Lifenotes
A Suicide Prevention and Community Health Newsletter
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A Perspective on the Fragmentation of Services to Aboriginal Youth

Bruce Leslie and Fred Storey, Aboriginal Relations Branch, Ministry for Children and Families

This paper was originally written as additional comments by the Ministry for Children and Families to the National Working Group responsible for the development of a national Aboriginal Youth Strategy. The Working Groups' mandate originated with Premiers and the five national Aboriginal leaders. These comments were presented to that forum by the B.C. Ministry of Aboriginal Affairs.

MYTH OF YOUTH AS A HOMOGENEOUS CULTURE

Aboriginal youth, especially in urban settings, may find they have more in common with mainstream youth than with their communities of origin. This is not to say that Aboriginal youth prefer mainstream culture and values. It is merely a recognition of the historical consequence of colonization.

As a result of this tendency of youth, across cultures, to seek out "youth-centered environments," government officials within departments, ministries, and non-Aboriginal community service organizations readily assume that all youth have the same basic needs. The definition of these needs is based on Western/European ideas about community borne out of the historical and social implications of the settlement of Canada.

Regarding so-called "at-risk" youth, their need for food, safety, clothing, and shelter appears, on the surface, to differ little among cultures. However, even at this presumed basic level, the assumption is that being served by the dominant culture is analogous to being served by Aboriginal communities and organizations.

The pre-contact indigenous cultures of the western hemisphere were magnificent in their variety and distinctiveness. Today's picture, especially since the advent of modern mass media technologies, is one in which indigenous societies have been irrevocably altered. Community norms, which formerly reinforced the uniqueness of each indigenous nation and maintained the distinctions between Indian nations and mainstream Canadian society, appear to have been lost.

Therefore, a cautionary note is needed to reiterate that there is no one Aboriginal or indigenous culture in Canada or North America. This will necessitate consultative processes within each Aboriginal community by all levels of mainstream bureaucracy about how services for youth are re-integrated into communities.

YOUTH: CHILDREN IN TRANSITION TO BECOMING ADULTS

How do children survive adolescence to become adults? This is an important question to ask because, sadly, many Aboriginal youth do not survive adolescence to become productive members of their communities.

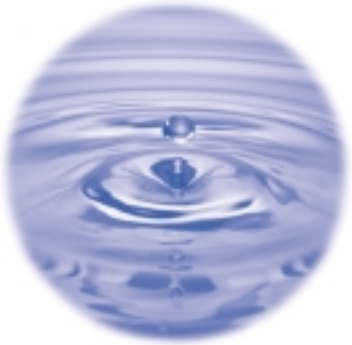
Despite the best intentions of governments, academics, and professionals, mainstream social and health services have done little to prevent Aboriginal youth from either taking their own lives or engaging in suicidal behavior. Research by Chandler & Lalonde (1998) on First Nations youth suicide in British Columbia[1] serves to illuminate an alternative approach to what has been a perplexing and seemingly unsolvable social policy conundrum.

According to the researchers, self-continuity plays a role as a protective factor against suicide. To briefly summarize the report's findings, the researchers found a direct correlation between the suicide rate of First Nations youth in B.C. and the extent to which the First Nation was engaged in one or more of six activities used to describe efforts to rebuild or maintain cultural continuity:

• *self-government* • *land claims* • *education* • *health* • *cultural facilities* • *police/fire*

The extent to which a community was engaged in none or all six of these activities correlated to a youth suicide rate of 800 times the national average or ranging to a low of nearly zero.

The study conclusively demonstrates that Aboriginal youth suicide rates are not, in and of themselves, the issue. The alarmingly high rates of Aboriginal youth suicide exist in environments devoid of processes which support cultural continuity and *Continued on Page 16*



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Lifenotes welcomes your thoughts and comments as a way to promote further dialogue on suicide prevention issues in BC. Please forward your letters to the Editor, Jennifer White.

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Note to Readers

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Science, Politics, and Practice: Considering the Field of Suicide Prevention

Jennifer White, Director, SPIRC, MHECCU, UBC

It is on the borders of our work, where we can explore different cultures and assumptions, that the most interesting and innovative things can often be achieved (Giroux, 1992).

The field of suicide prevention is characterized by a number of different and sometimes competing interest groups and traditions, each of which conceptualizes the problem of suicide quite differently. As I see it, there are at least two major influences, which serve to contribute to our knowledge base and shape our practice in suicide prevention. On the one hand our formal knowledge base is typically informed by a traditional scientific paradigm which encompasses contributions from medicine, public health and epidemiology, injury prevention, sociology, psychology, and other studies undertaken in the social sciences. On the other hand, our day-to-day practice is shaped – and sometimes constrained – by the existing social climate and current political context, which includes: government agendas, bureaucratic policies, resource allocation decisions, public opinion, as well as the specific interests of key stakeholder groups, including clinicians, mental health consumers, and survivors.

In many respects these two general streams of influence operate as independent enclaves with very little convergence or integration between the two, further fueling the familiar lament about "the serious gap between knowledge and practice." For their part, scholars and academics ask that their research findings be taken seriously by policymakers and program developers, and that their contributions be *faithfully* incorporated into all new program planning efforts. We live in an era of "evidence-based decision making" and "best practices approaches" to program development; ideas, which on the one hand reveal the dominance of the scientific agenda, yet on the other, hold broad appeal for decision-makers who place a high premium on accountability and fiscal responsibility. In fact, these highly rational approaches to program planning represent powerful and compelling ideas, since we would all like to do things that work and discontinue those things that may be ineffective, or worse yet, harmful.

Despite the persuasiveness and logical appeal of these notions, the reality of prevention work generally and suicide prevention work specifically, makes it very difficult for us to consistently engage in "evidence-based practice" since the evidence about what works in terms of preventing suicide is not always available, and that which does exist is by no means unequivocal. Further, even when there is strong agreement that a particular course of action will have a powerful effect on the problem, we rarely have the luxury of an unlimited budget or the infinite capacity to influence complex systems in order to ensure that they act in compliance with what the evidence suggests.

Indeed, it may be the case that those ideas that have the most potential for success demand the most commitment from us as program leaders and practitioners. In the face of these powerful ideas, we often choose simpler – less effective – actions rather than investing the time and energy necessary to catalyze fundamental change.

Time and space do not permit me to elaborate on these issues, and yet I hope that I have surfaced some of the key tensions that are serving as the backdrop to our day-to-day practice in suicide prevention. By making some of these ideas explicit, I hope that we can begin to see the multiple interests that are always at stake, thereby enabling us to undertake a broader view of the problem; one which underscores the need to be sensitive to our current context, while at the same time opening up new opportunities for taking constructive action.

While I certainly do not have any immediate answers for how we might go about reconciling some of these very real challenges, I have a series of questions that I hope will serve to animate some of the discussions currently taking place in suicide prevention:

- How do we strike the right balance between the need to develop sound strategies which will have a high potential to be effective with the need to be responsive to an urgent social problem that cannot wait for all of the evidence to be accumulated?
- How do we forge closer connections between researchers, policymakers, and front-line practitioners?
- How do we recognize the knowledge and wisdom of practitioners, consumers, survivors, and community citizens and how can we support more dialogue between these groups regarding important issues in suicide prevention?
- How can we begin to direct our attention to asking what's possible versus what's possible to measure?
- And, finally, how can each of us, in our own way, maintain an open stance to hearing the voices of interest groups other than our own so that we may reduce divisiveness and promote a more inclusive approach to solving this incredibly sad and complex problem?

I welcome any and all of your ideas. ■

BACKGROUNDER
Improving the Health and Well-Being of Canada's Youth

Toward a Health Future: Second Report on the Health of Canadians summarizes the most current information we have on the health of Canadians and the factors that influence or "determine" health. It suggests several priority areas for action in the new millennium.

A number of things are going well for young Canadians. For example, youth volunteering has increased dramatically and the number of young women completing post-secondary levels of education is at its highest point ever. At the same time, *Toward a Healthy Future* alerts to us some conditions affecting the psychosocial well-being of Canada's youth.

HIGHLIGHTS

- In contrast to the high levels of physical health enjoyed by most people, psychological well-being is, on average, lowest among this age group. Young Canadians aged 18 and 19 were the most likely to report high stress levels (37%) and to report being depressed. Young women aged 15 to 19 were the most likely of any age-sex group to show signs of depression (9%).

- The 1996 suicide rate of 19 per 100,000 among young men aged 15 to 19 was almost twice as high as the 1970 rate. Suicide rates among young men aged 20 to 24 were even higher (29 per 100,000). The suicide rate for Aboriginal youth is much higher than for their peers in the general population. As in the case of the population at large, young men are the most likely to commit suicide.

- Despite some recent improvements, youth unemployment and the underemployment rates remain high.

