Suicide and Community Wellness in Nunavut

A report prepared for the

Nunavut Task Force on Suicide Prevention and Community Healing

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> "Faced with unacceptably high and increasing levels of unemployment, on-going family violence and breakdown, increased alcohol/drug abuse and the continued erosion of Inuit cultural values and traditions, Nunavut may experience an epidemic of suicides that unless steps are taken right now to secure a future for Inuit youth, will make the present one seem insignificant by comparison"
>
> Stevenson, 1996: 8

Since 1999, the territory of Nunavut has witnessed over 100 deaths by suicide. Most of these individuals were young, between the ages of 15 and 24, male and Inuit. The suicide rate has been increasing in Nunavut and is far higher than the suicide rate in the rest of Canada. These numbers are obviously alarming in their own right. What the numbers cannot communicate however, is the extent of grief and suffering among families and communities in Nunavut who have lost loved ones. Suicide is one of the leading causes of death among young Nunavummiut. It is also preventable.

The following document was commissioned by the Department of Health and Social Services. It is intended to provide background information on suicide, suicide prevention and community wellness to members of the Nunavut Task Force on Suicide Prevention and Community Healing. The document begins by examining what we already know about suicide in Nunavut and then turns to what we can infer from information about similar populations in the circumpolar world. It examines what the mountain of northern suicide literature views as the causes of suicide and looks at suicide prevention and community wellness activities in Nunavut and in areas similar to Nunavut. The document focuses on the resources that are already available for people to read and examine, draws out the common links in the literature and the points on which there is disagreement. The document does not provide any recommendations, as this was not its intent, but rather provides a sense of 'what we know' and 'what we think we know' about community wellness and suicide prevention in Nunavut.

Before moving to the separate topics it is worth noting that suicide is less understood than it should be. We are not certain about what prompts individuals to attempt suicide, nor are we certain about how we can best protect people from thinking about suicide. This is not, however, for lack of effort. The past ten years has seen a number of conferences, workshops and reports, in addition to academic literature and media attention. Suicide may be little understood but this is not for lack of trying. There has been considerable attention devoted to the topic and considerable effort to encourage action. The result of all this activity is a fairly clear picture about what people in Nunavut *think* are the causes of suicide. We have facts to back up some of this information. In other cases, however, our perceptions of what causes individuals to turn to suicide are not backed up by sufficient information about the daily lives of individuals. This report distinguishes between what we know as fact and what we merely assume. Second, the report highlights the previous recommendations of the various workshops, conferences and reports, many of which have not been implemented. If anything stands out from the literature on suicide in Nunavut and the circumpolar north it is that there is considerable activity, many very good ideas, and very little movement on these ideas once they have been printed.

What do we know about suicide in Nunavut?

We know that the suicide rate in Nunavut is high and that it is getting higher. Figure 1 explores the suicide rate in Nunavut by region from 1975 to 2002. As the figure shows, the number of suicides ranged from 3 to 6 throughout the latter half of the 1970s and the early part of the 1980s. The exception to this was 1978, when 14 Nunavummiut died by suicide, half of these in the Baffin. From 1984, however, the number of suicides has risen in bursts, to 19 in 1989 and 22 in 1993. Since 1999 there have been at least twenty suicides a year, rising to a high of 28 in 1998 and again in 2000.

When we want to compare Nunavut to other jurisdictions we must convert suicides to rates. The most common rate is to report the number of suicides per 100,000. In Nunavut, this means multiplying the current population by a number (X) until it reaches 100,000 and multiplying the number of suicides by the same number (X). If we do this, we find that in 1999 the suicide rate in Nunavut was 73/100,000. One year later it soared to 98/100,000. Since then it has settled between these two rates. This is approximately eight times the Canadian suicide rate, which is 12/100,000 (Langlois and Morrison 2002).

We know that most suicides occur in the Baffin region. Until 1994, there were rarely more than four suicides a year in the Keewatin/Kivalliq and Kitikmeot regions combined. Obviously it is not desirable to have any suicides, and thus it is not reasonable to talk about an 'acceptably low' number, but it is worth contrasting the lower numbers in the 1970s and 1980s with the higher incidences in the 1990s. The number of suicides increased earlier in the Baffin, and has increased more than in the other two regions. If we calculate suicide rates we find that not only is the number of suicides higher in the Baffin but that the rates are higher as well. In other words, if the Kitikmeot, Kivalliq and Baffin were all the same population size, we would still see more suicides in the Baffin. This has an obvious impact on how we understand the causes of suicide and how we plan for suicide prevention. If the rate of suicide is higher in some regions than others, we must be wary of grounding explanations of suicide in events or circumstances that occur throughout Nunavut. Something different is happening in the Baffin that is exacerbating whatever is driving up suicide rates in other parts of the territory.

