation that has to built upon is hope.... Hope that good housing will become available; hope that when you finish your education there will be a job for you; hope that someone somewhere cares; hope that this wretched life is not all that a person is going to have. I believe part of [the Commission's] mandate is to help bring a measure of that hope to the Aboriginal peoples.
>
> *Paul Williams, Vicar, Anglican Church*
> *Rankin Inlet, N.W.T., 19 November 1992*

2

How Serious is the Problem of Suicide Among Aboriginal People?

In nearly every day of our public hearings, Commissioners heard that suicide and its roots in the lingering effects of colonialism are matters of the greatest concern to Aboriginal people. We were told that the death count, especially among young men between 15 and 24 years of age, is unacceptably high. More important, we were told that the number of deaths does not convey the extent of the problem. For each recorded death, there are untallied episodes of self-inflicted injury and failed attempts to die, many with disabling and scarring after-effects. The impact of each death, each attempt to die, and each 'cluster' of suicides and suicide attempts, is devastating for families and other members of close-knit communities. The professional resources of the communities are strained to the breaking point as they try to cope with one or a rash of wounds and deaths and with their aftermath of grief and blame.

It soon became very clear to us that in suicide, Aboriginal communities are facing one of their most urgent and troubling problems. The people who spoke to us had many different ways of telling us so.

What We Heard in the Public Hearings

The seriousness of suicide was demonstrated to Commissioners in presentations ranging from personal accounts of loss and pain to statistical analyses. We heard from survivors and caregivers. In particular, we sought the insights of youth, the age group most prone to suicidal behaviour.

Direct and lasting pain, coupled with hope, was the message given by one affected family member from Rankin Inlet in the Northwest Territories. Wishing to remain

anonymous, her (or his) story was told to us by a woman from the community who had been interviewing suicide survivors.

> I will read one more piece which I got from one other person I interviewed:
>
> > I lost a brother in the mid-seventies to suicide. He was my oldest brother. He was the President of the Student Council at the high school in Yellowknife. To this day, our family doesn't know why he did that. It is a very bad experience since we didn't know that he needed help. If I knew he was going to [go] through this, I would have given him family support. I was in elementary school when this happened and he was in a different community. It still comes to my mind that I wish he was still here with us. If only he knew how much we loved him, maybe it wouldn't have happened. I hope anybody [else] does not have to go through this. It makes you wonder why he did that, and it is like an unfinished book.
> >
> > My suggestion is that when somebody talks about committing suicide, take it seriously and don't joke about it because it is a serious problem. Give him or her family support and don't let them be alone during this time. Encourage them that they have a reason to live.... If you just wait, you will find the better day.
>
> *Angie Kabluitok*
> *Rankin Inlet, N.W.T., 19 November 1992*

The stories of pain we heard from individuals were reinforced by the presentations of caregivers working in community health, some of whom had compiled facts and figures on the incidence of suicide and self-injury in their regions. Whatever their professional perspective, they agreed on the severe impact that even one suicide can have in small and intimate communities – and not just on direct survivors.

> Today, the average rate of suicide in Canada is approximately 14 per 100,000. Statistics for the Northwest Territories suggest that the rate of suicide [here] is three times higher than the national average. Those most at risk for suicide are males between the ages of 15 and 25, and the most common methods used in suicides are firearms and hanging...
>
> National statistics will suggest that for every death by suicide, there are seven people directly affected. I would suggest that the number of people directly affected by suicide in the Territories [is greater than that, because] it may impact on several communities, not just one.
>
> *Karen Acorn, suicide prevention specialist*
> *Government of the Northwest Territories*
> *Rankin Inlet, N.W.T., 19 November 1992*

> Most communities...suffer with pain and shock every time a suicide, or even an attempted suicide, occurs. There are so many negative feelings arising that whole communities practically shut down in shock. The pain is so tremendous that, practically speaking, the entire town needs some form of professional help.... And the tragedy is that even before we've had a chance to recover from one suicide...news arrives of another.
>
> *Paul Williams, Vicar, Anglican Church*
> *Rankin Inlet, N.W.T., 19 November 1992*

Caregivers from other parts of the country described similar situations where suicide epidemics have threatened to swamp the very people with responsibility for coping. In most communities, resources to train staff or develop expert services are insignificant in comparison to the size of the problem, immediate or potential. In some communities, there are no resources for suicide intervention at all.

Even so, those who spoke to us about how better to respond to suicide and suicidal behaviour agreed that improved crisis services are not the whole answer. Crisis services can save some lives – can sometimes help people find new meaning in living. But until the underlying factors in Aboriginal life that lead so many to contemplate or commit suicide are changed, the continuous flow of self-destructive people will not be stopped.

> For the past four years, most of my time has been spent on dealing with crisis situations brought on by suicides and attempted suicides of youth within Shibogama communities.[5] My work has not been easy. It is difficult to attend funerals of young people that have taken their lives with their own hands. It is often overwhelming and painful to comfort a parent, a friend, a grandparent or the community members as a whole when a sudden and shocking tragedy such as the death of a young person occurs. This is the reality of working in the field of suicide prevention....
>
> Shibogama First Nations have suffered the loss of 11 young lives since 1987. The method used by the youth to take their lives in the Shibogama area is by hanging themselves, using whatever is available at the moment of complete despair.
>
> Within the Shibogama communities alone there were 135 reported suicide attempts between 1987 and 1991. In 1992, Kingfisher Lake reported another 22 attempts between January and August. Altogether we had 157 attempts [in the 4 communities]. The methods used in attempted suicides are either by hanging or overdose. Many other attempted suicides have not been reported and are not recorded. Most of the victims of suicides and attempted suicides range in the age group of 14 to 25

> years of age. Most of the victims are males, single and unemployed.... Most of [them] never received proper counselling due to lack of resources.
>
> Nodin Mental Health Service is expected to provide counselling to 28 First Nations with a budget of $55,000. Because of the high demand for their services, the...counsellors and local resource workers are experiencing severe burn-out. More dollars are required to hire and train more community-based workers in the area of suicide prevention. Most importantly, more funding is required to deal with the issues that give rise to suicidal tendencies.
>
> *Sarah McKay, health liaison worker*
> *Shibogama First Nations Council*
> *Sioux Lookout, Ontario, 1 December 1992*

We heard consistently that the problem of suicide is most serious among teenagers and youth. In some communities, we arranged to talk directly with Aboriginal youth. They had no difficulty explaining why so many Aboriginal youth are killing and injuring themselves. The causes, they told us, are all around them all the time: in the confusion they feel about their identity, in the absence of opportunity to make a good life, in the bleakness of daily existence where alcohol and drugs sometimes seem to offer the only relief. They wanted Commissioners to understand the powerful lure that suicide has for the young, as a way out of apparently insurmountable conditions and yawning spiritual emptiness. They told us that their communities should know more about suicide and, more important, that in order to do something about it, a tangle of interrelated problems has to be addressed simultaneously.

> Suicide is a major problem among Aboriginal youth. Racism, loss of culture, physical and mental abuse, family discord, feelings of boredom, loneliness and powerlessness all contribute to the personal pain that leads these young people to choose suicide. Drug and alcohol abuse tends to exaggerate the problem. "Suicide relieves the pain," as one student said. And another: "Suicide has crossed everyone's mind once or twice."
>
> Our communities must take suicide more seriously. Information must be made available to increase public awareness of the issue. Pro-active services must be established to prevent suicides. Some don't take suicide seriously. The result is death.
>
> *Dawn Campbell*
> *North Battleford Comprehensive High School*
> *North Battleford, Saskatchewan, 29 October 1992*

Youth workers in many of the places we visited confirmed that the urge to self-destruction among the Aboriginal teenagers with whom they work is common. They underlined their conviction that, however badly crisis services may be needed

in communities, suicide rates will not subside until more fundamental change is made in Aboriginal lives. They told us that the goal of policy and programs must be this: **to give Aboriginal youth reasons to believe that their lives have meaning and value, in the context of self-determination for Aboriginal peoples generally.**

> In my time [working] at the group home, I have come to witness the deep level of apathy experienced by our Native residents. I'm often moved by the hopelessness they feel for their future. "When I grow up, I want to be..." is not a sentence often finished by our Native residents. I feel a big contributing factor to this attitude is lack of identity. The one-time "subsistence living" of the Native people has taken on a new meaning. [Now they are not really living; they are just subsisting.] When life has no obvious value, suicide has no fear...
>
> I think the need to have control over their lives is a genuine [need] for the Native community. They need to feel that they know and can do what is best for their people. They need the chance to prove this to others and to themselves. No significant change will be made in the lives of the young people until someone takes control, and the best people to do that are the Native people themselves.
>
> *Jaimie Farrell, Labrador Group Home*
> *Happy Valley-Goose Bay, Labrador, 16 June 1992*

Commissioners gained much insight from these presentations, and indeed from all the testimony we heard about suicide and self-destructive behaviour in communities where people have the insight born of first-hand experience. As well, we sought the assistance of researchers, suicidologists and suicide prevention specialists from across Canada to help us understand the nature of the problem. Using information from all the sources available to us, we have attempted to establish the context for suicide by Aboriginal people in Canada today – both its history and its pattern in relation to current national patterns.

Historical Perspectives

> I am here today because my ancestors, starving as they often were, fought to survive. Why did the old people strive to live...and the young people now want to die?[6]

Suicide has been an aspect of human cultures throughout history and in all parts of the world. Among western nations, it is a long-standing social problem – and an increasingly serious one in many countries, including Canada. In global terms, approximately 1,000 people kill themselves every day.[7] In Canada, it has been estimated that 1 out of every 25 people attempts suicide at some time. Each year, more than 3,000 succeed.[8]

There are few written documents describing Aboriginal mortality patterns historically, but Aboriginal oral tradition tells us that suicide was rare in the time before contact with European peoples.[9] Despite the great diversity of Aboriginal cultures, they shared a firm foundation in spiritual beliefs that gave meaning to all life on earth. Most cultures had explicit proscriptions against suicide on the grounds that it contravened natural laws or the design of the Creator.

This impression from the historical record was echoed in the testimony of Aboriginal people appearing before the Commission. They told us that suicide was never seen by their ancestors as an acceptable way out of personal problems. In all likelihood, it was seldom considered: the family, clan and traditional caregivers provided a strong 'safety net' for troubled individuals. These speakers also made it clear that although the safety net has had some holes ripped in it by the erosion of traditional beliefs and values, suicide is in no way condoned in contemporary Aboriginal thinking.

> Too many [North] American Indian youths find this life devoid of meaning and worth little, whereas death is a way of finding peace and reunion with glorified ancestors. Suicide is often viewed as a brave, heroic act. Self-destructive behaviour becomes a learned and rewarded pattern. Those who die by suicide become idols of their peer group. This frame of thought is a fallacy, and this conception of martyrdom should not be construed as an acceptable belief among our people.
>
> *Tara Perley, Tobique First Nation*
> *Post-secondary student*
> *Tobique, New Brunswick, 2 November 1992*

> Our youth are now committing suicide. This was not our way. This is not our future.
>
> *Chief Allan Happyjack, Waswanipi First Nation*
> *Waswanipi, Quebec, 9 June 1992*

The pattern and meaning of suicide among Aboriginal people appear to have undergone a disturbing transformation over time. In the past, those few suicides that occurred were primarily acts of the old or the ill. Their deaths were acts of self-sacrifice, sparing others the burden of extra care.[10] Although they brought sadness and loss, these deaths were also a profound affirmation of life and of the importance of group survival. In contrast, Aboriginal suicide today is more likely to be an act of the young, an expression of hopelessness by those on the brink of life. As such, it is a negation of the future and deeply demoralizing to Aboriginal people.

Aboriginal and Non-Aboriginal Suicide: Comparing the Data

Many Aboriginal communities are small, and the number of suicides in any one age group in any one year, even when they are added together, is also small. This

demographic pattern could lead to distortions in our interpretation of the seriousness of the problem. For example, it is possible that outbreaks of suicide attempts in two or more widely separated villages or urban neighbourhoods – rightly experienced as shattering by those communities – could create the impression of a general tendency to self-injury by Aboriginal people that might not be accurate for the country as a whole. To find out how widespread suicide is among Aboriginal people and how the rates for Aboriginal people compare to those for non-Aboriginal people in Canada, the Commission examined the statistical evidence over time.

A cautionary note about these figures is in order. Although they are an important indicator of suicide rates among Aboriginal people in Canada, the so-called 'national' data have a number of inadequacies. At best, they refer only to 'registered' (or 'status') Indians and to Inuit residing in the Northwest Territories, omitting non-status 'Indians', Métis, and Inuit living elsewhere. At worst, they may omit some of the 'registered Indian' population and suffer from other quality control problems. It is widely agreed, however, that the available figures *under-represent* the actual incidence of suicide among Aboriginal people.[11]

The overall rate of suicide in the Canadian population places this country in the mid to high range among the countries of the world. The rate for adolescents (ages 15 to 19) only, however, suggests that Canada has the third worst suicide problem in the world.[12] Teenaged boys commit suicide 6 times more often than girls; but girls are hospitalized for attempting suicide at twice the rate of boys.[13]

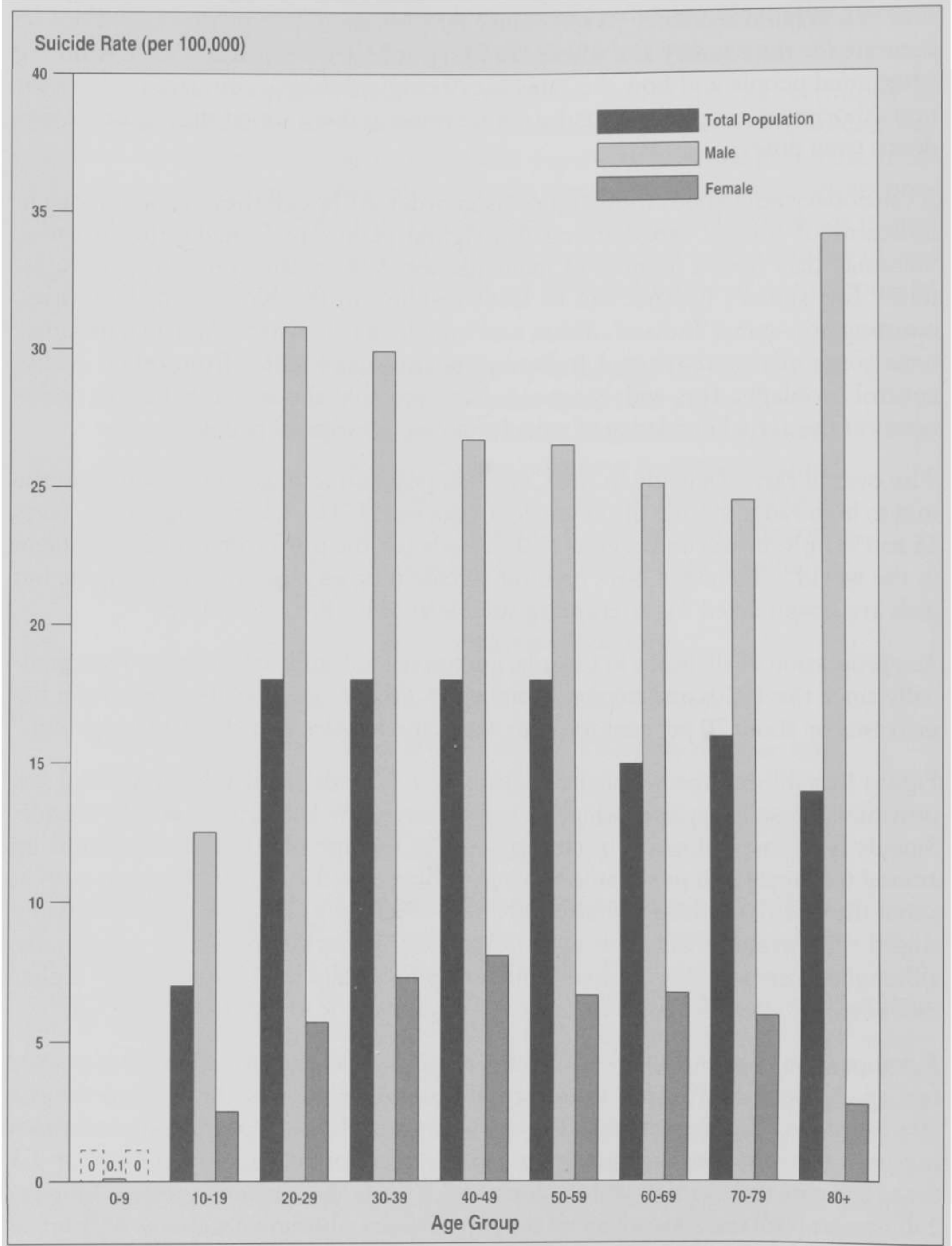
As a proportion of all deaths in Canada, intentional self-inflicted death has risen gradually since the 1920s and markedly since the 1960s.[14] In absolute numbers, it has increased by about 70 per cent for both males and females over that 30-year period.[15]

Figure 1 establishes the prevalence of suicide in Canada as a whole, by age and sex, providing a baseline against which to compare rates of Aboriginal death by suicide. Suicide is almost unknown in children under the age of 10. The rate jumps up among teenagers and peaks among young adults, aged 20 to 29. The rate stays at about the same level during adulthood (30 to 59), falling slightly for men and rising slightly for women. Between ages 60 and 69, it begins to decline marginally, although it increases sharply among men over 80. Males have a consistently higher rate of suicide than females. In most age categories, it is 3 to 4 times higher.[16]

A comparison of suicide rates over time suggests that those for Aboriginal people in Canada have been higher than for the general population throughout the last 30 to 40 years.[17] In the past 10 to 15 years, rates have been on average about 3 times higher.[18] Current statistics place the suicide rate for registered 'Indians' at 3.3 times the national average and for Inuit at 3.9 times the national average.[19] Figure 2 illustrates both the consistency of the gap between Aboriginal and non-Aboriginal rates and the greater volatility in the Aboriginal rate, reflecting the impact of particular local outbreaks.[20]

Figure 1

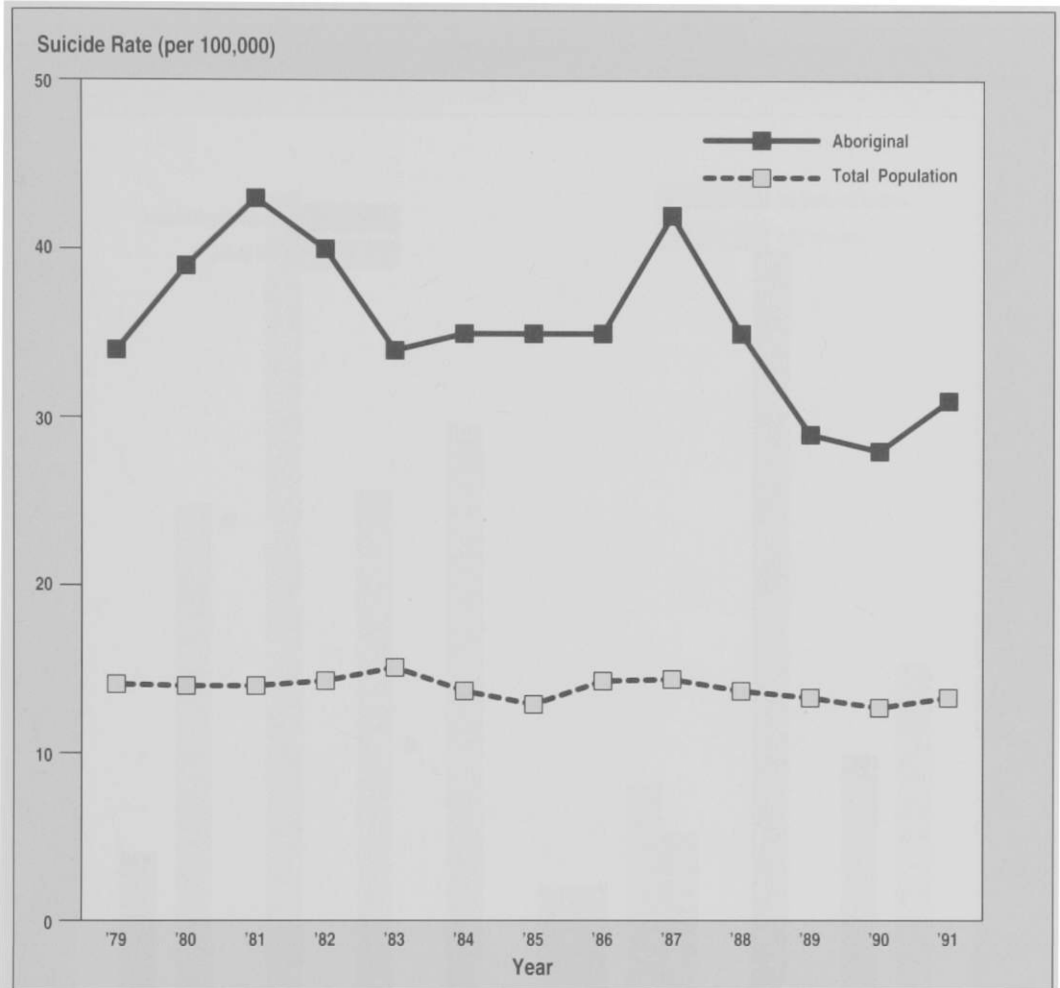
Total Canadian Suicide Rate, by Age Group and Sex, 1991



Source: Medical Services Branch, Health and Welfare Canada, Unpublished, 1993.

Figure 2

Suicide Rate for Registered Indians* and the Total Population, Canada, 1979-1991

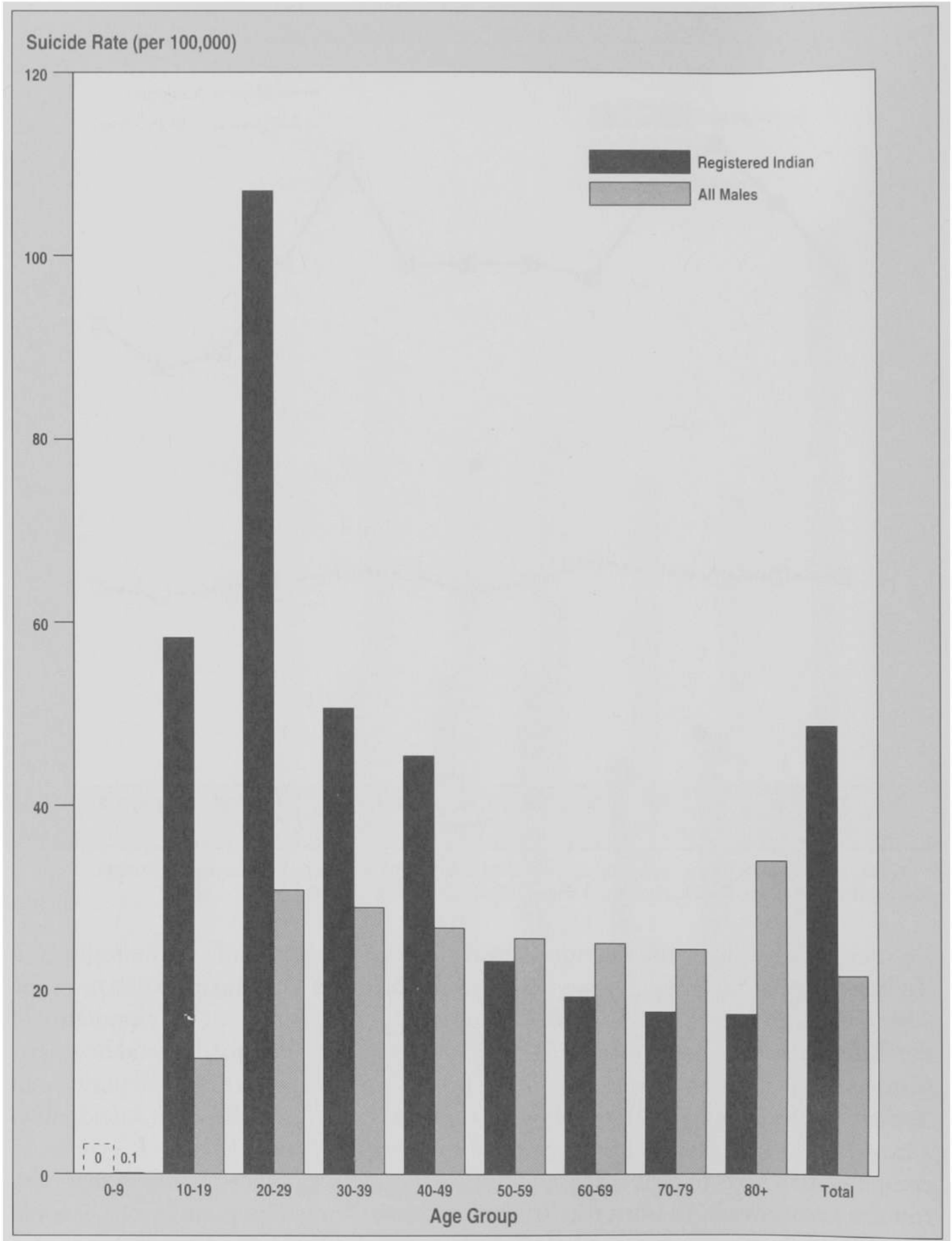


* The data for the Pacific region cover only the years 1979-1984 and for the N.W.T. only the years 1979-1986.
Source: Medical Services Branch, Health and Welfare Canada, Unpublished, 1993.

Figures 3 and 4 show the current pattern of age-related trends in the registered 'Indian' population by age group and sex and permit us to compare patterns in the Aboriginal and non-Aboriginal populations. The comparison speaks eloquently of the difficulties of growing up as an 'Indian' child or youth in Canada – and by extension, as an Inuk or Métis child. Based on data from the 1987-1991 period, an 'Indian' adolescent (aged 10 to 19) is 5.1 times more likely to die from suicide than a non-Indian adolescent: girls are 8 times more vulnerable; boys, 4.7 times. A comparison of boys to girls *within* the 'Indian' population, however, shows that boys run the greater risk. In both the 'Indian' and total Canadian populations, suicide rates are highest among those between the ages of 20 and 29. This differential is very much greater for 'Indian' youth. In the older age groups, the gap between

Figure 3

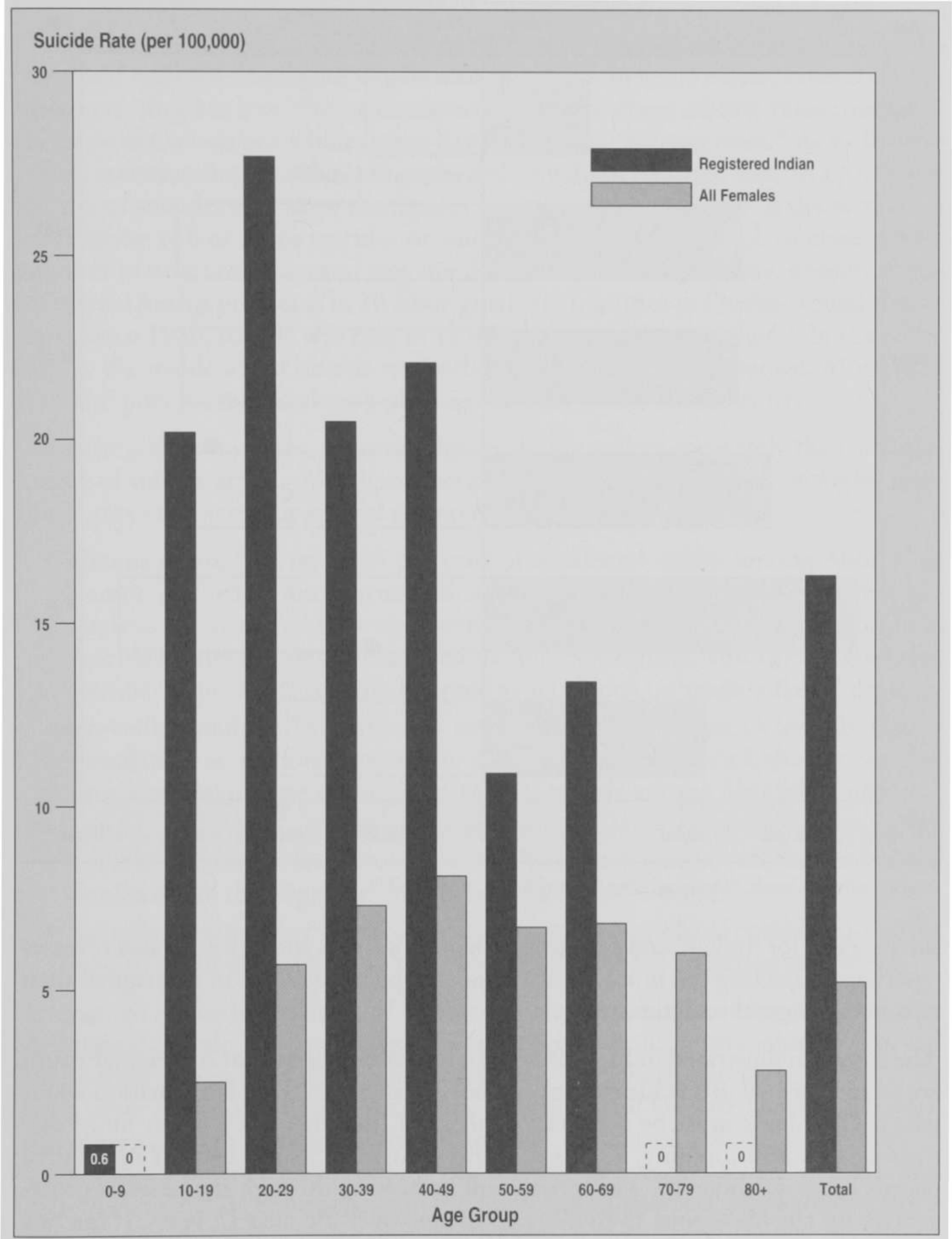
Male Registered Indian Suicide Rate, 1987-1991*
Compared to that of the Total Canadian Male Population, 1991



* Data for the N.W.T. and the Pacific region not included.
Source: Medical Services Branch, Health and Welfare Canada, Unpublished, 1993.

Figure 4

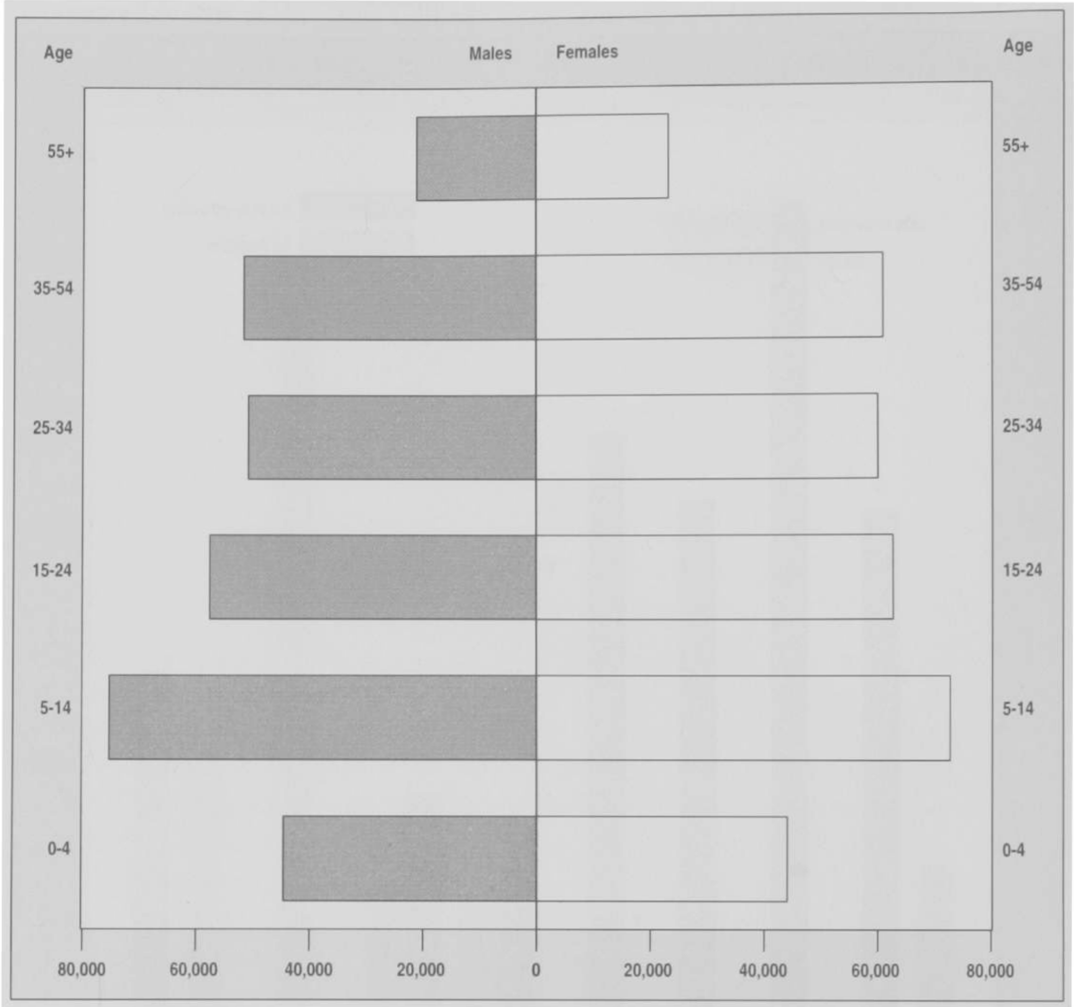
Female Registered Indian Suicide Rate, 1987-1991*
Compared to that of the Total Canadian Female Population, 1991



* Data for the N.W.T. and the Pacific region not included.
Source: Medical Services Branch, Health and Welfare Canada, Unpublished, 1993.