- Between 1990 and 1995, the proportion of young people aged 18 to 24 (with their families or alone) who lived in low-income situations (i.e. below Statistics Canada low-income cut-offs) increased form 21% to 26%.

- Education is often an important factor in determining whether young people obtain jobs that enable them to support themselves and their families. Young people who leave school before high school graduation (22% of young men and 14% of young women in 1995) are more likely to dislike school, to have failed a grade in the past, to come from low socioeconomic backgrounds and to be young parents.

- Young women aged 12 to 17 are particularly vulnerable to sexual abuse by a family member or date. Young women aged 18 to 24 are most likely of all age groups to report being assaulted by an intimate partner.

- Despite recent high profile events of youth violence, in 1997, the percentage of young people aged 12 to 17 charged with Criminal Code offences dropped 7% from the previous year. The 1997 rate, however, was still more than double that of a decade ago.

- Over the last 10 years, the rate of young women charged with violent crimes has increased twice as fast as that of young men; however, young men are still three times more likely than young women to be charged with violent crimes.

INVESTING IN THE WELL - BEING OF CANADA'S YOUNG PEOPLE

- *Making the healthy choices the easy choices.* Programs to address and reverse risk-taking behaviours are needed. At the same time, we need to recognize that personal lifestyle choices are linked to the capacity of homes, schools, communities, workplaces and governments to make "the healthy choices, the easy choices". Crowded housing, neighborhoods where there may be drug dealing, isolated living conditions with little to do, and threatening school environments contribute to increased violence, youth misuse of alcohol, tobacco and other drugs, and increase feelings of alienation and depression. Involving young people in the healing process is critical. ■

FOR MORE INFORMATION

Toward a Healthy Future: Second Report on the Health of Canadians was developed by the Federal, Provincial and Territorial Advisory Committee on Population Health in collaboration with Health Canada, Statistics Canada, the Canadian Institute for Health Information and the Centre for Health Promotion, University of Toronto. The full text can be found on the Health Canada Web site: http://www.hc-sc.gc.ca. Printed copies of the Report are available from Provincial and Territorial Ministries of Health of from:

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Dispatches From The Field – Cranbrook, B.C.

Larry Branswell, M.Sc., Child & Youth Coordinator, Youth Mental Health Services, Ministry for Children & Families

Over the past five years in my work as a child and youth mental health therapist, I have had occasion to debrief students in school settings following the deaths of classmates. These contacts have occurred following completed suicides, murders and accidental deaths. The age range of the students I have worked with on these occasions has encompassed the Kindergarten – grade 12 school system spectrum.

Most recently, a 12-year-old boy from a neighboring community died from a self-inflicted gun shot wound on a Saturday afternoon. Monday morning at 9:00 a.m. I was seated in his classroom talking with 23 former classmates. I was trying to help them navigate their grief in that first morning back at school. The classmates had been aware of the death prior to reaching school that morning. All except for one boy who was relatively new to the school and was obviously out of the loop. Arriving on the playground he had heard the news just before entering the classroom.

As the classroom teacher read a brief prepared announcement, sobs began around the room. Earlier she had identified a desire to draw the class into a circle to discuss the boy's passing, so at this point amid the sporadic crying but generally quiet mood, she asked everyone to form a circle. She then introduced me and a colleague as guests who were going to try to help them with some of their feelings.

Off to my right, a girl was crying loudly, being hugged by the child next to her. Across from me, off to the left, two boys sat with awkward grins plastered on their faces. I thought it best to begin with an identification of feelings and an acknowledgment of varied emotional and behavioral responses we all have. I contrasted the sobbing girl with the grinning boys (trying to defuse an anticipated angry misinterpretation of their awkwardness by other kids). I guessed aloud that the boys felt sad along with their crying classmates, but were also kind of

nervous and perhaps not sure of how to act. With a permission of sorts to act in any way they felt comfortable, their grins appeared to ease into seemingly more relaxed looks.

The girl to my right attempted to offer a eulogy of sorts, but couldn't get beyond her first few words. A couple of boys related their last contact with him hours before the end. Another girls shared feeling guilty that her last contact had been abrupt and curt and she wouldn't get a chance to tell him she really liked him.

I had been briefed by the principal and classroom teacher earlier in the morning. They identified the dead boy as having been an outcast, the semi-regular object of teasing and exclusion so we were anticipating that more than a little guilt would surface. I was also told that a boy in the class had lost his mother two months earlier to a completed suicide. They informed me that he had not spoken of the experience with anyone around the school.

As I creep up on my fortieth year, the father of two elementary aged children myself, I find that I go into these debriefing sessions with an odd mixture of emotion. One factor lies in the reaction I now have to the cumulative experiences. This last one was my sixth debriefing in the past four years. Typically an evening or weekend phone call has invaded my family time. News comes of death and a request is made to participate on a response team that is being organized. Were one compensated financially for expending mental energy that was work related, the metre would start ticking at this point.

I recall attempting to share what I go through around the whole crisis response/debriefing side of my work with an old mentor and former colleague several years back. I described visual images that I had carried away from a series of contacts . . . the endless sea of tear stained faces, teens clutching one another huddled in supportive circles in the school hallways, the unusual sense of quiet within the buildings, kids seeking increased proximity to their safe predictable care givers, parents lurking around the buildings, conspicuous in their presence (yet needing the assurance that their child wouldn't be next).

I went on with my friend, identifying a somewhat confusing range of emotional experiences that I encountered in this work. I felt some guilt that despite the sadness and grief around me, I came away with a certain vibrance, a sense of authentic human connection that occurs around crisis moments. A sense that all those little things that occupy too much of our daily living mean so very little in the greater scheme of things. I went on to add other feelings that accompany these; the general emotional fatigue, a sense of detachment on some level (allowing me to be present but not swept up in the emotion), some trepidation, definitely a great deal of satisfaction. Helping out at these times is very rewarding emotionally. I have always come away with the feeling that in some small way I have contributed to a child having a slightly healthier grief experience . . . and thus learned a life skill that will assist them with inevitable future losses.

So there we sat in our circle. The boy, who I had never met, had been fortunate to have a wonderful teacher. I would estimate that she's creeping up on retirement and while *Continued on Page 18*

Putting Best Practices Into Action, Revelstoke: A Community Profile

Lory Borges, School Based Prevention Worker, School District No. 19, Revelstoke, B.C.

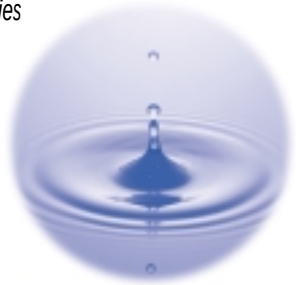
Suicide Prevention Demonstration Projects: A Seven Community Ministry for Children & Families Initiative of "Before-the-Fact" Youth Suicide Prevention Strategies

In March 1999, Revelstoke was chosen as one of seven communities to serve as a demonstration site in British Columbia for the Youth Suicide Prevention Initiative Putting Best Practices Into Action. The initiative is being coordinated by the Suicide Prevention Information & Resource Centre (SPIRC) of MHECCU, UBC and is being funded by the Ministry for Children & Families.

In Revelstoke, the project is being implemented through a partnership with many different agencies including School District # 19, School Based Prevention Program, Revelstoke Mental Health Services, and Revelstoke Child & Youth Committee. These partnerships are essential to the success of the project. To help coordinate our efforts a steering committee was formed which was composed of representatives from these different agencies. The steering committee will provide feedback and direction to the project and will also assist with the project's evaluation.

Revelstoke's project is entitled **Peer Support** and is being coordinated by the School Based Prevention Worker at Revelstoke Secondary School. The program works from a youth resiliency perspective. It is one way for individuals to build protective factors or resiliency against harmful situations. As a team, the peer helpers have the opportunity to identify school concerns, share responsibility for them, and make decisions about how to address those concerns. In identifying issues and working through them, the risks associated with youth suicide can be reduced. The peer helpers will serve as valuable links between youth and adult resources in the community.

The Peer Support program acts as an umbrella for our community's youth suicide prevention efforts. The program works hand-in-hand with many of our community's existing services to provide a cohesive response to youth suicide prevention. The program's logic is simple. The Peer Support



program will train interested and selected students in basic helping, communication and problem-solving skills. This training will help to strengthen the natural peer helping networks that already exist by formally training students. Two components will be offered. The first is an outreach component that will match students in-need with a trained peer helper. The second component will involve the peer helpers in awareness and prevention activities to specific target groups.

The Peer Support Program is directly linked to many of the best practices described in the *Manual of Best Practices in Youth Suicide Prevention.* These include peer helping, generic skill building, suicide awareness education, school climate, and youth participation. Many activities that are planned will address components of these best practices. For example, the peer helpers plan to deliver a program to the elementary schools in our school district to address self-esteem, coping skills, problem-solving skills, and the transition to high school. This active involvement by the peer helpers is essential to the success of the Peer Support Program.