Compared to other jurisdictions the suicide rate in Nunavut is even more alarming. Table 1 summarizes suicide rates in five circumpolar jurisdictions. This ranges from a low of 21/100,000 in Alaska to a high of 88/100,000 in Greenland (Henderson 2003). In each of these cases suicide rates are higher for indigenous populations. These data are consistent with what other people have been saying about suicide in the circumpolar north. In her investigation of suicide in the NWT, Alaska and Greenland Jette Jenson reported that Inuit have higher suicide rates than other indigenous populations and that Greenland had the highest rates of the three. The numbers get more alarming if we subject them to futher examination. Most of these suicides are by youth, aged 15 to 24. If we calculate the suicide rate for youth in Nunavut, rather than the entire population, we find that the suicide rate for youth is 842/100,000. This rate is among the highest in the world and sadly is not without parallel. In New Zealand, young Maori women aged 15-19 have a suicide of 490/100,000 (Lawson Te-Aho 1998)

But what do we know of those who commit suicide? We know that overwhelmingly, suicide in Nunavut concerns youth. Most who die by suicide are aged 15 to 24, most are male, and most are Inuit. If we focus on those who committed suicide since 1999 we find that most died by hanging. Table 2 summarizes facts we know about suicide victims in Nunavut and confirms that almost all of those who died by suicide were young Inuit men, who died by hanging. It is worth noting, however, that the use of firearms is increasing, as can be seen from the final column in the table. In 1999 100% of suicides were by hanging. In 2001 only 70% were by hanging, with the balance involving firearms. With few exceptions there were very few variations by region. In 2000, however, more young women committed suicide in the Kivalliq than young men. In the same year over 40% of Baffin suicides were by those younger than 15 or older than 24. Suicide is thus predominantly a youth phenomenon among Inuit men, but it affects non-Inuit, women, young children and older adults as well.

We have inconsistent data about suicide attempts. Those data we do have suggest that young women are attempting suicide in equal numbers as men, but that their attempts involve methods that are less likely to result in suicide. These are often seen as 'cries for help' rather than attempts to die. Data from the NWT suggests that women tend to attempt suicide by taking a drug overdose and are generally more likely to talk about their feelings before the attempt (Tilden 1997c).

We know a bit more about those who think about and attempt suicide. In a 1993 article psychiatrists reported that in the Baffin region suicidal ideation or attempted suicide was the second most common reason for referring an individual for psychiatric help. Depression was the most common (Abbey 1993). In his study of youth in the Baffin, Haggerty found that 45% of those who participated in his survey had thought about suicide in the previous week (Haggerty, Cernovsky, Kermeen and Mersky 2000) He also pointed out that among those who had contemplated suicide, 27% could be considered depressive, 24% exhibited severe anxiety and 64% had a personal history of alcohol abuse. In his study of mortality in the

Keewatin MacAulay found that 18% of those surveyed in the Keewatin Health Status Assessment Study had planned or attempted suicide. He found that sexual abuse was the strongest predictor of suicidal behaviour (MacAulay 2002)

Those interested in suicide rates over time or in the suicide rates for individual communities have several resources at their disposal. Until 1999 the coroner of the NWT was responsible for documenting the number of deaths by suicide in the eastern and western Arctic. Since then, the Nunavut coroner is responsible for releasing this data. The coroner provides information on the community in which the suicide took place, the age, sex and ethnicity of the individual, and the method of suicide. See topic 1 of the bibliography for specific titles. In addition, since 1997 the Department of Health and Social Services in the Northwest Territories has maintained a suicide database of 343 suicides from 1981 to 1996. The data relies on information from the coroner and RCMP to describe basic demographic data, method and activities in the final days of the deceased. This database tells us, for example, that 78% of the victims were male, 87% were Inuit, 73% were between the ages of 15 and 29 and hanging was the most frequent method. Because it covers the entire NWT the database contains information about suicides in Nunavut. The database also contains information currently not maintained by the Nunavut coroner. This extra information tells us that 68% were single, 53% were unemployed, and 77% were living with family members. Most suicides occurred in the bedroom of individuals, between 10pm and 10am, often when other people were in the home. More recent information about suicides in the Northwest Territories shows that the suicide rate has increased after division. In the western Arctic suicide predominantly affects Inuit or Inuvialuit men. The age group at highest risk is older in the NWT, between 30 and 44 (Little 2002). In addition, deaths by suicide tend to involve firearms rather than hanging. For all other statistics, however, the suicide profile of the NWT resembles that in Nunavut. Last, in their investigation of suicides in the NWT Isaacs et al found that suicide attempts in the north are not characterised by intoxication. This contrasts with suicides in southern First Nations communities or in Alaska, where high alcohols is implicated in 65% and 80% of suicides respectively (Isaacs et al 2000). We should be wary about data on alcohol, however, as it is dependent on the information collected by the coroner and the state of the individual when examined. At present the NWT gathers information on suicides by using Suicide Research Forms that are completed by the coroner or caregiver following death. The forms track the circumstances of death, the personal history of the individual and significant life events. Further information about the circumstances before suicide will be mentioned later in this report.

What do we understand about the causes of suicide in Nunavut?