Figure 5

Aboriginal Population in Canada by Age and Sex, 1991



Source: Statistics Canada, "Aboriginal Data: Age and Sex", Cat. no. 94-327, 1993.

suicide rates for 'Indian' and non-Indian people narrows and in some cases reverses – perhaps reflecting the more highly respected place of elders in Aboriginal than in non-Aboriginal societies.

The situation illustrated in Figures 3 and 4 indicates clearly that Aboriginal youth are at greater risk of suicide than non-Aboriginal youth. This is a situation about which Canadians must be seriously concerned. But there is a much more disturbing situation looming. Figure 5 shows that fully 38 per cent of Aboriginal people are now under 15. This group will be passing through the years of greatest risk for suicide (about 15 to 29 years of age) over the next 15 years. If the *rate* of suicide remains the same – that is, if the people and governments of Canada are unable to change the conditions leading to so many suicides by Aboriginal youth

– the *number* of those killing themselves will rise in this period, simply because there will be many more adolescents and youth enduring the same conditions.

The Numbers Don't Tell the Whole Story

Those are the trends. However, generalizations conceal wide variations in the local and regional Aboriginal experience of suicide. In some places, rates are high; in others, they are low.[21] Some communities have average suicide rates compared to those of Canada as a whole; some have lower than average rates.[22] As well, individual communities are subject to peaks and troughs in reported data, as a particular cluster of suicides may skew the figures in a given year. ('Cluster' is the term used to describe two or more suicides or suicide attempts that take place close to one another in time and space and may involve imitation.) For example, a recent study of mental health problems in 20 Aboriginal communities in Quebec found that at least since 1980, suicide was rare in 13 of the communities studied.[23] In the other seven, the incidence of suicide was well above the Canadian average. More than half the suicides recorded took place in just four of the communities.

More important perhaps, reported figures do not reflect accurately the true incidence of suicide among Aboriginal people. True rates are likely to be *higher* than those reported here, for several reasons:

- Estimates are that up to 25 per cent of accidental deaths among Aboriginal people are really unreported suicides.[24] In British Columbia, a recent reanalysis of coroners' files uncovered (1) a significant number of Aboriginal suicide victims wrongly classified as non-Aboriginal, and (2) a significant number of probable suicides counted as accidental or 'unclassifiable' deaths.[25]
- So-called 'national' statistics do not reflect the situation in the Aboriginal population as a whole. Systematic data collection is limited, thus presenting only a partial picture of the prevalence of suicide among Aboriginal people.[26]
- Suicide reporting is generally suspect because the cause of death may be difficult to determine, and because medical personnel may be reluctant to burden families with the stigma of an officially identified suicide.
- An unknown number of suicide attempts produce medical complications that lead to death at a later date, but these deaths are not recorded as suicides.

Even with these limitations of reporting, the conclusion is inescapable that Aboriginal people are more likely to end their own lives prematurely – to kill themselves – than non-Aboriginal Canadians.[27] They are also more likely to die from other forms of violence. According to Health and Welfare Canada, the leading cause of death among 'registered Indians', measured over all age groups, is injury. This is the mortality grouping that includes accidental death as well as homicide and suicide. By comparison, in the Canadian population as a whole, injury is only the fourth leading cause of death, following circulatory disease, cancer and respiratory disease.[28] The general picture of Aboriginal death in Canada is not one in which Canadians can take any pride.

Summary of a Serious Situation

- Commissioners learned of the gravity of the suicide problem from the direct testimony of Aboriginal people. Their hearts are being broken and their resources depleted by the numbers who have died and the numbers who have tried to die. What hurts and frightens them most are the deaths of the young.
- By looking at the historical and statistical evidence, we learned that suicide among Aboriginal people is more common now than in the past. Whereas it was once an infrequent choice of the old, now it is an all-too-frequent choice of the young.
- The statistical evidence showed us that rates of suicide among Aboriginal people are significantly higher than those of Canadians generally and that the gap is greatest among the young. Adolescents and young adults are in the category of greatest risk. Most concerning of all, we identified a strong possibility that the number of suicides among Aboriginal youth will rise in the next 10 to 15 years.

Commissioners regard suicide, and self-destructive behaviour generally, as an index of personal and collective despair. On the basis of the information we have compiled here, we must conclude that despair casts a significant shadow across Aboriginal communities in Canada today. The first question is, why? The second is, what can be done? The remainder of this special report attempts to answer these questions.

3

Why Are There So Many Suicides Among Aboriginal People?

> Suicide is a tragic and perplexing phenomenon, [posing] many unanswered questions and [inspiring] a multitude of conflicting theories... Identifying the chain of causal and triggering factors, which may in any event be highly individual, and deriving from this an overall prevention and treatment strategy, is perhaps one of the most vexing problems facing professionals in the health sciences.[29]
>
> Many reports written today about the suicides of youth...outline in great detail the contributing factors that lead to suicide. Yet these reports fail to clearly identify the reasons why the suicides occur. The contributing factors, such as sexual abuse, family violence, alcohol and drug abuse, solvent abuse, satanic practice, deterioration of family structures, lack of proper leadership, et cetera...are only the symptoms of a bigger and more devastating cycle of oppression and depravation...first initiated with colonial contact in 1492... We must stop the immoral behaviours caused by oppression. [That's how to] stop the suicides that are occurring amongst our youth today.
>
> *Sarah McKay, health liaison worker*
> *Shibogama First Nations Council*
> *Sioux Lookout, Ontario, 1 December 1992*

Suicidal behaviour – self-inflicted injury and death – is found in every human society. No matter where it occurs, it is hard to define or explain, and harder still to predict

and prevent. In relation to the general population, it has long been the subject of investigation and research. Scores of analysts have tried to answer the question that troubles us all when we think about suicide: why do people do it? Their answer comes in the form of a series of 'risk factors' – personal and social characteristics commonly found among those who kill themselves. In the view of Commissioners, an understanding of these risk factors is important in understanding suicide among Aboriginal people – but it does not give us the whole story.

According to mainstream researchers, Aboriginal and non-Aboriginal people who kill themselves share a profile of key risk factors, including early childhood separation from family members and significant others, disrupted or unstable primary relationships, conflict with authority, alcohol and drug abuse, physical illness, depression and other mental disorders.[30] The typical sequence of events leading up to a suicide attempt shows common patterns, too:

- a long history of 'getting into trouble' (from the point of view of authorities), or 'impossible life circumstances' (from the point of view of the suicidal person), culminating in
- a traumatic event, often related to conflict in an intimate relationship, that overturns the delicate balance between reasons to live and reasons to die.[31]

The full list of risk factors associated with suicide and self-harm is a long and messy one, reflecting both the complexity of the phenomenon and the still exploratory nature of the research base. Some describe the vulnerabilities of individuals. Others describe social and cultural factors that affect whole communities, whole peoples. By and large, the research tells us more about why a few people choose death or self-injury than why most choose life.

For purposes of our discussion here, we have grouped the major risk factors into four families of related attributes:

- **psycho-biological factors:** most important are the mental disorders and illnesses associated with suicide – depression, anxiety disorders and schizophrenia; however, certain personality disorders (e.g., hypersensitivity, perfectionism) and aspects of what is known as 'cognitive style' (e.g. negative thinking, rigid thinking, poor problem-solving ability) are also risk factors for self-harm.
- **life history or situational factors:** early childhood trauma (e.g., disrupted relations with caregivers, family history of suicide and premature death, experience of sexual or other abuse); current family dysfunctionality; conflict in intimate relationships or with authority; imprisonment; substance abuse; current access to lethal means (the ease with which a person can get access to a method of killing or injuring him- or herself, e.g., guns, pills, drugs, etc.); absence of religious and spiritual commitment.
- **socio-economic factors:** unemployment; individual and family poverty; relative deprivation or low class status; low standards of community health, stability and prosperity.

- **culture stress:** the loss of confidence by individuals or groups in the ways of understanding life and living (norms, values and beliefs) that were taught to them within their original cultures and the personal or collective distress that may result.[32]

Research indicates that these are the important risk factors for suicide among non-Aboriginal and Aboriginal people alike. But the relative balance among these factors is different. The pattern of risk experienced by First Nations, Métis and Inuit people reflects past and present life circumstances that are, in their dynamics, unique to Aboriginal people. The high rates of suicide and self-harm which in Aboriginal communities can be explained only by looking at the historical and continuing power imbalance between Aboriginal and non-Aboriginal people in Canada, which has created lives characterized by risk. Accordingly, we discuss all four categories of risk in this chapter of the report, but we pay particular attention to culture stress and the colonial relations that have produced it.

Psycho-Biological Factors

Mental disorders – especially depression and other 'affective disorders' – are found in a high percentage of non-Aboriginal people who attempt suicide.[33] The incidence of these conditions in the Aboriginal population is less well documented, although reports of psychiatric consultation in Aboriginal communities and the evidence offered by Aboriginal community health providers suggests that reactive depression and unresolved grief, assessed in clinical terms, may indeed be widespread problems.[34]

In the general population, there are other mental illnesses commonly found to be associated with suicide. These include so-called 'personality deficits' – schizophrenia and anxiety. Research done for the Commission suggests that such mental disorders are found less often among Aboriginal people who attempt suicide.[35] If so, this finding may reflect the fact that Aboriginal people have less access to diagnostic and treatment facilities for mental health problems – and are less likely to use them.

Many Aboriginal caregivers and policy analysts are critical of approaches to mental health and illness based on the catalogue of medically defined psychiatric disorders. Some prefer to talk in terms of imbalance or disharmony in the circle of mind-body-emotions-spirit that defines a healthy person and a healthy community according to most Aboriginal cultural traditions. Others say that it is a form of 'blaming the victim' to focus on such individual symptoms as 'depression' or 'negative cognitive style' among people who, after several generations of cultural domination, might be thought to have good reasons for these and other manifestations of loss and pain. They argue that the profile of mental disorders among Aboriginal people is primarily a by-product of our colonial past with its layered assaults on Aboriginal cultures and personal identities, and that the psycho-biological traits linked to suicidal and self-destructive behaviour among Aboriginal people cannot be understood except in that context.

Bill Mussell, an Aboriginal educator and director of the Sal'i'shan Institute in British Columbia, describes the state of imbalance derived from oppression that might drive an Aboriginal person to suicide this way:

> Individuals and families in a dominated society are [persuaded] to believe that they are not good enough to make it. That they are ignorant, incompetent and irresponsible, are messages often conveyed by the oppressor... Over time, people in the dominated society become fatalistic, emotionally dependent on the oppressors, and self-deprecating. Ultimately, they fear freedom and responsibilities... The wills of many have sunk into apathy.[36]

We will have more to say about the relationship between cultural domination and suicide later in this chapter of the report.

Life History Factors

Although the research yields no single, uncontested list, the individual life history characteristics most often associated with suicide and self-harm are

- chronic family instability or disrupted relations;
- a family history of mental health problems, including suicide attempts, alcoholism or depression in parents or caregivers;
- experience of physical or sexual abuse;
- substance abuse;
- a history of interpersonal conflict;
- recent extreme interpersonal conflict or the loss of a major relationship; and
- prolonged or unresolved grief.

From this list, Aboriginal people usually cite the disruption of families by outside intervention and by internal tension and violence, as well as the prevalence of alcohol and drug abuse, as the factors most closely related to suicide. In our public hearings, many speakers described the escalating impact of these factors from one generation to the next. According to one view,

> Two-thirds of that last generation to attend residential schools has not survived. It is no coincidence that so many fell victim to violence, accidents, addictions and suicide. Today, the children and grandchildren of those who went to residential schools also live with the same legacy of broken families, broken culture and broken spirit.
>
> *Chief Councillor Charlie Cootes*
> *Uchucklesaht First Nation*
> *Port Alberni, British Columbia, 29 May 1992*

Aboriginal people in Canada have experienced the disruption of family life time and time again during recent history, as a result of enforced attendance at boarding schools by their children, fly-out hospitalization for the treatment of chronic diseases such as tuberculosis requiring lengthy recuperation time, and dubious adoption policies. The long-term effects of such experiences are only now beginning to be assessed, but research on suicide confirms that early separation from family, and emotional deprivation generally, are prime risk factors for self-harm.[37]

The use of alcohol and drugs by Aboriginal people is incomprehensible except in the context of a history that includes the deliberate introduction of alcohol by Europeans to peoples unfamiliar with its effects in order to achieve trading and other advantages; the steadily increasing availability of alcohol along with the increasing domination of non-Aboriginal culture and social order generally; later laws of prohibition applying only to Aboriginal people; and the slowly growing social acceptability among Aboriginal people of intoxication to relieve unhappiness, personal problems and the pain of cultural alienation.[38]

There is a close association between alcohol and drug abuse and suicide in both non-Aboriginal and Aboriginal populations. Among non-Aboriginal people, measured rates of intoxication in those who attempt or complete suicide vary roughly from a low of 25 per cent to a high of 66 per cent.[39] Among Aboriginal people, the figures are generally found to be higher. In one B.C. study, 74 per cent of Aboriginal persons who completed suicide were intoxicated, compared with 36 per cent of a matched sample of non-Aboriginal suicides.[40] In an Alberta study, 80 to 90 per cent of Aboriginal persons who completed suicide were found to have alcohol in their blood.[41] Frontline workers in other places report similar high rates of intoxication in Aboriginal suicide victims.

Heavy drug users incur a risk of suicide that is 20 times greater than for non-users in the general population, although there are no comparable figures for Aboriginal users.[42] Solvent use, including gasoline sniffing, is frequently reported as a factor in suicide by Aboriginal youth. Chronic use of solvents can lead to brain damage and/or paranoid psychosis and thus to suicide. But those who habitually sniff gasoline or glue are likely already marked by extreme hopelessness and helplessness. Indeed, knowledge of the damaging effects of solvents is now so widespread in most Aboriginal communities that continued abuse can be considered a kind of slow suicide.[43]

Socio-Economic Factors

> Aboriginal suicide rates are three to four times higher than those of non-Aboriginal society, and 75% of [Aboriginal] suicides are alcohol and drug related. It does not take a genius to note that there is a connection between alcohol and drug abuse and lack of education and employment opportunities. It does not take a genius

to note that because these tragedies happen in Aboriginal communities, they are ignored.

Winston McKay, addictions counsellor
Metis Addictions Corporation of Saskatchewan
La Ronge, Saskatchewan, 28 May 1992

In general, suicide occurs more often among those who are poor, those who are unemployed, and those who live where poverty and unemployment rates are high.[44] As with each of the risk factors discussed here, this relationship is neither simple nor absolute. Other factors may intervene to change the picture, as for example where community and social cohesion is strong despite poverty and high rates of unemployment.[45]

Among Aboriginal people living on-reserve – and in most isolated villages and urban neighbourhoods as well – the prevailing socio-economic conditions are generally conceded to be inferior to those of most Canadians. The weight of evidence points to high rates of poverty, low levels of educational achievement, limited employment opportunities, inadequate housing, and deficiencies in sanitation and water quality, which are accompanied by high rates of chronic infection and parasitic and respiratory diseases.

Among these dispiriting conditions, unemployment is perhaps the key. Being without work, without adequate income or future prospects, has a profoundly negative impact on people in western industrial societies, affecting

- feelings of self-worth, security and optimism in the jobless person;
- the psychological well-being and physical safety of family members in relation to the possibility of depression or anger in the unemployed person; and
- the buying power, living conditions and overall economic status of family members.

The Canadian Mental Health Association considers unemployment to be a serious contributing factor to both the mental and physical health problems of Canadians.[46] Strangely, however, unemployment is not often identified as a major risk factor for suicidal behaviour among Aboriginal people, even though rates of unemployment are extremely high, especially on reserves and in isolated communities. This may be because the lack of paid employment has become so common in these communities that it seems to be a fact of life rather than a factor contributing to the risk of self-inflicted death.[47]

The socio-economic conditions of communities and the psychological states of individuals tend to reinforce one another. Substandard living conditions and limited life chances are associated with depression and feelings of helplessness and hopelessness. Conversely, depression and other mental and cognitive disorders prevent people from acting to change their life circumstances. Anger and despondency increase the probability that such people will have problems within their families,

with the law, with drugs and alcohol – with life and all its demands. The circle of interacting risk factors may feel like a noose.

Culture Stress

Culture stress is a category of risk that applies to those whose societies have undergone massive, imposed or uncontrollable change. It is studied primarily in relation to immigrant and indigenous populations, but research on the aftermath of natural disasters such as floods and earthquakes, and social disasters such as wars, reports similar symptoms of social breakdown.

Culture is the whole complex of relationships, knowledge, languages, social institutions, beliefs, values and ethical rules that bind a people together and give the collective and its individual members a sense of who they are and where they belong. It is usually rooted in a particular place – a past or present homeland. It is introduced to the newly born within the family and subsequently reinforced and developed in the community. In a society that enjoys normal continuity of culture from one generation to another, its children absorb their culture with every breath they take. They learn what is expected of them and they develop a confidence that their words and actions will have meaning and predictable effects in the world around them. When individuals stray from the path of culturally accepted behaviour, their own inner voice, and the expectations of those around them, supply the pressure necessary to bring them back within the frame of what is acceptable.

In cultures under stress, the smooth operation of society and the sense life makes to its members can be seriously impaired. Culturally transmitted norms that once provided meaning and guided individual behaviour become ineffectual as rules for living or sustaining relationships, and the rules themselves fall into disrepute. People lose confidence in what they know and in their own value as human beings. They may feel abandoned and bewildered and unsure about whether their lives have any real meaning or purpose.

Indigenous cultures around the world have been subjected to forces of change which are strikingly similar to the disruptions suffered by victims of war:

- loss of land, loss of control over living conditions and restricted economic opportunity;
- suppression of belief systems and spirituality;
- weakening of social institutions;
- displacement of political institutions;
- pervasive breakdown of cultural rules and values and diminished self-esteem;
- discrimination and institutional racism and their internalized effects; and
- voluntary or involuntary adoption of elements of an external culture and loss of identity.

The transformations that result from these oppressive experiences are gathered together in the term 'culture stress', which has a central role in predisposing Aboriginal people to suicide, self-injury and other self-destructive behaviours.

Colonial Relations, Past and Present

Aboriginal people experience the risk factors discussed earlier with greater frequency and intensity than do Canadians generally. The reasons are rooted in the relations between Aboriginal peoples and the rest of Canadian society – relations that were shaped in the colonial era and have never been thoroughly reshaped since that time.

Canadians take some satisfaction in the fact that relations between Aboriginal peoples and colonial society north of the 49th parallel seldom developed into armed conflict. But a closer examination of the record reveals that the early relations of respect and mutuality between Indigenous peoples and the new arrivals from Europe soon gave way to invasive and insistent attempts by colonial governments and Christian churches to remake Aboriginal cultures and societies in the image of European cultures and societies. In the process, Aboriginal beliefs, traditions and institutions were ignored and ridiculed; Aboriginal governments and ways of making decisions were legally suppressed.

Despite resistance to imposed institutions and belief systems, and despite the brave (or stubborn) unwillingness of some Aboriginal people to abandon traditional ways, all indigenous cultures were weakened as a result of their encounters with non-Aboriginal society. Aboriginal populations were decimated by relentless waves of premature death caused by 'foreign' diseases to which they had no immunity. They were displaced from their traditional lands and denied access to the resources that had always sustained them. Many were uprooted from places sacred to them and set down in reserves and settlements out of the way of the homes and businesses of the newcomers. Wherever they refused to give up their identity as Aboriginal people – refused to assimilate – they paid a price: marginalization within Canada. Some have lost hope that these facts will ever cease to dominate their lives.

The impact of the colonial and assimilationist policies of Canadian governments and churches can be seen in unfulfilled treaty agreements, self-serving land policies, paternalistic legislation, ethnocentric suppression of key Aboriginal beliefs and cultural practices such as the sun dance and the potlatch, and continuing inequities in the programs and services available to Aboriginal people of different origins and in different locations.

The terrible effects of these policies are most dramatically visible perhaps in the consequences of the residential schools and child welfare interventions that separated successive generations of Aboriginal children from their families and communities – in the case of the residential schools from about the mid-nineteenth century until well past the mid-twentieth and, in the case of child welfare policies, in some places until today.

Although the experience of growing up within these institutions was not uniformly bad for all, still they did extensive damage to

- feelings of self-worth,
- family connectedness,
- the intergenerational transfer of skills and traditions, and
- the essential core of trust in and respect for others from which all people must draw in order to build loving relationships and healthy communities.

Perhaps the most powerful message delivered to Canadians by the hundreds of Aboriginal people who shared their stories with Commissioners, and by non-Aboriginal people working to change the racist attitudes and policies they encounter in Canadian society, is that the insults and injustices of the past continue today. And the effects of past oppression live on in the feelings of anger and inadequacy from which Aboriginal people are struggling to free themselves.

A race relations co-ordinator who addressed the Commission in Winnipeg spoke frankly about the attitudes that, in his view, newcomers to Canada learn as part of their informal education in citizenship:

> In the Canadian context, it is a fact that the majority of non-Aboriginals accept the belief that Native Indians are inferior. This belief has been passed on from generation to generation through racist attitudes and actions, television, schools, movies, government policies, books and other media. Many immigrants to Canada quickly buy into the mistaken assumptions and negative stereotypes of the white majority without looking at the root of the problem. These beliefs have been expressed in many cases of blatant racism and prejudice against Aboriginals.
>
> *Harold Rampersand, co-ordinator*
> *Community and Race Relations Committee*
> *Winnipeg, Manitoba, 3 July 1993*

Roy Fabian, a Dene with broad experience in land claims negotiations and community leadership, described to Commissioners how external oppression becomes internalized, generating a vicious cycle of violence.

> When you are talking about oppression, there is a process that goes on. [First] there is a process that demeans us, that belittles us and makes us believe that we are not worthy, and the oppressed begin to develop what they call cultural self-shame and cultural self-hate, which results in a lot of frustration and a lot of anger. At the same time this is going on, because our ways are put down as Native people, because our cultural values and things are put down, we begin to adopt our oppressors' values and, in a way, we become

oppressors [of] ourselves... Because of the resulting self-hate and self-shame we begin to start hurting our own people [and ourselves].

When you talk about things like addiction and family abuse, elder abuse, sexual abuse, jealousy, gossip, suicide and all the different abuses we seem to be experiencing, it's all based on [the original] violence. It's all a form of [internalized] violence. [Churches and governments] made us believe that the way we are today is the Dene way. It isn't. That is not Dene culture...

The whole process of healing is becoming responsible for ourselves... If [Aboriginal] men abuse women, they have to take responsibility for that abuse. [But] we have been abused by the Canadian government and the churches, [and] *they* have to take responsibility for that.

Roy Fabian, Executive Director
Hay River Reserve Treatment Centre
Hay River, N.W.T., 17 June 1993

Throughout the history of contact with colonial society, Aboriginal peoples have suffered rejection of their languages, customs, values and beliefs and lethal damage to all those elements of culture that define the essence of identity and give structure and meaning to individual conduct and societal relations. They are now confronting the task of revitalizing their cultures, healing individuals, families, communities and nations – and restoring the strength and self-respect that will allow them to take responsibility for their future.

Aboriginal Youth and Suicide

When I walk around my community now, I seldom hear the children laugh, the way they used to in the old days. Instead we hear them cry. This should not be.

Unidentified speaker from the floor
Special Consultation on Suicide Prevention
Aylmer, Quebec, 14 April 1993

If you think that it is great to [live on reserve and] get handouts from the government, well, it's not. It's not, if you're just a teenager and [already] have kids. It's not, if you don't have an education [or a job]... It's not, if you don't have anything to do but sit around the house... That is why Native [kids] commit suicide, do drugs, become alcoholics, and waste their lives.

Dennis Peters, Long Plains First Nation
Grade 11 student, Crocus Plains Secondary School
Brandon, Manitoba, 12 October 1992

> The situation of our Aboriginal youth is pretty bleak... Many of [them] have committed suicide because of their lack of identity, their lack of things in life that most people take for granted... We also have to deal with racism, lack of education, lack of an economic base, lack of land and lack of our being in touch with our own culture.
>
> *Brian Cook*
> *The Pas, Manitoba, 19 May 1992*

In Aboriginal societies, as elsewhere, those most vulnerable to suicide are young people. Suicide, suicide attempts and suicidal thoughts are all at their highest among teenagers and young adults. Suicidal thinking is so common in adolescence that the age is sometimes treated as a risk factor in itself. The risk of suicide and self-injury among Canadian youth (ages 15 to 24) is high in international terms, as we have said – and the risk for Aboriginal adolescents and young adults is even higher.

Aboriginal youth share two fundamental experiences with other young Canadians: a time in the life cycle of intense physical transformation (adolescence) and the pressures of growing up in the competitive and uncertain global economy of our times. But Aboriginal youth face additional challenges. They have to deal with a surrounding society that devalues their identity as Aboriginal persons; and they may have few supports or role models in families and communities battered by the ill effects of colonialism. The personal and social dimensions of culture stress are about relationships, vocation and the values that will shape their adult lives. The difficulties they encounter in establishing a secure, self-confident sense of themselves is often described as an 'identity crisis'.

Identity issues

Essential elements of Aboriginal identity have been undermined over many decades through

- the neglect or misrepresentation of Aboriginal history and cultures in school curricula and the mass media;
- belittling or racist images of Aboriginal people and their behaviour;
- loss of land, languages, cultures and spiritual grounding;
- the general domination of public discourse and public policy by 'European' norms, values, imagery and heroes; and
- individual experiences of ridicule, stereotyping, discrimination and racism.

The majority of Aboriginal youth spend much of their lives immersed in non-Aboriginal culture. Many get little encouragement from the world around them to celebrate who they are, who their forebears were, who they could become as Aboriginal people. Some draw strength from the warmth and encouragement of

extended families and inspiration from rich and dynamic cultural traditions. But for others, the safety and support they need to face the challenges of growing up are missing.

In speaking to Commissioners, Aboriginal youth described both exclusion from the dominant society and alienation from the now idealized but once-real 'life on the land' that is stereotypically associated with aboriginality. The terrible emptiness of feeling strung between two cultures and psychologically at home in neither has been described in fiction and in art, as well as in testimony given before the Commission.[48] If they have few positive role models or clear paths to follow, Aboriginal youth may be forced to turn to one another, building tight bonds against a hostile world. Their inward-looking subculture may reinforce hopelessness and self-hate, and their only exits may appear to be the oblivion of drugs and alcohol – or death.

The reality of life in most isolated northern communities and many reserves is restricted opportunity for participation in the society and economy beyond their borders, with no real alternatives at home. In urban settings, intergenerational poverty, unresponsive institutions and racism limit the horizons of Aboriginal youth. Many feel that they have no meaningful choices to make, no hope of employment and independence – no future.

Those who spoke before the Commission were clear that the rediscovery of their cultures and traditions is of great potential significance to them in their struggle to grow up whole. Consistently, they asked for the chance to reassemble the fragments of their heritage as Aboriginal people. We recognize that those who addressed us do not necessarily represent the views of all Aboriginal youth, and that the renewal of traditional cultures will not solve all problems. But the rebirth of Aboriginal spirituality and traditions offers youth a powerful antidote to the temptations of self-destruction.

Family issues

> Drug and alcohol abuse, spousal assault, suicide and other problems are having a major impact on the next generation. Children from families with problems often grow up to have the same problems... Parents with problems may neglect their children's needs and they may be unable to provide the spiritual, emotional and cultural values needed to provide growth for the individual child and society as a whole.
>
> *Leetia James*
> *Baffin Region Agvvik Society on Family Violence*
> *Iqaluit, N.W.T., 26 May 1992*

> Was I born to be abused? If I was born to be abused, why shouldn't I kill myself?[49]

Research, interviews and testimony given before the Commission indicate that many Aboriginal youth feel socially and psychologically isolated, that their families and communities do not care about them. This is not atypical of the feelings of adolescents in general. However, some Aboriginal youth are coping with difficult family issues on a scale that gives special meaning to the isolation and neglect of which they speak. They feel abandoned by their parents in some cases because they are. The experiences of their own damaged childhoods have left some parents and grandparents with few strategies for living other than unacceptable ones: violence, abuse, addictions, self-destructive behaviour generally.[50] These patterns are deeply destructive not only to family life, but also to public life, as community leaders are not untarnished.

The relationship between suicidal behaviour and the experience of violence, especially abuse in childhood, is only beginning to be explored in research. One recent study concluded that adolescents who had been physically abused in childhood were 4.7 times more likely to attempt suicide than their peers who were not abused, 5.1 times more likely if the abuse was sexual, and 9.2 times more likely if it was both physical and sexual.[51] Estimates of child abuse in Aboriginal communities are inexact but high.[52] Frontline workers believe that abuse is a major factor in suicidal behaviour for both Aboriginal and non-Aboriginal people. In different words, many who spoke to Commissioners expressed the same thought as the Ojibwa elders who wished that child abuse was still the way it once was: *oh-je-e-tim* – just not done.[53]

More generally, research evidence is emerging of critical links between early experience and the development of coping skills.[54] These findings support the commonsense view that children who have love and security in early childhood cope better with stress and challenge in later life. Those who are abused or deprived have fewer inner resources. This research suggests strongly that although suicide is an act most often attempted by those aged 15 to 29, the protective – or corrosive – groundwork is laid much earlier. In policy terms, investment in early childhood can bring valuable returns measured in the mental and physical health of teenagers and adults.

Aboriginal people who spoke to the Commission argued consistently that suicide, and self-destructive behaviour generally, are the result of a complex fusion of personal, social and cultural factors that must be seen and understood together – holistically. The way they come together in a single life is illustrated in the story of Missy, told below. The way they come together in the life of a community is illustrated in the message from the Mingan people, told in the following section.

The Story of Missy

Missy (not her real name[55]) is a 28-year old Kwagiulth woman whose life history is marked by most of the risk factors for suicide that an Aboriginal person can experience. Her story illustrates that, just as the events leading to self-destructive

behaviour are many and intertwined, so are the forms of self-destruction. As a teenager, Missy exhibited most of the common forms: drug abuse, criminal activity, high-risk sex, violent relationships and more. She seemed doomed to die young – by accident or intentionally, by her own hand or someone else's. The line between risks is thin in a life like Missy's.

She had the kind of childhood most of us would like to think happens only in lurid fiction. At the age of 2 weeks, she was removed from her heavily addicted mother for the first of many times. For the next seven years, she was passed back and forth between her mother's home and a variety of child care placements. She became a permanent ward of the province of British Columbia when she was seven.

By the age of three, according to her account, she had suffered rape by "a number of men in the family", followed later by four years of continuing sexual abuse from a (non-Aboriginal) foster father. When she was eleven, her mother died of a drug overdose. She learned by accident that the step-father she had felt closest too, among the succession introduced into her life by her mother, had committed suicide some years before. When she realized that no one in her home village had told her of his death, she knew just how lost to them she was.

At thirteen, she had had enough of both family and institutional care and made the decision to run away to the streets of Vancouver.

> So at that time I remember thinking, "well, why am I letting these people take care of me?" I'd been in a foster place where I'd been abused, and then I'd been moved into this sort of high class group home... I'd been moved so many times to different homes at this point, from receiving homes, to foster placement and temporary placement – it was always a different home. And every time I was moved, I had to change who I was. There was a new set of rules, there was a [new] sense of the way I was to be as a person. And not one of these families was Native...
>
> So I figured I'd given the Ministry [of social services] enough chances. I figured they'd done a lousy job of looking after me, and there was nobody to depend on but myself, and my dreams had sort of died along with my mother. I think one thing that had helped me survive all those years before was that I had a dream that one day she'd straighten out her act, and we'd live happily ever after, and I'd be the best daughter in the world. And after she died there was nothing else to hang on to. So I went out on the street, you know. And I thought I'd be safer that way, looking after myself, than with [the authorities] looking after me.