To date our project has met many of our original goals. We began our peer helper selection process in June 1999 and received an overwhelming response with over 250 nominations being brought forward. From the nominations, our committee short-listed to 86 candidates from Grades 8 to 11. These candidates represented a broad spectrum of students at Revelstoke Secondary and included students who would be "good for the program" and students who the "program would be good for". We invited the 86 candidates to a brief orientation meeting and assessed interest level. We asked each candidate to indicate whether they would be interested in being involved with peer support. Approximately 75% of the candidates indicated an interest level. In September 1999, our steering committee decided to invite 25 students to the Peer Support Training Retreat. Many of the 86 students initially invited to participate are also active on school sports teams during the winter, so a second training retreat is being considered for spring 2000.

Training took place October 1st-3rd at Blue Lake Education Centre and was coordinated by the School Based Prevention Worker. The peer helpers were trained in four basic areas: communication skills, helping skills, conflict resolution and mediationskills and values clarification. There were many opportunities for the peer helpers to practice skills and receive feedback and support throughout training. Additional training will be provided on an as needed basis throughout the year. The training retreat was extremely successful and comments from both students and parents have been very positive.

With training complete, the committee's next focus becomes program implementation. Namely, the school community must decide how best to make use of a peer helping program within the school and how to best educate staff and students about peer helping. Recent visits to a School Board meeting and a Revelstoke Secondary School staff meeting will help with this education component. The peer helpers will continue to meet on a regular basis to share their experiences and to plan activities for their school. Evaluation of the Peer Support Program will continue throughout the year.

By imparting these skills to students we hope that we can begin to nurture a school environment where mutual caring and respect are shown. And work towards long-term program success. ■

First Nations Community-Based Suicide Prevention

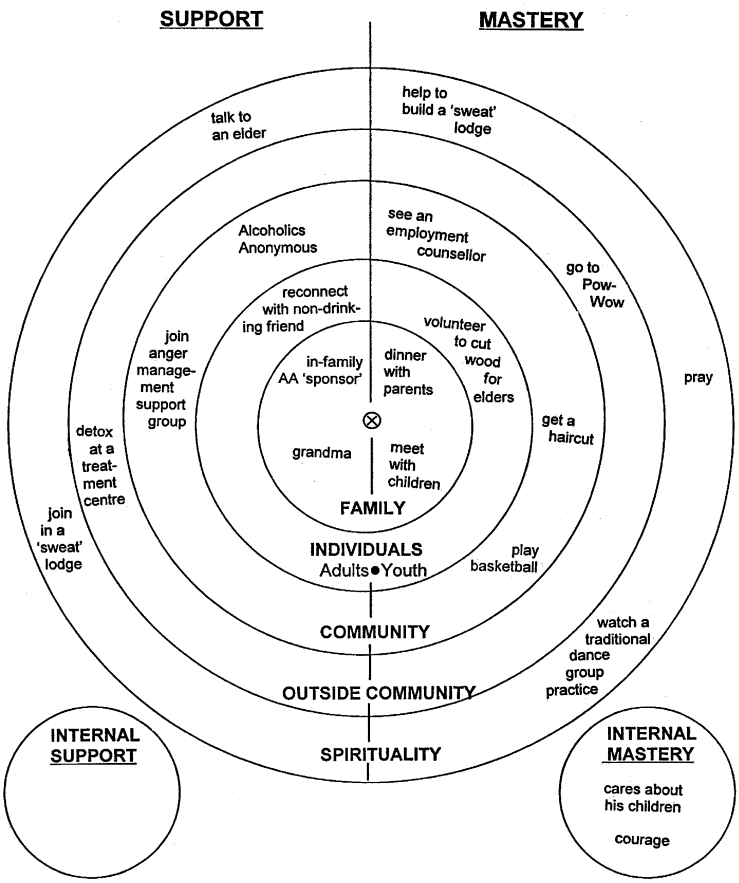
Darien Thira, Thira Consulting

Several explanations have been suggested for the fact that First Nations people on reserve are statistically up to six times more likely to die by suicide than non-native Canadians. These have included: the impact of 'residential school' on individuals, families, communities and aboriginal culture itself; the economic and social problems found on isolated reserves (including a lack of crisis-related resources); and the relative equality among young aboriginal men and women in terms of suicide attempt lethality. However, in many cases the statistic has itself contributed to a sense of helplessness within First Nation communities; as have paternalistic responses to the social crisis by non-native 'experts'.

What is required is a community-based suicide prevention effort which integrates professional and informal resources and builds on the capacity already existing within the community. From this perspective, all communities, no matter how isolated, are resource rich – the key is to identify and use those resources effectively.

To accomplish this, the *Through the Pain* community-based suicide prevention handbook and training program makes three assertions:

COMMUNITY RESOURCES AND SELF ESTEEM



1. Suicide is caused by *pain.*

The specific social and personal issues that underlie suicide have been called 'elusive'; however in practical terms, there is only one cause for suicide: unbearable emotional *pain.* In almost every case, a person considering suicide would choose to live if they could find a different way to deal with their suffering. Most suicidal people send out an S.O.S. *(signal of suicide)* to those near them because they are searching for an alternative. *Suicide is not about wanting to die.* If you can assist a person to reduce their pain, you will reduce their suicide risk. This is the essence of community-based suicide prevention and intervention.

2. *Self esteem* is the protective factor.

Self esteem is the sense of value that we have in ourselves: it is the source of our emotional strength. People who have a healthy *self esteem* feel that they are valuable and in control of their lives. They have the belief in themselves necessary to face their losses and challenges from a position of strength: to respond with courage and creativity; to use their skills and to their ability to learn; and, finally, to enlist the assistance of those around them. People who have low self esteem feel isolated, worthless and out of control – it is the pain of these emotions that leads to suicide. Self esteem is based on two foundations – one with an internal source and one with an external source.

The first foundation of self esteem is *support* – the sense that you are valued by those who are important to you. That is, you feel accepted by, connected to, or loved by a person outside of yourself, such as: family, friends, or a counsellor. A location (eg. in nature or a church/temple) or an object (eg. a photograph or ring) may also provide a sense of support.

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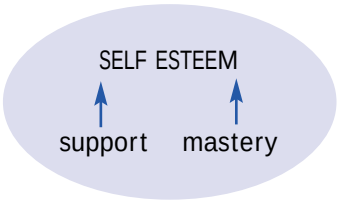
First Nations Community-Based Suicide Prevention . . .

The second foundation of self esteem comes from a sense of *mastery* – the belief that you are in control of your life and that you are valuable for who you are and what you can do. Mastery is based on an internal sense of value; people find mastery in: personal growth, family responsibilities, work, social status, self-discipline, a particular skill or ability, etc.



This model of self esteem offers direction for the healing of a person in crisis and the protection of those 'at risk' of crisis: *increasing self esteem decreases suicide risk.*

3. Communities are *resource rich.*

Once the person's immediate safety is dealt with, the community's task is to provide resources which will offer an individual the opportunity to raise their self esteem and, thus, to increase their ability to respond positively to their lives. Although they may not be formally acknowledged, every community has many such resources – people with the necessary life experience, training, role in the individual's life, or role in the community. Activities, places, and social situations can also be resources that build a person's sense of support and mastery.

In order to explore the wide range of resources available to any community member, it is valuable to consider the community in which they live. Surrounding a particular person, a community can be considered to be made up of five inter-dependent parts, their:

- *family (and/or clan)* as identified by the individual in crisis
- *individual youth and/or adults* (eg. friends, elders, professional and non-professional caregivers, sponsors, mentors, coaches, teachers, etc.)
- *community* (ie. agencies, services, institutions, community centres, schools, support groups, etc.)
- *outside community* (eg. neighbouring communities, regional services, treatment centres, regional political leaders or youth idols, the media, the Internet, etc.)
- *spirituality* (ie. any individual, activity, institution or place that is identified as relevant to spiritual well-being)

In addition, every individual has internal resources (even if they feel out of reach at first).

- *internal support and mastery resources* (e.g., hope, previous resiliency, self discipline, caring, etc.)

When combining this five-part model of a large or small community with the two-part model of self esteem, a resource 'map' can be created to meet the specific needs of an individual in crisis or at risk of crisis. This map would be developed collaboratively with the person in crisis and each identified resource becomes the basis of an 'action plan' (which may require the participation of caregivers to accomplish). The attached figure offers an example of the process for a young man in a semi-isolated community struggling with a variety of issues which have a negative impact on his self esteem (*eg.* alcohol addiction, unemployment, poor anger management, strained relationship with parents, has children who live with estranged girlfriend). The same model can be applied to a family in crisis or the community as a whole. In the latter case, in fact, it provides the structure for a locally sensitive and effective suicide 'postvention' protocol. By building support and mastery, the use of the *Community Resources and Self Esteem* map reduces the pain that is the cause of suicide. ■

For copies of the *Community Resources and Self Esteem* map and/or more information on the *Through the Pain* Workshop or Handbook, please contact Thira Consulting at (604) 255-0181 or the Provincial Residential School Project at 1-800-721-0066.