If the previous section was able to inform us about the irrefutable facts of suicide in Nunavut, the rest of the report deals with less certain material. Suicide in Nunavut is remarkable both because it is so high, and because it has attracted so much attention. The increased rate should not be seen as evidence of a lack of effort among government workers and individuals in the community who are attempting to get to the bottom of the problem. There is considerable consensus about the potential causes of suicide. Rarely is this consensus backed up by data although research conducted in Nunavik helps to animate some of the main arguments. This section explores what people are saying about suicide in Nunavut, how they are identifying causes, and identifies the key points on which there is agreement of disagreement.

The academic literature suggests that suicides can be distinguished between two types of sources, those stemming from psychological disorders and those stemming from elevated exposure to stress (Kirmayer et al 1998: 8). In general, suicide in Nunavut is associated with the latter. Thus, the elevated suicide rate in Nunavut is not attributed to higher rates of mental illness or psychological disturbances but is seen as a result of elevated exposure to daily stressors. Much of this argument stems from the presence of serious and obvious stresses in daily life. Mental health literature suggests that exposure to or experience of physical abuse, sexual abuse or substance abuse, having a friend or family member who committed suicide, a sense of alienation or hopelessness and mental health issues such as depression could put individuals at higher risk of suicidal behaviour. In Nunavut, higher rates of alcoholism and substance abuse, a high education drop-out rate and rapid cultural change could all be considered the types of stressors that would result in social rather than psychologically-motivated suicide. This is a reasonable assumption, but it is still an assumption. For the most part we are lacking information about the psychological health of young Inuit. We know from research in other parts of the country that First Nations Canadians tend to have higher rates of depression. It would not be unreasonable to assume that the same is true for Inuit in Canada. In short, we know that young people in Nunavut are suffering from above average stress. We don't know, however, whether they are also suffering from above average psychological disorders that would provoke thoughts of suicide (often referred to as 'suicidal ideation').

When studying suicide in Nunavut we can distinguish between predictors of suicidal behaviour that affect all young people in Canada, and predictors that would only be relevant for Inuit. An example further illustrates this point. We know that families prone to alcohol abuse, substance abuse and violence are more likely to produce teenagers who think about suicide. This relationship, between family behaviour and teen behaviour, would be the same in Manitoba as it is in New Brunswick and in Nunavut. We might call these 'general' predictors. We also know, however, from research on indigenous

populations in the United States, Australia and New Zealand, that rapid cultural change can lead *eventually* to higher suicide rates in populations. We might call these 'specific' predictors because they are specific to certain populations. This is something that would be relevant to Inuit in Canada, but would not necessarily be relevant to all individuals in Manitoba or New Brunswick. If the suicide rate in Nunavut is higher than in other provinces or territories, we must ask whether it is due to a) a higher rate of 'general' predictors, b) the presence of 'specific' predictors, or c) a combination of both.

The various reports from conferences, workshops and consultants in Nunavut, in addition to literature from other Inuit jurisdictions in the Northwest Territories and Nunavik suggest that a combination of general and specific predictors are driving suicide rates among Inuit in Canada. The literature also suggests that we should distinguish between background factors that inhibit the ability of individuals to deal with stress – and thus make them more prone to contemplate suicide - and the more immediate factors that prompt someone to attempt suicide.

Examination of the background factors argues that Inuit youth are characterised by a sense of hopelessness and helplessness. Youth appear to be caught between two worlds, between traditional Inuit society and contemporary society, and don't appear to fit in well in either world. Many of the reports suggest that young Inuit feel a sense of loss over their weak integration into traditional culture. These same young people do not necessarily possess the skills that would allow them to adapt to a contemporary economic world. Low literacy rates, high drop-out rates and high levels of unemployment are undermining the sense of hope that young people might have for their future. Young people are disconnected from their elders, are not encouraged by their parents to pursue full-time education and are let-down by an education system that is less culturally relevant than it should be. In addition, young Nunavummiut are often coping with family stress, with violence, physical and sexual abuse, alcohol and drug abuse either personally or in the larger family unit, often in crowded housing conditions that exacerbate any existing conflicts. Research in other jurisdictions clearly identifies the links between alcohol, violence and suicide (Rossow 2000). General levels of physical health are also lower in the territory. Stout and Kipling report that alcohol consumption among pregnant women is higher, there is a high incidence of middle ear infections that have a detrimental effect on hearing, high levels of dental decay and prevalent clinical depression, all of which creates additional physical stress for individuals. (Stout and Kipling 1999). Health Canada and Santé Quebec report that Inuit have lower life expectancies, lower rates of physical activity, higher infant mortality and higher rates of respiratory diseases. (Health Canada 2000, Santé Quebec 1992). This suggests that both the physical and mental health of Inuit requires attention.