Missy knew a few street people, and two of her uncles were living in the skid row area of Vancouver, so she had some useful connections. Sometimes they gave her

shelter, food, protection. But it was not long before she needed to earn her own money – in the usual ways thrust upon street kids.

> The first time I remember doing a trick, I guess I was about 14 years old. I was living with my grandparents for a short time then, and one of my grandfather's friends would come over...and he started abusing me. At that time, it was the first time I had been united with any of my family for a number of years, so I was too afraid to say anything, for fear that they might move me [again]. Well, anyways, this man started to give me money...so I wouldn't say anything. And then...I moved out of my grandparents' house because I couldn't handle that any more. But after a short time I went back to see this man, [because] he was paying me basically.

For the next short period of time, Missy survived on the money paid to her by this man, and by a small number of 'regulars' she accumulated gradually. But she was beginning to drink more and more heavily, so that her small income from casual prostitution was no longer sufficient. She had to take the next step. And then the next, and the next.

> After I started to drink heavily, I wasn't getting enough money coming in, and so I went out and started working the streets. And I still continued to have my regulars as well... If I wasn't standing on the corner, I used to hitchhike, and I would hitchhike around and that's how I'd pick up my dates...
>
> I used to rob people too. Many of the tricks I used to rob. I used to steal wherever possible. And then I got tired of working the streets...so I started dealing drugs. At first it was marijuana, and then it was cocaine and other types of chemical drugs... When I first started dealing...it wasn't something I sort of decided to do on my own. It was sort of somebody who'd come to me, "deal these drugs and this is what you'll get for it" [i.e., her own drugs].

During all this time, Missy continued to choose the dangers of street life rather than go back to her family or reconnect with social services. She risked violence from 'johns', the danger that an out-of-control pedophile would hurt or kill her, pressures from various street people wanting favours, and a mixture of sexual and racial exploitation that was profoundly disturbing to her.

> In the area I was working, downtown and Chinatown, I'd say approximately 75% were Native girls and women at that time, as well as some Native transsexuals who were working also...
>
> One thing that really used to bother me was that men looked at me differently [from the other girls]. I always felt really dirty all the time. Men used to look at me and undress me with their eyes

just anywhere, or try and pick me up thinking I was just easy. That used to really bother me.

I think men prey on Aboriginal kids. I still see them doing that today. You know, I see these men who are living very, very well off in different communities, high class communities, and have well paying jobs, doctors and lawyers and politicians, and they still go downtown and look for kids... Native kids are targets for them. They think Native kids won't talk. If there's a rape that happens in the area, it's usually done to a Native kid because they feel the Native kids won't report these things.

Thinking back on her years on the street, Missy has come to the conclusion that the child sex trade is tolerated by society, despite loud public condemnation of its horrors. Her own experience of apparent immunity from the law despite her many crimes is one of the bases for her suspicions.

I was never charged. I'd been under investigation a few times for theft. I'd been charged a few times for shoplifting, but the charges were dropped... When I was prostituting, I was stopped a couple of times by the police, and they collected information in their little books on [all the] women who prostitute. They take down your name and your picture, and put it in the book in case you go missing. But basically, I was never charged.

The over-hanging threat of death from alcohol and drugs, from a beating or from suicide eventually drove Missy to look for other ways to live. By the time she began to reconsider her lifestyle, she had lost not only her mother but a series of other relatives and friends to alcohol and suicide. She knew that between her own substance abuse and the physical risks she ran on the streets every day, her chances of long-term survival were minimal.

During this time, I lost a lot of people in my family and friends due to alcoholic and drug related deaths...just basically drinking themselves to death until they had cirrhosis or dementia. I also had one cousin who was shot by the police. He had a walkman and he'd been drinking and been in a fight and was chased by the police, and they killed him. There's been about 10 [relatives and friends die from] cirrhosis of the liver or overdoses... As well as those, there'd been quite a few suicides as well...

As for the boyfriends I had, from beating me up – and I took a good many beatings for nothing basically – I learned that it was time to get out of this situation. I was beaten until I couldn't take any more... And I was pretty scared that one of these beatings would eventually kill me if I didn't get out... I was pretty fed up with the life in general, and I felt like one day I would not wake,

> and I would die in my sleep from using too much drugs, and I decided it was time I did something about it [all].

An equally powerful reason to change was the birth of her son, when she was 19. The baby seemed to put Missy back in touch with the possibility of value in herself, to give her a sense of responsibility and a future worth living for. "Just looking into his innocent little face every day was very reassuring to me." She took the advice of a street worker who urged her to go into a substance abuse treatment program.

> I went to Round Lake Treatment Centre in Vernon. It's an Aboriginal treatment centre, and I stayed there for 6 weeks. And basically I learned a lot about myself there, a lot about my past. They do a lot of group work... And they do a circle session for a few hours, and they also do workshops on different life skills.

The program at Round Lake began to help her find a positive identity as an Aboriginal person. She realized it was a critical aspect of herself that had been completely missing.

> I didn't know anything about my Native culture. I didn't know anything about what kind of a Native I was, or even who my father was. There was loss of identity... I didn't know what category I belonged to from the white society or from the Native society, and neither one accepted me. So I felt really dirty about being an Indian. I wasn't proud to be an Indian... I could fake it and be white as well if I wanted to, depending on how smart the other person was, you know. Some people could tell I was Native right off the bat and other people would mistake me for Italian or something, you know, so it was [utterly confusing]. I didn't belong anywhere...
>
> In the group homes I lived in, they were all white, and they were raised differently, very differently from what Native people are raised like. Then when I was with my real family...I didn't get to know anything about [Native culture] either... There was just alcoholism, addictions and abuse basically, so we never learned any of that...
>
> [Since then] I've participated in sweat lodge ceremonies, and I find that very powerful, as well as pipe ceremonies, and I believe in them. It's just really hard to explain, I guess, how you feel when you're in those ceremonies. But it's, I guess, a sense of being alive and being in touch with yourself.

Missy is slowly rebuilding her sense of self-worth, finding solid ground to stand on in her work as a youth counsellor and in her new family. But she told her interviewer that she is extremely worried about today's Aboriginal street youth.

They face the same predatory environment on the streets that she faced, but they are the double victims of disappearing support services in the deficit-conscious cities they run to.

> If people don't start taking a look at it [the street situation], we're going to see a lot more kids dying from overdoses and suicides and violent death... There are kids out there who are dying [now]. We see them every day.

Missy's is the story of just one survivor, but it has elements common to many: a seriously dysfunctional family in a reserve community without the authority or the resources to protect its children, a series of destructive encounters with provincial child welfare services and care facilities, a well-founded need to run, and eight years of freedom and hell on the streets. It is also a demonstration that the deep need to nurture life survives even in people who have every reason for despair, and that reconnecting with Aboriginal culture can be a life-line that draws a young person back from the brink of self-destruction.

A Message from the Mingan First Nation Community

The presentation of the Mingan First Nation was made to Commissioners by Chief Jean-Charles Piétacho and Sylvie Basile, a young band member, at a public hearing held in Montreal on May 25, 1993. They came to bring the message that the young people of their nation would not stop injuring and killing themselves until the community had achieved self-determination and had won the opportunity to begin the slow, painstaking work of rebuilding their diminished cultures and communities.

Chief Piétacho and Sylvie Basile presented alternately. Chief Piétacho told us the history of the community and its unequal relations with Canada and recounted the feelings of his people about the past and the future. When he paused, Mrs. Basile illuminated his words by reading from a poem written by another member of the First Nation.

> *Jean-Charles Piétacho* [translation]: In the spring of 1993, a 14-year-old Montagnais boy committed suicide in Mingan. He was not the first. There have been others in the past few years – a nephew, an adopted brother, a friend, a brother from a neighbouring community, all of them young. We have had enough. We have already waited too long.
>
> The loss of another of our children has become intolerable... We know there is a message in the despair of our young people. So we have come together as a community and we have reflected.
>
> *Sylvie Basile* [translation]:[56]
> Do you not hear your sister the river, calling you?

She flows like the blood in your veins.
Do you not hear your brother the wind, speaking to you?
He says: Give me a little of your pain.

Jean-Charles Piétacho: As a society of communities, we cannot acknowledge suicide as a "normal act", a strictly private act, and do nothing. Beyond the private universe, which conditions the life or death of the individual and concerns him before all else, there is his public universe, his social environment, his future.... All of this also conditions to the highest degree the hope or despair of individuals.

Sylvie Basile:
The despair of a people lives in the eyes of a child,
And in each of us lives the child who is afraid of saying yes to the truth.

Jean-Charles Piétacho: We have little control over people's private lives, and this privacy must be respected, but we have a collective responsibility toward life in society. We, the Montagnais of Mingan, have this responsibility; we, the Montagnais Nation, also have this responsibility; all of us, Aboriginal and non-Aboriginal people alike, have this responsibility, because we all have an influence on the decisions that are made or not made concerning our destiny. All of us must share in this pain as we confront the future and seek solutions.

Sylvie Basile:
Where did that time go, when we used to fly our kites together, seeing whose would reach the ever-rising heavens?
Why have you hidden yourself, my sun, who used to make my sleeping days shine?

Jean-Charles Piétacho: We feel powerless as friends, as brothers, as sisters, as leaders and as parents [in the face of these suicides], but we do not want to feel like cowards. We cannot sink into affliction or anguish.

Sylvie Basile:
Don't tell me you want to die,
Don't tell me you want to go,
When everything around you breathes with life,
When the earth, your mother, nourishes you.

Jean-Charles Piétacho: Suicide is the most radical act of despair and denunciation of life that anyone can commit. It is an act to put an end to inner suffering. The phenomenon of despair has spread like

gangrene to many Indian communities in Quebec and Canada. It is expressed in violence against others or oneself. We must stop putting our heads in the sand; we must react before the sickness is irreversible, before other limbs are afflicted, before our will to act is poisoned as well.

Collective despair, or collective lack of hope, will lead us to collective suicide. This type of suicide can take many forms, foreshadowed by many possible signs: identity crisis, loss of pride, every kind of dependence, denial of our customs and traditions, degradation of our environment, weakening of our language, abandonment of our struggle for our Aboriginal rights, our autonomy and our culture, uncaring acceptance of violence, passive acknowledgement of lack of work and unemployment, corruption of our morals, tolerance of drugs and idleness, parental surrendering of responsibilities, lack of respect for elders, envy of those who try to keep their heads up and who might succeed, and so on.

Sylvie Basile:
In my heart the sun no longer shines,
For the clouds have become overwhelming,
Torturing me endlessly.
The sun's rays cannot penetrate the rift
I have made with my cries and my laughter.

Jean-Charles Piétacho: We wanted to reflect upon these matters, and to make a simple humanitarian appeal to your Commission, for if the human element does not occupy the most important place in what we do, we are condemned to make structural changes that will be empty...

Sylvie Basile:
And from the well of my silence
I have drawn up the truth,
Which in reality
I had always hidden.

Jean-Charles Piétacho: One day, in the 1970s, some large deep-sea fishing vessels were made available to us so that we could supply 'our' fish plant. This must have been very expensive, but the intention was to create jobs for us and to make the plant, which was run by a company from the lower St. Lawrence, profitable. They had forgotten that the management company was concerned mainly about the profitability of all of its plants and production – not just in our own community. They had also forgotten that the Montagnais are primarily hunters and inshore

fishermen, not open-sea sailors. No one wanted to work on these boats. No one wanted to leave his family for long periods, especially at a time of year when we were feeling the pull of our ancestral lands. And then there was the fear of the open sea. The plant closed.

One day in the 1960s, the federal government forcefully relocated, Roman-style, the members of the Montagnais community of Saint-Augustin or Pakuashipi to the Lower North Shore. It was for their own good, they said. Poor in material things, but rich in their culture, their territory and what remained of their independence, most of these Montagnais returned to Saint-Augustin the following winter, travelling nearly 200 kilometres on foot. Two persons died during this arduous journey.

The decisions had been made by others, by people in power who live far from our social, cultural and physical environment. They spoke a different language from us. They did not know our values and our attachment to Mother Earth. They did not respect the life values of the people concerned, or above all, their integrity.

The point of this is to demonstrate to you the importance of directing our own destinies. ...

Sylvie Basile:
I walked through the door that destroyed my universe,
But no one saw me do so,
For I was like the river water
That freezes in winter.

Jean-Charles Piétacho: We are painfully enduring the consequences [of the transition from our ancestors' way of life], the most obvious of which, for a small community of 394, are social violence, three suicides by young people in five years – not to mention attempted suicides – alcoholism and drug addiction, general unemployment, lack of motivation to work, the low standard of living, a dismal record on health...

Suicide is the ultimate denunciation of the absence of choice for an individual or a community. We therefore have to organize ourselves so that these choices exist, both for the individual and for the community.

Some tell us that these are universal social problems, and that there is no relation between these specific problems and the condition of our people. To them I say that they are making the same mistake as all those who have always made decisions for us on issues of concern to us, by underestimating and ignoring our cul-

tural and community values and by marginalizing us ever more in terms of use of our ancestral land and decision-making powers over our collective life. ...

Sylvie Basile:
When will this struggle end? Probably never.
Now we address ourselves to the one who has guided us for centuries, for this is who has enabled us to survive.
For our cry is no longer heard, our tears no longer reach you.

But as long as the steps of our children and grandchildren are guided by the eternal spirit of respect for our fellow human beings and for our Mother Earth, we will survive, with an ever-burgeoning strength of spirit.

Jean-Charles Piétacho: We will do our duty among ourselves, starting with respect for our fellows and respect for our Mother Earth, for Nature. It is for us to define our own healing process, based on our traditional, spiritual values of respect, pride, dignity, sharing, hospitality and mutual aid.

The Crown must also conduct a fundamental revision of its methods of intervention in Aboriginal communities. The Crown is responsible for providing us, as long as we ourselves do not have the means, with the resources that are appropriate to our own needs, characteristics and aspirations.

[Now] we are governed by a set of laws that are external to our ways of thinking, acting, and correcting our societal defects. We do not receive much information about these laws. Most of the members of our community do not understand their implications. These laws were adopted without our consent, and they are foreign to our culture and our way of thinking. ...

We have been consulted as a matter of form (when we were consulted at all) on certain of these policies, but our opinion has had very little weight, being swamped as a minority by another culture, in a situation where sheer numbers prevail. ...

Sylvie Basile:
When you build your future between four walls,
You let your destiny fly away like a leaf in the wind.

Jean-Charles Piétacho: The education, health and social services systems seem to be there primarily to impose a foreign value system upon us, probably as a result of the historical good intentions of those who wanted to civilize and convert us with one hand while

they stripped us of our physical, social, mental and spiritual resources with the other.

Under these circumstances, the possible courses of action are numerous. They must be based, as they have been in the past and still are now, on respect for others and for nature.

We have to assume our own responsibilities, independent of the bureaucratic compartmentalization of every service delivered in our communities. We have to develop what we call an original organizational culture that is specific to our own values, with common and concerted social objectives.

Governments have to be attentive to our requirements and our needs, and not to their own standards and constraints. Governments must not impose upon us programs that have been planned in Quebec City or Ottawa, but place at our disposal the resources we really need to complete our process of social healing. Give us a real chance to determine our needs and to act upon them. ...

Our collective suicide is of as much concern as the suicide of our young people. The only way to build an alternative to despair is to develop a blueprint for a society in which elders will feel loved and useful, parents will feel competent to counsel and guide their children, and the young people will want to build their future. A social blueprint affects the basic components of collective life. It inspires, it creates a desire to learn, to work, to sing, to love and to hope. We must be able to make our own choices about the society we want, and not have those of others imposed upon us.

It is particularly necessary for our young people to rediscover their vital inner strengths, so that the feelings of discouragement and tragic failure they are now experiencing can be overcome. The next life that is lost to suicide will be too much. It will become intolerable if we are not sufficiently quick and effective in stopping the implacable clockwork of this social time bomb. ...

Sylvie Basile:
The children will have to struggle against a system where individuality reigns. We must give them a true identity, so that they can be proud to call themselves Aboriginal, today and tomorrow.

For the road is long and perilous...

> But we must always move forward and never be discouraged, so that the others who see us may say: Behind you, there is a people.
>
> Thank you for listening to us.

Moving on from Despair

There are no studies to tell us why some people who face difficult life circumstances try to commit suicide while others in the same circumstances do not. But there is evidence in research and in Aboriginal experience that a clear and positive sense of cultural identity and institutions that allow for collective self-control, along with strong bonds of love and mutual support in family and community, can act as protective forces against despair, self-destructiveness and suicide.[57]

Understanding the factors that lead to disproportionate rates of suicide and self-harm among Aboriginal people is one step toward change – but just a first step. The real work lies in modifying those factors. Aboriginal people do not ask others to 'rescue' them from the circumstances in which they find themselves. They ask for help in removing the injustices that survive in Canadian legislation and institutions, so that their own efforts at healing can take full effect.

In many places they have begun the process, as we will see in the next chapter of this report.

4

Saving Their Own Lives: Aboriginal Communities Take Charge

Throughout our public hearings, Aboriginal people pointed to high suicide rates as an accurate indicator of depressed human spirits in their communities. The concern we felt as we listened was intense. But our concern was to some extent balanced by what else we heard: stories of people and communities that have begun to change the conditions that lead to suicide – stories of hope.

When we asked Aboriginal people about the solutions to high rates of suicide and self-destructive behaviour in their communities, we heard many answers. This seems to us to reflect quite accurately the complexity of the matter. Suicide among Aboriginal people is, at one and the same time, the result of a series of highly personal acts of despair *and* the result of general patterns of exclusion of Aboriginal people from the common wealth of their country, of community marginalization and of institutional racism. Likewise, to prevent suicide among Aboriginal people is sometimes to reach out directly and take a weapon from a teenager's hand. At other times, it is to awaken the life-saving capacities of a community or a whole people.

When they are awakened, these capacities lead in different directions – toward an early childhood development program or an elder-led exploration of spiritual tradition, a wilderness youth camp or an after-dark urban safety patrol. These are all suicide prevention strategies.

What follows are just a few examples of suicide prevention initiatives that Commissioners have heard about. Some are local community initiatives; some are

tribal council or regional initiatives; some began with the determination of just one person. Some are aimed directly and exclusively at preventing suicide; others are concerned more broadly with the causes and consequences of violent and self-destructive behaviour. They provide a number of insights into the prevention of suicide and lead to at least one important conclusion: that Aboriginal people can make an enormous impact on community problems such as suicide – but not alone. We offer them here to policy makers and community leaders as a source of ideas and principles that can be adapted and built on elsewhere.

Suicide Prevention Over 20 Years: Wikwemikong

The Wikwemikong reserve is located on Manitoulin Island in Lake Huron, Ontario. Its population of about 2,500 is scattered among six small settlements and across the land in between them. In less than a year, from December 1974 to November 1975, there were seven suicides in one small sector of Wikwemikong. Depending on the figures used to make the comparison, this number of suicides represented a rate 10 to 20 times greater than the rate for Canada as a whole at that time. It was one of the first so-called 'epidemics' of suicide in an Aboriginal community to capture the attention of the national media and thus the general public.

The regional coroner's office requested not only an inquest but a research study of the events of that terrible year and their causes. The inquest jury used the results of the study as the basis for a series of wide-ranging recommendations covering both direct suicide intervention services and long-term suicide prevention activity. The jury recommended a combination of public education, to help people understand and respond better to suicidal behaviour, and community development to change underlying conditions.

The response from government authorities, in consultation with community caregivers, was to fund two local service agencies as a base from which the immediate problem and some of its indirect causes could be tackled. This was the point of origin for Rainbow Lodge, a non-medical alcohol and drug treatment and prevention (outreach) facility, and the Wikwemikong Counselling Program, an independent mental health support service. Because of its 20-year history of suicide prevention and the array of strategies used, the Wikwemikong experience is of particular interest to the Commission.[58]

Rainbow Lodge began its work with two commitments: treatment of alcohol and drug abuse, which had been identified by the inquest as a key factor in the suicides; and community healing and rebuilding after the year of crisis and loss. Its approach to suicide involved five widely supported program components: prevention, with a focus on youth; public education; treatment; rehabilitation; and staff training. There were unique aspects to the Rainbow Lodge approach as well. Organizers and staff took the position that suicide prevention was a whole-community responsibility and that involvement of the whole community was essential for success.

> We felt that if Rainbow Lodge was going to succeed, it had to belong to the people, so community involvement became a key ingredient. While there were paid alcohol and drug counsellors and prevention workers, we felt that the strongest component to Rainbow Lodge [should be] the volunteers. So we developed and formalized a volunteer program...but we involved all the people in the community as well. [For example,] if we were going to have a community event...we would go out to the community and get the families to cook those 23 turkeys... They were involved from the word go.[59]

The community pulled together to raise the money and provide the labour to renovate and refurnish the aging Rainbow Lodge building. Its refurbished facilities became a hub for discussion of any and all local problems. One of the ideas about prevention that quickly became a theme of its work was to strengthen community self-respect in every way possible. The importance of self-esteem was a new idea then. At Rainbow Lodge, it influenced everything from program priorities to the way clients were counselled and supported. Eventually, it began to influence community management more broadly.

> We felt that Indian people are an unaffirmed people, people with low self-esteem, and it just seemed that there was never much affirmation of our people, especially our young people. We felt that we had to have an environment that nurtured and nourished the people who took part...so that if our kids broke the Rainbow Lodge rules that they themselves developed, we would get on their case...but all the way through, affirming them all the time, letting them know that they were important in the success of the movement of Rainbow Lodge.[60]

The first four years were hard for the staff at Rainbow Lodge. There was a heavy load of grief, alcohol dependency, and violent and self-destructive behaviour to manage, and few treatment models to follow that were sensitive to Aboriginal cultures and values. As pioneers, they sometimes felt lonely, but at least they felt they were making progress – when the next crisis struck.

> Around 1982, we were starting to get just a little bit proud of our program, we thought that we were doing good things, people were getting involved, we had a large volunteer force, and at the community events there would be 300-400 people taking part. And then we had another crisis. We lost over 110 jobs in one day in our community when Indian Affairs pulled out all the programs, and the community went into another trauma. [Within a few months] our suicide attempts went back up, our family violence rates went back up, and we had lost all our support systems... I remember when we went into the [staff] retreat in September, we were very

> much afraid. There were only seven of us [left on staff], and we said, how are we going to do it, how are we going to cope?[61]

The staff of Rainbow Lodge were understandably afraid that a resurgence of hopelessness would lead to another rash of injuries and deaths. But the community as a whole had learned a lot from the 1975 outbreak of suicides. First and foremost, they had learned that they could do things for themselves, find their own answers to problems, without government direction. Second, they had come to realize that they had to celebrate the things that made life worth living in Wikwemikong, especially in the face of crisis.

Their first action after the enormous economic loss they had suffered was to organize a community appreciation feast, honouring 25 local people whose efforts had made a difference to local health and wellness. It was a declaration of continuing community strength and self-confidence in the face of great stress. But of course there was more to be done than that.

> We rolled up our sleeves and started over again, and that is what happened in 1982. We did a lot of peer counselling. We taught our young people to do peer counselling with their friends because it was nothing during the summer of 1982 and 1983 to find groups of 15, 25 kids, at three o'clock in the morning in the school yard, talking about suicide the way you and I talk about a cup of coffee. We began to develop very strong youth leadership programs, where we would help the kids develop the skills that they needed to be able to function in their environment...and we had to start developing programs to try to help parents and kids get together in a problem solving process.[62]

One of the things the staff did, working with other community caregivers, was review the findings of the 1975 inquest and the research study that had accompanied it. They realized that their young people were showing many of the same signs of despair and hopelessness that they had been showing then. So they developed a crash course of public education about the signs and symptoms of suicidal distress and the means that can be used by almost anyone to provide support and help. Although self-destructive behaviour (including attempted suicide) did increase, there was no second wave of deaths in 1982-83.

In 1991, the Lodge was reorganized and incorporated under a new name: Ngwaagan Gamig Recovery Centre. Now under a new director, the Centre has continued to develop its core policy of strengthening the Aboriginal family, moved to new premises in the centre of the settlement, and focused on the creative application of holistic healing ideas from the traditions of the Ojibwa, Odawa, Pottawatomi – and indeed, all cultures – to the addictions-related problems of its clients. Using the family systems approach, for example, allows staff to 'map' the intergenerational effects of culture loss and personal trauma that leads some to addiction, others to suicide.[63]

Besides Rainbow Lodge (Ngwaagan Gamig Recovery Centre), the events of 1975 had led to the establishment of the Wikwemikong Counselling Service. In the early days, it was operated by two local people trained as counsellors and backed up by the director of psychiatry at what was then the Sudbury Algoma Sanatorium (later, Hospital). For a brief time, the service belonged to Wikwemikong alone, but in 1983 its catchment area was expanded to include all the First Nations communities on Manitoulin Island and another on the mainland nearby; program sponsorship was then transferred to the Sudbury Algoma Hospital (a division of the Network North Community Mental Health Group).[64] To symbolize its expanded mandate, the name of the counselling service was changed to Nadmadwin Mental Health Clinic – Nadmadwin meaning 'people working together' in Ojibwa.

Nadmadwin began as a stand-alone community-based mental health program. In the beginning, the staff faced a struggle for community acceptance of the very idea of a 'mental health' service, which seemed to stigmatize whoever walked in the door as being out of control or even 'crazy'. At first, referrals to Nadmadwin came mostly from the hospital and from other professional caregivers. Staff spent much of their time trying to make direct contact with people having problems, build trust, and promote the use of the counselling service as a preventive measure against suicide and other threats to individual, family and social stability. They took every opportunity they could find to educate the community about mental health issues from a holistic perspective – including their belief that if individuals are to be healthy, the community as a whole must be functioning well too.

Gradual acceptance of the ideas of mental health promotion and community development has strengthened the counselling service – and the community – since the suicide outbreak of 1975. Today, the people of Wikwemikong are more likely to refer family and friends with problems to Nadmadwin and to seek help for their own. The emphasis at the clinic has shifted from one-to-one counselling, which was needed to cope with the crisis situation in the '70s, to family treatment and support aimed at preventing individual problems from reaching the flash point of suicidal behaviour. As well, the clinic now uses a mix of mainstream psychologistic and traditional Aboriginal approaches to mental health. Its position as part of Network North has brought advantages: access to the resources of its integrated system (psychiatric services, education and promotion services, etc.); back-up for high-risk cases; support for local workers in danger of burn-out; protection from local political interference.

The community-based programs at Wikwemikong have not completely rooted out the distress that puts young people at risk. In the words of one caregiver, "the threat of suicide is always with us".[65] A recent survey of children and youth in the local elementary and high schools revealed that 25 per cent felt worried or depressed most or all of the time. About 35 per cent said that there was rarely anyone for them to talk to when they felt 'down'. About 20 per cent said that when they felt down they thought about hurting themselves.[66] Adolescents still represent a big portion

of the caseload at Nadmadwin. A recent program review called for more staff, more time to be spent on community development to promote long-term mental health, and the establishment of a local board of directors to help review and revitalize a service that has done so much, yet faces new challenges in changing times.[67]

Although problems have not disappeared, community-based mental health programs have clearly helped. In 1993, there was one suicide and about ten attempts in the Manitoulin-North Shore catchment area. The manger of the Nadmadwin Clinic attributes the current level of psychological stability at Wikwemikong to two things: the success of public education to build awareness of and collective responsibility for mental health and wellness, such that personal, family and social problems are usually referred for help before they become severe; and community development more generally, such that programs for collective self-care are much better developed in Wikwemikong today than they were 20 years ago when seven young people chose to die in one year.[68]

Healing Our Sorrows: Big Cove[69]

In the six weeks between June 11 and July 17, 1992, four young men on the Big Cove reserve in New Brunswick committed suicide.[70] By the time the inquest into the first four deaths could be convened (in December 1992), three more had killed themselves. At the inquest, the director of child and family services testified that there had been 75 attempts at suicide in the first eleven months of that year – 40 of them in just over a month. Big Cove is considered a large reserve, with about 2,000 residents, but even so, these were shocking figures.

After the seventh suicide took place, the federal government came forward with emergency funds for additional new houses above the reserve's annual allotment,[71] for a school counsellor to work with children in crisis, and for a new suicide prevention program. The jury for the inquest (five members of the Big Cove band) made 16 recommendations for sweeping changes in community life and new social programs. Their proposals included greater restriction of alcohol and drugs,[72] job creation to alleviate high rates of unemployment (estimated at 76 per cent[73]), provision of permanent mental health services on-reserve, and speedy progress toward self-government.

It seemed as if those who died might have sparked the kind of protective action that could have supported them in life. But the recommendations of inquests are not binding. Months later, community caregivers were still coping with the aftershocks of the year's events – and with new suicide attempts. They had begun meeting as a group a few days after the fourth suicide, called together by then-Chief Albert Levi to pool their ideas about how to stop the mounting tide of self-destruction. They came together for the first time: social workers and police, addictions counsellors and teachers, priests and traditional healers, leaders who cared. No matter what their position in the community, they knew they had to co-operate to find new approaches to the old problems.

One of their observations was that people in distress were not reaching out to the health and social services already in place.[74] They concluded that something more than routine services was needed: something extraordinary, to match the extraordinary depths of despondency into which so many were sinking. They began to plan an exercise in 'community visioning' – a collective consultation about the kind of community Big Cove could become if everyone were to take responsibility for making it better.

The Big Cove caregivers were in agreement that alcohol and drug use was a key factor in most of the suicides, as the inquest jury had said. But in the group's view, the underlying cause of both the addictions and the deaths was a pattern of family and community breakdown and silence about social problems (including sexual abuse) that existed on the reserve. Perhaps equally damaging was the near-collapse of traditions of mutual support, sharing and spiritual strength.

One of the possible routes to renewed wellness identified by the caregiver group was greater dependence on traditional values, rituals and healing ceremonies. As Chief Levi pointed out, the Micmacs had taken care of their own – armed with nothing but those beliefs and practices – for thousands of years before the arrival of Europeans. Perhaps somewhere in their fading traditions lay some of the missing pieces of the puzzle of community wholeness and individual mental health.

After much discussion, the group proposed to the band council the idea of a week-long community gathering for mourning and healing. The rituals and support structures of Micmac spirituality, Christianity and western psychotherapy would be brought together to contribute to the recovery and community visioning process. All regular activities would be cancelled so that everyone could participate. The chief and council passed a resolution in support of the plan. In keeping with traditional Micmac values, they proclaimed it a week of complete abstinence from drugs and alcohol.

In the interests of promoting community unity, the week of mourning and healing was scheduled for early March to coincide with Mission Week, a revived church custom in which special services and religious activities are held in Big Cove. Co-operation between Christians and traditionalists was one of the most positive aspects of the plan, both in the planning process and during the events of the week. The gathering was also supported and solemnified by the presence of the grand chief and grand council of all the Micmac people. They had not met at Big Cove since 1911. With them came scores of relatives and friends from across the province, lending their support to acknowledge Big Cove's losses and, at the same time, exploring with interest the new-old ceremony of mourning and healing.

At 6:00 a.m. each day, there was a sunrise ceremony conducted by an elder. He or she made offerings to the Creator and asked for guidance, comfort and enlightenment for those participating in that day's activities. On the first day, after a community breakfast and mass in the church, the community gathered to hear the purpose of the week described by the organizers:

1. to give the people of Big Cove and their brothers and sisters from near and far a chance to mourn and get back in touch with their reality;
2. to allow the caregivers the opportunity to educate the community about the complexities of suicide; and
3. to begin the healing process through sharing circles and other activities, both traditional and modern.[75]

Every day there was a succession of talks and workshops by counsellors, therapists, spiritual leaders and elders. There were many opportunities for people to explore their personal experiences with suicide and their personal pain. Prayer services, AA meetings, sharing circles and special gatherings for youth and for elders followed one after another. Every night, there was drumming and dancing (a traditional form of prayer) and a Pipe Ceremony. On Saturday, a severe snowstorm hit the region. Volunteers struggled through the night to keep the Sacred Fire lit.

On Sunday, about 200 people attended a final community sharing circle. They were asked to work in groups to answer the question, where do we go from here? At the end of two hours, 184 thoughts and recommendations for the future had been collected. They were later analyzed and grouped into the following categories of ideas for change, in order of priority:

- community responsibilities
- community solidarity and support
- cultural programs and activities
- cultural education and spirituality
- drug and alcohol abuse prevention
- education and curriculum
- networking and sharing resources
- social programs
- inter-religious harmony
- Native autonomy and sovereignty
- life-skills training
- politics/economics
- racism

A paper that groups and presents the ideas and insights of the whole community of Big Cove is reprinted as Appendix 4 to this report.