Squamish Nation Crisis Centre

The Squamish Nation Crisis Centre opened its doors to the community in July 1999. What follows is an outline of the program offered by the Centre.

PROGRAM OUTLINE:

Under the Program Co-ordinator, the Program will provide immediate and effective support to primarily Nation members, but will accept any First Nations person experiencing trauma and crisis in their lives. Through effective training of staff and volunteers, they will be able to determine the current or post traumatic stress disorder and its relationship to historical or current abuse. The program will provide the community with an immediate response to crisis situations and allow for time to develop a readiness to enter into community resources and support. By providing individual, family and community support, we will address the dysfunctional behaviours within the entire family system and determine what process will enable a long term change. Through education and information sessions, we will provide background history of the survivors experiencing life crisis situations.

The program will provide the following services to meet the needs of the community:

- Crisis intervention; immediate response to individuals, families and community experiencing physical, mental, emotional or spiritual distress and trauma.
- Treatment; brief individual and group support therapies both traditional and psychological, support groups and referrals.
- Education and prevention; individual, family and community education and support to anyone who is experiencing trauma or loss within the family unit or community impacted by critical incident stress.
- Crisis line; 24 hour access to immediate response and referral, counselling and intervention services on a needs basis
- Research community development; ongoing research to ensure that gaps and weak areas of community support are identified and plans are developed to address the needs.

The program will provide support and services to all members and sectors of the Squamish Nation; in particular those that are suffering impacts of generational trauma through acts of neglect, violence, abuse both inward and outward, addictive self destructive patterns, depression and grief and other symptoms of post traumatic stress disorders that could lead to suicide, homicide, long term illness, violent emotions and involvements.

The program will continue to liaise with all service providers and agencies that are currently providing support and relief to survivors of trauma, current trauma and perpetrators of trauma. Through development of an inter-agency network, workshops, information sessions, case conferencing when necessary and referrals we will be maintaining a solid balance of resources and links to enhance both the Crisis Centre and existing services.

The Squamish Nation Crisis Centre is sponsored by the Squamish Nation Residential School Committee and is funded by the Aboriginal Healing Foundation. ■

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Cultural Continuity as a Protective Factor Against Suicide in First Nations Youth

Michael Chandler, Ph.D., Psychology Department, University of British Columbia
& Christopher Lalonde, Ph.D., Psychology Department, University of Victoria

No one, or at least no one watching the evening news, can have escaped the fact that suicide among First Nations youth is a contemporary tragedy of epidemic proportions. The trouble with such "facts" is that they are only half truths that risk sending us off in all the wrong directions. We do not wish to be misunderstood here. Taken as a group, aboriginal youth in BC and across Canada do, as advertised, take their own lives at a rate that is arguably several times higher than that of their non-Native counterparts – a rate that is said to be the highest reported for any culturally identifiable group in the world (Kirmayer, 1994). The problem with such across-the-board statistics is not that the actuaries have somehow made a mistake in doing their sums, but that such generic claims can easily led us to wrongly imagine that we actually know something useful about the prospects for life or death in any particular First Nations community. We don't. Forget Canada-BC alone is home to nearly 200 First Nations each with their own history and cultural practices. In the face of all of this evident diversity, casual claims about First Nations as a whole are at best arithmetic fictions that often tell us worse than nothing. Still, for want of a commitment to making a better job of it, the enumerators go on rough-sorting the living and the dead into loose generic piles – Native here; non-Native there.

One line of our own ongoing program of research into the course of identity development in Native and non-Native youth is also epidemiological in nature, but aims to say something more differentiated, and so hopefully more useful, about the variability in rates of suicide among First Nations groups. An important part

of what sets our own efforts apart from others is that, instead of simply attempting still another global Native/non-Native comparison, we took the further (and, as it proved, rather difficult) step of tracing back to their band of origin every known Native youth suicide that occurred in the Province between the years 1987 and 1992. In short, we succeed in calculating, not only how many such suicides occurred within the province as a whole, but also the actual number of such deaths that occurred in each of the province's different Native bands and tribal councils. Having done so made it possible to bring out two facts that bear some repeating.

Fact one is important because of its extravagance. No one would be surprised to learn that the rate of youth suicide is marginally higher in some Native groups than it is in others. This would likely be true even if, against all reason, the real risks of dying at one's own hand were to arise simply as a result of being a First Nations person. Given the small numbers involved, a difference of two, or even ten fold, would not have seemed an impossibility. Our data is not like that. As it is, more than half of the bands in the province experienced no youth suicides during the reporting period, while others suffered suicide rates more than 800 times the national average. Even at the aggregated band council level, some 90 percent of the known suicides occurred in less than 10 percent of these extended communities. The simple and sovereign truth to be found in all of this extreme variability is that the high rate of suicide said to characterize First Nations youth as a whole cannot be explained simply by pointing to whatever factors might serve to distinguish aboriginal from non-aboriginal people. That, we hope, will not surprise you.

Fact two presupposes the first, and is meant as a partial answer to the question of why the youth suicide rate is so high in some First Nations communities and so low in others. Clearly, some bands are successful in insulating their young from suicide in ways that others are not, and it hardly puts too fine a point on it to say that figuring out how they manage to do so is a very real matter of life and death.

Evidently, there are two general ways of going about finding an answer to such questions. One of these (and the path most traveled by) proceeds by simply trolling through the sea of differences that might divide various First Nations communities, all in the blind hope of accidentally snagging something-anything-that might distinguish those groups with low, as opposed to high, suicide rates. The obvious problem with such fishing expeditions is that the flotsam and jetsam that they commonly dredge up is usually empty of actionable meaning. Suppose, as might well be the case, *Continued on Page 11*

that average income were to pop-up as a discriminator, such that being from a band with low earnings was found to be associated with high youth suicide rates. For those eager to take action, such "facts" are often worse than no facts at all. If there were some obvious road leading out of desperate financial circumstances it would have already been taken. The alternative is to have a "theory" or, failing that, some good idea about where to best look. We think we have such an idea. This is it.

For more than a decade we have been struggling to understand how it is that young persons-first of different ages, and then of various mental health statuses, and now of different cultures-differently understand their own personal persistence in the face of inevitable developmental and social change. What lends real weight to the importance of finding solutions to this problem is that without some means of counting oneself as continuous in time there would be no reason to show appropriate care and concern for one's own future well-being. It is for such reasons, our earlier research indicates, that adolescents who encounter special difficulties in solving the puzzle of their own persistence in time are at especially high risk to suicide.

Ordinarily, when young persons find themselves in the usual throes of adolescent turmoil, and, for a time, lose their footing, they are backstopped by certain cultural continuities that afford them some sense of permanence and connectedness to their own past and building future. Unless, of course, as has been the case with Canada's First Nations, their government undertook, as a matter of official policy, to forbid their language, to criminalize their religion, and to remove, root and branch, their parents' rights to rear and educate them. Then, one might suppose, their best remaining hopes would lay in whatever efforts their community's leaders might make to preserve, rebuild, and reconstruct their culture, by wrenching its remnants out of the control of federal and provincial government agencies. Guided by these prospects, we hypothesized that the rates of youth suicide within BC's First Nations communities would vary as a direct function of the degree to which individual bands and band councils were actively engaged in concrete efforts to preserve and rehabilitate their threatened cultures. To this end we identified six readily available proxy measures of cultural continuity including evidence of efforts:

(a) to secure aboriginal title to traditional lands;

(b) to achieve a measure of self-government;

(c) to secure some degree of community control over educational,

(d) health,

(e) police and fire protection services; and

(f) to establish within their communities certain officially recognized "cultural facilities" to help preserve and enrich their cultural lives.

The results of these efforts to build some quantitative measure of cultural continuity are unambiguous. In every band or band council in which all six of these "protective factors" were in place, there were no reported youth suicides during the 5-year study window. By contrast, communities that lacked evidence of having taken one or more of these steps toward the preservation of cultural continuity experienced suicide rates 5 to 100 times the national average. The strong conclusion supported by these findings is that the frequency with which the young persons of any First Nations community undertake to kill themselves appears to be a direct function of a series of factors over which that community has some measure of local control. Of course, some will say these results are merely correlational-that the relation between suicide rates and cultural continuity may be the work of some third as yet unmeasured thing. Maybe so. Maybe not. You will need to choose. ■

Arthur Sommer-Rotenberg Chair in Suicide Studies

Research Studies at St. Michael's Hospital, University of Toronto

Arthur Sommer-Rotenberg was a prominent family physician in Toronto who took his life at age 36. Mrs. Doris Sommer-Rotenberg developed the idea of a university Chair at the University of Toronto dedicated to her son Arthur. "Called forth by tragedy, my hopes for the Arthur Sommer-Rotenberg Chair in Suicide Studies [ASRCSS] is that it will help prevent both personal despair and societal loss."