These background factors create a sense of overwhelming stress and at the same time undermine the ability of individuals to cope with that stress. This low resilience is compounded by more immediate factors. The loss of romantic relationships, impulsivity and access to firearms are all seen as factors that turn suicidal ideation into attempts. Young people who are worn down by daily stressors, who feel no hope for the future and feel cut off from their culture react poorly when, for example, their romantic relationship ends or a close friend with whom they identify commits suicide (Wilkie, Macdonald and Hildahl 1998). In addition, the higher rates of suicide among men are attributed to the greater disruption in their societal roles. The role of women in traditional Inuit society has more in common with their contemporary caring roles. Some reports suggest that if anything, women enjoy greater empowerment now than in traditional society. The opposite is true for men, whose roles as hunters and providers have been undermined by the imposition of a wage economy for which they were ill-prepared. Kirmayer et al warn, however, that the greater discontinuity among male roles is a hypothesis and not grounded in evidence (Kirmayer, Malus and Boothroyd, 1996: 15). Nevertheless, in a *New York Times* article one Baffin activist pointed out "When you reduce the usefulness of men in society, it is bound to have psychological effects" (Brooke 2000). This combination of general and specific factors animates what we often say about suicide in Nunavut.

Some of this is clearly supported by evidence. Research for First Nations communities in southern Canada clearly links cultural disruption with family breakdown and low levels of resilience (Quantz 1997, Stack 200a, Stack 2000b). In addition, research in Greenland argues that the increase in suicides in the 1970s suggests rapid modernization is partially responsible for creating a deterioration in social conditions (Bjerregaard and Curtis 200, Leineweber 2000, Leineweber, Bjerregaard, Baerveldt and Vostermans 2001). Research on Inuit communities in Canada provides even more compelling evidence. Over the past ten years Laurence Kirmayer of McGill has conducted a number of surveys and investigations of youth suicide in Nunavik (Kirmayer 1994, Kirmayer, Malus and Boothroyd 1996, Kirmayer Fletcher and Boothroyd 1998, Kirmayer Bootroyd and Hodgins 1998, Kirmayer et al 1998, Malus, Kirmayer and Boothroyd 1998). The suicide profile of Nunavik is similar to that of Nunavut. In a 1992 survey of 100 youth he found that 34% had attempted suicide at least once. Almost half of the sample had contemplated suicide. He indicates that parental substance abuse, a personal history of abuse or mental health problems, a sense of alienation and having a friend who committed suicide could all be associated with an elevated risk of suicide. Doing well in school and regular church attendance were the only things associated with a lower risk factor. In a later survey Dr Kirmayer confirmed these findings and identified differences in risk factors for different sexes. Sexual abuse is a strong predictor of suicide among women while death of a close relative while under the age of twelve was a strong predictor of suicide for males. He noted that adoption and employment tended to have no influence on

suicidal behaviour. In other words, individuals who were adopted or unemployed were not more likely to contemplate or attempt suicide. In his investigation of Mortality in the Keewatin MacAulay found that solvent abuse, parental substance abuse, the recent loss of a romantic relationship and involvement with the justice system were strong predictors of suicide attempts (MacAulay 2002). His examination of records suggest that friends and family noticed emotional distress among most of those who died by suicide, including elevated levels of aggression, and a voiced intent to commit suicide. Almost one third had at least one previous psychiatric diagnosis on their medical charts although the range of diagnoses was quite large, including alcohol and drug abuse, depression, a personality disorder and schizophrenia.

This is what most of the reports say about suicide in Nunavut. The discussion of the risk factors also raises a number of key debates, some of which would have an impact on the creation of any suicide prevention program in Nunavut. Each of these debates deals with the cultural change that occurred within Inuit society from the 1940s to the present. Cultural change is a *specific* predictor perceived to produce higher rates of *general* suicide predictors in Nunavut. While change occurs in other cultures, it is rare that it would occur at such a rapid pace. The effect is a population that differs greatly by age cohort. Kral and Minore suggest that there are in fact three distinct groups within Inuit communities (Kral and Minore 1999). The first group consists of elders who lived traditionally for most of their lives and are often unilingual Inuktitut speakers. The second group consists of adults who were perhaps born on the land and who were placed in residential schools where they learned English. According to Kral and Minore the majority of these Inuit are now devout Christians. The third group is youth who speak English among themselves, have difficulty communicating with their parents and elders, if not in the same language then at least in terms of the values and goals that they have for their lives. The authors suggest that the gap between these generations is contributing to a sense of social disintegration and is driving up rates of sexual, physical and substance abuse.

We must be careful arguing that rapid cultural change causes suicide. The group that witnessed the most extensive change – the unilingual Inuktitut-speaking generation that was born on the land and now lives in communities – does not have a high suicide rate. In fact Inuit elders have a lower suicide rate than other Canadians of a similar age cohort. Undergoing change itself does not make a person more likely to commit suicide. Instead, cultural change over generations affects a society in such a way that inter-generational differences become striking. Pain and bewilderment are evident among adults and elders but it is the youth who are committing suicide. Cultural change and the relationship between traditional society and contemporary society involves two associated issues, first, the relationship between parents and the education system, and second, the relationship between elders and youth.