On the last day of the gathering (Monday, 15 March 1993), a special mass was held at the school. Its service was a fusion of Catholic and traditional spiritual practices. The Big Cove drummers performed traditional songs as the procession entered, led by the chief carrying the Sacred Bundle. Other community leaders followed, carrying the Holy Crucifix and the Bible. Seven children and seven elders came next, carrying seven eagle feathers, which symbolize the characteristics of youth

in Micmac tradition: honesty, innocence, open-mindedness, purity of heart, trust, strength and unconditional love. After a mixture of ceremonies and final addresses, there was a feast, followed by an alcohol-free dance and social event. When the last drum fell silent, the Sacred Fire was extinguished, and the Creator was thanked for making the week-long ceremony such a success. Everyone agreed that healing had begun.

But healing from the loss and grief suffered in a colonial relationship is a long journey, and not likely to be an easy one. Three more young people have taken their lives since the inquest, the most recent a 17-year-old girl in June 1994. The community has continued to put pressure on the federal and provincial governments to comply with inquest recommendations, but so far without notable success. Their proposal for a comprehensive five-year community development plan, taking up the ideas of the community visioning process, was submitted to the Brighter Futures funding program of Health and Welfare Canada later in 1993. It is still under consideration.

One agency that has been responsive is the RCMP. In May 1994, the Richibucto detachment hosted a week-long suicide prevention training program for about 12 police officers (two of them Aboriginal) and about 12 Aboriginal caregivers from across New Brunswick. It was judged so successful that the RCMP is discussing a country-wide program of a similar nature.[76]

The Key is Training: Northwest Territories

Suicide among Aboriginal people in the Northwest Territories – particularly among Inuit of the Eastern Arctic – has been a matter of deeply felt concern there for some time. In the 1989 winter session of the territorial legislative assembly, a lengthy and emotional debate on the subject led to the appointment of a co-ordinator to develop a comprehensive strategy and the beginnings of a major suicide prevention program.

A four-day grassroots forum held in Rankin Inlet in 1990 sparked a series of seven regional forums. These brought together more than 300 people, both lay and professional, to begin a process of, first, frank and searching discussion of the issues and, second, development of recommendations to the territorial government about how best to combat suicide and suicidal behaviour and how best to support grieving individuals and shocked communities following a completed suicide.

A total of 26 days of presentations, workshops, debates and discussions took place. Sessions touched on matters as diverse as the decline of traditional cultures and the mysteries of brain chemistry. Participants concluded that suicide is a multidimensional problem for which there is no quick fix. Suicide and self-destructive behaviour have many causes, they agreed, and so must be tackled from many angles. They called for a comprehensive prevention and intervention strategy accessible to all communities in the territory – but one whose precise steps and pri-

orities would be local and community-based. They specified the following program objectives as essential:

- training for community caregivers, both lay and professional;
- information dissemination and educational programs for community people;
- the promotion of healthy lifestyles;
- a focus on the problems of youth; and
- improved referral, treatment and follow-up for individuals identified as suicidal.[77]

One of the most intensely felt conclusions reached by forum participants was that suicide prevention is *everyone's responsibility* and that community members of all ages should become aware of the issues and risk factors. At the same time, participants recognized that the communities needed help to begin addressing so complex an issue, as well as support in their efforts to change contributing conditions. That help and support seemed most likely to come from governments. So they recommended that (1) all territorial government departments assess their potential to contribute to the strengthening of families and communities, the bulwarks against suicide; and that (2) more resources be made available for local, community-based initiatives. Their recommendations pointed to the need for a territory-wide training initiative to promote understanding and problem solving at the community level.

Participants in the forum process came away buoyed up that at last they were beginning to tackle the haunting problem. They were both encouraged and cautioned by the words of Dr. Ross Gray, of the department of psychology at Sunnybrook Health Centre in Toronto, who addressed the final suicide prevention forum in this way:

> The problems related to suicide in the Northwest Territories are many and deep. Some of the most fundamental difficulties are tied to national and global trends in economics, politics and social values and are thus not easily addressed through individual and community action. In some ways, efforts at this level are like a person with a bucket trying to stop a tidal wave... Even if the government remains committed to addressing the issue over time, and provides necessary funds to follow up on the initial regional consultations, the road will be long and hard. It is probably unrealistic to expect an observable lessening of suicide rates in the short term...
>
> This consultation process is not the answer to suicide prevention. But just as surely it is making a difference, pointing us in the direction of a healed society.[78]

The government of the Northwest Territories (GNWT) accepted that the main role of its departments and agencies should be one of support and concrete assistance

for a community-based program. The decision was taken that a training program on suicide prevention for community caregivers was the place to start.

> A primary role of the Department of Social Services, in concert with other government and non-governmental agencies, will be one of facilitator and trainer. It will act as a source of information and a resource to those professionals and lay workers engaged in front line activities at the community and regional levels.[79]

Accordingly, the GNWT entered into a partnership with the Canadian Mental Health Association and the Muttart Foundation of Edmonton to develop a Suicide Prevention Curriculum, which is currently in the final stages of testing and revision for use across the territory.

Faced with the high degree of interest in training expressed in the communities and the need to limit costs, the GNWT has taken what is known as a 'train the trainers' approach. The curriculum will be offered in regional training sessions about six times a year. It is designed to enable trainees to return to their communities prepared to act as a resource for others. In fact, one of the conditions for acceptance into the training program is that each participant must agree to conduct at least three presentations on suicide and its prevention to people in her/his home community within a negotiated period after the training.

The training course lasts two weeks. The selection criteria for applicants give priority to those working at the grassroots level in their communities – alcohol and drug counsellors, community health representatives, women's shelter workers, volunteers of all kinds. Nurses, social workers and members of the RCMP are given lower priority, in part to encourage the sense of self-help and shared community responsibility that decades of dependence on outside experts have undermined.

To facilitate the training of people not necessarily comfortable with formal teaching methods, the program uses the experiential approach of popular education. Popular education emphasizes learning by doing, active participation in learning activities, discussion and reflection, evaluation and application. The general framework of the training program leads trainees through an examination of the past, present and future of their home community so that they can understand how suicidal behaviour has become a problem and begin to imagine a future free of it.

Evaluation of the curriculum during its testing period showed that it will be well received in the communities of the N.W.T. Trainees made suggestions for revisions, but in general they agreed that they had learned a lot that would help them in their home communities. They emphasized the need for sensitivity to issues of cultural difference among the different Aboriginal peoples in the North who will be taking the training and recommended delivery of the course by Aboriginal trainers.

While pleased with its success, some program administrators and professionals in the mental health field have expressed concern that community expectations for

the GNWT training curriculum are enormous. They are worried that it may now be seen as 'the' answer to suicide prevention.[80] It is, they warn, just a beginning.

> There are many factors that contribute to suicide and suicidal behaviour. It is very much a multi-dimensional phenomenon. More than one type of intervention is necessary since no one intervention can singly produce "a cure"... It is [also] recognized that any strategy will be limited in its long-term effectiveness without a concerted effort...to deal with the underlying contributing factors [such as] advances in education, recreation, housing, employment, economic development and so on.[81]

Bear Clan Patrol Watches Over the Neighbourhood: Urban Safety in Winnipeg

For more than two years now, the streets of North End Winnipeg have been safer because of the work of the Bear Clan Patrol – a volunteer force dedicated to helping and protecting the vulnerable in this urban Aboriginal community from violence and exploitation and to intervening where Aboriginal lives are in danger from any cause, including suicide.

The initiative grew out of the annual Aboriginal youth assembly of 1991. In other years, the primary concerns of youth had been related to Aboriginal identity and to drug abuse. In 1991, street violence involving rival gangs and the risks faced by prostitutes – many of them Aboriginal and many of them very young – were of greater concern.

As a result, the staff of the Ma Mawi Wi Chi Itata Centre, an Aboriginal child and family welfare agency in downtown Winnipeg, became interested in the idea of a volunteer citizens' patrol. They consulted with people who operate a similar and well respected Aboriginal service in Minneapolis. The idea was fleshed out and publicized in the local community. Interest was immediate and overwhelming. Within a few weeks, 200 volunteers had signed up.[82]

The goals of the patrol are broadly protective and preventive. One key objective at the outset was to reduce the child sex trade in the North End, a business that brings degradation, violence and despair to countless Aboriginal children. But patrol organizers and volunteers soon came to realize that in the tense urban environment, there is no single 'worst' problem. Almost as soon as its vehicles hit the streets, the Bear Clan Patrol was responding to fights outside bars and in alleys, intoxication and overdoses, petty crime, family violence and threats of suicide. The volunteer co-ordinator estimates that in the first six months of 1994, four or five potential suicides were 'talked down' to a state of reason and reconsideration.[83]

The volunteers receive about 20 hours' training in first aid, life-saving techniques, safety precautions and conflict resolution. They offer protection to Aboriginal girls and women being harassed by johns and others. They give rides home to unsu-

pervised children, mediate conflicts and assist anyone who is intoxicated, self-destructive, or in need of help that is within their competence to give. The official philosophy of the patrol is to be non-violent and supportive rather than confrontational. Volunteers are instructed to intervene only if their help is clearly wanted. They know whom to call if a problem is beyond their skills, and they have developed a largely co-operative relationship with the Winnipeg police.

The patrol operates between 9:00 p.m. and 3:00 a.m., Friday and Saturday nights. Several cars equipped with citizens' band radios cruise the mean streets, watching for trouble. Each car has at least one woman in the team of several people aboard. Most teams also include youth. The majority (though not all) of the volunteers are Aboriginal.

A typical few minutes in the work of the Bear Clan Patrol might go like this:

> It's Friday night in Winnipeg's North End, a troubled, low-income district with a largely Aboriginal population. A familiar scene unfolds. Two Aboriginal teenage girls walking along the street are accosted by a man in a car, a 'john' who assumes they are prostitutes simply because they are Aboriginal and live in this part of town. The girls ignore him but he persists until he spies an approaching car with a familiar logo and a driver with CB radio in hand. Exit the 'john'. The car that spooked him belongs, not to the police, but to a citizens' group known as the Bear Clan Patrol.[84]

The patrol takes its name from the clan that, in Cree tradition, was responsible for peace keeping and justice. Following tradition still further, its board of directors is made up entirely of women. By modelling traditional values and aspects of the ancient clan system in action, the Bear Clan Patrol is providing more than the obvious service. It is demonstrating initiative and ownership of Aboriginal community problems, and it is allowing youth an active role in prevention – a role that makes good use of their special knowledge of the street scene.

In the words of the patrol's vision statement,

> Our community, many of whose members have grown up as minorities in a hostile environment, needs to understand that their people once had their own territory, languages and cultures... More importantly, they need to realize that these values, traditions and institutions remain viable today.[85]

The patrol has had some problems of its own. As a high-profile and action-oriented initiative, it has attracted a few volunteers delicately described by one person who spoke to the Commission as "non-standard" – that is, people who have difficulty controlling their own aggression. In the early days there were a couple of incidents in which volunteers behaved dangerously or unwisely. Organizers took immediate steps to develop more stringent selection procedures and provide more careful training.

Control of volunteers is by its nature challenging. It is made more so in this case because the Bear Clan Patrol operates without secure funding. It depends on small donations from Aboriginal people and organizations and help from Ma Mawi Wi Chi Itata. The co-ordinator, who generally puts in more than 40 hours a week, is unpaid. Funding is becoming an increasingly urgent matter. The patrol has received numerous requests to extend its hours and the scope of its services, yet Ma Mawi Wi Chi Itata may be forced by its own financial situation to cut back its support.[86]

One path to a firm financial footing may come from an off-shoot licensed security service that has just been established. Impressed with the work of the patrol, several Aboriginal organizations, including the new Indian and Metis Friendship Centre and the Manitoba Metis Federation, wanted to hire the patrol to provide security for their premises and functions. This posed problems of insurance, bonding and licensing. The federal Department of Human Resources agreed to provide money for the design and delivery of a training program, based on – and in fact exceeding – industry standards as set out by the Canadian General Standards Board for the preparation of security guards. After a 12-week course, nine Aboriginal people are now qualified to work as paid security guards under the Bear Clan Patrol name. Profits from their work will be directed to the volunteer service, which will permit Bear Clan Patrol organizers to improve and extend its extremely popular services.

However great its direct impact on suicide among Aboriginal people in Winnipeg, the existence of the patrol contributes to suicide prevention by offering the community a popular and effective means of self-help.

Canim Lake: Layers of Pain and Healing

> At one time I used to believe the myth that if our people sobered up, our problems would be solved. Now I know that all [that] does is take one layer off the onion... We are dealing with a number of different issues...related to our people's experience over the last 80 or 90 years... I believe that the whole issue of residential school [and its effects] is an issue that's going to take at least a minimum of 20 years [to work through].
>
> *Maggie Hodgson, Executive Director*
> *Nechi Institute on Alcohol and Drug Education*
> *Canim Lake, British Columbia, 9 March 1993*

Canim Lake (population 450) is one of a group of small reserve settlements of Shuswap First Nations people located in the central interior region of British Columbia known as the Cariboo. Its closest neighbouring communities are Alkali Lake, Soda Creek and Williams Lake – also Shuswap reserve communities. In Canim Lake, suicide is seen as just one expression of the pain accumulated by

Aboriginal people over many generations, as a result of their experiences as objects of British and Canadian government policy.

The people of Canim Lake share with their neighbours a history and a culture that stretch back thousands of years. In the more recent past, they have shared the effects of sending their children, from the age of 6 or 7 until the age of 16, to St. Joseph's Residential School at Williams Lake. The school was an extension of the St. Joseph's Mission of the Oblates of Mary Immaculate order of the Roman Catholic church. During a 90-year period, from its opening in 1891 to its closure in 1981, the staff of St. Joseph's Residential School were responsible not just for the basic education of many hundreds of Shuswap children, but for their lives and well-being too.

The destructive consequences for Aboriginal people of compulsory residential school attendance has been criticized bitterly and effectively in recent years, not least by people who testified before the Royal Commission.[87] The school at Williams Lake has a particularly nasty history. Charges of mistreatment date back to the earliest years of the school's existence. As well, there have been at least two instances of suspicious deaths among its students, one by exposure and one by suicide.[88]

Enforced separation from family and community at an early age, deliberate suppression of language and culture, substandard living conditions and second-rate education are only the top layer of offences brought about by a school system that had three main purposes: to 'civilize' and Christianize Aboriginal children, to integrate them into the culture imported from western Europe, and to prepare them to take their place at the bottom of Canada's social hierarchy. Worse still, the evidence of physical abuse and sexual assault is now a matter of record.[89]

Like many who attended one of the network of residential schools across Canada, the Shuswap children who were sent to St. Joseph's learned to despise the traditions and accomplishments of their people, to reject the values and spirituality that had always given meaning to their lives, to distrust the knowledge and lifeways of their families and kin. By the time they were free to return to their villages, many had learned to despise themselves. As adults, they survived by deadening explosive feelings with alcohol abuse and other addictions. When feelings could not be suppressed, they were sometimes turned inward to self-destruction, sometimes turned outward to violence.

The links between the abuse that took place at St. Joseph's Residential School and the internal violence plaguing the Shuswap communities in the 1970s and '80s began to be explored only after the people had taken some remarkable first steps. Over a period of just a few years in the mid-1980s, led by pioneers at Alkali Lake, they achieved almost total sobriety where alcoholism had once been rampant.[90] To the dismay of many, however, community problems persisted. A few community leaders were willing to probe still deeper for root causes. As the layers of unresolved pain and unexpressed grief and anger were peeled back, they revealed, first, abuse within the communities – then the underlying history of abuse by church and state.

The RCMP officer called in to investigate the allegations against St. Joseph's staff made a significant discovery: many of the alleged victims of abuse at the school – people he was looking for in order to take statements from them – had become violent or self-destructive as adults.

> [They] were on parole for sexual assault, were on probation for sexual assault, had been convicted in the past of sexual assault, or were in jail for sexual assault. In fact, of the first 10 victims I identified, seven of them had become offenders themselves... One of the other things [I discovered was]...that a lot of them were dead. And we are talking about people that would have been in their late 30s and early 40s, and it seemed to me to be a disproportionate number of, men primarily, that had met early deaths... Also, there were a large number...[that had] committed suicide... In Alkali Lake I was looking for 23 people, and seven were dead.
>
> *Constable Bob Grinstead*
> *RCMP Investigative Services*
> *Canim Lake, British Columbia, 8 March 1993*

There is widespread agreement, including among the churches that ran them, that the impact of residential schools carried far beyond the individuals directly hurt.[91] In our hearings at Canim Lake, Commissioners were told that no one living in the Shuswap communities today is untouched by the negative effects of St. Joseph's Residential School and its policies. Survivors who went on to have children of their own had only a limited understanding of how to raise them with love and self-respect, having been loved and respected so little themselves in childhood. Some have worked hard to heal themselves and to reverse the social and psychological processes that have done such widespread damage. While Commissioners were in Canim Lake, we were honoured by the willingness of one family to share their stories of suffering and recovery with us.

> I wondered, all these years, you know, ever since my children grew up, when I would let them know my secret – my secret being [what I went through in] the residential school...
>
> When I was a young boy like my son Billy here, my head never used to lift up like this. It was [hanging down] like this, licked and beaten... For the longest time, I didn't have a real smile, I didn't have a real laugh, but today I laugh and I cry and it feels really good. For many years I lived in rage and anger, despair, loneliness. I even brought that on my children, and they felt that. After being sober for seven years I was still carrying that thing [into my family relationships], and I never knew it was happening...
>
> I needed to deal with all these addictions, to deal with my gambling and to deal with my alcoholism... Then I could talk with my

> loved ones... Then I could hear them... Today I have a relationship with my wife that's so beautiful. Today I have a relationship with my children that's so beautiful. It's life, it's life.
>
> *Dave Belleau, Alkali Lake First Nation*
> *Counsellor, Nechi Institute on*
> *Alcohol and Drug Education*
> *Canim Lake, British Columbia, 8 March 1993*

The long struggle by the people of Canim Lake to restore themselves to wholeness of body, mind, spirit and community began with the example set by some of their leaders. With determination and courage, they began to confront their own issues of addiction and abuse, starting in the 1970s. Their weapons in the struggle have ranged from therapy and the rediscovery of spiritual roots to new treatment programs for sex offences based on models of justice found in Shuswap culture.

One of the most powerful of those weapons has been the rediscovery of traditional values and spirituality – the old ways of communicating with the Creator and restoring inner harmony through song, dance and ceremony.

> The biggest weapon I have with me is my heart, and the spirit that flows strength into my heart so I can speak in the language of my people of [our] pain...
>
> I remember getting strapped [at St. Joseph's] for the first time when I was nine years old – just the look of power and control in that man's eyes. Just remembering it, I [could start] squealing like heck, you know... Today, I [can] take that experience and have the sweet grass and the sage absorb it, and take it up to the Creator... All the shame that I felt, all the guilt, all the abandonment, the rejection, are in that sweet grass and in the sage... All the screams, the nightmares that I remember, are in the prayers.
>
> *Dave Belleau, Alkali Lake First Nation*
> *Counsellor, Nechi Institute on*
> *Alcohol and Drug Education*
> *Canim Lake, British Columbia, 8 March 1993*

> I stopped drinking in 1977 or '78, something like that...[and] ever since, I've been a traditional dancer... That's what helps me stay sober, that's what keeps me going...because sometimes when I'm feeling kind of, you know, down at heel...I always tell my husband, I feel like a pow-wow. I feel like going to a pow-wow just to get back my energy and, well, get back into living I guess.
>
> *Josephine Johnson, sister of Dave Belleau*
> *Canim Lake, British Columbia, 8 March 1993*

Their struggle also involves several community development projects to solve problems and restore community initiative. One is an innovative higher education

program designed to increase skills and confidence; in May 1993, 21 people from Canim Lake graduated with Bachelor of Education degrees in Native Leadership from Gonzaga University in Spokane, Washington. Another is a community-controlled research program to investigate the effects of the residential school experience from the Aboriginal perspective, which led to a national conference on the issue in June 1992. A third is Canim Lake's comprehensive family violence program, now in search of secure funding, which will offer healing strategies appropriate to each generation – youth, adults and elders – and take account of all the layers of pain and damage that linger in Shuswap communities.[92]

> We [know we] need to take a holistic approach to dealing with issues around residential school, around sexual abuse, around suicide and everything else we have to be facing within the community.
>
> *Charlene Belleau, family violence co-ordinator*
> *Canim Lake, British Columbia, 8 March 1993*

As the community of Canim Lake builds step by step upon its successes, a sense of family and community solidarity, a wave of energy and optimism, are gradually replacing the helplessness and hopelessness that pervaded the community in the past. Commissioners share the feeling expressed by local leaders that the Shuswap people are firmly on the path to recovery.

> I want to say that I am proud of the things we've done here at Canim Lake, things that [we pulled off] because of that community support, that family support... That's the same thing that we are trying to do with this community-based violence program, is to provide the vehicle to heal our community, to deal with those ghosts of the past that still haunt a lot of our people today...
>
> Today, our community is at the stage where we are providing the leadership to deal with such an emotional issue, not only for the individuals within our community but for the community as a whole. If we want to have healthy communities, we have to have healthy individuals, healthy families, and we've started on that process.
>
> *Roy Christopher, former chief*
> *Canim Lake First Nation community*
> *Canim Lake, British Columbia, 9 March 1993*

The Meadow Lake Tribal Council: Children Are Our Future[93]

In the mid-1980s, the children of the nine Cree and Dene reserve communities making up the Meadow Lake Tribal Council (MLTC) in northwestern Saskatchewan were in trouble.[94] A few were facing the worst problems to face kids anywhere:

neglect, abuse, the effects of family violence, the effects of parents' drinking – in short, the lack of a nurturing environment in which to develop. Some were in danger physically or psychologically. Many were in danger culturally because they were growing up untutored in their languages and traditions. Elders and caregivers were worried by what they saw. They were concerned about the wounds these children would carry with them into the future – if indeed all of them lived to see the future.[95]

In the same period, the MLTC economic development strategy was in trouble, in part because students were dropping out of educational upgrading classes. They had no one to care for their children while they were in class or studying. Others faced the absence of child care when they left the community for advanced training or for substance abuse treatment.

There were two problems: one long-term and one immediate. The answer to both appeared to be the same: daycare. But, as the Tribal Council knew, turning that idea into reality would not be simple. There were no trained daycare workers in the communities. No appropriate facilities existed locally. How could they be found or developed? How could they be paid for? The federal government, with responsibility for "Indians, and Lands reserved for the Indians" had no comprehensive daycare policy. (It still does not.) The provincial government, with responsibility for the education and health needs of its residents, was already providing daycare in neighbouring communities – but could not or would not do so on reserves.

The idea might have died, except for two things. The Meadow Lake Tribal Council had come to see human development as a necessary underpinning for economic development. They had also come to see the health and healing of all their people – but especially the children – as a central goal of self-government. Not only did they want to control the programs and moneys spent on their behalf by the federal government, they wanted to spend it differently: on their own priorities, defined and addressed in their own way. Despite the obstacles, the MLTC decided to pursue the idea of community-based daycare.

Social worker Mary Rose Opekokew had a vivid memory of the first meeting of the organizing committee for child care.

> I remember it so clearly even though it happened back in 1988. MLTC executive director Ray Ahenakew told us to dream the best possible child care program we could imagine. And so we did.[96]

Some who attended that first meeting may have believed that nothing would come of their dream, as nothing had come of so many dreams before. But gradually, the idea of fighting for daycare took hold in the communities. After months of discussion and community consultation, it became an ambitious plan for (1) a child care program to be guided by First Nations culture, traditions and values, and operated according to the highest standards of education and care in the

country, and (2) a training program to certify local Aboriginal people for work in the child care field. The plan aimed to provide facilities and staff for a 40-place district daycare centre on one reserve and a series of small, home-based daycare facilities on the other eight.

The success of the training component of the plan depended on establishing a partnership with a post-secondary institution with expertise in child care education. In 1989, the Tribal Council approached Dr. Alan Pence of the School of Child and Youth Care at the University of Victoria to discuss the possibilities. Dr. Pence was attracted by the idea of helping to develop a curriculum for Aboriginal child care workers – especially because Aboriginal people would be in charge of its content and design.

> I was very impressed by [the executive director]'s... vision of how child care fit into MLTC's economic, educational and cultural goals. Within 45 minutes I was hooked... The UVic School would be contributing to the project, not defining it. We would develop the educational framework [the Meadow Lake people] decided they needed. That's what felt right to me.[97]

The curriculum that was developed and delivered over the next three years is uniquely adapted to the needs and priorities of the Meadow Lake communities. Its approach was to blend the knowledge of early childhood development from mainstream educational experts with traditional Cree and Dene ideas about child rearing. The curriculum development team assembled from the University of Victoria and the Meadow Lake communities was determined that every unit would be infused with Aboriginal values – no 'beads and feathers' add-on programming. Each new teaching unit was revised before delivery in light of comments and input from the Aboriginal students and elder-advisers on the previous one.

The elders had been sceptical of the invitation to participate in the project at first, wary of the token nod to tradition typified by a quick prayer before meetings. But the young women developing the child care course knew they could not base the curriculum on traditional values without the elders' help. Only they had the knowledge and understanding to do it right – with depth and accuracy. By mutual agreement, the elders were involved in every step of the curriculum design and gave a block of teaching time in each week of the course. A member of the first group of graduates from what became known as the Child and Youth Care Curriculum Development Project said of their contribution:

> The elders have given us a positive and new outlook on child-rearing... [For example] they told us how they used to talk to their children every night before they went to sleep, and [how to] treat them with respect.[98]

The Flying Dust community was able to purchase a building just outside its reserve to house the training program and the district daycare facility – now

known as the Wakayos Child Care Education Centre. From the day it opened, it was filled with Meadow Lake children from on- and off-reserve.

In the first two years of operation (1991-93), the training program produced seven graduates with two-year diplomas in child and youth care[99] and 55 graduates of a 60-hour family daycare home-provider course. All the diploma students have found work at Wakayos or elsewhere. Some, but not all, the short-course graduates are caring for local children in their homes under licence from the Tribal Council, an authority recently granted by the provincial government.

The spin-offs from the development of the child care program have been remarkable. The most important is the shift in attention of people in the community toward general concern with the welfare of children and their families. Said former program director Marie McCallum, "There's much more talk in the communities these days about improving the environment for children. There's definitely a ripple effect. And it took a program like this to get things rolling."[100] One contributing factor is the presence of the 55 graduates of the short course, who are models of good parenting whether or not they are able to run home daycare centres.

Specific spin-offs include

- a toy lending library and a parent information and education centre;
- a permanent record of songs, stories and ideas about child rearing gathered from the elders;
- a continuing role of significance for elders in community affairs;
- an edited and packaged version of the child care curriculum to be made available as a resource for other Aboriginal communities; and
- a comprehensive plan to take over child and family services and redesign them to reflect community values as the daycare program does.

In fact, the Meadow Lake Tribal Council's child care program is only part of an expanding vision of health and wellness for all its people.[101] It is a holistic vision that sees healing, community development and the self-respect that comes from self-government as central to the kind of community health that can protect against high rates of suicide and self-destructiveness among Aboriginal people. The child care program is just one aspect of the overall plan but one of the most important: it provided the spark that lit up the Meadow Lake reserves with a contagious blaze of ideas to change the way their children live and grow.

The money to launch the daycare program came from the Child Care Initiatives Fund of Health and Welfare Canada. This fund is available for pilot projects only. Its support was due to end at first in August 1993; then it was extended for one year only.[102] A partial solution to the looming crisis appears to be available, but only because of a technicality. The location of the building for the Wakayos Child Care Education Centre – which by coincidence lies just outside reserve boundaries – makes it eligible for provincial funding, which is now being negotiated. However,

no money is available from either level of government to subsidize the daycare places offered by the home providers on-reserve. Some are discouraged by what seems to be the uselessness of their training.[103] And the proper care of some of Meadow Lake's children is still not entirely guaranteed.

What We Know About Successful Suicide Intervention

> Any program which improves the community and helps the people who live in it feel worthwhile, will serve as a suicide prevention program.[104]

The case studies described here – and others we have not touched on – offer a range of responses to suicide, from direct intervention to indirect, long-term community development. Their 'success' is hard to define or measure. Direct intervention may only postpone a death until another time; long-term community development may, over years, transform the social and psychological environment leading to suicide and reduce rates significantly. In any case, specialists warn that few prevention or intervention strategies have been adequately studied.[105]

Commissioners believe that if the ideas for suicide prevention and supportive community change come from a careful process in which the community looks into its heart for its direction, they are almost never wrong. This is because the act of looking into the heart – the act of thinking deeply about how things are in a community, and making plans to move a little piece of the mountain that blocks community well-being – is empowering. It is an announcement that the community cares – about itself, about its children, about its future – and it is part of suicide prevention. This is not to say that expert opinion and analysis have no part to play; rather, 'mental health' is an objective so vast and so subtle that it must be a community responsibility.

Despite the difficulty of assessing suicide interventions and evaluating their effectiveness, it is necessary for the Commission to try, in order to develop valid policy. A large number of studies have attempted to establish what works and what does not – or at least to identify the initiatives that appear most promising. Their conclusions are summarized below, in three categories: (1) strategies to identify those at greatest risk and refer them for care or treatment, (2) strategies for direct intervention with those at immediate risk, and (3) strategies to reduce known or suspected risk factors in the environment.[106]

1. What we know about prevention strategies aimed at identification and referral of high-risk individuals

- There is support for the idea of providing suicide-specific education to 'gatekeepers', especially to primary health caregivers (doctors and nurses) but also to others such as teachers, clergy and the police, who are likely to encounter those at greatest risk.[107]

- There is support for general public education, not just about suicide but about depression and other forms of mental illness and about the acceptability to asking for and offering help.
- There is some need for caution in relation to school-based suicide education programs. Those that focus on helping staff recognize signs and symptoms seem to be well supported, but those that consist of brief, one-time information lectures for students may be ineffective and may even encourage teen suicide. It appears that discussion of suicide is most likely to contribute to prevention when it is tied to skills development around help-seeking behaviour, self-esteem enhancement, problem solving, and life skills generally.[108]
- Although it is not a widely studied strategy, there is evidence that enhancing cultural knowledge, cultural identity and pride in roots and heritage have positive effects, particularly for youth. This finding has resonance with many of the powerful statements made to Commissioners about the importance for Aboriginal people of recovering the elements of lost identity and, in some cases, of traditional spirituality.
- There are good grounds for establishing programs to identify and support young children (below the age of 12) who are at risk, as many of the problems connected to suicide and self-harm have their roots in experiences and situations, particularly in relation to home life, that begin to bite at an early age.
- There are good grounds for considering special outreach aimed at young adults, who are at equal or greater risk but are much less likely than adolescents to be the beneficiaries of support programming.

2. What we know about prevention strategies aimed at individuals in crisis

- Counselling and related psychotherapeutic techniques are widely advocated, although their effectiveness has not been demonstrated conclusively and their cultural appropriateness for Aboriginal people is largely unknown. Counselling programs designed by or with Aboriginal caregivers are likely to be adapted to Aboriginal values and traditions of supportive behaviour.
- Those who have attempted suicide once are at high risk for doing so again. This suggests the prime necessity of developing follow-up and aftercare procedures for those recovering from a suicide attempt and those who have shown an inclination toward self-harm. For adolescents, one technique that appears to be successful in a range of circumstances is peer counselling.
- One suicide can sometimes lead to another. This implies the importance of interventions to minimize 'contagion' – to support those in the family and the community who are most distressed by the suicide and to honour and assist them in the grieving process.
- Crisis hotlines appear to have had limited impact on suicide in the general population. However, their value may be greater in small, isolated communities, where other kinds of help may be unavailable.[109]

- Restricting access to 'lethal means' (firearms, drugs, razor blades and so on) is one proven technique of preventing suicide, at least in the short term. Easy access, especially to firearms, is thought to be a significant factor in impulsive suicide attempts and attempts made under the influence of drugs or alcohol. In developing a strategy to restrict access, it is important to restrict opportunity as well. This implies strict supervision of anyone considered to be at high risk of an immediate suicide attempt.