The ASRCSS was established in 1997. Since the Winter of 1997, the Arthur Sommer-Rotenberg Chair has been assumed by Paul Links, M.D., Professor of Psychiatry, University of Toronto and Deputy Chief of Psychiatry of the Wellesley Central/St. Michael's Hospital's joint Mental Health Service.

MISSION

The Arthur Sommer-Rotenberg Chair in Suicide Studies is an academic program drawing on the strengths of many professionals and dedicated to creating societal and health care advances to reduce the losses and suffering from suicide and suicidal behaviours.

GOALS

- Understanding the causes leading to suicide and suicidal behaviour;
- Developing effective treatments and preventive approaches to reduce the risk of suicide in high risk groups and individuals;
- Providing education and advocacy to health professionals, policy makers and the general public.

The education and advocacy activities of the ASRCSS are numerous. Members have been invited to present their work in a variety of settings, locally, nationally and internationally. Students and fellows have successfully completed their studies within the ASRCSS and new ones have joined. As well, several major public educational events have been hosted by the ASRCSS. Some highlights of recent advocacy efforts are: consultations with Toronto Transit

Commission around public safety; consultations with the City of Toronto concerning bridge barriers; drafting recommendations regarding a national strategy on suicide prevention with the Canadian Alliance on Mental Health and Mental Illness and working with key figures in the media to educate the public about the effects of contagion.

RESEARCH IN PROGRESS INCLUDES:

- *Predictors of suicidal ideation and behaviours among adult shelter users.* PhD Thesis in Medical Sciences: R. Eynan-Harvey, MA. Thesis Supervisor: Dr R. Heslegrave
- *Adult Self Harm and Suicide Among those with Childhood Sexual and Physical Abuse* PhD Thesis in Nursing: Elaine Sta. Mina, MscN, Committee Members: Drs. R. Gallop, P. Links & R. Heslegrave
- *Suicidal Ideation Among the Depressed Elderly* MSc Thesis in Epidemiology. Committee Members: Drs. A. Colantonio, P.Links, R. Heslegrave and A. Rhodes
- *Suicide Attempts – Agreement on the Constructs* Investigators: Drs. A Rhodes, P Links, D. Streiner, I. Dawe & D. Cass
- *The Effects of Paroexetine in Suicidal Persons Observed through Brain Imaging.* Investigators: Drs. J. Meyer; S. Kennedy, P. Links, R. van Reekum, R. Heslegrave & A.Rhodes
- *A Psychosocial Intervention Group for Persons with a History of Suicidal Behaviour.* Investigators: Yvonne Bergmans, MSW; Drs. P. Links & I. Dawe
- *The Acute and Continuing Effectiveness of Paroxetine for Persons with a History of Suicidal Behaviour.* Investigators: Drs. P. Links, R. Heslegrave, R. van Reekum & A. Rhodes
- *Help Seeking and Treatment of Men within the Context of Violence.* Investigators: Drs. A. Rhodes and P. Links, R. Eynan-Harvey, MA, Yvonne Bergmans, MSW and Howard Kravitz, MSW
- *Suicidality and Assertive Community Treatment for the Severe and Persistently Mentally Ill* Investigators: Drs. J. Langley; D. Wasylenki & R. Heslegrave

PUBLICATIONS BY MEMBERS OF THE ASRCSS INCLUDE:

- *Childhood Sexual and Physical Abuse and Adult Self-harm: A Literature Review,* E. Santa Mina, PhD student & Dr. R. Gallop
- *The Association between Homelessness & Suicidal Ideation & Behaviours: Results of a Cross-sectional Survey,* R. Eynan-Harvey, PhD candidate, Drs. J. Langley, A. Rhodes as part of the Homelessness & Suicide: Data from the Pathways into Homeless Project. In press.
- *Impulsivity and Suicide: Research Issues,* Drs. R. Van Reekum, P. Links,& R. Heslegrave
- *The Iowa Personality Screen: Development and preliminary validation of a brief screening interview.* Angbehn DR, Pfohl BM, Reynolds S, Clark LA, Battaglia M, Bellodi L, Cadoret R, Grove Wm, Pilkonis P, Links P.
- *Suicide & Severe & Persistent Mental Illness,* Dr. J. Langley
- *Suicide and Suicidal Behaviours: Implications for Mental Health Services,* Drs. A. Rhodes & Paul Links
- *Interventions for Preventing Recurrent Suicidal Behaviour for Canadian Family Physicians.* Links PS, Balchand K, Dawe I, Watson WJ ■

To contact the ASRCSS directly to learn more about their work and efforts in advancing suicide prevention efforts, please call telephone: (416) 864-6099, or fax: (416) 864-5480.

Blame After Suicide: A Third Perspective

By Bonny Ball

The March 1998 and September 1998 Lifenotes issues included articles about families (and society) blaming health care professionals after a suicide. As someone who lost a treasured son to suicide, I know all about "cognitive dissonance" after suicide (Barnabas Walther), and that suicide grief typically includes a "blaming" phase (Linda Rosenfeld). I can personally confirm that both articles are correct.

But I also think both these articles sidestep a third alternative – sometimes the anger is justified. Admittedly, Linda Rosenfeld acknowledges the possibility of survivor anger being justified in another article of hers "I Can't Hear the Music" in the book *Suicide In Canada*, 1998. I only wish she had included this comment in her Lifenotes article. There is medication given without due caution. There are bureaucratic screw-ups. There are destructive teachers, coaches, schools and workplaces. There is poor therapy. There are cases where family and friends' input and concerns are discounted and dismissed.

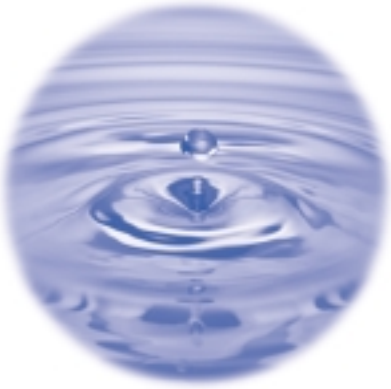
Also interesting is that neither Lifenotes article discusses the impact of the suicide on the professional caregivers, gatekeepers, physicians, school staff, clergy, coaches, social workers, workplace/union health and safety counsellors), and the systems that support them when someone in their care suicides. Quite legitimately, they must go through their own cognitive dissonance and grief, including the desperate need to avoid self blame. Unfortunately, to family/friend survivors these very understandable reactions, not only can look like, but can be, professional protectionism and an unwillingness to review the issues.

I am not advocating "witch hunts", lawsuits or trial by media, or (to quote Barnabas Walther) "presumption of service provider fault, before all the evidence is in." As survivors, just as we have to learn to forgive ourselves for the things we perceive we did or did not do, we must also cut the professional caregivers and gatekeepers some slack. Helping suicidal people find life and hope is incredibly complex – as much art and intuition as science. Suicidal people are often elusive clients. And the service providers we trusted before the suicidal crisis became evident were probably just trying to do the best they could with what they had – just like family and friends. As survivors we need to respect that.

What I am asking is that professional caregivers, gatekeepers and our support systems remember that tucked inside all the anger and blame is sometimes a kernel of truth or a germ of an idea that might trigger more effective approaches to suicide prevention. Please don't dismiss us yet again.

I am currently a member of the B. C. Provincial Advisory Committee for Suicide Prevention – the first survivor so honored. I am encouraged by the fatality review process implemented by the Children's Commission. I am told that findings from the Coroner's behavioural investigations are incorporated into these reviews, and as part of this process there is finally a forum for survivors of youth suicides to speak. Not in anger, not in blame, but as stakeholders wanting to improve the process, so that, as a Village, we can do a better job of caring for each other. Thank you for that.

In her Lifenotes article, Linda Rosenfeld comments that "the survivor often mourns outside a supportive context." Often true. Thus, it is critical that those who support survivors help us find safe ways to release our anger without hurting the professional caregivers (and others) who were "in the trenches" with us and the suicidal person. It is equally imperative that professional caregivers and our mental health care system help us find appropriate ways to give voice to valid issues. ■



P. Bonny Ball lost her 21-year-old son to suicide in 1994 in Calgary, 18 months after she and her husband had moved to Vancouver. Her son was never "in care" or formal therapy in Alberta or B.C.