Much of the literature suggests that Inuit have lost the power to parent. This is not to suggest that Inuit parents are irresponsible but rather that the role of Inuit parents has been drastically diminished by the education system. If children once spent all day in the company of their parents, they now spent a large portion of it in the care of teachers. This is exacerbated by the removal of an entire generation of Inuit from their parents. Those who attended residential schools did not learn from their parents, and thus watch parenting-in-action, but were educated by a religiously-based system that sought to strip them of their culture. As a result, this generation has not had the same exposure to lived-lessons in parenting. In addition, the movement to settled communities, the introduction of universal education and a wage-economy requires skills and abilities that do not have obvious parallels in the traditional skills once taught by parents to children. The report from the Pauktuutit Inuit mental health workshop points out that children benefit from establishing a strong sense of attachment to their families. The ability of parents to provide this is hampered if they have been sexually abused in the past (Pauktuutit 1991) In short, some parents are coping with terrible incidents that occurred in the past, some parents are less able to impart the contemporary skills necessary for success in a wage economy, and these skills are not being taught well by the education system. This relates to the concept of discipline and the immediacy of life lessons. Traditional Inuit society had a functional view of discipline. Children were treated as small adults and expected to make decisions for themselves (Pauktuutit 1991, McDougall 1994). Some of the reports on suicide suggest that children feel let down by parents who did not require them to finish their education (Kivalliq Consulting 1986). For these parents, no doubt, the decision was to be made by the child. In addition, lessons learned in traditional society were more immediately relevant. Hunting practices and survival on the land were essential lessons of obvious importance. This is not the case in contemporary society, where the benefit of skills learned in the education system often aren't relevant until after students leave school. The result is a lack of motivation made worse by the high turnover in education staff, the low proportion of Inuit teachers and the tendency among some parents to not encourage children to stay in school.

The second issue is the relationship between elders and youth. Rapid cultural change means that elders and youth have led very different lives (NSDC 2000). In addition, contemporary society has changed what it means to be a young Inuk. Traditional Inuit society did not have a developmental phase equivalent to adolescence. Instead, individuals were either children or, when they reached puberty, were considered adults. For young men, adulthood began with the first hunting kill. Currently, young people are not treated as adults. They are excluded from the economic activity of adulthood and lack the same rights and privileges as adults (McDougall 1994). Young people living in abusive family situations often do not

qualify for access to housing that would remove them from the home. At the same time their absence from the labour market denies them financial self-sufficiency. In short, youth have been disempowered by contemporary society. At the same time, youth are confronted with suggestions of their empowerment. The education system teaches them to be far more vocal than they would have been in traditional Inuit society. Media, particularly television, provides images of youth faced with boundless opportunities. The result is that young Nunavummiut have expectations about the way they should be treated and that these expectations are not necessarily how elders believe young people should be treated. In their investigation of the feasibility of conducting psychological autopsies Davidee et al suggested that young people are more selfish than they used to be (Davidee et al 2003: 13). Without question young people are dealing with problems that were not faced by their parents or elders.

The relationship between elders and youth also speaks to the transformation of the family unit. Kral et al note that traditional Inuit society was characterised by a vertical family unit in which there were strong bonds across generations (Kral et al 1998). The movement to settlement, universal education and a generation gap between elders and youth has created a horizontal family united in which the strongest bonds are among those of similar age cohorts. Generations are thus increasing segregated from one another. Younger people visit elders less frequently than they used to. Kral suggests that this shift, from vertical families to horizontal families, is common in all societies undergoing change. What makes it so present in Nunavut is the speed at which it occurred. Individuals living in larger communities tend to see their families less often, even if they live relatively close to one another by southern Canadian standards. Elders that Kral interviewed argued that arenas were keeping young people from spending time with their families and were preventing them from learning traditional practices. Youth, in contrast, tended to appreciate the opportunity to engage in activities away from their homes, where they could enjoy privacy and visit with friends.

The last issue related to cultural change and youth-elder relationship is the concept of success. Many young people feel that they do not belong in either context and feel a profound sense of failure. Equally worrying are those who appear to be doing well, appear successful whether in school or sports or employment, but feel a tremendous burden from their family or community. Some research shows that older favoured children who are doing well in school are at higher risk of suicidal behaviour (O'Neil 1984, Kirmayer et al 1998). Part of this is driven by pressure for success. Paradoxically, part of this is driven by shame. Bachman reports that efforts to return to traditional values may lead some who are successful in a contemporary context to feel shame (Bachman 1992). In both these cases, otherwise successful individuals feel a considerable burden that exacerbates any normal setbacks that they may face. We must be worried when individuals who do not succeed feel a lack of hope and individuals who do succeed are faced with such pressure that both groups see suicide as a viable option.