These are strategies that focus largely on individuals at risk. But there is reason to believe that the individual approach to suicide prevention may not be the most effective for Aboriginal people. The decision to take one's life, whether sudden or considered, is almost always an attempt to escape intolerable life conditions. Successful prevention strategies may aim at reducing individual vulnerabilities by promoting self-esteem, teaching stress management, building peer support networks and enhanced family bonds, and so on. But where intolerable life conditions extend beyond individual circumstances to entrap whole communities or whole peoples, the individual approach is not enough. What is more likely to be effective is a comprehensive process of community and social development.[110]

3. What we know about prevention strategies aimed at community and social development

- They promote change in individuals and communities, so that people achieve greater control over their lives.
- They promote cultural identity and the transmission of language and traditions from elders to young people.
- They support (or develop) symbols and symbolic enactments of group and community pride and integration: ceremony, ritual, celebration.
- They include culturally appropriate ways of dealing with chronic social problems such as substance abuse and family violence.
- They train Aboriginal caregivers to provide a full range of health and social programs, including those relating to mental health promotion, counselling, and family and social network intervention.

A review of the six Aboriginal community initiatives described in this chapter shows that they incorporate some – or many – of the program characteristics supported by research findings. But the research is unlikely to have all the answers for Aboriginal people. It is seldom done in Aboriginal settings, and even when it is, it is generally designed and interpreted by non-Aboriginal people. Several factors that do not appear in the literature on suicide prevention stand out as significant in the case studies examined by the Commission:

- They grew out of community initiative, either directly or in co-operation with a tribal council or other regional Aboriginal organization.

- They depended on community consultation and on the insight, drive and energy of the people most closely affected.
- Most drew on carefully controlled partnerships with outside agencies that had expertise to share.
- They looked for inspiration (and concrete program ideas) from traditional values and spirituality and from the contributions of elders. In this way, they sought to promote self-respect and pride in Aboriginal identity.
- They tended to focus on children and youth as their primary target groups.
- They were generally holistic in design; that is, those involved took a broad view of the problems they were going to address and the means they would use to combat them.

The Importance of Action

As a Commission, we began our deliberations on suicide among Aboriginal people with the hope that we could do what so many in the communities asked us to do: find a solution. What we found instead was a complex and lasting problem of human behaviour that is nowhere in the world responsive to simple answers or quick fixes. In the case of Aboriginal people, it is a problem additionally burdened by the individual and collective injuries they have suffered in their relations with Canada. We found that suicide by Aboriginal people is a crisis of long standing in this and other countries and that it threatens to get worse.

It seemed a discouraging picture at first – until we began to recognize that sustained community action, in an array of forms, offered the best hope for change. After studying both Aboriginal experience and the findings of social scientific research, we have concluded that the first step in reducing the incidence of suicide among Aboriginal people lies in accepting and building on the fact that there is no one answer – *there are many answers*. There is no one formula for success, but there are many ingredients that can help. There is no one way of assembling the ingredients; there are many ways. Indeed, there are as many ways of combatting Aboriginal suicide as there are Aboriginal communities willing to try. The essential thing is to try.

In showing themselves willing to try, communities demonstrate that they are neither hopeless nor helpless – thus directly contradicting the inner message of those on the verge of suicide. In exploring their own experience and the expertise of others, communities will discover the directions they need. Not all lives will be saved by any particular program or course of action. The state of our understanding of suicide and its prevention falls far short of that. But the actions communities initiate, together with the message they deliver by taking action, will contribute to healing, to hope and to life.

> Don't worry about the size of the problem, and how complicated it is. Start somewhere. Paralysis is the biggest barrier.[111]

5
Barriers and Solutions

In this report, the Commission has described how suicide has become, on the one hand, a bleak symbol of the conditions that lead to feelings of despair and futility in Aboriginal people and communities – and, on the other, an energizing symbol of the need for action and a magnet for ideas to make change.

- We have reported a number of encouraging signs that many Aboriginal communities are taking action on their own behalf to change the conditions that predispose their people to self-destructive behaviour.
- We have outlined a number of current initiatives that hold the promise of reducing suicide, and we have measured them favourably against the (limited) research-based findings about the suicide interventions that work.

But all we have seen and heard that is positive risks being overwhelmed by the barriers standing in the way of self-help by Aboriginal communities in relation to suicide.

Barriers to Action

Some of the barriers are in the communities themselves. **First,** in some places, the leadership is less interested in 'social problems' (like suicide and its prevention) than in economic development and self-government. Although all three are interrelated, the first must not be allowed to take a back seat to the other two. It is often Aboriginal youth, women and women's organizations who are leading the search for innovative ways to address social problems and advancing the agenda of healing.

Second, in some places, the events and risk factors tied directly to suicide are a matter of shame and secrecy, for they implicate community members – including community leaders and other people of influence – in damaging, destructive and sometimes criminal behaviour, ranging from boot-legging and drug dealing to abuse and incest. In some places, weakness in Aboriginal child welfare services is an issue. The tendency to cover up and deny these matters is understandable, but unacceptable. Means must be found to expose, understand and remedy the wrongs that have been done.

Third, in a more general way, adults in many communities are failing to behave as role models for the young by demonstrating how to live well according to traditional Aboriginal standards. As we heard so many Aboriginal people say in our hearings, everyone has a personal responsibility not just to 'talk the talk', but also to 'walk the walk' – to reflect in their lives the beliefs and values they now may honour only verbally.

Fourth, in some communities, old rivalries and conflicts prevent the concerted action that is so badly needed to counteract hopelessness and helplessness. Whether those conflicts involve ancient tensions between groups or families or newer ones between political or religious factions, they must be overcome in the interests of finding – or creating – reasons to live for all the people in Aboriginal communities.

At the same time, Aboriginal people face a series of barriers to action that stem from the fact and character of control by non-Aboriginal governments over the programs and opportunities available to them. Throughout our work, we have found that solutions imposed on Aboriginal communities by outside agencies seldom achieve either their own objectives or those of the communities they are meant to assist. Indeed, solutions imported from the outside often create as many problems for Aboriginal people as they solve.

It is true that the general principle of community-based decision making by Aboriginal peoples has achieved a measure of acceptance in some – not all – sectors of government. However, Aboriginal people have provided ample evidence to Commissioners that the principle has barely begun to be translated into reality. The reality for most Aboriginal people continues to be that control over significant areas of life is exercised by non-Aboriginal governments. The fact of that control is offensive in itself to peoples who were self-determining in the past and are confident they can be that way again in the present. The nature of that control has put a series of specific barriers in the way of action to prevent suicide, as we describe below.

The problems stemming from control by non-Aboriginal governments have little to do with individual intentions. The women and men who are elected to form such governments, and those who work as administrators of their policies, clearly believe they are doing their best to be of assistance to Aboriginal peoples. It is rather that the rules of Aboriginal life are written and policed by legal, political and bureaucratic institutions that are not of their own making. Whatever the inten-

tions of people enforcing rules made in this way, the effects are destructive. The Commission has identified six themes characteristic of governments' responses to suicide among Aboriginal people. Together, they constitute a formidable set of barriers to self-propelled action.

1. Non-Aboriginal governments have been reluctant to act in relation to suicide among Aboriginal people.

A steady stream of studies and reports by Aboriginal and non-Aboriginal analysts over at least 20 years has called attention to the problem of suicide, with little result.

- Canadian research published in the late 1970s and early 1980s began to point out the disproportionately high incidence and critical impacts of Aboriginal suicide.[112]
- In 1980, under the direction of the Honourable Mr. Justice Thomas Berger, the *Report of the Advisory Commission on Indian and Inuit Health Consultation* drew national attention to violence and accidents as the leading causes of death among Aboriginal people. The report pointed out that the rate of suicide among Aboriginal people had doubled since 1975. It agreed with other analysis that, if an equivalent pattern and ratio of deaths were to occur in the non-Aboriginal population, it would be "viewed as a national disaster".
- Mr. Justice Berger's conclusions about suicide were highlighted in the 1983 report of the Special Committee on Indian Self-Government (the Penner report), where the need for Aboriginal peoples to establish control over health care services and their delivery was put forward (by a parliamentary committee that included Aboriginal people among its members) as the key to improvement in all areas of Aboriginal health and well-being.[113]
- The 1987 *Report of the National Task Force on Suicide in Canada* identified Aboriginal people as one of seven high-risk populations. It called attention to the under-reporting of suicide among Aboriginal people and drew a direct correlation between high suicide rates and Canada's history of forced assimilation of Aboriginal people into mainstream society.
- In recent years, suicide has been a focus of attention by the Federation of Saskatchewan Indian Nations, the Section on Native Mental Health of the Canadian Psychiatric Association, the Nechi Institute on Alcohol and Drug Education, Pauktuutit (the Inuit Women's Association), the Government of the Northwest Territories and others.[114]

These documents presented a long march of compelling evidence that Aboriginal people have been dying by their own hands much too often and for much too long. Yet Canadian governments made no pre-emptive response. Despite urgent calls for long-term, holistic, community-based and community-controlled prevention measures, suicide among Aboriginal people has never become a high-priority issue for Canadian governments.

2. Non-Aboriginal governments have responded primarily in times of crisis.

The majority of suicides by Aboriginal people pass unnoticed except by those most grieved. Only occasionally does a particularly shocking death or rash of deaths rivet the attention of the media – and Canadian governments – on the need for emergency measures to address the problems spotlighted by that suicide.

Emergency measures tend to be disorganized, fragmented, partial and enormously frustrating to Aboriginal people. Usually, they take no account of the dynamics of self-destructiveness originating in the legacy of colonialism and unavoidably implicated in the factors related to suicidal behaviour: high rates of substance abuse or family violence, feelings of shame and active denial of problems, lack of economic opportunity, lack of resources for youth programming, and so on.

Frequently too, emergency measures come after years of unanswered requests for support and action to solve precisely the same problems now targeted for attention. Thus, they may convey a cruel message to Aboriginal communities: that non-Aboriginal people and governments care, but only after blood has been spilt. Worse, they force Aboriginal communities into the role of supplicant, pleading for help instead of planning for change. The highly publicized suicide attempts in Davis Inlet in January 1993, for example, have been the catalyst for government action to resolve outstanding issues that have been plaguing that community for decades. About this, Commissioners can only feel glad. But the lesson it teaches is grim: the more visible the tragedy, the greater the publicity; the greater the publicity, the more visible the action.

3. There is no comprehensive, nation-wide mental health policy applicable to all Aboriginal peoples.

Until 1992, the federal agency with responsibility for health care on reserves and in territorial Inuit communities – the Medical Services Branch of Health and Welfare Canada – had no policy on, or funding for, the promotion of Aboriginal mental health. Faced with a general demand for some means to address the pressing concerns of the communities in this area, in 1989 the Branch began a process of consultation with its recognized clients (registered Indians and Inuit) to define problems, needs and strategies. The resulting recommendations to Cabinet led to the inclusion of a special fund for reserve and Inuit communities (only) as part of a larger program in support of Canadian children announced in May 1992, called Brighter Futures. Inuit living outside the Northwest Territories, First Nations people living off-reserve and all Métis lack targeted resources under this program. They have access to general Brighter Futures funds on the same basis as other community groups or applicants.

The Indian and Inuit component of Brighter Futures includes a Community Mental Health Initiative, as well as a Child Development Initiative and a Solvent

Abuse Initiative.[115] The Community Mental Health Initiative is designed to assist selected communities develop mental health and wellness strategies. Its budget is projected to rise over five years from $8.5 million in 1992-93 to $65.5 million in 1996-97, subject to normal government review. Reserve and Inuit communities may apply for resources to carry out activities such as: needs assessment, staff training, research and information exchange, consultation and other start-up activities.

The Commission is encouraged by this evidence of the federal government's recognition of the pressing need to encourage action in support of Aboriginal mental health and wellness, and especially by its recognition of the necessity for community-based programming. We were further encouraged by the announcement on 26 September 1994, of additional funds for the Community Mental Health Initiative.[116] Even so, the provisions of the Brighter Futures Aboriginal program component fall short of the high-priority status that the Commission seeks to give to the prevention of suicide by Aboriginal people:

- The incorporation of the mental health component into Brighter Futures lowers the profile and significance of mental health.
- The degree to which the mental health program is used depends in part on the activities of Medical Services Branch regional offices, which vary in the emphasis they give it. Testimony before the Commission suggests that the program has been poorly advertised in some regions and that many Aboriginal health care workers are unaware of its existence.
- Even with the recent infusion of new moneys, resources are small in light of the range of critical issues the program is supposed to address. Further, First Nations and Inuit communities must compete with one another for those limited resources. The success of one application means rejection for another that may be needed just as urgently.
- Finally, as we discuss below, the program is constrained by current administrative conventions according to which only First Nations ('Indian') people living on-reserve and recognized Inuit communities can benefit from targeted federal programs, while provincial and territorial programs and services apply to other Aboriginal people – but only in competition with all Canadian citizens.

4. There is a fundamental inequity in the program opportunities available to Aboriginal peoples.[117]

Access to resources and programs that might be used to help combat the causes of suicide in Aboriginal communities is controlled at the most general level by the legal definition of who is an 'Indian'. The federal government is charged with special responsibilities for the welfare of 'Indians', a category that has been interpreted to include Inuit but not Métis. Further, the definition of 'Indian' has been limited in several ways over the years to exclude a large number of Aboriginal people who identify themselves as Aboriginal but do not qualify as such according to the government's definition and are thus excluded from federal programs and benefits.[118]

The problem grows larger still when we consider the many thousands of 'status Indians' who have left their reserves to live in towns and cities elsewhere in Canada. By leaving their reserves, they lose access to federal programs and services that, however flawed they may be, are targeted to their particular needs. They gain eligibility for provincial and territorial programs, but these seldom take account of issues and risk factors related to aboriginality. In the case of suicide and self-destructive behaviour, this casts serious doubt on their usefulness. Further, those who leave the reserve must seek services from provincial, territorial and municipal agencies whose rules they do not know, whose working methods may be alienating to them, and whose very existence they may know nothing about – exclusion in fact if not in law.

Similarly, Métis and 'non-status Indians' are eligible *as individuals* for federal, provincial and territorial programs available to Canadians generally. But many of the risks they face arise from their *collective* situation as Aboriginal people – the consequences of the colonial past in social, economic and cultural terms. Since their problems are not the same as those of Canadians generally, the effectiveness of general services is doubtful. Some provincial (and many territorial) programs include special provisions or target a portion of general moneys for Aboriginal people – but in a limited, unsystematic and unpredictable manner. Some regions receive funding under particular arrangements that add to confusion and inequity, as in the case of the Inuit of Labrador:

> In order to achieve better mental health [in this] community, we will be seeking funds for a suicide prevention coordinator, the services of a psychologist, training for local community members to become mental health counsellors... Our greatest stumbling block is the serious lack of availability of provincial and federal government programs in northern Labrador communities. The Canada and Newfoundland Contribution Agreement for the Benefit of Inuit Communities in Northern Labrador should not be a deterrent for our community to access other federal and provincial programs. Without funding, it will not be possible to improve existing or introduce the new programs [needed] to save the lives and souls of our people. [translation]
>
> *Johannes Lampe, Mayor*
> *Nain, Labrador, 30 November 1992*

The Commission estimates that roughly 60 per cent of Aboriginal people in Canada fall outside the self-defined responsibility lines drawn by Parliament and interpreted by federal government departments and agencies.[119] In contemplating a comprehensive strategy for suicide prevention, this fundamental inequity poses a major barrier to fair and equal opportunity.

5. The multiplicity of funding sources creates confusion.

The main funding sources for the *minority* of Aboriginal people who are eligible for federal programs are the Department of Indian and Northern Affairs, and Health and Welfare Canada through its Medical Services Branch. But many other government departments offer program opportunities to 'status Indians' and Inuit living in the Northwest Territories as well. However excellent the objectives of these programs may be, the communities experience them as an unpredictable hail of paper, announcing this or that new or revised program – each with its own requirements and limitations, and the whole with no logical relationship to their needs and priorities.[120]

Government officials frequently consult with Aboriginal communities about these programs, so the departments see themselves as responsive to and supportive of local control and autonomy. But with no *overall* autonomy, the communities see themselves as being at the mercy of a demand for endless consultations with departments that do not consult with each other and that routinely tie 'opportunities' to pre-set program objectives that have inappropriate timetables, rules and criteria. Band and settlement councils spend a lot of their time trying to adapt their problems to fit existing program criteria. Sometimes they are diverted completely from assessing and defining their own needs and solutions because of the kind of effort it takes to respond to 'Ottawa'. The situation is an invitation to frustration – and passivity.

No matter what their official status, all Aboriginal people suffer from the lack of an overall map of what support is available to them. They depend on federal, provincial and territorial agencies to communicate the possibilities, and if they fail to do so effectively, communities may miss out on opportunities for which they are genuinely eligible.

6. The information and training resources available to Aboriginal communities on suicide prevention are inadequate.

The information available to Aboriginal communities about suicide and its prevention is limited by the generally unsystematic approach governments have taken to the issue. The Commission is particularly concerned about the limited amount of funding available for the training of community caregivers. The provisions offered under the Brighter Futures funding umbrella allow some Aboriginal communities to search out training opportunities for mental health workers; more impressive, in at least one jurisdiction (the Northwest Territories), training in suicide prevention for every community is a territory-wide commitment. This is not enough.

It is apparent to the Commission that the transition to – and success of – all self-managed health and healing systems depend on the quality and skills of managers and caregivers. Effective community-based programming is not possible without dramatically increased opportunities for local staff development. Suicide prevention skills are merely one case in point.

In relation to suicide, frontline health care workers – including nurses, community health representatives, addictions counsellors and others – have long borne the brunt of the distress at the community level. Whatever their training or their job description, they have been pressed into service to rescue the desperate, to cope with the injuries and deaths of those they could not save and, in the aftermath of a crisis, to anticipate the ricochet of effects in the community and try to prevent more deaths.

In small communities, caregivers may be related to or well acquainted with the person at risk of suicide. This can lead to conflicted loyalties, high levels of stress around confidentiality, and increasing pain if death occurs. If suicidal behaviour becomes epidemic, caregivers are on call day after day, 24 hours a day. Where self-harm and suicide pose a continuing threat, community health caregivers are in danger of exhaustion and burnout. As they told Commissioners during our special consultations on suicide prevention, few have been trained in the specific skills of suicide prevention, intervention and grief counselling. They need opportunities to learn, to explore their own feelings and issues in relation to suicide, and to discuss current cases. They need both peer support and access to back-up from more experienced caregivers.

A Framework for Action

The Commission has concluded that only a comprehensive approach to suicide prevention has any hope of changing the existing picture. A comprehensive approach must include plans and programs at three levels of intervention:

- those that focus on building direct suicide crisis services;
- those that focus on promoting broadly preventive action through community development; and
- those that focus on the long-term needs of Aboriginal people for self-determination, self-sufficiency, healing and reconciliation within Canada.

Commissioners see these three strands of action not as choices, but as necessary components of a realistic program to combat suicide among Aboriginal people and to reduce its incidence measurably. Our commitment to a three-part approach reflects our conviction that Aboriginal communities face a continuum of *essential needs* if self-inflicted death and injury are to be reduced.

1. Crisis services

Crisis services are a pressing need where blood is being spilt. Every Aboriginal community faces that possibility, if not the immediate reality. The threat is real enough now, but it is likely to get worse as today's Aboriginal children enter their teens and twenties.

Further, suicidal behaviour by Aboriginal youth has a tendency to occur in clusters. One incident can have a contagion effect, leading to a storm of related

episodes. The contagion effect appears to work either by increasing the attractiveness and acceptability of self-harm to other youth, by increasing their hopelessness and depression, or both. Thus, communities can remain relatively untouched by suicide for many years, only to find themselves suddenly caught in a rapid succession of attempted and completed suicides, with repercussions that swamp their personal and professional resources.

Once a crisis is under way, it is too late to develop effective strategies and services. The capacity for response must be developed beforehand. The present pattern of waiting for crisis to arrive before action is contemplated, whether by governments or by communities, is not an acceptable option.

Evidence from crisis services operating in non-Aboriginal settings is encouraging. It indicates that lives can be saved by direct intervention. Crisis services that draw on existing models but are adapted to Aboriginal realities are a *necessity* – not a luxury – in all Aboriginal communities.

In Appendix 1 of this report, we offer a more extended description of these services.

2. Community development

Programs and services directed to individuals on the point of self-injury are essential to save lives, but they will not, by themselves, change the overall picture of high rates of suicide among Aboriginal people. As things stand in many communities, there is a constant supply of potentially suicidal Aboriginal people. Commissioners believe that the best hope for the eventual, lasting reduction of suicide rates is offered by transformation of the underlying causes of self-destructive behaviour.

The evidence before the Commission has led us to conclude that high rates of suicide among Aboriginal people are primarily the result of severe social and cultural disorganization. Its causes lie in the legacy of domination endured for many years by Aboriginal communities and cultures. Its effects at the community and family level include the now familiar problems of substance abuse, violence and self-destructiveness, helplessness and hopelessness that are the risk factors for suicide. For this reason, the second point on the continuum of action proposed by the Commission is social and community development. Its goals are to

- strengthen the bonds of care and mutual support available to individuals and families in each community; and to
- rebuild the social, cultural and economic foundations of communities.

In Appendix 2 of this report, we offer a more extended discussion of community development.

3. Self-determination

Commissioners are firmly of the view that, in the long term, only the development of self-determining Aboriginal governments and institutions and reconstruction

of the fundamental building blocks of Aboriginal cultures will reverse the personal, social and economic conditions that lead some Aboriginal people to take their own lives. Albert Levi, former chief of Big Cove, put it this way in response to yet another suicide in the community, even after a significant amount of emergency funds and resources had been made available.

> The government's response is always to give us another bunch of band-aid solutions. It won't work. It's just more hand-outs. Poverty, unemployment and hopelessness will go on in Big Cove until the system is changed and Natives are allowed to determine their own future. Self-government will not immediately solve the suicide problem, but without it, [the problem] will never be solved.[121]

Visionary submissions to the Royal Commission from the Meadow Lake Tribal Council and the Ma Mawi Wi Chi Itata Centre in Winnipeg, among others, described how self-government, economic self-sufficiency and full personal and community health and wellness are related in a circle of cause and effect.[122] To be successfully self-governing, Aboriginal peoples need alleviation of their social and economic problems. To obtain the resources and control necessary to solve social problems, they need to be self-governing. The current situation has all the qualities of a vicious circle – a trap threatening to cripple Aboriginal efforts at self-betterment.

It is, of course, the substance of the Commission's overall mandate to reverse the circle and make its components – self-government, self-sufficiency and overall wellness – mutually reinforcing. In the transition period, while the critical issues of jurisdiction, governing structures, access to a land base, control over resources and other matters are being negotiated, action on social problems must go forward.

In placing the strategy of self-determination as the end-point on the continuum of needs for suicide prevention, in no way are we saying that action to reduce suicide must wait for self-government. On the contrary, we want to be very clear that it *cannot, need not, and must not wait.* This report concludes with recommendations for immediate action. But until the full agenda of self-determination is achieved, that which can be done to reduce suicide rates will be partial, and Aboriginal people will continue to die self-inflicted deaths. In the meantime, and simultaneously with efforts to move that agenda forward, the Commission strongly recommends action on the first two fronts: crisis services and community development.

In recommending a continuum of action, the Commission's concern is that governments might give precedence to crisis services over medium- and long-term family and community development and commitment to action on self-determination. The attractions of focusing on crisis services are magnetic: the possibility of direct action, measurable outcomes, short-term (apparent) cost containment. But to move along this path alone would be a mistake. The path of greatest urgency – and greatest promise – is that of family, community and cultural renewal. The persistence of suicide among Aboriginal people in the face of past

attempts at crisis management is convincing proof that rates will be brought down only as a result of genuine community transformation.

Key Elements in Community Plans for Suicide Prevention

The Commission has now identified the three levels on which action must be taken to stop suicide among Aboriginal people. In Appendices 1 and 2, we describe in greater detail some of the ideas involved in developing programs at the first two levels – crisis intervention and community development. We expect that in considering plans for suicide prevention, each Aboriginal community (or group of communities working together) will come to a unique view of its needs, strengths, priorities and preferred action plans at each level of action. Program details, both for crisis services and for community development, will vary from place to place.

Earlier in this report, we identified some of the features found in Aboriginal initiatives to prevent or reduce the frequency of suicide that seem to be working now, and we showed that there is some research support for their effectiveness. However, we can find no basis in experience or research from which to develop what those concerned about suicide and self-injury would like: the definitive list of prevention measures and program characteristics guaranteed to bring results. The state of human understanding of suicidal behaviour has simply not reached that point of certainty. Nevertheless, the Commission has identified seven elements or criteria that, in our judgement, are fundamental to the design of an effective local strategy:

1. cultural and spiritual revitalization;
2. strengthening the bonds of family and community;
3. focus on children and youth;
4. holism;
5. whole-community involvement;
6. partnership; and
7. community control.

Individually, these criteria are not new. Aboriginal people have been advocating most or all of them for a long time. What *is* new is to link them together as the necessary components of a comprehensive, community-based strategy to stop suicide in Aboriginal communities. We recommend them here to be used *as a guide* by those who have responsibility, in communities and governments, now and in the future, for developing programs aimed at reducing suicide by Aboriginal people.

1. Cultural and spiritual revitalization

There is a widespread and growing conviction among Aboriginal people that colonization and the ensuing replacement of their cultures and spiritual beliefs by the values and beliefs of others have been significant factors in the deterioration of their personal and collective well-being. From the time of the first explorers, the ideas and practices that had given meaning to Aboriginal lives through the ages were sub-

jected to incomprehension and scorn, to condemnation by Christian missionaries, and eventually to school-based programs of enforced 're-education'. Commissioners were told that weakened commitment to those profound beliefs has undermined fundamental Aboriginal identity and self-respect, and that it contributes to the alienation and despair that lead to suicide.

> Indigenous people had a way of life that was spiritually directed and reflected in the systems of education, governance, social relationships, economics and culture. The goal of the individual in the community was to live a life of harmony...and peace with all creation... The underlying premise upon which all else was based was to recognize and fulfil the spirit of life within oneself and with all others in the circle of individuals, relationships, community and the land. This was achieved through concerted efforts of developing the spirit through prayer, meditation, vision quests, fasting, ceremony, and in other ways of communicating with the Creator. [These beliefs] provided the guidance that an individual needed to ensure that all life was respected...
>
> [But] the spirit has been devastated by the cumulative effect of 500 years of genocide, forced assimilation, destruction of the natural world and internalized oppression. This has resulted in the highest national statistics of suicide, violent deaths, alcoholism and various forms of abuse [occurring in Aboriginal communities]...
>
> Where do we go when [the] spirit of a people has been totally shattered and devastated to the point where we are living in an environment of abuse, abuse that is even generated within ourselves...? Where do we go to be able to heal as human beings? I think...what we have to do is return, we have to embrace the way of life that has been given to us by none other than the Creator. It is a way of life that is full, that adds up to our survival, that brings happiness and healing of the spirit, where again we can be a strong people and a strong nation.
>
> *Dave Courchene, Jr.*
> *Mother Earth Spiritual Camp*
> *Fort Alexander, Manitoba, 30 October 1992*

There is convincing evidence that continuity or revitalization of Aboriginal cultures and spirituality is an effective means of protecting against loss of inner meaning and direction. The National American Indian Court Judges Association has noted that "sociological studies of Native American adolescent suicide show that in communities where the suicide rate is low the traditions are strong, and [that] the customs, religious ceremonies and traditional healing methods provide adolescents with a feeling of security and a sense of belonging."[123] Throughout our public hearings, frontline community health and social services workers told us that

high-risk Aboriginal youth are missing just those things: feelings of security and belonging. We heard many people speak about the emptiness, confusion and hopelessness of existing without a cultural and spiritual foundation, without a sense of self in life. The most profound expression of this emptiness comes from Aboriginal youth who see no other means of alleviating their unhappiness except through self-destructive behaviour, self-injury and suicide. For some, the way to fill the void is to adopt another culture, another identity, but for many, the nameless emptiness just continues and grows ever deeper.

In the story of Missy, we saw how important it was to her, in rebuilding her life, to make contact with the Aboriginal traditions and worldview she had never learned in her childhood. The need for a return to the traditional principles of balance, harmony, order and self-control in everyday life and the need to restore a sense of connectedness to the land and other elements of traditional spirituality were evoked consistently as a major strategy for healing by Aboriginal people who participated in our learning circles and hearings. Sometimes this necessary connection to fundamental life forces was hard to define, but all – be they First Nations people, Métis or Inuit – accepted its reality and validity.

We heard from many community leaders and elders, knowledgeable in Aboriginal tradition, that the ways and beliefs that guided pre-contact Aboriginal societies must be restored and honoured in order for inner peace and community integrity to return to Aboriginal people. As one such person has said, "The emptiness of our people can only be filled by what is naturally our own."[124] We heard stories from people who spent years of their lives searching, and eventually finding, that which enabled them to begin building in themselves a stronger sense of who they are and what it means to be Aboriginal. They did so by participating in feasts and ceremonies that have survived all attempts to eradicate them, by listening to those still in touch with traditional ways, by learning their lost languages. We also learned that many Aboriginal youth have their first positive experience of Aboriginal traditions and spirituality in correctional institutions and treatment programs. This fact is testimony to the perilous loss of cultural continuity in families and communities, but also to the power of Aboriginal traditions to aid in the recovery of lost souls.

Commissioners have come to believe that cultural and spiritual restoration and maintenance must be one of the cornerstones of individual and community health and healing and one of the main principles guiding community strategies for the prevention of suicide. Of course, in making this declaration, we acknowledge and affirm the freedom of Aboriginal people to choose the spiritual beliefs and cultural constructs that make most sense to them.

2. Strengthening the bonds of family and community

The history of cultural disruption and loss we have described has had deeply negative effects on the Aboriginal family. Extended families and clans have lost their

numbers and their interconnections. The key functions of the traditional family – protection and provision for members at all stages of their lives – have been taken over by other parts of the Canadian social and economic system: schools, churches, hospitals, and governments. The health and integrity of Aboriginal families have been weakened overall. In some cases, the bonds built on caring and sharing, once taken for granted, have been replaced by neglect and indifference, violence and fear. Too often, the result has been a wedge separating men from women, adults from children, youth from elders.[125]

Yet despite disruptions to healthy functioning, the Aboriginal family continues to be the key social institution in Aboriginal communities. Bill Mussell of the Sal'i'shan Institute has written:

> The family is the primary institution of Indigenous communities. It is not uncommon for individuals to value family over individual needs and wants, although there is evidence of movement toward increasing individualism... New strategies...to solve the problems that sap the energies and limited resources of Indigenous communities...must build on the traditions and cultural strengths of the people. The family, both nuclear and extended, is the key social institution.[126]

Some of the most moving testimony Commissioners heard about the importance of the Aboriginal family came from young men in correctional facilities who declared that for them, the road to prison (which is sometimes the road to suicide) began with desperate trouble within their families. They pleaded on behalf of Aboriginal children to "keep families together" – and to restore them to their role as places of safety and nurturance for all.

We must emphasize that keeping families together cannot mean ignoring the neglect and abuse that take place in some. Rather, it means that Aboriginal families must become the object of long-term community-based efforts to reinforce parenting skills and stop the violent and abusive behaviour that can happen behind closed doors. It means that the denial and abuse of power that allow some leaders and persons of influence to escape accountability for their part in family violence must come to an end. It means that Aboriginal people must return to the traditional values that nourished family life: respect for women and children, mutual responsibility and, above all, the general creed of sharing and caring.

3. Focus on children and youth

> I believe the focus must be taken where we look at the children, when they are this high. In my opinion, that's when suicide prevention starts.
>
> *Tom Erasmus, co-ordinator of Native services*
> *Alberta Mental Health Association*
> *Lac La Biche, Alberta, 9 June 1992*

Aboriginal youth are at high risk of self-destructive behaviour and suicide throughout their 20s. But many if not most of the factors in their despair begin to affect them in childhood. It is for this reason that the Commission recommends an urgent preventive program focus not just on adolescents, as has often been recommended before, but on young children as well.

Support for children implies holistic or multi-dimensional support for families as wholes, as we discussed briefly above. Of particular urgency is that each Aboriginal community develop and publicize a detailed policy of zero tolerance for violence against women and children. (The Commission will have more to say on family violence in its final report.) There appears to be a need to develop culturally appropriate counselling services and other techniques to rebuild the inner resources of very young children who have not been adequately protected. The Meadow Lake case study is one approach to child wellness that offers hope of protection against suicidal ideation and attempts in later life, and there are of course others in other Aboriginal communities.

Support for adolescents entails the recognition of their need to be taken seriously as having ideas of their own. It means finding ways to mobilize them to articulate and address their own (and by extension the community's) problems, across a range of issues.[127] School-based suicide awareness programs have been criticized for 'normalizing' suicide as an escape for troubled adolescents.[128] Evidence that we discussed earlier suggests that it is preferable for educators to develop programs on coping skills, including the ability to ask for help when it is needed.

There are two additional areas of particular concern in relation to youth and suicide: recreation and employment.