Since her son's death and her retirement from a career as a business analyst in Human Resources systems, Bonny has become active in suicide prevention. She developed the brochure "Living With Someone Who is Suicidal" (available from SAFER and SIEC; website: http://www.compusmart.ab.ca/supnet/livingw.htm). She also wrote "It Takes a Village" for this publication, and then revised and expanded it for AGATE, the Journal of the Gifted and Talented Education Council of The Alberta Teacher's Association. In addition to sitting on the Provincial Advisory Board for Suicide Prevention, Bonny is a member of the planning committee for the Canadian Association for Suicide Prevention (CASP) conference to be held in Vancouver Oct 11-14, 2000. She thanks both SAFER and SPIRC for helping her find her voice as she moves from bereavement to advocacy.

Aboriginal* Suicides in British Columbia 1992 - 1997

"GRAPHIC ISSUE"

Number of Suicides

	FEMALES						MALES					
	Year						Year					
Age Range	1992	1993	1994	1995	1996	1997	1992	1993	1994	1995	1996	1997
0-4	0	0	0	0	0	0	0	0	0	0	0	0
5-9	0	0	0	0	0	0	0	0	0	0	0	1
10-14	0	1	0	2	0	1	1	0	0	0	0	1
15-19	2	3	3	1	1	1	5	4	2	3	4	6
20-24	2	3	3	1	5	0	8	5	5	3	5	3
25-29	3	0	0	0	1	0	11	9	5	9	1	9
30-34	0	1	1	0	3	2	3	10	4	6	2	2
35-39	1	2	3	0	1	0	2	3	3	3	3	5
40-44	3	0	1	2	0	1	0	0	0	1	1	2
45-49	2	0	0	1	0	0	1	0	1	1	3	5
50-54	0	1	0	0	0	0	1	1	0	0	0	0
55-59	0	0	0	1	0	0	0	0	0	1	0	2
60-64	0	0	0	0	0	0	1	0	0	0	0	0
65+	0	0	0	0	1	0	1	0	0	0	2	0
TOTALS	13	11	11	8	12	5	34	32	20	27	21	36

Aboriginal population

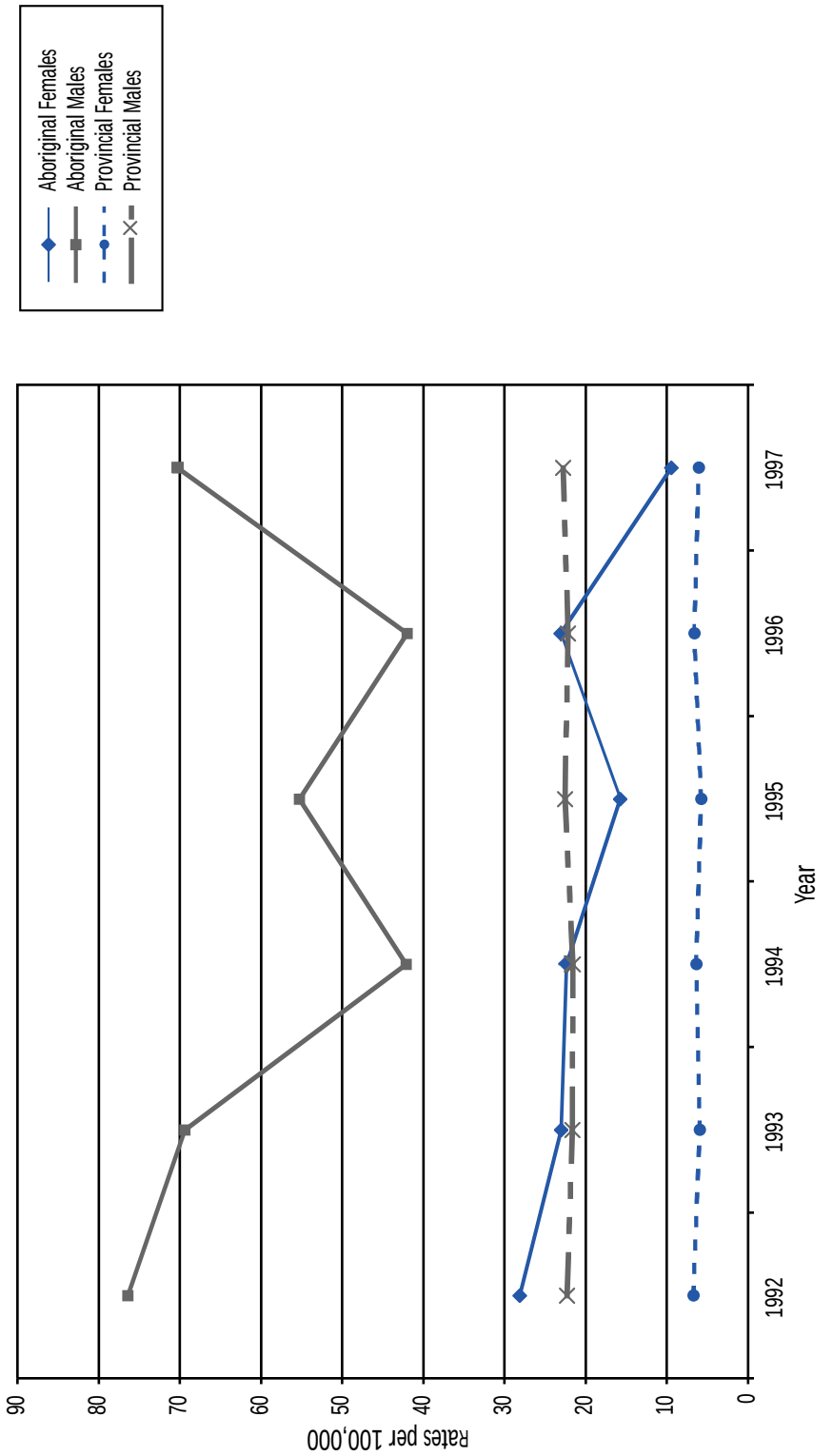
	FEMALES						MALES					
	Year						Year					
Age Range	1992	1993	1994	1995	1996	1997	1992	1993	1994	1995	1996	1997
0-4	3,451	3,507	3,733	3,894	3,871	3,882	3,813	3,897	4,102	4,266	4,205	4,172
5-9	4,551	4,751	4,882	5,098	5,166	5,246	4,780	5,025	5,262	5,462	5,651	5,793
10-14	4,253	4,390	4,569	4,730	4,939	5,067	4,572	4,786	4,877	5,055	5,168	5,275
15-19	4,290	4,373	4,350	4,414	4,458	4,519	4,468	4,461	4,501	4,553	4,670	4,817
20-24	4,588	4,601	4,571	4,506	4,493	4,492	4,667	4,706	4,708	4,651	4,628	4,603
25-29	4,930	4,823	4,781	4,738	4,767	4,749	4,648	4,677	4,675	4,747	4,748	4,788
30-34	4,903	5,191	5,231	5,322	5,224	5,124	4,443	4,648	4,778	4,815	4,804	4,766
35-39	4,005	4,180	4,402	4,652	4,846	5,045	3,426	3,632	3,794	4,034	4,329	4,554
40-44	2,880	3,131	3,356	3,611	3,885	4,105	2,607	2,787	2,962	3,156	3,305	3,467
45-49	2,305	2,421	2,550	2,657	2,811	2,942	1,946	2,089	2,198	2,316	2,447	2,599
50-54	1,763	1,881	1,991	2,098	2,201	2,322	1,472	1,564	1,665	1,748	1,845	1,909
55-59	1,258	1,366	1,464	1,566	1,614	1,753	1,113	1,179	1,203	1,254	1,324	1,418
60-64	1,050	1,090	1,120	1,150	1,199	1,250	884	929	975	1,005	1,031	1,061
65+	2,027	2,171	2,299	2,389	2,524	2,674	1,676	1,750	1,809	1,832	1,922	2,019
TOTALS	46,254	47,876	49,299	50,825	51,998	53,170	44,515	46,130	47,509	48,894	50,077	51,241

Sources: BC Coroners Service and
Indian and Northern Affairs Canada

Prepared by: Suicide Prevention Information & Resource Centre (SPIRC)
MHECCU, Department of Psychiatry, UBC
November, 1999

* Includes on-reserve (on-reserve and on crown land) and off-reserve, Indian and Northern Affairs Canada

Aboriginal* Suicide Rates in British Columbia 1992 - 1997



Sources: BC Coroners Service and
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November, 1999

* Includes on-reserve and on crown land) and off-reserve, Indian and Northern Affairs Canada

GUEST ARTICLE *continued*

A Perspective on the Fragmentation of Services to Aboriginal Youth . . .

are almost non-existent within First Nations pursuing cultural continuity on many fronts.