The process of cultural change from traditional to contemporary society has produced diverse interpretations of the challenges facing young Inuit. The negative impact of contemporary society on social cohesiveness has been highlighted by some who feel that "rock music lyrics" and "television violence" have been promoting suicidal behaviour (Tilden 1997c). In the conclusion of her three-part series of articles on suicide in Nunavut Jennifer Tilden reported that former NWT MLA Mark Evaloarjuk believed that women's shelters were leading to increased suicides (Tilden 1997c). By providing battered women with an opportunity to leave their homes the shelters were facilitating broken homes. According to Evaloarjuk this in turn was discouraging husbands and wives from working out their problems. The loss of romantic relationships is seen in much of the literature as an immediate predictor of suicide. In a second interpretation, Mark Stevenson suggests that the collapse of the market for seal skins is responsible for the disproportionately high suicide rate in the Baffin (Stevenson 1996). Long the centre of sealing activity Nunavut communities such as Pangnirtung and Qikiqtarjuaq were hardest hit by the decline of the industry. Suicide rates in each of these communities have been high since the collapse of the seal market in 1983.

What information do we have about successful suicide prevention and community wellness programs?

Suicide profiles in Greenland, Alaska, and even farther away in Australia and New Zealand suggests that indigenous populations who lived through periods of acculturation and rapid change to their social and economic lives are coping with similar issues to Inuit in Nunavut. We can look to action within Nunavut and action in these places to determine how communities are able to organize themselves, and what impact they are having on suicide rates. This section is divided into five parts. First, it explores the relationship between community wellness and suicide prevention. Much of the literature suggests that these two issues must be addressed at the same time. In isolation, suicide preventions programs will have a limited impact on suicide rates. In addition, without a specific attention to suicide, community wellness programs will not necessarily result in lower suicide rates. In short, the two issues are related. This first section examines the issue of healthy

communities, what they look like and how they operate. It then continues to discuss cases where communities coping with the grief of suicide mobilized to heal themselves and erect suicide prevention programs. The final two sections examine effective partnerships and suicide prevention programs. The document looks at existing programs but also summarizes the recommendations of the various reports and commissions.

There is considerable activity on the topic of suicide prevention in Nunavut. Table 3 summarizes activities in the last thirteen years that attempted to better understand the issue of suicide and to provide a way forward. This is far from an exhaustive list, but provides a sense of the range of activities. An initial burst of energy in 1990 led to a NWT suicide prevention strategy, regional suicide prevention forums and mental health workshops. After 1999, the Department of Health and Social Services has been the lead government department on suicide prevention. Recent initiatives include an inter-departmental symposium to identify suicide prevention and community wellness programs in the departments. The meeting report (DHSS 2001) demonstrates that the Department of Health was engaged in training workshops for RCMP, social workers and youth, covering such diverse topics as peer counselling, addictions, abuse, depression, and suicide prevention. At the same time the Department of Community Government and Transportation was offering community activities through Sports Nunavut and Recreation and Leisure, including girl guides and igloo building courses. It was anticipated that these activities would help to engage young people. The Department of Justice was offering a Community Justice program that dealt with individuals outside the mainstream court system. The RCMP was then, as now, involved in the Dare program, a 17 week drug awareness program that covers issues relating to alcohol, violence and self esteem. The workshop also discussed resources made available by volunteers within communities. These include healing circles in Pangnirtung and grief kits made available to schools in the Baffin region. One year after this inter-departmental meeting the Department of Health and Social Services made $2.2 million available for a mental health strategy that would include suicide prevention activities.

The past year has been a particularly busy one. In 2003, the Canadian Association for Suicide Prevention held its annual conference in Iqaluit, an event that coincided with two workshops of the Department of Health that brought together elders and youth from across Nunavut. The report from the Inuuqatigiisiaqniq workshop has several important recommendations mentioned later in this report (Brackenbury 2003). Also in 2003 EIA's Evaluation and Statistics Division commissioned a study of psychological autopsies and arranged for a workshop on the evaluation of suicide prevention programs. The psychological autopsies, discussed later in this report, would gather information on the circumstances surrounding suicide and would supplement information currently collected by the coroner or available through the file review process. The evaluation workshop highlighted both the presence of diverse suicide prevention programs and the lack of evidence-based evaluation of their success. Also Last, Nunavut Tunngavik Incorporated released a suicide prevention video that discusses the types of background factors and immediate factors discussed earlier in this report. The video stresses the importance of Inuit values as a protective factor against suicidal behaviour. In short, there appears considerable activity within Nunavut and considerable momentum in 2003 to the creation of a comprehensive suicide prevention policy. The following sections discuss the main themes raised in other suicide prevention and community wellness policies.

Community Wellness

Suicide is usually seen as the result of a wider problem of mental health and community wellness. To be healthy, individuals must feel capable of overcoming any problems that they may face and must feel that they have support from others, whether within the family or in the wider community. They must also feel a balance between their physical, mental, emotion and spiritual sides (Pauktuutit 1991). Research on First Nations suicide in southern Canada and the United States suggests that a high level of cultural spirituality orientation and strong social identity is a protective factor against suicide (Garroutte et al 2003, Eckersley and Dear 2002). Much of the literature argues that suicide in Nunavut is the result of a breakdown in the cohesiveness of Inuit society. Individuals who once depended on each other and supported each other are now less aware of the problems suffered by others and thus less available and able to assist. Cohesion speaks to the relationship among families and generations, between traditional and contemporary culture, between Inuit and Qallunaat. Other literature suggests that healthy communities are empowered, in charge of their own affairs and future. In their investigation of suicide rates in First Nations communities Chandler and Lalonde found that the degree of self-government affected suicide rates (Chandler and Lalonde 1998, Lalonde 2000). Communities that had greater control over their governance, were at an advanced stage in treaty negotiations, had local education and child protection initiatives tended to have lower suicide rates. A third theme in the wellness literature suggests that communities must be active. Much of the literature suggests young people lack activities that encourage self esteem and promote both physical and mental health (Stout and Kipling 1999). In addition, boredom is seen as predictor of suicidal behaviour (Malus et al 1998).