Recreation is an important part of healthy human development for everyone. It can also be a way out of the monotonous and often soul-destroying life of non-work and non-school that faces so many Aboriginal youth. It can provide an effective context in which to develop physical, social and emotional skills and self-confidence. The history of sports and recreation programming is characterized by its commitment to the goal of developing 'good character' in the young and preventing 'delinquency' (however defined). Yet Commission research has shown that recreational facilities and opportunities for participation are severely underdeveloped in reserve and isolated communities.[129] In urban communities, opportunities are great, but without the means of access (money and transportation), many Aboriginal people have no real way to take advantage of what is available. Both Aboriginal leaders and members of the professional community of educators and criminologists have expressed their belief to Commissioners that restricted access to sports and recreation activity is linked to complaints of boredom, episodes of drug and alcohol experimentation, and other forms of self-destructive behaviour by the young. Many who appeared before the Commission argued for the provision of increased resources, targeted particularly to Aboriginal youth, for the development of sport and recreation.

Limited employment prospects and a highly competitive labour market are general problems facing all youth as Canada nears the end of the twentieth century, but for Aboriginal youth, they have been a serious impediment to hope and prospects for financial security for much longer. The development of proposals to alter fundamentally the economic conditions in all Aboriginal communities is one of the main goals of the Commission's work, and the topic will be considered at length in our final report.

4. Holism

In our public hearings, Aboriginal people often used the term 'holistic' to describe the kind of health and healing programs they believed would be effective. Holism (as Aboriginal people use the term) means sensitivity to the interconnectedness of people and nature, of people and their kin and communities, and within each person, of mind, body, emotions and spirit. Seen in this context, self-inflicted death is the final and most fearsome act in a group of self-destructive behaviours. Loss of life alone is therefore not the appropriate object of public health policy. Initiatives should target a wider range of behaviours, including

- high-risk activities such as unprotected sex, drug and alcohol abuse, eating disorders, interpersonal violence and law-breaking;
- self-wounding and self-poisoning (parasuicide);
- attempted suicide; and
- suicide.

Suicidal thinking, as well as the full range of self-destructive behaviours that may or may not lead to death, are all signs of trouble in individuals and communities. A tight focus on completed suicide, which is merely the most dramatic of those signs, is likely to lead to program responses with limited terms and objectives – responses that fail to meet the test of 'holism'.

> We need to address suicidal ideation and suicide attempts. We need to move beyond seeing suicidal actions as a manipulative tool. We need to begin to recognize it for what it really is: a cry for help, an action that states that there are serious underlying problems here that need to be addressed.
>
> *Karen Acorn, suicide prevention specialist*
> *Government of the Northwest Territories*
> *Rankin Inlet, N.W.T., 19 November 1992*

At the same time, suicidal behaviour has specific dynamics, as we discuss in more detail in Appendix 1. It cannot be reduced simply to one instance of a general class of high-risk behaviours. Although suicide prevention should be situated as part of an approach to self-destructive behaviour more generally, it has its own signs and patterns, to which program design and public education on suicide must be sen-

sitive. The balance is not an easy one to maintain, but it is an important one to consider when developing community prevention programs.

5. Whole-community involvement

Broad community consultation about ways to counteract suicidal behaviour and continuing involvement of community members in prevention initiatives are clearly features of the community case studies we described earlier in this report. But the idea of community involvement and responsibility has another application in relation to suicide prevention.

Suicide is such a fearful matter and, in some cultures and belief systems, such a taboo subject that most people prefer to avoid it. But, paradoxically, it is the people closest to a suicidal person who have the best chance to recognize the warning signs and take preventive action: family, friends, co-workers and supervisors, and only in some cases, professional caregivers. It is important for all such people – and that means everyone in every community – to take responsibility for first-stage suicide prevention among those close to them. It is not a simple or casual matter to recognize and evaluate the clues to suicidal intention offered by those at risk – but almost everyone can learn the basic skills and how to apply them. One of the most important skills to learn is how to judge the severity of the risk and when to get trained or professional help for someone who is in immediate danger of self-harm.

Because those who are considering suicide may signal their intentions to almost anyone, people everywhere share a whole-community responsibility for suicide prevention – no matter how uncomfortable that may feel.[130] This implies the necessity of education and training for parents and the public at large, for gatekeepers (those such as teachers and social workers who, in their professional capacity, may well encounter suicidal people), and, of course, for health care professionals who have to take a higher level of responsibility for those at extreme risk or found in the act of self-harm. (Appendix 1 contains more information about how community members can play a role in suicide prevention.)

Most people find it difficult at first to imagine themselves taking steps to assess risk or intervene in any way to stop a possible suicide. Sometimes they fear that talking about it makes it happen, or that intervention is an invasion of individual privacy or a failure to honour personal choice. Talking about suicide does have to be approached carefully, especially in relation to teenagers, who are particularly sensitive to blame or judgement and tend to make impulsive decisions to attempt suicide. However, talking openly and supportively with a person who is on the point of suicide can change the outcome.[131] Some guidelines are suggested in Appendix 1.

Intervention in the personal lives of others is a sensitive issue in some Aboriginal cultures. Some appear to have proscriptions against it, or to equate respect with non-interference. Yet a number of Aboriginal people who spoke to the Commission

on this point maintained that the proscription against intervention was never absolute – in other words, that traditional norms of non-interference always had limits, permitting intervention when people were at risk. It was also pointed out that non-interference is part of a way of life that, for most Aboriginal people, has been replaced by a more conflicted and dangerous way, in which non-intervention may no longer be wise or safe – especially for Aboriginal children. In this regard, it is important for public education about suicide to aim to reduce the stigma associated with open communication of personal feelings and the expression of grief and to encourage reconsideration of traditional norms of non-interference where they might interfere with whole-community responsibility for those at risk of suicidal behaviour.

6. Partnership

As with the Meadow Lake child care undertaking, community-based prevention programs may benefit substantially from access to outside expertise and high-calibre information drawn from research, clinical and sister program sources. The natural structure for support from outside the community is through Aboriginally controlled partnerships with selected agencies, organizations and people who have expertise and specialized knowledge to share.

In Aboriginal communities today, the balance is shifting from asking for help from governments and outside experts, to demanding the opportunity to help themselves. Commissioners applaud this development. We are wary, however, of two possible negative tendencies. The first is a tendency for governments to withdraw from providing assistance too soon, as part of a drive to shift financial responsibility onto other shoulders. At its best, withdrawal from Aboriginal affairs by governments reflects a recognition of the rights and responsibilities of Aboriginal people and communities for self-care. At its worst, it is an abdication of government obligation, or a failure to understand the stresses of the transition from dependency to independence and to provide support during this time.

A second tendency that we see as negative, indeed as self-defeating, is for Aboriginal communities to turn self-reliance into a form of rigid isolation in which the help of anyone or any agency that does not come from within is rejected. By taking this stance – perhaps in reaction to their experience of ignorance, arrogance or interference from outside agencies – Aboriginal communities run the risk of cutting themselves off from skills and knowledge they need and from genuinely productive partnerships. Partnerships with outside agencies are not always easy or successful, but their value is demonstrated in several of the case studies we explored earlier.

7. Community control

Among the experiences Aboriginal peoples have shared, regardless of legal status or geographical location, is frustration with social programs designed and deliv-

ered by administrators and caregivers who have little knowledge of their clients and no accountability to them. In the period of transition to self-government, community control will involve the continuing transfer of responsibility for services from federal, provincial and territorial agencies to existing and emerging Aboriginal authorities. In the longer term, it will mean the development of new or revised structures of Aboriginal government with clear lines of accountability to local communities. No matter what administrative arrangements exist at the national level, community-based programming ensures that local ideas and methods of healing prevail over centralized planning, whether by non-Aboriginal or Aboriginal authorities, during transition and thereafter.

Community control is a matter of proven effectiveness in relation to problems like suicide. Research supports the commonsense proposition that the most effective solutions to social problems generally come from those with the most direct involvement.[113] Further, the collective experience of those in the field tells us that there is no one way to solve the social problems facing Aboriginal communities, including suicide. Many of the caregivers who shared their insights with the Commission asserted that the important thing is to begin, to try, to start taking responsibility. As well, we know that Aboriginal people are often reluctant to seek help from non-Aboriginal services and are more likely to respond to programs and services designed and delivered by other Aboriginal people.

Programs to prevent Aboriginal suicide should reflect the seven elements or criteria for effectiveness we described above:

- Programs should be community-driven, community-designed and accountable to local communities, regardless of the extent to which outside expertise is involved.
- Programs should be holistic in design, addressing the physical, social, emotional and spiritual needs of Aboriginal people in the context of their family and community relationships, in ways that build self-confidence and self-respect.
- Programs should be situated in a broad, problem-solving approach that addresses the underlying causes and changes the conditions contributing to suicide and self-destructive behaviour.
- Programs should balance direct crisis management with efforts to strengthen families and enhance the capacities of communities to protect and support their members.
- Programs should set a priority on ensuring that children have a safe, nurturing environment in which to develop and that youth have an opportunity to make a meaningful contribution to identifying and solving their own problems.
- Programs should give priority to the education and training of Aboriginal caregivers in the most effective methods of preventing suicide and self-injury and to building support networks to assist caregivers in meeting their responsibilities.

- Programs should encourage whole-community involvement in preventing suicide and self-injury through public education and participatory approaches to community problem solving.

The specific ideas for preventive community action suggested by these criteria are many and rich, and we are unable to present all that have been placed before us. A summary of ideas and recommendations for specific initiatives to reduce suicide, which were made by Aboriginal leaders in the field of suicide prevention at the Commission's two special consultations on suicide prevention, is presented in Appendix 3. In Appendix 4, we reproduce a paper summarizing the major recommendations for suicide prevention made by the community healing circles in Big Cove, New Brunswick, at the end of the week of mourning and healing described earlier in this report.

behaviour among Aboriginal people has never received the high priority for public action that Commissioners believe it warrants. The most promising efforts to change the picture through broad-based community healing strategies have come from Aboriginal communities, acting out of anguish for their losses or fear for the future of their children.

The communities have done much, working alone or together with neighbours and Aboriginal organizations, sometimes with the help of federal, provincial or territorial governments. And they can do more. But all too often they are stymied in their efforts by the barriers we have described in this report: the remnants of the colonial past, in the form of the searing social problems it has left in its wake, and the hobbling effects of inappropriate Canadian laws and government programs. The result is that Aboriginal people and communities are not yet fully empowered to address suicidal behaviour to the best of their abilities.

The Commission's goal is to promote a Canada-wide effort to enable all Aboriginal communities to take effective action to heal from the lingering effects of past suicides and to prevent future incidents of self-inflicted death and injury. In order to start this work now, without further delay, the effort must begin outside the slow-moving negotiations for self-government and Aboriginally controlled health institutions – but in a manner consistent with their development.

Our primary purpose is to promote community action. The communities hold the keys to change, and they must be given the means to turn them. The job of governments and Aboriginal organizations is primarily that of support and facilitation. The evidence of the past 50 years has taught that the interventions of outside agencies into Aboriginal affairs, well intentioned or otherwise, cannot provide effective answers to the persistent problems of personal and cultural survival. By the nature of the unequal power relationships those agencies embody, they encourage passivity and dependency in Aboriginal people.

If answers are to be found, Aboriginal people will find them – indeed, as we have demonstrated, they are already beginning to do so. But in most cases, Aboriginal communities do not start from a base of independent means and powers. In the period of transition to full self-government, they need from Canadian people and governments the support and resources to develop the plans and programs that will give all Aboriginal people more reasons to live than to die. They cannot, nor should they have to, shoulder the responsibility alone. It is a responsibility all Canadians share, by virtue of past injustices that they alone can remedy, directly or through their governments, and by virtue of their interest in a relationship of respect and reconciliation with Aboriginal peoples from which all will benefit.

As a result of the analysis and findings in this report, Commissioners believe it is a matter of utmost urgency that the people and governments of Canada, Aboriginal and non-Aboriginal alike, join in a concerted effort to bring high rates of Aboriginal suicide and self-injury to a rapid end. We believe that a high-priority, compre-

hensive approach, involving all communities and governments, will help to achieve this purpose, because

- it will place the issue of Aboriginal suicide and related self-destructive behaviour firmly on the public agenda of Canada;
- it will ensure the continuing commitment and accountability of Aboriginal and non-Aboriginal governments and communities to agreed goals for change; and
- it will give all Aboriginal communities, regardless of ascribed 'status', the chance to participate and benefit.

Recommendations

The Commission has identified a three-part community-based approach as the best strategy for reducing suicide. Its components are

- local prevention and crisis intervention services;
- community development to address the most pressing local causes of suicidal hopelessness and helplessness; and
- the opportunity to achieve autonomy and self-determination as Aboriginal peoples.

In the recommendations that follow, it is our purpose to mobilize the resources and action necessary to enable all Aboriginal communities to develop all three components. **Accordingly, the Royal Commission on Aboriginal Peoples recommends**

1. That all Aboriginal communities, national and regional Aboriginal organizations and governments, and the governments of Canada, the provinces and territories, join together in a **shared commitment** to stop suicide and self-injury among Aboriginal people.

2. That communities, organizations and governments give substance to their commitment by launching a high priority, **Canada-wide campaign** to prevent Aboriginal suicide and self-injury, controlled and implemented at the local level.

3. That communities, organizations and governments establish a **10-year timetable** for the campaign, with progress toward primary goals to be evaluated in the fourth, seventh and tenth years.

4. That the primary goals of the campaign be

   4.1 To ensure that all Aboriginal communities have in place a suicide **crisis response capacity**; that is, the capacity to respond effectively to current and potential occurrences and outbreaks of suicide and self-injury.

   4.2 To ensure that all Aboriginal communities have the capacity to initiate a **community development plan** to address the underlying causes of suicide and self-injury.

4.3 To support Aboriginal peoples and communities in their efforts to secure the future of their nations through **progress toward self-sufficiency and self-government**.

5. That all governments that share responsibility for promoting the health and well-being of Aboriginal people collaborate with local Aboriginal communities in meeting their requirements for a **crisis response** capacity by

   5.1 Enabling each community to conduct an **immediate audit** of its capacity to respond to current or potential outbreaks of suicide and self-injury, including the identification of strengths and weaknesses, needs and current capacities.

   5.2 Ensuring that by 1997 every Aboriginal community has at least **one resource person** trained in suicide prevention, intervention and postvention (grief support) techniques.

   5.3 Facilitating the creation of local and regional resource teams and support networks to **provide back-up** for any community that experiences an outbreak of suicide and self-injury and mandating regional teams to develop emergency plans for immediate mobilization in case of crisis.

6. That all governments that share responsibility for promoting the health and well-being of Aboriginal people collaborate with them to **identify and correct the underlying causes** of self-destructive behaviour through community development by

   6.1 Enabling each community to identify its **priority strategies** for preventing suicide and self-injury in the medium and longer term.

   6.2 Ensuring that by 1998 every Aboriginal community has at least **one resource person** trained in community development planning and methods.

   6.3 Facilitating the development of an overall **community plan for health and healing**, with suicide prevention as one of its major objectives.

7. That plans and programs to prevent Aboriginal suicide through crisis management and community development be guided by the following **criteria:**

   7.1 Initiatives must be **community-driven**, community-designed and accountable to local communities, regardless of the extent to which outside expertise is involved.

   7.2 Initiatives must be **holistic** in design, addressing the physical, social, emotional and spiritual needs of Aboriginal people in the context of their family and community relationships, in ways that build self-confidence and self-respect.

7.3 Initiatives must be situated in a **broad, problem-solving approach** that addresses the underlying causes and changes the conditions contributing to suicide and self-destructive behaviour.

7.4 Initiatives must balance direct crisis management with efforts to **strengthen families** and **enhance the capacities of communities** to protect and support their members.

7.5 Initiatives must set a priority on ensuring that **children** have a safe, nurturing environment in which to develop and that **youth** have an opportunity to make a meaningful contribution to identifying and solving their own problems.

7.6 Initiatives must give priority to the **education and training** of Aboriginal caregivers in the most effective methods of preventing suicide and self-injury and to building **support networks** to assist them in meeting their responsibilities.

7.7 Initiatives must encourage **whole-community involvement** in suicide and self-injury prevention through public education and participatory approaches to community problem solving.

8. That **local Aboriginal communities**, whether First Nations, Inuit or Métis, take responsibility for

8.1 **Designing an overall plan** for the development of strategies to prevent suicide and self-injury, including both a crisis response capacity and longer-term community revitalization.

8.2 **Delivering programs** pursuant to the plan, participating in **evaluation** of results, and **sharing information** with other communities and organizations.

8.3 **Mobilizing voluntary and public resources** for the purpose of enhancing the quality of life and reducing the risk experienced by any and all members of the community.

9. That **Aboriginal leaders** at all levels set a clear priority on stopping suicide and self-destructive behaviour in Aboriginal communities by

9.1 Publicly **endorsing** the Canada-wide campaign.

9.2 **Working to change factors in the community** that may contribute to suicidal feelings and behaviour, including abuses of power and evasion of responsibility by Aboriginal people, whether they are taking place in the family or in public office.

9.3 **Actively supporting community, family and individual initiatives** designed to prevent suicide and ensuring that resources allocated to support preventive action are channelled to local communities.

9.4 **Actively supporting regional initiatives** to prevent suicide and enhance community well-being.

9.5 **Seeking partnerships** with agencies and organizations able to assist in meeting suicide prevention objectives.

9.6 **Pressing governments** to maintain a focus on the goal of stopping suicide among Aboriginal people.

10. That **federal, provincial, territorial, municipal and Aboriginal governments** take responsibility for carrying forward the Canada-wide campaign by

10.1 Collaborating with Aboriginal organizations and communities and with one another to explore, evaluate and implement the most effective ways of **deploying existing resources** to meet the goals of the nation-wide campaign.

10.2 Supporting Aboriginal communities to establish priorities and design approaches to suicide prevention **consistent with the criteria** set out in recommendation 7.

10.3 Assessing gaps in service and **allocating additional resources** where necessary to reach the goals of the nation-wide campaign.

10.4 **Ensuring equitable access** to suicide prevention and community development programs by all Aboriginal communities, wherever they may be located.

10.5 Ensuring that **agencies under their authority**, particularly those in education, child welfare, justice and corrections, are aware of issues relating to Aboriginal suicide and self-injury, responsive to expressions of need, and supportive of grassroots initiatives to counter problems of self-destructive behaviour.

11. That the government of Canada support Aboriginal governments and organizations in convening a **National Forum on the Prevention of Suicide among Aboriginal People** in the first, fourth, seventh and tenth years of the nation-wide campaign. The forum should bring together representatives of federal, provincial, territorial and municipal governments, Aboriginal governments and organizations, health care providers, elders and youth. Within the National Forum, there should be strong regional components. The Forum should encourage the sharing of experience and co-ordination of prevention efforts within and among regions.

12. That the **responsibilities of the National Forum** be to promote the goals of the nation-wide campaign by

12.1 **Communicating** the nature and seriousness of suicide among Aboriginal people and the nature and goals of the nation-wide campaign, so as to enlist broad public support and the active co-operation of individuals,

organizations (professional, educational, private), the media and all government agencies.

12.2 Facilitating the **exchange of information** on suicide prevention programs and program effectiveness at the community level.

12.3 Promoting **equitable access** by all Aboriginal communities, wherever they are located, to programs and resources for the prevention of suicide and self-injury.

12.4 Performing as a **watch-dog** body, to ensure that governments, organizations and communities are fulfilling their commitment to the nation-wide campaign.

12.5 **Monitoring, evaluating and publicizing** the success of the campaign in meeting its goals.

13. That **funding** for the National Forum and a small secretariat to co-ordinate its functions be cost-shared among the federal, provincial and territorial governments, with a reasonable contribution (in cash or in kind) from Aboriginal governments.

A Special Report on Suicide: A Minority View

Paul L.A.H. Chartrand

The tragedy of suicides among Aboriginal people has been the focus of concerned attention in Canada. Members of the Royal Commission on Aboriginal Peoples heard such concerns in the public hearings held by the Commission in Aboriginal communities, and there is no doubt that where the problems exist and the community requests assistance, an appropriate federal policy should be in place to provide assistance.

The particular recommendations in this report were not urged upon us in the public hearings, and the approach favoured in this report represents a direction in policy that seems objectionable for a number of reasons.

The depth and breadth of the factors that contribute to the incidence of suicide, which is admitted to be a symptom of underlying problems, suggest recommendations might better have been made in a later or final report setting out a more comprehensive policy agenda. Historically, federal policy has concerned itself primarily with those Aboriginal people defined as 'Indians' by federal law, and generally resident on reserves, and with Inuit people. Further, policy has been developed in a relatively ad hoc fashion in a number of policy areas. The wide-ranging mandate of this Commission has given it the valuable and historic opportunity to take into consideration the variety of specific policies currently operating in the social policy field and to harmonize them with other policies and initiatives in education, in the economic sphere, and in other related areas. Proper recommendations to effect the important shifts in policy direction required to expand the administration of Aboriginal policy beyond the people and places to which it has traditionally been extended, and to rationalize the making of policy across the var-

ious spheres in the Commission's mandate, require decisions on difficult matters. More consideration must be given to such matters than has been possible in this report, which collapses into its discussion a number of significant issues in the Commission's mandate, including that of 'self-determination'.

The details of some of the specific recommendations lack the required certainty. For example, it is not clear what might constitute an 'Aboriginal community'; nor is it clear whether workers are now available for the positions proposed to be established in communities.

Some of the arguments in favour of applying the same policy approach to *all* Aboriginal communities are less than compelling. If that case were to be made, more attention should have been given to proximate causes of suicide. The proposal to extend the same policy recommendations to all communities arises from the report's creation of a symbolic characterization of the relationship between all Aboriginal people and Canadians generally. Thus the report states, "suicide is one of a group of symptoms, ranging from truancy and law breaking to alcohol and drug abuse and family violence, that are in large part *interchangeable* as expressions of the burden of loss, grief and anger experienced by Aboriginal people in Canadian society" (emphasis in the original). This technique does not pay sufficient attention to the different characteristics of various Aboriginal communities; it seems designed to avoid the consequences of having to rely on a partial statistical base that does not include all Aboriginal communities.

Strategically, the timing of the publication of this report and important parts of its recommendations, which will require major investments during a ten-year campaign, place emphasis on symptoms rather than underlying causes. The emphasis arises from the symbolic characterization of suicide and other social problems, which are assumed to exist everywhere. A preferable policy approach might emphasize the actual and potential strengths that are certainly present in all Aboriginal communities, in the cultures, knowledge and undiminished human decency of the people. It is the strengths of Aboriginal people that have permitted them to survive the effects of past government policies, and it is upon these strengths, nurtured by a positive image of Aboriginal people, that future policy should be built. The details of such a policy direction remain to be developed, but it is more likely than not that virtually all Aboriginal communities would welcome and benefit from better education, enhancement of economic opportunities, and other initiatives that strengthen individuals and communities. A preferable policy approach would also change the past tendency to decide policy priorities for Aboriginal people, rather than providing them with the means to make decisions for themselves regarding the allocation of resources.

Furthermore, there is a real possibility that some of the recommendations, and the publicity that must be expected to accompany the national campaign that is recommended, might harm vulnerable individuals. The Commission has been advised that publicity can contribute to conditions that promote suicide. The report itself

cautions that talking about suicide, a central component of the recommendations, "has to be approached carefully" because of the danger that certain persons may react to the discussion by attempting suicide.

I must respectfully decline to endorse the approach to policy making this report represents, but I do emphasize that appropriate measures ought to be adopted to deal with the concerns of those communities in which suicides are identified as a problem and that request assistance.

Appendix 1

Crisis Services: Direct Suicide Prevention

Crisis services focus on (1) the direct prevention of suicide and self-harm through the identification of individuals at immediate risk and intervention to prevent them from inflicting injury or death on themselves, and (2) support for communities and families under stress from suicide in their midst. It is the view of the Royal Commission that all Aboriginal communities should have a basic capacity to do both, with a plan for access to specialized facilities and back-up resources in case of an emergency that exceeds their capacity to respond.

The assumption underlying direct suicide prevention services is that *most suicides can be prevented* – if the risk is recognized in time and if people in the emotional ambit of those at risk are willing and able to intervene. Research has shown that help for someone who is suicidal can come from a variety of sources. Whoever can gain and hold his/her attention has a chance to initiate an intervention and perhaps the responsibility to try.

This commitment to whole-community responsibility for suicide prevention necessitates two kinds of education and training:

- professional skills development for health caregivers and gatekeepers – social workers, teachers, probation officers, drug and alcohol counsellors, and so on; and
- public education for as many people in the community as possible.

Crisis services aimed at preventing suicide and self-harm involve three component skills:

1. **Risk assessment:** identification of individuals, families and groups in a community who are vulnerable to suicide and assessment of their immediate risk.

2. **Intervention:** crisis action to stop an impending suicide or to address the immediate medical needs of those who have just attempted suicide.

3. **Postvention:** aftercare for those who have attempted suicide, grief support for intimate survivors, and community support for the wide circle who may be profoundly affected by a suicide or suicide attempt.[133]

Risk Assessment

Recognition of those at risk is the key to effective suicide prevention. What is involved is a combination of skills and knowledge that can and should be shared widely in the community.

Contrary to popular belief, those who are thinking seriously about suicide almost always signal their intentions. Most people tend to ignore or discount the signals. But if clues and warning signs go unnoticed, the chances to prevent death or injury are very much reduced. An understanding of the common signs and signals of suicide, and a willingness to take them seriously, can save lives.

No list of signs and signals can predict all suicides. The best list is likely to be the one drawn up by those who are working on a community prevention plan, reflecting local cultures, conditions and experience. A starting point is the following:

1. Early warning signs of possible suicide or self-injury:
   - withdrawal, isolation, loneliness, depression;
   - extreme lack of self-esteem, negativity about self;
   - continuing problems in primary relationships;
   - physical disorders associated with stress (tension headaches, stomach aches, ulcers);
   - eating disorders;
   - behaviour change that is negative, e.g., personal neglect, problems at school, problems with the law;
   - unusual interest in death, dying, the occult;
   - family history of suicide, addiction, violence;
   - unresolved grief;
   - a previous attempt at self-harm.
2. Immediate signs and signals indicating high risk:
   - absence of emotion ('flat aspect');
   - talk about death and dying, especially if persistent;
   - remarks like "I'd be better off dead" or "They'd never care if I died";
   - extreme or unusual risk-taking behaviour;
   - a major crisis in personal life, especially the suicide or sudden death of a loved one or the end of an intimate relationship;
   - activities suggesting a settling of affairs, e.g., writing a will, paying debts, giving away possessions, forgiving others for real or imagined hurts;
   - access to lethal means (guns, pills, etc.), or talk of acquiring lethal means;
   - having a definite, feasible suicide plan;
   - sudden calm, sense of peace, suggesting that a decision may have been made.

As a general rule, no one factor is an accurate predictor, but the presence of four or five factors should be treated as significant.

There is considerable risk of completed suicide among those who have already made an attempt. A significant percentage – perhaps 50 per cent – will repeat their

attempt. About 15 per cent will ultimately succeed. According to research, the single most reliable predictor of completed suicide is a history of one or more previous attempts. Even so, taken on its own, it is not a terribly helpful predictor, as about 80 per cent of completed suicides occur on the first attempt.[134]

Especially among adolescents, suicidal thoughts and talk are fairly common and do not always signal an impending attempt. But they certainly indicate unhappiness, and there is no way of knowing how deep that unhappiness goes without follow-up. Follow-up can be done formally, using psychological tests and counselling skills, or informally through calm, straightforward and sympathetic conversation about feelings, intentions and plans.

According to clinicians, talking about personal problems, including the desire to die, is much more likely to deflect suicide than to provoke it. However, there are skills involved in listening without judgement or panic, while at the same time conveying concern and care. Suicide education and awareness programs that incorporate the norms and values of Aboriginal cultures, including those about how to give support in times of severe personal crisis, very much need to be developed. Potential support persons do need at least some training, for not all the most helpful techniques come naturally.

In the case of a low-risk individuals – those who show some early warning signs of personal distress or the possibility that suicidal thoughts have crossed their mind – the people closest to them might consider these strategies:

- offering help to address lifestyle issues and personal problems;
- offering reassurance that the individual is loved and valued and deserves to live;
- support to give up the pressures of overly high expectations and perfectionism;
- watchfulness, both for the intensification of negative feelings and for sudden triggering events;
- organizing an informal support network or initiating thoughtful discussion with significant others;
- restricting access to lethal means.

If warning signs escalate, trained help is necessary.

Intervention

Intervention includes both the management of crisis, i.e., a set of strategies to interrupt a suicide attempt that is imminent or in progress, and longer-term support to reduce the risk that someone with suicidal thoughts will proceed to the next (active) step. The central strategies of crisis intervention are

- establishing the extent of immediate threat to life: is there a definite suicide plan? has any part of the plan been enacted? are lethal means near at hand?

- persistent, caring engagement with the suicidal person;
- direct, non-judgemental talk about what is going on and why;
- constant attendance until the crisis is past;
- assisting the person to acknowledge and connect with the part of him/her that wants to live;
- identifying sources of immediate and long-term help;
- ensuring aftercare.

In crisis intervention, the first objective is to ensure the suicidal person's physical safety during the period of most intense danger. The second is to assist him/her take action on the issues prompting the immediate crisis. The starting point is to establish a trusting relationship that can help anchor the suicidal person to life. Ideally, she or he should then be assisted to address underlying issues. It is the goal of intervention to restore the suicidal person to management of his or her own life as quickly as possible.

Support, counselling and problem solving can be part of ordinary, caring relationships between people, but those who are suicidal often need professional assistance. Continuing intervention may involve one or more caregivers, professional and non-professional, with varying skills and perspectives to contribute.

In Aboriginal communities, the design of long-term intervention services should be sensitive to several issues:

- The need to develop approaches to intervention and counselling that are sensitive to Aboriginal cultures, norms, values and traditional healing practices.
- The need to address the strengths and weaknesses not just of the troubled individual, but of his/her family, clan and community as well.
- The need for special Aboriginal services in urban settings, co-sponsored and designed by community mental health agencies and regional Aboriginal health authorities. Program goals for these services should include cultural awareness training for non-Aboriginal staff, direct involvement of Aboriginal advisers or caregivers on staff and the facilitation of links between urban Aboriginal people and their home communities, as well as traditional healers or elders and other positive Aboriginal role models.
- The need to develop links to local and regional hospitals, especially for isolated communities.

Postvention

Postvention is a set of strategies to support individuals, families and communities after a completed suicide or suicide attempt has taken place. It addresses the needs of those who have been wounded or destabilized by the suicide or attempted suicide of an intimate. It must also address the continuing needs of those who have attempted suicide (aftercare).

Studies and community presentations to Commission agree that in the period immediately following a suicide attempt, family and friends are at high risk of experiencing trauma and depression, which may lead to further acts of violent or suicidal behaviour. Among Aboriginal adolescents in particular, there is a risk of serial suicide attempts by friends and peers. The risk is greatest in the first three months after the event and remains significant for at least six months. In some cases, the period of grieving and heightened vulnerability may go on much longer, especially where buried pain is brought to the surface.

There is good evidence that media coverage of suicide, unless handled with care, can increase the likelihood of clusters or contagion.[135] The more intense the coverage, the greater the risk of contagion. The national media have a responsibility to understand their role in this dynamic and develop guidelines for responsible journalism in the wake of a suicide. Small, local media have an equal responsibility to co-operate with Aboriginal communities in the development of codes of reportage that are sensitive to the possibility of suicide clusters and to the role that the media can play in igniting or defusing them. It is of prime importance for media coverage to avoid dramatizing or romanticizing suicide, thus inadvertently enhancing its attractiveness to teens.

Phillips and his colleagues suggest the following guidelines on media handling of suicide reporting:

- Headlines should not mention suicide explicitly.
- Alternatives to suicide should be presented in the article.
- The negative outcomes should be emphasized rather than, for example, portraying suicidal youth as heroic representatives of a betrayed culture.
- Suicide stories should be short and not repeated frequently.
- The media should not create 'epidemics' by juxtaposing suicides from different parts of the country.
- People conveying anti-suicidal messages should be recognizably similar to members of the targeted audience.
- Stories should make it clear that suicide is rare and should elaborate on alternative ways of coping with loss, pain, rejection, depression, stress and family or social problems.[136]

This having been said, public discussion of suicide and the reasons for it can be positive if it contributes to public awareness of underlying causes and immediate prevention strategies.

Commissioners heard from Aboriginal people that there is a need in their communities to recreate or develop new collective responses to relieve the contained pain of violent death. In traditional Aboriginal cultures, death was not simply 'talked through' but acted through in ceremony. Healing ceremonies gave people an opportunity to transform death into a time for family and community renewal.