Another way of looking at the issue of cultural continuity for Aboriginal youth is to think about how adolescents and young adults figure out if there will be a place for them in the future.

THE CRISIS OF IDENTITY FOR ABORIGINAL YOUTH

Most youth are at a stage in their lives when they are exploring the ramifications of becoming responsible for their own decisions. They are going through what developmental psychologists refer to as an identity crisis. In the process, they need to ask questions like:

- Who am I?
- Who will I be in the future?
- Where do I belong?

These questions have to do with self-esteem.

Most Aboriginal youth seek to identify with their Aboriginal community in order to secure a sense of belonging and context as they struggle to formulate a self-identity as an Aboriginal person.

However, if their cultural community has been all but assimilated into a foreign culture to which they can not relate, or if they have been separated from their cultural community, then they will have no sense of belonging. Their low self-esteem is the consequence of this alienation process.

As a result of chronic and inter-generational low self-esteem, these youth will experience great difficulty envisioning their future. Common self-statements would be, "I'm a loser" and "I'm lost."

Therefore Aboriginal youth act as though neither they nor their community and culture have a viable future. Suicide and suicidal behavior now become practical alternatives to mask the pain of feeling cut off from self and Aboriginal community.

The result is the loss by family and community of the promise of a productive Aboriginal community member. The consequence for governments is the over utilization by Aboriginal youth of mainstream social, health, and corrections services, i.e., youth-in-crisis approaches; and, an under representation of Aboriginal youth in the mainstream education system.

The significance of the Chandler & Lalonde research results for government officials is that the solutions to the Aboriginal youth suicide dilemma would appear to lie not in the creation of an ever escalating number of prevention and intervention programs. Rather, the solution to this problem is in the engagement of Aboriginal youth and their communities in efforts to recover from the effects of colonization, and in the movement of the Aboriginal community toward culturally appropriate institutions of self-governance.

Aboriginal youth are never adequately served by the Western/European approach which declares that services to individuals have paramountcy over holistic services to communities.

The consequence of this approach, of treating the individual as a discrete unit separate and apart from their community, is the continual fragmentation of Aboriginal community and culture by non-Aboriginal ways of doing business.

Also important to realize is that responding to Aboriginal youth issues in isolation from issues encountered in pre-adolescence further encourages fragmentation of community and family structures, and ensures that service responses will always be in crisis mode.

Governments have made valiant attempts at resolving complex social questions regarding identity and community where Aboriginal youth are concerned. But rarely has this labour borne fruit.

The message to the mainstream is clear: Aboriginal youth do not thrive through independence from community and family.

Maslow's hierarchy of needs, although Western/European in its roots and perspective, is useful in illustrating that in order to arrive at a place where healthy self-esteem is enjoyed, Aboriginal youth must first get to "belonging." Belonging will be forever elusive without a strong connection to community through a commonly held cultural and world view, for example, *I am Haida, I am Nuu-chah-nulth, Cree,* or *Metis.*

So now we must ask ourselves, what will be an approach that works?

CULTURALLY APPROPRIATE SERVICES FOR ABORIGINAL YOUTH

Some economies of scale, as in the instance of large hospitals and universities serving particular geographic areas, may be justifiably maintained by Aboriginal and mainstream governments. However, for the vast majority of social, health, and correctional services, Aboriginal youth will be better served through culturally-appropriate services provided by communities of origin or urban Aboriginal communities of convenience.

COLLECTIVITY, INDIVIDUALISM, AND FRAGMENTATION

Government officials are generally expedient by nature. They have a finite amount of resources to spend and a certain time within which to spend them. Who gets to employ these resources on behalf a community?

Within the mainstream of Canadian society, proposal calls are announced and organizations are chosen to deliver services based on who can write the best proposal, who is more cooperative, who has connections, who is best organized or has developed administrative capacity, etc. *Continued on Page 17*

This method of operating, of getting government dollars to "my" organization so that "my" particular interests will be served, is contrary to the fundamental organizing principle of Aboriginal culture and community which, as recognized by the Supreme Court of Canada in the *Delgamuukw* (1997) decision, is *collectivity*. In contrast, mainstream Canadian culture has as its underlying precept the notion of *individualism*. The post-European experience in Canada has been defined by individuals who have coalesced to form geographic and economic communities of convenience.

GETTING TO THE INTENDED RESULT

It is not until we contrast this most singular difference between Aboriginal and non-Aboriginal culture that we catch a glimpse of how different a new approach by governments to provide culturally appropriate services for Aboriginal youth might be. And was not the desired outcome, as recognized by national leaders, of the creation of a National Aboriginal Youth Strategy?

WHAT CAN MAINSTREAM GOVERNMENTS DO?

The National Aboriginal Youth Strategy could incorporate a recognition of this unique difference between the Aboriginal and mainstream Canadian culture. Governments and national Aboriginal leaders could strive for a broad, joint policy mechanism. This would bring about the cessation of unintended results which, notwithstanding good intentions, only support the fragmentation of Aboriginal communities and services for youth and do little to provide Aboriginal youth with positive outcomes.

Decisions about which Aboriginal organizations received funding to serve youth would no longer be based on a "best proposal" or the "throw money in the air" approach both of which require Aboriginal communities and organizations to fight over scarce or shrinking government funding. This non-Aboriginal process flies directly in the face of a desire by Aboriginal communities to work together toward consensus decisions, especially where services for children, youth, and families are concerned.

STRENGTHEN ABORIGINAL COMMUNITIES TO SERVE YOUTH

Therefore the federal, provincial, and territorial governments could adopt a broad community-strengthening approach[2] which recognizes the inherent responsibility and cultural imperative of Aboriginal communities, rural and urban, First Nation, Metis, and Inuit, to engage in collective consensus-building and decision-making.

Adopted formally as working policy by all governments and implemented over the next five to seven years, this approach would require bureaucracies to seek out a consensus from Aboriginal communities in order to ascertain which organizations were mandated to provide services for youth. This would also provide an interim process for mainstream governments until such time as Aboriginal institutions of self-governance resumed this broad social policy function.

Without a community-strengthening strategy, governments in each jurisdiction will continue to create more categories of services, more boxes, more stove pipes, more fragmentation, all in well intentioned but misdirected activities to support Aboriginal youth to reach those ever elusive positive outcomes.

Aboriginal and mainstream governments and communities desire a reversal of current outcomes in such areas as employment, suicide and suicidal behavior, connection to community services, substance mis-use, secondary and post-secondary graduation, and contact with the justice system.

UTILIZE EXISTING RESOURCES AND CAPACITY (STUDIES, MODELS, AND PROGRAMS) DEVELOPED BY ABORIGINAL COMMUNITIES

Over the years, much work has been undertaken by Aboriginal communities and organizations in an attempt to have a positive impact on outcomes for youth. As discussed in this paper, previous approaches developed to implement these programs by mainstream governments have been largely ineffective.

However, a serious body of work exists which can assist Aboriginal communities and youth to create program approaches which could be effective if implemented in a climate conducive to self-determination. ■

Prepared by:

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[1] Chandler, Michael J. and Lalonde, Christopher. 1998. "Cultural Continuity as a Hedge Against Suicide in Canada's First Nations." Transcultural Psychiatry 35(2): 191-219.

[2] See the *Strategic Plan for Aboriginal Services (1999)*, Ministry for Children and Families, Province of British Columbia, as an example of a broad strategic policy approach to strengthening the capacity and authority of Aboriginal communites to develop and deliver their own services.

Dispatches From The Field . . .

I'm sure she's earned the rest it will be this school's loss when it occurs. Meeting under these sad circumstances, I could see she cared greatly for her charges. I couldn't have asked for a more ideal teacher to have been invited in by. She followed up the boys' guilt ridden recollection of their last contact with her own admission.

She related an interaction that no doubt occurs hundreds of times weekly in schools. The regularly disorganized child requests assistance at the eleventh hour etc . . . Well our teacher shared that her response to their departed classmate the previous week had been . . . curt and that she too felt guilty, and sad, that she would never get to tell him she really liked him and she wasn't that upset about a homework assignment.

She was marvelous to watch. Composed by several days of private grief and her faith, she was so very strong for these kids. She modeled a range of thoughts and feelings for the class. Effectively giving them permission to feel as they may and share the experience in a safe manner. At one point after other kids had recalled amusing memories, she offered out that she kept catching herself looking at the door half expecting him to come through the door, "because he was always late". It brought forth both laughter and more tears. A girl away over on my right altered her teacher's image to one of half expecting him to burst through the door declaring his prank.

Then a sense of quiet hung over the room for a moment. The finality of it all seemed to descend on to them. Giving a voice to the unspoken, I offered out, "but he's not coming back is he?" More pain-filled sobbing from the girl off to my right, more hugs. Intermittently a couple of boys directly across from me had related accounts of teasing the dead boy, some of the shared memories were of their misdeeds, others were observed incidents. The frequency of these boys' contributions to the go-round discussion led me to believe that at least one of the two had been a major tormentor. I wondered if either was the boy whose mother had died.