Communities must not only be cohesive, empowered and active, they must also deal with grief and suffering caused by the experience of colonialism and the more recent experience of suicides. Colonialism is credited with producing a collective sense of shame about cultural identity. Residential schools destroyed the social fabric and created docile, obedient,

"unthinking followers" (Pauktuutit 1991). Research from reserves in southern Canada suggests that colonialism has created a socio-economic "incompleteness" in the lives of First Nations people (Carstens 2000, Coulthard and, Sinclair 1998)

In Nunavut there are many activities designed to create active, cohesive and empowered communities. One recent report highlighted some of the positive developments currently being made in Nunavut. It emphasised the importance of community events, play groups, Inuit RCMP members, elder-youth camps, youth counselling and sports activities (Brackenbury 2003). At present there are several government activities that seek to fund and thus promote community wellness. An investigation of some of these highlights the relationship between healthy communities and suicide prevention.

Under such programs as Building Healthy Communities and Brighter Futures communities have sponsored community events, play groups, youth camps, sports activities, elders centres, and breakfast programs. Tables 4 and 5 examine the range of activities available through government-sponsored funding. Table 4 examines activities for 1998-1999, the last year that programs were administered by the GNWT. The table identifies the number of suicides from 1999 to 2002 so that these numbers may be examined in light of activity levels. Next it reports the total funding available through government programs. Funding totals include Brighter Futures and Building Healthy Communities , the Canada Prenatal Nutrition Program, the Aboriginal Head Start Initiative, the Aids Community Action Program, the Community Action Program for Children, the Community Animation Program, The Population Health Fund and the Healthy Children's Initiative. It reports the total number of activities taking place under these various programs. In addition, it identifies whether the community had a suicide prevention coordinator, a community wellness coordinator, a nutrition program that provides food for young people and last, a suicide prevention program. Included in the latter are one-off workshops, conferences and ongoing programs. In short, it casts a relatively wide net. Last, among the *remaining* programs (ie those not involving community wellness coordinators, nutrition or suicide prevention) the table identifies the number of activities that emphasised traditional skills or events, and the number of activities that emphasised contemporary skills or events. The table further distinguishes between short activities that ran for fewer than two weeks, and ongoing activities. Some of the activities could not be classified because of lack of information and in some cases it was not possible to identify whether the emphasis was on traditional or contemporary skills. Thus, the number of activities will not necessarily be the same as the number in the total column. This is intended to provide only a rough estimate of the general activity levels of communities and the tendency for them to provide a blend of traditional and contemporary activities. Table 5 includes the same information for 2003 but here the information is limited to the Brighter Futures and Building Healthy Communities programs. For this reason both funding levels and total activity levels will appear lower than in 1999. This reflects the data available and should not suggest that individuals or communities are less active than in 1999. Further information on these activities may be found in the Community Wellness reports for the NWT and, since 1999, in the year-end reports of the Brighter Futures/Building Healthy Communities projects, published by the Department of Health and Social Services. Additional activities are made possible through the Department of Justice in Canada. Nunavut Crime Prevention Initiatives include counselling at schools, judo classes, community justice committees and life skills courses. (Department of Justice 2002).

The tables show a wide range in funding and total activity levels. For the most part larger communities hold a larger number of activities. There does not appear to be a pattern to the balance of traditional or contemporary activities. While placing some activities in one category or the other proves difficult, it is possible to classify most of the activities as either traditional or contemporary. In many cases, communities that offered more traditional activities in 1999 tended to offer more contemporary activities in 2003. The reverse is also true. Communities seem happy to provide a range of opportunities and vary these activities from year to year. In 1999 there appears to be a marked distinction between very active communities, offering greater than 10 activities, and communities that offer fewer events and programs. By 2003 this disparity has been replaced with a more even distribution of activity levels. Some of these active communities have very low suicide rates. Sanikiluaq, Gjoa Have and Kugaaruk, for example, have had one or fewer suicides between 1999 and 2002 and offered ten or more community activities in 1999. Keeping this in mind we can look to two other programs that seek to promote suicide prevention through community wellness.