The erosion of traditional ceremonial life has created a vacuum in which individuals and families are isolated and may be unable to acknowledge their grief or obtain public recognition of their loss. It is a special responsibility of postvention programs to encourage the revitalization or creation of appropriate rituals. This may involve the restoration of traditional practices such as condolence ceremonies or spirit dances, or the development of community grieving circles and memorial gatherings, as we described in the case study of Big Cove.

The United States Centers for Disease Control have developed guidelines for postvention, summarized as follows:

- A community should have a postvention plan in place before suicide occurs.
- The plan should involve the resources of all sectors, voluntary and professional.
- The plan should identify a lead agency to co-ordinate responses in case of suicide clusters or 'epidemics'.
- The first step is to identify those at risk, make contact, and assess their situation.
- Designated authorities should provide accurate and timely information: avoid glorification of the victims or sensationalization of events.
- Media co-operation should be secured.
- Those at risk should be supported to express their grief and engage in mourning.
- Elements in the environment that might intensify risk should be identified and changed.[137]

Full postvention services may be outside the capacity of individual Aboriginal communities. Regional response teams, including Aboriginal caregivers, are probably the most practical alternative. Their responsibilities should include the promotion of a community plan to mobilize the full range of local resources (including churches, schools, police and so on) in an emergency situation, and their direction should remain in the hands of local authorities.

Appendix 2

Community Development

Between the immediate impact of crisis services and direct injury prevention on the one hand, and the long-term transformation expected to flow from self-government on the other, lies an intermediate strategy of critical significance to Aboriginal people in any concerted drive to change the conditions leading to suicide: community development.

Community development means different things to different people. It refers to both a general objective and a process. The objective is to build a vibrant, confident and caring community using the collective resources of all the people living there to achieve the most productive and satisfying lives for everyone. This entails a vision for the future, identification of major problems or barriers, and construction of staged goals.

The process of working out these ideas is the key. Some would argue that it is more important than the end itself. It involves a searching exercise of community self-analysis to identify and assign priority to primary problems and construct plans for change.

One definition is as follows:

> Community development is a process of social action in which the people of a community organize themselves for planning and action; define their common and individual needs and problems, make group and individual plans to meet their needs and solve their problems; execute the plans with a maximum reliance on community resources; and supplement those resources where necessary with services and materials from government and non-governmental agencies outside the community.[138]

The proponents of community development usually share some general ideas about people and the world:

- that progress is possible;
- that 'top-down' programming seldom works;
- that ordinary people have the capacity to make change on their own behalf;
- that the changes people make for themselves have more meaning and validity than those imposed or imported;
- that collective action is more effective than individual action, and that participation in the public life of a community by all its citizens is a valuable thing;
- that fundamental change in society involves the rebalancing of power relations.

Perhaps most important, they believe that the *experience of participating* in community development is as significant as the particular goal and its success or failure. This is so because, by engaging in the process, a community will improve its ability to act purposefully and democratically to meet its needs. In that sense, community development is in fact a technique for 'empowerment' – the more commonly used phrase today.

Empowerment is defined as the ability to assume control and mastery over one's life and environment. Powerlessness, or the lack of control over one's destiny, is seen increasingly as a risk factor for social and physical ill-health. In the case of Aboriginal people, the experience of powerlessness has been widely internalized, so that many are unable to see themselves as able to affect the conditions of their own lives.[139]

Community development is a vital link in the growth and renewal process that many Aboriginal communities are searching for – not least to protect against suicide and self-destructive behaviour, but not only for that purpose. In the wake of so many years of loss, domination and diminished self-confidence, many Aboriginal communities are now experiencing something like a post-trauma recovery period. Some of the basic elements of social health and well-being have been weakened or distorted. Commissioners have been told that there is a need for healing, for recovering the basis of sharing and caring, for restoring collective ethics and perhaps some of the traditional values that sustained Aboriginal peoples in the past. Community development is a process for beginning to move toward greater social health and community cohesion.

It is also a process for re-establishing local initiative after decades of dependence or powerlessness enforced by government authority. It has room for trial and error. Community development projects move only as fast as the community is ready to move, because their leaders or *animateurs* value the confidence and competence that members develop though participating and taking on responsibility. In fact, the 'bottom-up' approach of community development increases the likelihood that ideas and programs will succeed, because

- ideas for change come from within the community;
- they are community-owned and internally rewarded;
- planning and decision making are participatory;
- people work together co-operatively, not hierarchically;
- a high value is placed on consensus.

The basic steps in community development are these:

1. Someone (or some group) in the community identifies a problem, initiates a process of discussion and creates the impetus for action.
2. Community analysis: the identification of needs and action issues; the creation of a vision for change; the beginning of community organizing or mobilization.

3. Planning and implementation: the development of plans; the identification of key participants and community resources; team building; extension of support into the whole community.
4. Action: putting the plan into motion; revising and modifying.
5. Evaluation and follow-up.[140]

Community development projects can take many forms, linked only by the goal of greater community vitality. The number of projects and undertakings that could qualify as part of a suicide prevention strategy is limited only by the imagination of community members – from starting a support group for teenaged parents, to negotiating a collective goal of community sobriety, to recording the memories, teachings and stories of surviving elders. The five-year Community Development Plan drawn up by the community of Big Cove, for example, includes five major components:

- a community mental health initiative
- a child development initiative
- an injuries among children initiative
- a solvent abuse initiative
- a healthy babies initiative.

This plan was constrained by the need to fit the program criteria of the Brighter Futures initiative, to which it has applied for full funding. However, to the extent that community members were involved in a process of discussing and deciding on community needs and priorities, it will have been an exercise with a value extending beyond the task itself.

The Commission believes that the opportunity to act leads to energy and hope. Given the space and support to begin, Aboriginal communities will devise their own strategies for problem solving in relation to suicide and self-harm. What they choose to do will vary, and this is as it should be. What they need is programmatic support to engage in the process.

Appendix 3

Recommendations from the Commission's Special Consultations on Suicide Prevention

First Special Consultation
convened by the Assembly of First Nations and the
Royal Commission on Aboriginal Peoples

Suicide in First Nations Communities

Aylmer, Quebec
14-15 April 1993

Recommendations from the Discussion Groups[141]

1. *To Communities:*
   - Focus on education, which would involve the treatment of survivors, long-term planning to develop solutions, and the reallocation of resources. (First Nations in Eastern Canada should have access to the Nechi [Institute on Alcohol and Drug Education] model of training.)
   - Emphasize the importance of [positive] mental health in the community and encourage all sectors to get involved (recreation, education, volunteers, health, etc.).
   - Use research to help determine how to deal with suicide.
   - Ensure that external services coming into the community are guided by the community.
   - Focus models of healing on individuals through traditional and cultural means.
   - Build post-trauma units and develop post-trauma teams.
   - Work on strengthening the family as a unit.
   - Leaders need to become more involved in the healing process.
   - Solutions must emanate from the First Nations.
   - The justice system should be community-based and focus on traditional practices and knowledge.
   - A support system for wellness within the workplace should be made available and should address the issue of suicide.
2. *To the Royal Commission on Aboriginal Peoples and the Assembly of First Nations:*
   - The Royal Commission on Aboriginal Peoples (RCAP) and the Assembly of First Nations (AFN) should establish a national clearinghouse of information for mental health that would remain under First Nations control.

- AFN should become involved in media training to help communities deal with the media in times of crisis so that distortions of facts can be clarified.
- RCAP should promote public awareness on suicide and other issues, serving as a mediator between the non-Aboriginal public and the First Nations.
- RCAP and AFN should advocate government action, lobbying governments to make changes in its policies, resource allocation and programs, in order to deal with suicide and mental health.
- RCAP should start a dialogue with churches to help them understand the impact they've had and the role they could play in the reconciliation process.
- AFN and RCAP should lobby the government to address the issues surrounding the residential schools, including their consequences.
- AFN should ensure government action on issues that have already been raised. (Many reports have been written and committees formed, but government has done little to act on recommendations.)
- AFN should promote networking and information sharing on the question of suicide.
- AFN should examine the quality of children's education to ensure eventual job readiness. (Need to strike a balance between western and traditional education.)
- AFN should expedite and promote government action on the recommendations of previous commissions and task forces that had First Nations support.
- AFN should examine traditional pre-contact leadership models as part of Aboriginal cultural survival.

3. *About Research:*
   - Identify high-risk groups while engaging in research with First Nations from across Canada.
   - Need effective prevention resources that respect Aboriginal cultural norms while taking into account the uniqueness and diversity of Aboriginal communities throughout Canada.
   - Need accurate information on the gravity of the problem, including suicide rates, suicide attempts and accidents (natural suicide).
4. *To the Federal Government:*
   - Prepare and make cabinet submissions on First Nations mental health.
   - Resolve the federal-provincial jurisdictional problems.
   - Resolve the issue of self-government since it underlies all other issues affecting Aboriginal people.
   - Recognize the responsibility for resource development.
5. *About Training:*
   - Form regional and local teams to deal with post-trauma.

- Need training in prevention, intervention, treatment and postvention.
- Provide community-designed training and orientation for teachers.
- Provide cross-cultural training for resource people.
- Build communication skills so that people are able to share their feelings and needs more openly.
- Training must be accredited and academic.
- Develop parenting and nurturing skills.

Second Special Consultation
convened by Royal Commission on Aboriginal Peoples
Metis National Council
Native Council of Canada
Native Women's Association of Canada
Inuit Tapirisat of Canada
Pauktuutit (Inuit Women's Association)

Ottawa, Ontario
7-8 June 1993

Facilitators' Report[142]

After [the first day's] sessions, the facilitators from the national groups met to compile the lists of recommendations. They grouped the recommendations under four headings, as listed below. The recommendations of the Native Women's Association follow the facilitators' report.

Nelson Mayer of the NCC presented the following recommendations:

1. *Ownership*
    - Culturally specific education that teaches customs, ceremonies, traditions, and language must be funded, according to specific cultural groups, e.g., Métis, Inuit, Cree, and others.
    - Academic education must be prepared by and accountable to the specific cultural group. This could include post-secondary courses, thesis programs in cultural languages, and curriculum development by cultural groups.
    - Education should promote self-awareness and self-esteem about one's cultural identity.
2. *Governance*
    - Participants respectfully request that leaders be sober and healthy role models.
    - Leadership should be made accountable for previous recommendations made at other conferences.

- Women should be encouraged to run for elected [office] and appointed to leadership [positions].
- Government appeal committees and boards should include equal representation from cultural groups (e.g., Métis, Inuit).
- National leaders should be elected by communities, rather than by chiefs, a few Métis leaders, or a delegate system.
- Current policies should be reviewed and new ones developed to identify the number of Métis, Inuit, and other cultural groups in child welfare, mental health, and justice programs. Culturally specific groups must be made aware of their numbers, particulary in the cases of fatalities.
- Protocols should be developed to contact the Métis Nation, Inuit population and other cultural groups when members of the groups are involved in the mainstream system. Decisions must be made in accordance with [the] group's worldviews.
- The Métis Nation must be recognized by the Canadian nation, with honest and open dialogue.
- Programs should benefit all Métis people, not just organization members.
- Strategic planning should facilitate a national agenda for the Métis Nation.
- Leaders should be held accountable for the implementation of recommendations resulting from the National Métis Child Welfare conference and the National Indian Child Welfare Conference.

3. *Communities*
   - Develop a national newsletter.
   - Establish a national [toll-free] number.
   - Develop a national strategy to develop holistic processes for respective cultural groups.
   - Create a national network between cultural groups (e.g., annual conference).
   - Establish opportunities for community training that are community-specific.
   - Develop community diversion programs for youth at risk.
   - Develop culturally specific approaches to justice matters.
   - Develop strong inter-agency groups and committees within communities.
   - Provide support for self-help groups.
   - Provide a place for Métis [and] Inuit [elders] and elders from other cultural groups in schools, community groups, child care centres, etc.
   - Establish seniors' drop-in facilities for Métis, Inuit and other cultural groups.
   - Recognize ourselves as resources and begin looking 'within' instead of 'without' for consultants and expertise.
   - Provide resources for the National Métis Child Welfare Conference and other cultural groups.
   - Establish grieving circles.

4. *Resources*
   - Research funding should be allocated to look at Métis, Inuit, and female populations identified specifically in police reports, by the court system, by child welfare, and in coroners' reports. Participatory and qualitative research should be done by the cultural group being studied. Accountability to this group should be established.
   - Adequate funding should be allocated for community strategies to address critical social and health problems from a holistic perspective.
   - A multi-purpose facility to accommodate battered families, children at risk, and pre- and post-treatment clients should be established.
   - A national labour market analysis should be done to identify workers in the area of health and wellness. Training dollars should be allocated to the following areas: crisis team and post-trauma; family violence; child welfare; substance abuse; corrections; parenting (cultural, spiritual, ceremony); mental health workers; holistic teams that cross boundaries (leadership, organizational development); traditional healers; traditional teachers; metamorphicalization (story telling); grieving using cultural approaches; acceptance of people (gays and lesbians); sexuality; and evaluation.
   - Provide training for organizational development. This will help develop cohesive working relationships.
   - Major churches should hold an annual collection to benefit former residential school students (victims) and their children. These funds should be put into a national foundation to be administered jointly by affected cultural groups and the churches. This will help the healing of those people who choose not to press charges and for cases where the perpetrator has died and cannot be charged.

Native Women's Association Recommendations

Facilitator Ruth Norton presented a summary of the recommendations developed by NWAC.

1. *Primary Elements of Suicide Prevention*
   - There is a process happening across the country with people believing in themselves.
   - We have to develop our own history and teach young people about the shackles of colonialism.
   - Our customs, traditions and language matter.
   - Young people need to learn about Aboriginal philosophy and spirituality. They need to learn it, believe it, and live it.
   - Young people need jobs and to feel a part of society.
   - We have to teach our young people arts and crafts as part of developing their identity. This would preferably be done in a traditional setting. Communities should provide recreational activities for youth.

- We need to develop our own ways of healing by learning the traditional teachings.
- There is a need for sharing and networking.
- We need to be able to talk to each other and network through our families.
- People need to be able to trust. Caring and encouragement are primary ways of preventing suicide.
- There is a need for the training of youth in the social norms of our communities.
- There is a need to encourage youth to have a role in the community. In learning these skills, youth will build self-esteem and gain a sense of responsibility.
- We must tell youth they matter. They are the lost generation.
- We must look at successful urban programs. Healing circles should be part of institutional groundwork.
- We must teach the native worldview. It's the sweats and ceremonies that help us work out the hurts that lead to suicide.
- We must learn patience from the Elders. We must respect their right to speak. Patience is a gift from the Creator and is something we can give back to the community.
- Health and wellness include many elements: traditions; spirituality; emotional, physical, and mental well-being.
- We must train people to take responsibility or help take responsibility.
- People at the local level need assistance from regional and national representatives.
- RCAP needs to understand that we have our own process and each community has its own way of dealing with this issue.
- Governments can provide financial support. They have to respect us enough to take our considerations seriously.

2. *Policy Recommendations*
   - Government should look at healing lodges as a form of suicide prevention.
   - Women need a place to go.
   - We must deal with pre-crisis before it becomes a post-crisis situation.
   - Help must be provided when it is needed.
   - Victims need a support group.
   - We need healing homes and workshops.
   - Crisis lines are needed in every community.
   - Crisis workers need training in Aboriginal languages.
   - We must teach our own philosophies and histories.

Appendix 4

Recommendations from the Community Sharing Circles Big Cove, New Brunswick, 14 March 1993[145]

The community of Big Cove hosted a Mourning and Healing spiritual gathering in the week of March 8 March 15, 1993, after this community lost seven young lives to the tragedy of suicide over a nine-month period. The purpose of the gathering was threefold: to mourn the tragedies of suicides; to educate the community to the complexities of suicide and the services available to help combat the suicide dilemma; and to begin the healing process through unity and talking/sharing circles, and the knowledge gained from those circles. Approximately 200 people participated in the Community Sharing Circles which took place on March 14, 1993. The Community Sharing Circles were composed of fifteen smaller circles which reported to one large circle consisting of all fifteen circles, and the community and guests.

Out of the 184 concerns and recommendations that arose out of the Community Sharing Circles, the most significant was "community responsibility". This was a common theme, the underlying motive that ran through all concerns and recommendations; but the primary focus of community responsibility was on self-reliance, looking into themselves for the answers, working together as a unit, and the setting of positive role models for the youth to follow.

The concerns and recommendations that arose out of the Community Sharing Circles covered up a wide range of categories: community solidarity and support, cultural programs and activities, cultural education and spirituality, native autonomy and sovereignty, drugs and alcohol abuse prevention programs, social programs, education and curriculum programs, religious equality and inter-religious harmony, politics/economics, establishing communication lines and the networking of resources, life-skills training, and racism.

This report provides an analysis and break-down of the concerns and recommendations, and attempts to put them into a perspective that the public can digest. The results of the Community Sharing Circles are provided at the end of this report so they can be viewed at face value. It was the general opinion of the Circles that it was up to the people of this community to help themselves through this crisis and stop looking for others to blame; it is the responsibility of the community to act on the recommendations of the Circles.

1. Community Responsibility

Concerned participants were of the opinion that the community had to work together as one large group; everybody, from young children to grandparents, had

to do their part and share in the resolution of the suicide dilemma at Big Cove. To do this, the community has to unite, to stop quarrelling and fighting, to accept each other as equals, to make no distinctions between lower, middle, or upper classes; and everybody has to become a positive role model for the youth of this community to follow. For example, one child experienced the sweat-lodge for the first time and enjoyed it immensely, but regretted that his parents didn't go to the sweat-lodge; he had to find out about it on his own.

The involvement and input of all walks of life is necessary to bring about change, from the leaders to volunteers, from the youth to the elderly. It was suggested that grandparents should assume responsibility in disciplining children. Parents have to take responsibility for their children's actions, and not look for other reasons to blame. Children complained that adults pay no attention to them, that adults criticize them and don't listen with an open mind. Clearly, the generation gap must be bridged. It was also recommended that the elders of this community be given a bigger role in the community; it was suggested that a Council of Elders be created to act as consultants in community, social, and curriculum development.

All the concerns and recommendations require the full involvement of this community; it was declared that if the community waited for outsiders to come in and help, then they would be waiting for a long time. And even then, how could outsiders know what is best for the community? Only the people of Big Cove know what is best for them; they have to take control of their lives.

2. Community Solidarity and Support

The next issue in level of importance was the unity of this reserve, the whole MicMac nation, and the many Aboriginal nations across this continent. Traditionally, the best support has always been in unity, everybody working together for one common cause – the welfare of the community and nation. To accomplish this, native traditional values and customs have to be supported and promoted.

The youth complain that adults don't listen or pay attention to them; they feel withdrawn and alienated, and pull away from family and friends. The elders feel neglected and unappreciated, that the younger people think of them as boring and simple-minded, and having little to offer to the community. Middle-aged adults blame outside sources as the cause of all their problems. These are all symptoms of community breakdown. Clearly, nobody is working together or helping each other.

Traditional values were seen as a way of bringing everybody together again. For starters, everybody has to accept each other as equals and make no distinctions between classes (lower, middle, or upper). Gossiping, quarrelling, bickering, and inter-family feuding have to be stopped; attitudes towards each other must be changed. The old attitudes have to be replaced with the traditional values of trust, respect, forgiveness, reconciliation, hospitality, sharing, and love.

Many people of this community were delighted to see their MicMac brothers and sisters from other reserves coming together at the gathering to help out and show their support. To many, it was the first time they had seen such a show of support. It was seen as good and more Mourning and Healing gatherings were encouraged. In fact, it was suggested that the unification of the whole MicMac nation could be achieved through more spiritual gatherings and activities, such as Pow-Wows, sharing circles, spiritual workshops, and Grand Council meetings at each reserve, and inviting all other reserves to attend. Where Pow-Wows are already an annual event, these Pow-Wows should be expanded.

The roles and responsibilities of all members of society have to be redefined. Adults have to discipline their children and encourage them to follow the traditional ways. Elders must assume the responsibility of sharing their knowledge and wisdom. Children must listen to and obey the elders. All members of the community have their part to play in finding solutions to its social problems.

Another matter brought up was the formation of support groups for rehabilitation clients, single mothers, students in white schooling systems, cultural and spiritual activities, and the elderly. All participants of the sharing circles were very appreciative of the services of the spiritual leaders and suggested that they be fully supported, as well as the Mi'kmaow Warrior Society for their services.

These support groups must have more determination and commitment, and resource persons must have adequate training in their fields. Inherent to the success of any program or policy is the fact that lines of communication have to be opened within the community; and the networking of their resources with other communities must be performed efficiently. These programs have to reflect a native perspective. The people of Big Cove have to establish and nurture their cultural pride and identity in order to escape from the predicament they have found themselves in and begin to form a new era of unity among the MicMac nations.

3. Cultural Programs and Activities

A lot of the reasons why people, both young and old, turn towards drug and alcohol abuse is because of boredom, the lack of anything else to do. Promoting traditionalism and spirituality was seen as the best way to combat this problem. Firstly, traditionalism strongly discourages the consumption of alcohol or drugs; and secondly, it promotes cultural identity and pride. People would no longer feel worthless and good for nothing else but drinking and getting drunk.

The children of Big Cove must be exposed to their culture and tradition at an early age, even before they reach school. They should be encouraged to attend Pow-Wows and spiritual gatherings; and most importantly, in doing so, they will follow the ways of their parents, and if their parents do not drink and follow native spirituality, then that is what their children will do if they do not see any sign of booze or drugs in their community. Before they reach school they will know of their cultural identity.

Even in school, this policy should continue to be supported. The school curriculum should be redesigned to promote cultural identity and reflect their native perspective. For instance, it was suggested that drumming and singing become part of the school program.

Other forms of recreation should be explored. Besides hockey and baseball, other sports could be looked into; a community swimming pool was one suggested alternative. Input from the community is needed to help determine where their interests lie. What is needed is more involvement from the community, and more dedicated and committed volunteers.

All proposed activities should be designed to unite the community and the MicMac nation. Big Cove should expand its present Pow-Wow and encourage its members to attend other Pow-Wows. Drumming and chanting should become a weekly event. Sharing circles/talking sticks should become a regular event to keep tabs on the wants and needs of the community. Sober dances, and drug and alcohol free sports events should be organized and promoted. Facilities should be provided for all cultural activities. The community was encouraged to use its spiritual leaders as resource persons in organizing cultural events.

On a more serious side, Grand Council meetings on the reserves should be held regularly. The elders' sharing circle should be institutionalized as a form of government and authority. Everybody was encouraged to visit each other and talk about the things that mattered to them, without the involvement of alcohol or drugs such as house parties. People were reminded that they could visit each other without having to drink.

4. Cultural Education and Spirituality

The importance of promoting cultural education in the schooling system was expressed. In order for the people to be able to respect and love one another, they have to get back to their traditional values. Native spirituality was seen as the only way to do this. All native communities have to observe and celebrate spiritual ceremonies and gatherings, and have more of their members become involved in spirituality.

A lot of people who attended the Mourning and Healing gathering complained that they know very little about the purpose and function of gatherings and other aspects of tradition, and would like to know more. People want an education program on all aspects of tradition and spirituality: the sacred pipe ceremony, the medicine bundle, the sacred fire, fasting, the sweetgrass purification ceremony, the sweatlodge ceremony, the sharing circle, Pow-Wows and spiritual gatherings, drumming and singing, sunrise ceremonies, and feasts.

5. Drug and Alcohol Programs

What the majority of participants wanted to see for Big Cove was a zero tolerance of booze and drugs and activities that involved booze and drugs. To prove their

resolve, the participants want a referendum concerning the banning of drugs and alcohol in the community. One motion was constantly surfacing: "get rid of the bootleggers and dope pushers". The abuse of prescription drugs was also addressed; prescription drugs are easily obtainable from some doctors, which is why they can be sold on the streets.

People want to see that their children get an education on the dangers of drug and alcohol abuse. The school curriculum should be developed to educate the students on drug and alcohol abuse prevention. Dances and sporting activities are to be drug and alcohol free. People felt that everybody should be able to visit one another without running into a house party where booze and drugs are involved. Spiritual gatherings and cultural activities were seen as being crucial to the termination of drug and alcohol abuse.

6. Education and Curriculum Programs

The curriculum program of the Big Cove school must be redesigned to reflect the native ancestry of the community. Education should emphasize mutual respect and reinforce traditional values and customs. A Council of Elders is needed to help teachers develop this school curriculum. Drug and alcohol abuse prevention has to be a major element in the curriculum.

Some people called for a reformation of the Association of Native Educators whereby the principles of teaching by native peoples in the education process is re-examined. Another point of concern was that children go to school hungry; there is a need for a lunch program where children are provided with at least one square meal a day, preferably two. Also, a transitional program for native students leaving the reserve to further their education was discussed. People also expressed a need for more funding for training programs.

7. Establishing Communication Lines and the Networking of Resources

Of prime importance to the participants was the collection of information from the community on what their interests are and the wishes they would like to see fulfilled, and how to go about achieving these goals. The most obvious way of doing this is through sharing circles. The advice and guidance of a Council of Elders would be very valuable in the formulation of community social programs and development. Ways must be found to incorporate the wants and needs of the community into the school curriculum. The results of the Community Sharing Circles must be shared with all Band Councils and native organizations.

Another matter of concern was the generation gap that exists between the youth and the elders. There needs to be more dialogue between children and adults. This same type of gap exists between students and teachers; teachers must be invited to become involved in community sharing circles. Additionally, there was concern

that there is too much gossiping and spreading of rumours, that this is responsible for the fighting between families, and the unjust persecution of families with a bad reputation.

People were convinced that the networking of the various reserves and their caregiving agencies and programs would be the best way to help a community facing the same crisis. Also, this type of networking would be valuable if a community experienced an increase in suicide attempts and needed additional help-line and crisis counselling. A networking of federal and provincial governments with the Band Administration was another recommendation.

Community television and radio stations were seen as a way of communicating with the population. Ways can be found to utilize this form of communication in delivering information to the community about the social programs available to them. Cultural information and cultural programming could be delivered in the same manner.

8. Social Programs

A Council of Elders must be consulted before making any commitments in social programming and development. Follow-up studies should be done on drug and alcohol rehabilitation programs to help determine the efficiency of these programs. Treatment and support for rehabilitation clients should be on-going, and not cease after the 28-day program is completed. Many social programs must be designed as a support group for those in need; hungry children need proper nutrition; single mothers need a babysitting pool so they can go back to school or enter the work force; and people in general need counselling and therapy in their personal problems. People see a need to hire more people to work in drug and alcohol abuse prevention and treatment. Unqualified resource persons and helpers can work under the supervision of qualified workers.

9. Inter-Religious Harmony

Up until about twenty years ago, the primary religious persuasion in Big Cove has been the Roman Catholic faith. Native spirituality is making a comeback in its own right, but many now combine it with Christian practices. A fundamental concern of the elders circle, as well as the Community Sharing Circles, was the need for these two religions to co-exist in harmony. A mutual respect of one religion for the other is crucial in order for this community to unify. Native spirituality or Christianity – both are seen as good for the community.

10. Native Autonomy and Sovereignty

Peace and unity were seen as a common cause; it is very important to unite this community, and not break down into small groups, and make distinctions between upper, middle, or lower classes. People want a government of the people, by the

people, and for the people. Natives must take control of their own lives. They propose to institutionalize the concept of the sharing circle and talking stick into the Band Council governing system. The services of spiritual leaders should be given more priority, and they should be fully supported for all the good they do for the community. The Warrior Society was seen as a unique alternative to community policing and a good example of native sovereignty.

11. Life-Skills Training

Life-skills training should be community-oriented; it should be designed to teach people skills they can use in the community; no one should have to move away from the reserve in order to find work if they do not wish to leave. Life-skills must teach self-confidence, self-esteem, and self-respect. There should be a literacy program for drop-outs, perhaps private tutoring. Parenting skills is another field that should be explored.

12. Politics/Economics

The people of Big Cove feel that funding is a problem for training programs, and feel that the federal and provincial governments must honour and respect their financial commitments and responsibilities to native people, not just for their special status, but as a fundamental human right. Also, the people of Big Cove feel that the Department of Indian Affairs has too much control over the lives of native people, that too many bureaucrats have too many powers over native people. The people of Big Cove feel that there are "too many chiefs" in Ottawa, Amherst, and wherever there is a D.I.A. office.

13. Racism

Students from Big Cove feel that they are segregated when they leave the Big Cove schooling system for high schools in Rexton and elsewhere. Many cannot cope with this and thus fail to make a successful transition and wind up dropping out completely. Some complained that racism is alive in all aspects of life, from social to economic to political to religion.

Notes

1 The Royal Commission uses the phrase 'Aboriginal community' to refer to any group or concentration of Aboriginal people living in close proximity to one another and sharing life experiences on the basis of aboriginality. The commonly held picture of the small, isolated First Nations reserve as the typical Aboriginal community is incorrect. About 65 per cent of Aboriginal people are excluded from that snapshot. (Statistics Canada, custom tabulations from the Aboriginal Peoples Survey, 1991, figures adjusted for non-responding bands.) This is an important point to keep in mind when considering public policy to address suicide among Aboriginal people. Existing social services distinguish among Aboriginal communities and individuals based on imposed categories of aboriginality. Commissioners take the view that this distinction has damaging and inequitable effects and that the administrative apparatus built upon it should be reformed.

2 Reliable data on attempted suicide are hard to come by. In a review of issues related to Aboriginal suicide done for the Royal Commission, Laurence Kirmayer and his colleagues cite a rate of 800 suicide attempts per 100,000 people as a guideline for the non-Aboriginal population. To help us estimate the number of suicide attempts in the Aboriginal population, Kirmayer et al. cite an American study in which 17 per cent of American Indian and Alaskan Native high school students reported at least one suicide attempt at some time in their lives. In their own study of young Inuit in a Northern Quebec community, the self-reported lifetime rate of attempted suicide was 34 per cent. Laurence J. Kirmayer et al., "Suicide in Canadian Aboriginal Populations: Emerging Trends in Research and Intervention", draft research study prepared for the Royal Commission on Aboriginal Peoples (April 1993), 13. This study, like others cited in this report, was conducted under the auspices of the Royal Commission's research program and as such will be part of the information base available to scholars, researchers and other interested parties in a variety of forms after the Commission completes its work.

3 In all populations for which there are data, some suicides are linked to the occurrence of mental illnesses and disorders, including clinical depression, schizophrenia, anxiety disorders and other afflictions. We know less about the prevalence of these conditions among Aboriginal people. Even if rates were found to be high, this finding would not offer a *competing* explanation for Aboriginal suicide but rather a *related* one: mental health and illness are themselves affected by "social, cultural, economic and psychological dislocations". Moreover, when particular mental imbalances are considered to contribute to suicide, they are usually thought to be predisposing factors rather than direct causes.

4 Ovide Mercredi, quoted in *The Globe and Mail* (12 May 1994), A2.

5 The Shibogama Tribal Council serves four First Nations communities in northern Ontario: Wawakapewin, Wapekeka, Kingfisher Lake and Wunnumin. Their combined population is between 900 and 1000.

6 Peter Tapatai, speaking at the Suicide Prevention Forum, Baker Lake, N.W.T. (October 1992). Quoted in *Working Together Because We Care* (Government of the Northwest Territories, 1992), 5.

7 World Health Organization, *Prevention of Suicide*, Public Health Papers No. 35 (Geneva: WHO, 1982).

8 Suicide Information and Education Centre, information pamphlet, no date (1615 – 10th Avenue S.W., Calgary, Alberta, T3C 0J7). The original sources include R.J. Dyck, R.C. Bland, S.G. Newman and H. Orn, "Suicide Attempts and Psychiatric Disorders in Edmonton", *Acta Psychiatrica Scandinavia* 77/suppl. 338 (1988), 64-71; and R. Ramsay and C. Bagley, "Prevalence of Suicidal Behaviour, Attitudes and Associated Social Experiences in an Urban Population", *Suicide and Life Threatening Behaviour* 15/3 (Fall 1985). (Telephone communication, Gerry Harrington, Director, SIEC, 18 June 1994.)

9 Rare, but probably not unknown. In general, evidence of social problems – including suicide – has been found in all societies studied formally. (Kirmayer et al., "Suicide in Canadian Aboriginal Populations"; C.J. Pine, "Suicide in American Indian and Alaska Native Tradition", *White Cloud Journal* 2/3 (1981).) In this, academic analysis may be at odds with Aboriginal oral tradition, which emphasizes the relative absence of social problems. There is no dispute, however, about the fact that suicide among Aboriginal people is much more common now than it was in the pre-contact period.

10 The frequency of 'altruistic' suicide – that is, suicide committed for the sake of others – is impossible to establish with confidence. It seems to have been associated with desperate conditions, including times of epidemic brought on by contact with Europeans. (Kirmayer et al., "Suicide in Canadian Aboriginal Populations".)