I found myself trying to draw out the new boy who had only learned of the death an hour or so earlier. He was very quiet, across from em to the left of the circle. He looked frightened to me. I recall making a mental note to catch up with him later when we could talk on our own.

The class spent that first hour of the morning talking about memories both happy and sad. We discussed life and death. The loss of innocence was most profound. Try to imagine making sense of death at the age of 12. Add to the equation that these kids knew that either accidentally or purposefully it was a self-inflicted death. They had all aged over the weekend. Deaths occurring out of the natural sequence tend to have that effect.

About three quarters of the way through the hour, a hither-to quiet lad spoke up tentatively. He said, "I just don't know why people have to go and kill themselves". The tears were welling up behind his blue eyes, his cheeks were getting flushed. In a rush of tears and emotion he finished with, "don't they know how much we miss them when they're gone? My mother killed herself and I miss her so much".

The room erupted into tears. Ever alert to the kids needs the teacher and principal moved closer to embrace and comfort the boy. He accepted the hugs, hanging on for dear life. He looked relieved on a level, or perhaps that was just my thought. A colleague who was in the room as well (there were four of us adults) later commented that she remembered being curious about whether I would turn to the child or the group as this occurred.

My thought had been that the boy was being well cared for and the strength of the group could be a resource from which to draw. I pointed out to the children, struggling to be heard above the crying and sobbing, that death meant different things to each of us. To some it will be in part a guilty lesson in how we treat one another, a very painful lesson. I can remember feeling a sense of caution at this point. I perceived that there was a need to walk a metaphorical tightrope between not rescuing these children from their guilt while not placing responsibility for a death too near their fragile 12 year old shoulders.

I went on to offer a few other possible meanings their classmates' passing might have for them. It might evoke memories of other losses they have had, it might scare them, they might find themselves thinking about things in a way they had never thought of before realizing that there won't be any new memories to add of their departed pal. A classmate frozen in time.

They seemed "cried out" at this point. In an effort to help them with the transition into the rest of their day, I drew from a brief guided imagery exercise I had been taught. Asking them to look to where a wall met the ceiling, I asked them to try to envision a leaf falling gently to the floor. I explained that it would fall slowly to the floor as I counted backwards from ten to zero. I asked them to practice breathing in deeply through their noses and exhaling slowly through their mouths. I counted down aloud, slowly. Several more deep breaths and then I offered some encouragement to draw together and support one another over the next little while. I shared that I had seen some students in their grief get irritable, argue and snap at usual pals. I proposed not pushing each other away, but leaning on each other.

We headed off to see identified kids in clusters or individually as the rest of the school day moved along. I spent some time with the boy whose mom had committed suicide. He struck me as a nice kid. As he described his own experience for me I was impressed with the way his father had appeared to support him. Dad seemed to have done many healthy things. While I left the school that day feeling confident that this boy would be okay, looking into those reddened eyes I recall feeling sad that this poor kid's childhood innocence had ended prematurely. ■

ANNOUNCEMENTS

CONFERENCES

Canadian Association for Suicide Prevention (CASP) 11th Annual Conference
Suicide Prevention in Canada: Exploring Our Diverse Landscape

October 11 – 14, 2000

Robson Square Conference Centre, Vancouver, BC

For further information or a copy of the Call-for-Papers, please contact Shannon Vandekerkhove, Conference Coordinator, Tel: (604) 669-7175, Fax: (604) 669-7083, E-mail: shannon@ebd.bc.ca

Schools Crisis & The Community: Planning for Effective Responses

Pre-Conference: February 15 – 16, 2000
Conference: February 17 – 18, 2000

Simon Fraser University at Harbour Centre (Downtown Vancouver)

- Meet leading experts in school-based critical incident response.
- Learn from the experiences of others.

For further information call (604) 264-9595, or visit www.educ.sfu.ca/cirt

Voices from Each Generation: Reclaiming Wellness in Aboriginal Communities

February 17 – 19, 2000

Executive Plaza and Conference Centre Coquitlam, BC

Sponsored by the Justice Institute of BC
For more information contact:
Renee Nyberg-Smith at
Tel: (604) 528-5621 or
e-mail: rnyberg@jibc.bc.ca

American Association of Suicidology (AAS) 33rd Annual Conference

April 12 – 16, 2000

Regal Biltmore Hotel, Los Angeles, CA

For further information contact:
e-mail: debbiehu@ix.netcom.com
AAS
#408 - 4201 Connecticut Ave., NW
Washington, DC 20008, USA
Tel: (202) 237-2280

INFORMATION / STUDIES

BC CAMPAIGN 2000

BC Campaign 2000 is part of the work of First Call: The BC Child and Youth Advocacy Coalition. First Call is a coalition of 40 provincial organizations and numerous community groups who have come together to ensure that children and youth have first call on society's resources. BC Campaign 2000 is a movement vested in raising awareness of child poverty issues. We believe that children and youth are everybody's responsibility and that they are potentially vulnerable and need community support. Research now shows that if we as a society do not meet the needs of children and youth when they are young that the long-term costs are great.

In 1989 the parliament of Canada unanimously passed an All-Party Resolution to "seek to eliminate child poverty by the year 2000." Since 1991 Campaign 2000 was established to monitor the progress on the resolution. In BC one in five children is now living in poverty. Sadly, child poverty rates are higher than at the inception of the resolution. For this reason, we feel it is important than ever to act and to do so as a community.

For ideas, more information, a child poverty video, presenters, to get on the calendar or to get involved call First Call at (604) 895-5786. With your participation we can join together to send a powerful message to our decision-makers.

KINDRED SPIRITS
Support Group for Parents of Severely Depressed Children and/or Children Who Have Talked About Suicide or Have Attempted Suicide

Kindred Spirits is a free support group for parents of severely depressed children and/or children who have talked about suicide or have attempted suicide. The support group meets every other Tuesday evening from 7:00 p.m. to 8:30 p.m. at the Mid-Main Community Health Centre, 3998 Main Street, 2nd floor (at 24th Ave.) Vancouver, BC.

This group is ongoing and will support participants in:

- Sharing feeling
- Looking after your needs
- Dealing with your fears and anxieties
- Getting help for you and your family from community resources
- Networking with the healthcare system

For more information please call:
Sherry Wasserman,
Registered Family Counsellor
at 872-6944.
Please be sure to call Sherry before you attend.

ANNOUNCEMENTS *continued*

BOOKS / PUBLICATIONS

"Before-the-Fact" Interventions: A Manual of Best Practices in Youth Suicide Prevention, 2nd Printing

SPIRC is pleased to announce that additional copies of this Manual, which has been favorably received by individuals and service agencies throughout BC since its initial release in June 1998, will now be made available by the Ministry for Children and Families (MCF) through the Government Publications Centre. To order a copy, please **send your request in writing via fax** to Government Publication Services at (250) 387-1120 or mail PO Box 9452 Stn. Prov. Gov., Victoria, BC, V8W 9V7. Please be sure to include your full mailing address, contact name and phone numbers. Please be aware that in the interests of cost-effectiveness, some minimal cosmetic changes have been made to the second edition. These include the conversion of the document to black-and-white as well as reproduction on less costly paper. The original cover will also be replaced with a less expensive version. The content remains the same throughout.

PHYSICAL SAFETY

Canada Rates Poorly in Gun-Related Child Deaths

Firearms are a leading cause of death among youth aged 15 to 24 in Canada. Between 1991 and 1995, gun-related deaths and injuries claimed more than 250 young lives and caused more than 100 to be hospitalized. The rates of firearms deaths for youth vary widely among provinces and territories, rising in direct proportion to the number of homes with guns.

Forty-three per cent of gun-related child deaths in Canada are unintentional, 17 per cent are homicide, 35 per cent are suicide, and 4 per cent are undetermined. Approximately one in 11 child homicides in Canada are committed with a firearm, as are one in four suicides.

Canada, which has stricter controls on firearms than the United States, also has a rate of gun-related child deaths that is four times lower – 0.4 per 100,000 population, compared to 1.6 per 100,000 in the U.S. However, an international study of 26 developed countries showed that firearms-related child deaths are higher in Canada than in 21 other countries. Only the United States, Finland, Northern Ireland and Israel had higher rates than Canada, bolstering the call by public health and safety groups for stricter firearms legislation here.

Public health professionals have pointed out that gun-related child deaths are preventable. Such groups call for improved regulations, education, and changes in weapon designs as ways to reduce the number of child deaths due to firearms.

Source: *The Progress of Canada's Children 1998: Focus on Youth, Canadian Council on Social Development*

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