11 Written communication, Ellen Bobet, Medical Services Branch, Health and Welfare Canada, 5 November 1993.

12 The overall ranking is based on the figures presented in the report of the National Task Force on Suicide in Canada, *Suicide in Canada* (Ottawa: Health and Welfare Canada, 1987), 20. The special case of adolescents was reported in a recent UNICEF publication ranking the achievements of countries in relation to child health and welfare, family planning and the progress of women. Its figures indicate that suicide by teenagers (ages 15-19) in Canada has increased over the past two decades, such that Canada now has the third highest rate (after New Zealand and Finland) of suicide in this age group. Peter Adamson, ed., *The Progress of Nations – 1994* (New York: United Nations Children's Fund, 1994).

13 Louise Hanvey, Denise Avard, Ian Graham, Kristen Underwood, Joan Campbell and Carrie Kelly, *The Health of Canada's Children: A CICH Profile*, Second edition (Ottawa: Canadian Institute of Child Health, 1994), 97.

14 National Task Force on Suicide in Canada, *Suicide in Canada* (Ottawa: Health and Welfare Canada, 1987).

15 Maxim and Keane, 1992. Quoted in Wayne Warry, "Unfinished Dreams: Suicide, Self-Determination and Healing in Aboriginal Communities", draft research study prepared for the Royal Commission on Aboriginal Peoples (1993), 2.

16 Current trends are reported in Kirmayer et al., "Suicide in Canadian Aboriginal Populations", figures 2 and 3. The original data come from the Medical Services Branch, Health and Welfare Canada, 1991. As we have said, reliable national data on rates of attempted suicide are unavailable. However, it is generally agreed by those in the field that girls and women have much higher rates of attempted suicide than boys and men.

17 The 30-year figure is cited in Warry, "Unfinished Dreams", 2. The 40-year figure is based on the oral testimony of elders, reported in Sid Fiddler, *Suicides, Violent and Accidental Deaths among Treaty Indians in Saskatchewan* (Federation of Saskatchewan Indian Nations, 1986), 70.

18 Kirmayer et al., "Suicide in Canadian Aboriginal Populations"

19 These figures are cited in Warry, "Unfinished Dreams", 3. The most recent national figures published by Health and Welfare Canada describe the 1990 age-standardized suicide rate for registered Indians as being twice the rate of the general population (Health and Welfare Canada, 1992). The Royal Commission on Health Care and Costs (British Columbia, 1991) found the suicide rate among Aboriginal people in that province to be 3 times higher than the rate among non-Aboriginal people. Figures reported by the government of the Northwest Territories place the overall rate of suicide there at about 2.5 times that of Canada generally; however, averaging of figures from across the Territory conceals the fact that the rate is dramatically higher in the eastern arctic, where Inuit greatly outnumber all other ethnic groups, than in the western arctic. (Northwest Territories Department of Social Services, Suicide Prevention Program, "Northwest Territories Completed Suicide Statistics, January 1983 to December 1992" (Yellowknife: 1992).)

20 It should be noted that suicide is normally measured as a rate per hundred thousand people. When the population base is small, as it is locally and regionally for Aboriginal people in Canada, a cluster of suicides in a particular community will cause a sharp peak in the figures for that year that is not representative of real trends. It is therefore preferable, wherever possible, to average suicide figures for Aboriginal people over several years.

21 In the Sioux Lookout region of Ontario, for example, 800 serious suicide attempts were recorded in the past six years, and the suicide rate across all ages is reported to be seven times the national average. (Donna Roundhead, testimony before the Royal Commission on Aboriginal Peoples, Sioux Lookout, Ontario, 1 December 1992.) Statisticians caution, however, that regional differences may be, in part, a reflection of reporting differences.

22 P.M. Mortensen and B. Tanney, *Suicide Among Canadian Natives* (Calgary: Suicide Information and Education Centre, 1988); M. Cooper et al., *Aboriginal Suicide in British Columbia* (Burnaby, B.C.: Institute on Family Violence, 1991). Both studies suggest that high rates are found more commonly among Aboriginal people living on-reserve than off.

23 Bella H. Petawabano, Eric Gourdeau, Francine Jourdain, Aani Palliser-Tulugak and Jacquelin Cossette, *Mental Health and Aboriginal People of Quebec* (Boucherville, Quebec: Gaëtan Morin Éditeur, 1994), 25.

24 *Health Status of Canadian Indians and Inuit, 1990* (Ottawa: Health and Welfare Canada, Medical Services Branch, 1991), 45.

25 M. A. Cooper, R. Corrado, A.M. Karlsberg and L.P. Adams, "Aboriginal Suicide in British Columbia: An Overview", *Canada's Mental Health* 40/3 (September 1992).

26 Written communication, Ellen Bobet, Medical Services Branch, Health and Welfare Canada, 5 November 1993.

27 A recent report drawing on in-house statistics from the Medical Services Branch, Health and Welfare Canada, indicates that gains have been made in reducing the frequency of suicide in the 'registered Indian' population as a whole during the last decade. (Pran Manga and Associates, *Health Care Financing and Health Status of Registered Indians* (Ottawa: First Nations Health Commission, 1993).) The authors point out, however, that the rate among Indian youth has continued to be higher than that among non-Aboriginal youth even during this period. Moreover, a cluster of suicides occurring in any given year will result in a jump in the rate, reversing an apparent downward trend.

28 Health and Welfare Canada, *Aboriginal Health in Canada* (Ottawa: 1992), 32.

29 National Task Force on Suicide, *Suicide in Canada* (Ottawa: Health and Welfare Canada, 1987), 3.

30 Kirmayer et al., "Suicide in Canadian Aboriginal Populations".

31 Some interveners have pointed to a very different pattern, in which some of the brightest young people in Aboriginal communities, heaped with the hopes and expectations of their village or neighbourhood, and often given leadership responsibilities beyond their years, may be driven to suicide.

32 Culture stress in relation to Aboriginal people in North America has been studied by, among others, J. W. Berry, "Acculturative Stress in Northern Canada: Ecological, cultural and psychological factors", in *Circumpolar Health 74*, ed. R. Shepard and S. Itoh (Toronto: University of Toronto Press, 1976); J.W. Berry, "Psychological and Social Health of Aboriginal Peoples in Canada", paper presented at the Workshop on Children's Mental Health and Wellness in First Nations Communities, Victoria, B.C., March 1993; Group for the Advancement of Psychiatry, *Suicide and Ethnicity in the United States* (New York: Brunner-Mazel, 1989); R. Bachman, *Death and Violence on the Reservation* (New York: Auburn House, 1992); Mortensen and Tanney, *Suicide Among Canadian Natives*.

33 Interpretation of this finding is not straightforward. The diagnosis of mental illnesses and disorders involves difficult and possibly subjective judgements, and suicidal behaviour may be used as evidence of their occurrence. It is difficult, therefore, to be sure that they are assessed and correlated independently. Furthermore, evidence of mental illness is not a sufficient cause for suicide, as many people with such conditions do not try to kill themselves. These conditions interact with social problems, increasing the vulnerability of the individual to stressful life events and conditions.

34 H.M. Sampath, "Prevalence of psychiatric disorders in a Southern Baffin Island Eskimo settlement", *Canadian Psychiatric Association Journal* 19 (1974), 363-367; L.T. Young et al., "Psychiatric Consultation in the Eastern Arctic: Referral patterns, diagnoses and treatment", *Canadian Journal of Psychiatry* 38 (1993); Medical Services Branch Steering Committee on Native Mental Health, *Statistical Profile on Native Mental Health*, Background Report of the Statistical and Technical Working Group #1 (Ottawa: Health and Welfare Canada, 1991); Personal communication, Clare Brant, M.D., F.R.C.P., 30 September 1994.

35 Kirmayer et al., "Suicide in Canadian Aboriginal Populations"

36 W.J. Mussell, W.M. Nicholls and M.T. Adler, *Making Meaning of Mental Health* (Chilliwack, B.C.: Sal'i'shan Institute, 1991), 17, 22.

37 Kirmayer et al., "Suicide in Canadian Aboriginal Populations", 27.

38 An extended discussion of the history of alcohol use by Saskatchewan Indians and its complex relationship to other forms of self-destructive behaviour can be found in Sid Fiddler, *Suicides, Violent and Accidental Deaths Among Treaty Indians in Saskatchewan* (Federation of Saskatchewan Indian Nations, 1986), 53-58.

39 Kirmayer et al., "Suicide in Canadian Aboriginal Populations", 30.

40 Cooper et al., *Aboriginal Suicide in British Columbia*, 104.

41 Mortensen and Tanney, *Suicide Among Canadian Natives.*

42 Kirmayer et al., "Suicide in Canadian Aboriginal Populations", 30.

43 Kirmayer et al., "Suicide in Canadian Aboriginal Populations", 30.

44 Kirmayer et al., "Suicide in Canadian Aboriginal Populations", 38ff; Sharon Kirsh, *Unemployment: its impact on body and soul* (Canadian Mental Health Association, 1992), 50-51.

45 In Newfoundland, for example, suicide rates are comparatively low despite economic disadvantage.

46 Kirsh, *Unemployment.* The Comité de la Santé Mentale du Québec takes a similar position. See Petawabano et al., *Mental Health and Aboriginal People of Quebec, 63-64.*

47 T. R. Thompson, "Childhood and adolescent suicide in Manitoba: A demographic study", *Canadian Journal of Psychiatry* 32/4 (1987), quoted in Kirmayer et al., "Suicide in Canadian Aboriginal Populations", 39.

48 For a more technical description, see Fiddler, *Suicides, Violent and Accidental Deaths*, especially pp. 47-53.

49 Oral testimony given at the Pilot Learning Circle, Cultural Identity research project, Royal Commission on Aboriginal Peoples, Ottawa, 9-10 February 1993.

50 In one study of Aboriginal adolescents who had attempted suicide, it was discovered that much of their unhappiness centred around their parents' inappropriate behaviour. The children cited parents' drinking, violence, infidelity, lack of positive communication and inability to express feelings as their major life problems more often than school, peer relations, concern about job

prospects, etc. (Harvey Armstrong, "Anomie", in *Suicide in The North American Indian: Causes and Prevention*, ed. C.C. Brant and J.A. Brant, Transcribed and Edited Proceedings of the 1985 Meeting of the Canadian Psychiatric Association Section on Native Mental Health (Shannonville, Ontario: 1985), 37-46.

51 R.A. Hibbard et al., "Behavioural Risk, Emotional Risk and Child Abuse among Adolescents in a Non-clinical Setting", *Pediatrics* 86/6 (1990).

52 Evelyn Zellerer, "Background Paper on Family Violence and Aboriginal People", draft research study prepared for the Royal Commission on Aboriginal Peoples (August 1993).

53 Joyce Timpson, "Aboriginal Families and Child Welfare", draft research study prepared for the Royal Commission on Aboriginal Peoples (October 1993).

54 Daniel Keating and Fraser Mustard, "Social Economic Factors and Human Development", in *Family Security in Insecure Times*, Proceedings of the National Forum on Family Security (Ottawa: Canadian Council on Social Development, 1993); Clyde Hertzman, "The Lifelong Impact of Childhood Experiences: a Population Health Perspective", paper presented at the Honda Foundation Conference on the Determinants of Health, Toronto, 16-18 October 1993; International Conference on Promoting the Mental Health of Children and Youth, *A Special Issue of the Canadian Journal of Public Health* 79/supplement (November/December 1988).

55 The story of Missy is drawn from one of the case histories of Aboriginal street youth, documented and analyzed for the Royal Commission on Aboriginal Peoples by Lauri Gilchrist of the School of Social Work, University of Victoria. (Lauri Gilchrist and R. Anthony Winchester, "Urban Survivors: Aboriginal Street Youth, Vancouver, Winnipeg and Montreal", draft research study prepared for the Royal Commission on Aboriginal Peoples (March 1994).) It recounts events that may have been seen differently by others involved.

56 The words recited by Sylvie Basile were written by Rita Mestokosho, a young Montagnais woman from Mingan.

57 Kirmayer et al., "Suicide in Canadian Aboriginal Populations"

58 The story of Rainbow Lodge was told primarily by Bea Shawanda, its director during the early years. The story of the counselling program was told primarily by Daniel Manitowabi, its current manager and one of the original staff.

59 Brant and Brant, ed., *Suicide in the North American Indian: Causes and Prevention*, 65.

60 Brant and Brant, *Suicide in the North American Indian*, 65.

61 Brant and Brant, *Suicide in the North American Indian*, 67.

62 Brant and Brant, *Suicide in the North American Indian*, 67.

63 Telephone communication, Alphonse Shawana, director, Ngwaagan Gamig Recovery Centre (Rainbow Lodge), 21 October 1994. The Centre now offers programs covering prevention, treatment, aftercare and employee assistance for Aboriginal people of all ages and backgrounds who are having problems with alcohol or drugs.

64 The Network North Community Mental Health Group, an evolution from and now including the Sudbury Algoma Sanatorium/Hospital, has three program divisions: the in-patient psychiatric service; the community services division, consisting of eight community clinics and addiction services programs; and the education and mental health promotion division. It provides services throughout the Sudbury-Manitoulin area.

65 Telephone communication, Alphonse Shawana, director, Ngwaagan Gamig Recovery Centre (Rainbow Lodge), 21 October 1994.

66 Jolanta Legiec, *The Wikwemikong Youth Survey*, Executive Summary (Sudbury: Network North: 1990), 4-5.

67 ARA Consulting Group, *Nadmadwin Mental Health Clinic Operational Review* (Ottawa: Fall 1992).

68 Telephone communication, Daniel Manitowabi, manager, Nadmadwin Clinic, 29 June 1994.

69 This account is based on oral presentations by Big Cove community caregivers who attended the Royal Commission's Special Consultation on Suicide Prevention, Aylmer, Quebec, 14-15 April 1993, on mimeographed documents distributed by them at that time, and on Stephen J. Augustine et al., "Social Profile of Big Cove: Case Study Analysis", draft research study prepared for the Royal Commission on Aboriginal Peoples (October 1993).

70 Big Cove is located 12 miles west of the town of Richibucto, on the banks of the Richibucto River.

71 Lack of adequate housing was cited by the inquest jury as one of the major factors in the suicides. There is a serious and continuing shortage of shelter at Big Cove, such that at worst, six families have been known to share a single small house. One in four units is considered overcrowded, and almost as many are either condemned or judged to need major repairs. (Augustine et al., "Social Profile of Big Cove", 12-15.) In June 1993, the Department of Indian and Northern Affairs allocated nine new houses in addition to the ten that had already been funded for 1993. This was still about 70 short of the number that the community has said are urgently needed.

72 In the last 20 years, 60 per cent of all deaths in Big Cove are judged to have been caused directly or indirectly by the effects of alcohol use. As well, drug and alcohol abuse is generally believed by community caregivers to contribute to child abuse, family violence, marital break-up, school drop-out rates, vandalism, suicide and other forms of premature death. (Augustine et al., "Social Profile of Big Cove", 40.)

73 Augustine et al., "Social Profile of Big Cove", 16.

74 Services in the community of Big Cove at that time included those of the Roman Catholic Church, the Big Cove Child and Family Services Agency, the Big Cove Community Police, the RCMP, the Non-Drinkers Recreation Club, the Lone Eagle Rehabilitation Centre, the Big Cove Suicide Prevention/Intervention Program, and various counsellors and psychologists to which band members had access.

75 Nelson J. Augustine, "Mourning and Healing: A Spiritual Gathering – Schedule of Activities", mimeo, March 1993.

76 Funding for this event came from the Department of the Solicitor General, RCMP headquarters in Ottawa, and the three local RCMP detachments in New Brunswick. (Telephone communication, Sergeant Jacques Ouellette, Crime Stoppers Co-ordinator, RCMP Fredericton, 24 June 1994.)

77 Ewan Cotterill and Associates, *Working Together Because We Care, Final Report of the Suicide Prevention Regional Forums in the Northwest Territories* (Yellowknife: Government of the Northwest Territories, June 1992), 13.

78 Cotterill, *Working Together Because We Care*, 19.

79 Northwest Territories Department of Social Services, *Working Together: A Strategy for Suicide Prevention in the Northwest Territories* (Yellowknife: 1991), 1.

80 Telephone communication, Vera Morin, suicide prevention co-ordinator, Northwest Territories Department of Social Services, 28 June 1994.

81 Northwest Territories Department of Social Services, *Working Together: A Strategy*, 5, 1.

82 New Economy Development Group, *First Nations Children: Success Stories in our Communities* (Ottawa: Children's Bureau, Health and Welfare Canada, 1993).

83 Telephone communication, Ron Desjarlais, co-ordinator of volunteers, Bear Clan Patrol, 30 June 1994.

84 New Economy Development Group, *First Nations Children*, 32.

85 Quoted in New Economy Development Group, *First Nations Children*, 36.

86 Telephone communication, Ron Desjarlais, co-ordinator of volunteers, Bear Clan Patrol, 30 June 1994.

87 Among other sources, Cariboo Tribal Council, *The Lasting Effects of Abuse in a First Nations Community* (Williams Lake, B.C.: Cariboo Tribal Council, 1991); R.D. Chrisjohn et al., "Faith Misplaced: Lasting Effects of Abuse in a First Nations Community", *Canadian Journal of Native Education* 18, 161-197; E. Furniss, *Victims of Benevolence: Discipline and Death at the Williams Lake Indian Residential School, 1891-1920* (Williams Lake, B.C.: Cariboo Tribal Council, 1992); Celia Haig-Brown, *Resistance and Renewal: Surviving the Indian Residential School* (Vancouver: Tillacum, 1990); J.R. Miller, *Skyscrapers Hide the Heavens: A History of Indian-White Relations in Canada* (Toronto: University of Toronto Press, 1991). The subject of residential schools will be addressed more fully in other parts of the Commission's work.

88 Furniss, *Victims of Benevolence*.

89 Assembly of First Nations, *Breaking the Silence: An Interpretive Study of Residential School Impact and Healing as Illustrated by Stories of First Nations Individuals* (Ottawa: 1994). Investigations into the history of the St. Joseph's residential school have resulted in three prosecutions. In May 1989, Father Harold McIntee pleaded guilty to 17 counts of sexual assault against children from the school. In April 1991, Brother Glen Doughty pleaded guilty to four counts of gross indecency involving children at the school. The charges of sexual impropriety laid against Bishop Hubert O'Connor were dismissed in December 1992, on the grounds that the Crown had failed to disclose significant evidence to the defence. (Wendy Grant, Vice-Chief, Assembly of First Nations, testimony before the Royal Commission on Aboriginal Peoples, Canim Lake, B.C., 8 March 1993.)

90 The successful battle by the people of Alkali Lake to reorient their community is told in the film "The Honour of All: the Story of Alkali Lake" (Phil Lucas Productions, 1985, video, 56:48m.).

91 See especially "A Brief prepared by the Anglican Church of Canada for submission to the Royal Commission on Aboriginal Peoples at a Special Consultation between the Members of the Commission and Representatives of the Historic Mission Churches", Ottawa, 8-9 November 1993.

92 The program consists of seven phases: community orientation, amnesty or deferred reporting, pre-treatment assessment, primary intervention, reunification, maintenance or support services, and research. Further details appear in documents describing the family violence program, tabled with the Royal Commission by the Canim Lake First Nation community on 8-9 March 1993.

93 *Children are our Future: Meadow Lake Tribal Council and UVic School of Child and Youth Care Curriculum Development Project* (Victoria, B.C.: Beacon Hill Communications Group, n.d.); Sylvia Fanjoy, "The Meadow Lake Tribal Council Indian Child Care Program", *Focus* (1993); Meadow Lake Tribal Council, *MLTC Indian Child Care Program Policy and Procedure Manual* (n.d.); Alan Pence, Valerie Kuehne, Margo Greenwood-Church and Mary Rose Opekokew, *Generative Curriculum: A Model of University and First Nations Cooperative Post-Secondary Education* (Victoria, B.C.: University of Victoria School of Child and Youth Care, n.d.).

94 The nine communities are Buffalo River, Canoe Lake, English River, Flying Dust, Island Lake, Turnor Lake, Waterhen Lake, Makwa Sahgaiehcan and Big "C".

95 The Meadow Lake communities had known suicide, although not in 'cluster' form. (Telephone communication, Marcia Mirasty, Health Promotion Co-ordinator, Meadow Lake Tribal Council, 22 June 1994.)

96 *Children are our Future*, 2.

97 *Children are our Future*, 5.

98 *Children are our Future*, 8.

99 The MLTC wanted the child care students to have as many career options as possible and worked with the University of Victoria to develop what they called 'the child and youth care career ladder'. After one year of the two-year program, students could step into an assistant's job in child care. Later, they could return to school and complete the second year of the training program, which would qualify them for a supervisory position in child care. The two-year program they received at Meadow Lake would be the equivalent of two years of university education. Students could carry these credits to the university and complete a B.A. at the University of Victoria School of Child and Youth Care. (*Children are our Future*, 4.)

100 *Children are our Future*, 7.

101 Meadow Lake Tribal Council and St. John Ambulance, *Vision of Health and Wellness of the Nine Meadow Lake First Nations Peoples*, a submission to the Royal Commission on Aboriginal Peoples, Ottawa, 27 October 1993.

102 Telephone communication, Marie McCallum, former director, MLTC Child Care Program, 30 June 1994.

103 Telephone communication, Marie McCallum, former director, MLTC Child Care Program, 30 June 1994.

104 Pauktuutit, "Special Issue on Suicide", *Suvaguuq: Inuit Women's Association of Canada Newsletter* 5/1 (1990), 6.

105 United States Centers for Disease Control and Prevention, "Programs for the Prevention of Suicide Among Adolescents and Young Adults", *Morbidity and Mortality Weekly Report* 43/RR-6 (1994), 6.

106 This description of the characteristics of successful intervention is based largely on the survey carried out for the Royal Commission by Laurence J. Kirmayer and his colleagues, covering a research study base of over 250 items. (Kirmayer et al., "Suicide in Canadian Aboriginal Populations".)

107 Primary health caregivers are less likely to be familiar with the symptoms of mental disorders than with those of physical disorders and may need education in this area. They need additional education with regard to adolescents at risk of suicide, as adolescents are less likely than other age groups to discuss issues of mental health with their physicians. (Kirmayer et al., "Suicide in Canadian Aboriginal Populations", 52.)

108 Dryfoos (1990) examined 100 prevention programs in the areas of juvenile delinquency, pregnancy, drug abuse, school failure and acting out behaviour. Work on these problems is relevant to suicide prevention since they share many common risk factors. Dryfoos concluded that "programs with multiple goals that include educational enhancement, job preparation, aid to dysfunctional families and restoration of community pride were more successful than others... Programs that were most likely to be successful integrated multiple rather than single goals, i.e., drop-out prevention, pregnancy prevention, improvement in child placement." (Discussed in Kirmayer et al., "Suicide in Canadian Aboriginal Populations", 56.)

109 The crisis line in the Baffin region of the Northwest Territories is argued by local organizers and health caregivers to have been extremely helpful. (*National Suicide Prevention Workshop, March 22-24, 1993, Summary of Proceedings* (Ottawa: Health and Welfare Canada, 1993), 12-15.)

110 J.W. Berry, "Psychological and Social Health of Aboriginal Peoples in Canada", paper presented at the Workshop on Children's Mental Health, Victoria, B.C., March 1993; J.A. Davenport and J. Davenport, "Native American Suicide: A Durkheimian Analysis", *Social Casework* 68 (November 1987), 533-39; J.E. Levy and S.J. Kunitz, "A Suicide Prevention Program for Hopi Youth", *Social Science and Medicine* 25/8 (1987), 931-40.

111 Dr. Ron Dyck [Chief Suicidologist for the Province of Alberta], in *National Suicide Prevention Workshop, March 22-24, 1993, Summary of Proceedings* (Ottawa: Health and Welfare Canada, 1993), 26.

112 See in particular the work of Jarvis and Boldt (1982), Syer (1979), Syer-Solursh (1982), Termansen and Peters (1979), Timpson (1986), Ward (1977), and Ward and Fox (1984).

113 House of Commons, *Indian Self-Government in Canada: Report of the Special Committee* (Ottawa: Queen's Printer, 1983).

114 Fiddler, *Suicides, Violent and Accidental Deaths*; Brant and Brant, *Suicide in the North American Indian*; Nechi Institute on Alcohol and Drug Education, *Suicide, Death and Dying: A training module* (Edmonton: Nechi Institute, n.d.); Northwest Territories, Department of Social Services, Suicide Prevention Program *Working Together: A Strategy*; Lucie Tsai, "The Problem of Suicide Among Inuit Youth" (Ottawa: Pauktuutit, 1989).

115 Other major federal programs with a direct impact on possibilities for suicide prevention in Aboriginal communities include the Medical Services Branch's Addictions and Community Funded Programs (which encompasses the old Native and Northern Alcohol and Drug Abuse Program); the inter-departmental Family Violence and Child Sexual Abuse Initiatives Program; and the Indian Health Transfer Policy. These programs have not been evaluated from the standpoint of their contribution to this goal, an undertaking that would become necessary if the Royal Commission's recommended general strategy is implemented.

116 In the announcement made by Health Canada on 26 September 1994, it was suggested that "new funding" in the amount of $104.6 million had been added to the Mental Health Crisis Management program component. Figures obtained by the Royal Commission from the Medical Services Branch suggest that only $9.1 million is, in fact, new.

117 Some of the barriers discussed in this chapter are also identified as problems in a recent report on the mental health problems of Aboriginal people living in Quebec. See Petawabano et al., *Mental Health and Aboriginal People of Quebec*.

118 In the past, 'registered Indians' were required to give up their status in order to join the armed forces, go to college or university or, in the case of women only, marry a person without registered Indian status.

119 Statistics Canada, custom tabulations from the Aboriginal Peoples Survey, 1991, figures adjusted for non-responding bands.

120 Canim Lake, for example, has been forced to go through lengthy negotiations with the federal Department of Justice and the provincial Office of the Attorney General to secure funding for its innovative culturally-based treatment program for sex offenders because of restrictions in program criteria.

121 Quoted in the Moncton *Times Transcript*, 29 July 1993.

122 Meadow Lake Tribal Council and St. John Ambulance, "Vision of Health and Wellness of the Nine Meadow Lake First Nations Peoples", a submission to the Royal Commission on Aboriginal Peoples, 27 October 1993; Ma Mawi Wi Chi Itata, "Self-Determination and/or Self-Government for the Aboriginal Community of Winnipeg: Results of the Stakeholders Consultation", a submission to the Royal Commission on Aboriginal Peoples, 19 October 1993.

123 Native American Indian Court Judges Association, *Linkages for Indian Child Welfare Programs: Suicide Among American Indian Adolescents* (Washington, D.C.: n.d.).

124 Health and Welfare Canada, Medical Services Branch, *Talking About Our Healing Journey – A Discussion Guide for Community Helpers Using the Healing Journey Video* (Ottawa: 1994).

125 A recent analysis of mental health problems among Aboriginal people living in Quebec, commissioned by the Comité de la Santé Mentale du Québec and based in part on interviews with Aboriginal community members to identify underlying problems, concluded that "dislocation and dysfunction of the family unit" were the primary factors. See Petawabano et al., *Mental Health and Aboriginal People of Quebec*, 48.

126 W.J. Mussell, "Deficits, Foundation and Aspirations Signal Need for Restructuring", in *The Path to Healing*, Report of the National Round Table on Aboriginal Health and Social Issues (Ottawa: Royal Commission on Aboriginal Peoples, 1993), 114-16.

127 Note, for example, the role given to youth by the Nishnawbe-Aski Nation (NAN) in northern Ontario, which conducted a youth forum throughout the summer of 1993 to consult with young people in all the NAN communities about their problems and the solutions they see for them.

128 Kirmayer et al., "Suicide in Canadian Aboriginal Populations", 55.

129 Neil Winther, "A Comprehensive Overview of Sport and Recreation Issues Relevant to Aboriginal Peoples in Canada", draft research study prepared for the Royal Commission on Aboriginal Peoples (September 1993); Leslie Pal, "Aboriginal Youth Policy: An Inventory and Analysis of Federal, Provincial and Territorial Programs", draft research study prepared for the Royal Commission on Aboriginal Peoples (March 1994).

130 This point is argued in Gilliland and James, *Crisis Intervention Strategies*, and is one of the bases of the widely praised Suicide Prevention Training Programs (SPTP) of the Canadian Mental Health Association in Calgary. It was also argued in testimony before the Royal Commission by Dr. Paul King, Chief Psychologist, North Bay Psychiatric Hospital (Public hearings, North Bay, Ontario, 11 May 1993) and at the second Special Consultation on Suicide Prevention (Ottawa, 7 June 1993).

131 L. E. Fujimura et al., "Suicide: Dynamics and Implications for Counselling", *Journal of Counselling and Development* 63 (1985); Gilliland and James, *Crisis Intervention Strategies*.

132 Edward Bennett, "Community-based economic development: A strategy for primary prevention", *Canadian Journal of Community Mental Health* 11/2 (1992), 11-33; Marcia Nozick, *No Place Like Home: Building sustainable communities* (Ottawa: Canadian Council on Social Development, 1992); Brian Wharf, *Communities and social policy in Canada* (Toronto: McClelland and Stewart, 1992).

133 A more technical aspect of postvention is the 'psychological autopsy', an investigation of the factors contributing to a completed suicide, which is recommended as routine by some suicidologists in order to increase our understanding of the problem. Such investigation involves the highest degree of sensitivity. Aboriginal communities and caregivers who may be interested in this form of information gathering will want to give careful consideration to approaches and methods.

134 All figures here are based on the review done by Kirmayer et al., "Suicide in Canadian Aboriginal Populations", 31-32.

135 See Kirmayer et al., "Suicide in Canadian Aboriginal Populations", 21.

136 D.P. Phillips, K. Lesyna and D.J. Paight, "Suicide and the Media", 510-13.

137 United States Centers for Disease Control, "CDC recommendations for community plan for the prevention and containment of suicide clusters", *Morbidity and Mortality Weekly Reports* 37/8-6 (1988), 1-12.

138 Quoted in John Van Willigen, *Applied Anthropology: An Introduction* (Westport, Connecticut: Bergin and Garvey, 1993), 92.

139 Meadow Lake Tribal Council and St. John Ambulance, *Vision of Health and Wellness of the Nine Meadow Lake First Nations*, a submission to the Royal Commission on Aboriginal Peoples, Ottawa, 27 October 1993, 3.

140 Based on a presentation to the Royal Commission by Tom Erasmus, Special Consultation on Suicide Prevention, Aylmer, Quebec, 14 April 1993.

141 As recorded in the transcripts of the first Special Consultation on Suicide Prevention.

142 As recorded in the transcripts of the second Special Consultation on Suicide Prevention.

143 This analysis of the 184 specific recommendations put forward by those who participated in the community sharing circles was prepared by Nelson J. Augustine of Big Cove. It was tabled at the Royal Commission's first Special Consultation on Suicide Prevention, Aylmer, Quebec, 14-15 April 1993, to assist in our discussions. It is reprinted here, verbatim, because it illustrates one community's determination to take responsibility for their part in the problems contributing to suicide, it contains many specific ideas for community action to prevent suicide that are worth sharing, and it provides an example of the kind of creative thinking that can emerge from a community development approach to a shared problem.

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A Proposal for Fundamental Change

Suicide and self-injury in Aboriginal communities together constitute a problem with effects so damaging to community life, and a message of public policy failure so compelling, that the Royal Commission on Aboriginal Peoples has decided to recommend immediate measures to combat it.

It is sometimes argued that suicide among Aboriginal people is "just a symptom" of the deep malaise in Aboriginal communities that flows from the continuing colonial character of their relations with Canada. Commissioners agree that it is a symptom, but not *just* a symptom. In the first place, each self-inflicted death of an Aboriginal teenager or young adult is of concern in itself. Second, suicide is so galvanizing an issue that it can be used as a point of entry into the tangle of related community problems that are otherwise so hard for Aboriginal people to name and solve. Third, the issue of suicide offers itself as a meeting ground for Aboriginal and non-Aboriginal people and governments, precisely because it has become so highly charged a symbol to Aboriginal people of their continuing disadvantage and oppression within Canada. Country-wide public commitment to the prevention of suicide among Aboriginal people could signal a new day in the relationship that connects us, one and all.

There can be no doubt that the Aboriginal people of Canada are longing for such a new day. The Commission believes that non-Aboriginal people wish for it too. The governments now in office have the power to make it so. There is no reason to delay taking action.

Yet for all the sincere public dismay expressed in recent times about suicide among Aboriginal people in Canada, the fact of persistently high rates of self-destructive