Example 1: Alaska Community-Based Suicide Prevention Program

Alaska has a high suicide rate. The current suicide prevention program is grounded in the belief that empowered and active communities will produce healthy individuals. As a result the program offers non-competitive grants for which communities may apply. Funds are used to hire a co-ordinator and to provide a number of community activities. Communities may decide which activities they want to hold and need not include the word 'suicide' in the name of the program. Evaluation of the program suggests that communities holding between six and nine activities are able to focus their efforts and resources in a way that provides for successful events. Communities in which the program operates have seen an overall decline in their suicide rate. The number of First Nations suicides in the state has decreased by 22% recently but communities with active programs have seen a 51% reduction in suicides.

Example 2: Going for Goal (GOAL), New Zealand
This is a sports activity program piloted for Maori in Dunedin, New Zealand and follows closely the organization of the 25 established programs in the United States. The program uses sports as a metaphor for life and aims to teach young people to set goals and to focus on the process involved in reaching those goals. Participants are encouraged to identify and limit health-compromising behaviours and to seek support from their social network. Organizers believe that setting goals in a sports setting will encourage individuals to identify life-goals. The program also aims to provide individuals with leisure activities and thus reduce boredom and help to channel aggression through physical exercise.

Moving beyond the walls of silence

It is not clear how communities can move beyond their grief to begin the healing process. Many efforts begin with communication and encouraging individuals who are living with grief to open up about their past experiences. In Nunavut there are plans for elders to visit communities and meet with individuals seeking to talk about suicide. This will certainly meet the need of individuals to talk about their problems. Examples of similar activities in other jurisdictions suggest that communication is an important first step in the healing process. In his investigation of suicide in Australia Tatz warns, however, of the stress that communication about suicide can cause. Care should be taken so that all individuals, both those coping with suicide and those who are listening, receive sufficient support and counselling. The researchers assisting Tatz , for example, required regular counselling through their project. A recent conference on "Lifting the silence" in Alberta encouraged communities to begin dealing with suicide by identifying those at high risk and behaviours that would help to protect them. The conference report urges individuals to consult *Aboriginal Youth: A Manual of Promising Suicide Prevention Strategies*. Talking about suicide prevention is seen as the first step in acting to combat it. Two other examples show how different communities are attempting to move beyond the walls of silence.

Example 1: Stolen Generations Project
The Stolen Generations Project is a web-based effort to encourage Aboriginal Canadians to deal with the consequences of residential schools and adoption. The website collects stories from individuals about their experiences and seeks to increase awareness about the Aboriginal experience with residential schools and adoption, to "reclaim culture identity" for affected Aboriginal individuals and establish a support network for affected members. By encouraging individuals to talk about their experiences the website hopes to encourage a healing process among affected individuals while at the same time ensuring that Canadians are made aware of the diversity of Aboriginal experiences.

Example 2: New Zealand Suicide Prevention Policy
In 1997 the Government of New Zealand sought to create a suicide prevention policy. The suicide profile of Maori youth in New Zealand is similar to that in Nunavut. Cultural change has resulted in substance abuse, depression and family breakdown. Risk factors associated with suicidal behaviour include previous attempts, having a friend who died by suicide, low self esteem, loss of a romantic relationship and cultural alienation. A research report on suicide in New Zealand indicated that "indigenous mental illness is thought to be related to the outcomes of trying to live in two worlds and fitting into neither" (Lawson Te-Aho, 1998: 16). This will sound familiar to those analyzing suicide in Nunavut. To inform the development of the suicide prevention policy the Department of Maori Development facilitated the creation of a Maori Reference Group. The group was responsible for ensuring that the national policy reflected the needs of the Maori population. To ensure that the group adequately understood the needs of Maori it focused on facilitating communication with individuals interested in suicide prevention. The group held community meetings and focus groups with members of the public. The public was also invited to make submissions. The reference group was particularly interested in hearing from young people. Evidence from these activities suggested that suicide was associated with an erosion of cultural identity, that individuals felt alienated from their land and culture and that they felt dispirited. Young people felt they had no one to go to for support, and that they had little understanding of what was expected of them. The group recommended that the suicide prevention strategy focus on strengthening participation in the community and strengthening a sense of Maori identity. It argued

that communities need better information about the causes and risks of suicide and recognized the importance of the informal support networks surrounding individuals. It recommended an increase in education scholarships and an increase in youth activities such as sports teams and youth committees and the establishment of cultural orientation in prisons, schools and hospitals. Last it suggested that improved accuracy in the recording of attempts and deaths and a comprehensive evaluation of suicide prevention programs was necessary to ensure the effectiveness of the prevention strategy.

Effective partnerships

Partnerships are essential to suicide prevention and community wellness because it takes a whole community to heal a community, because the task is often so large that all available individuals are required, and because different people have different skills to bring to suicide prevention. Often, partnerships are between governments and other institutions but they can also be between elders and youth, between schools and parents, between medical institutions and traditional healers. In its review of the NWT regional forums on suicide prevention, "Working Together Because We Care" argued that because suicide is indicative of a larger problem within the community, it isn't something that should be left to one government department. Suicide prevention should involve not just the Department of Health, for example, but should integrate those dealing with education and economic issues. Coordination with these departments, in addition to the health providers, clergy, local government and volunteers will allow for a more comprehensive approach. Sometimes partnerships can be between governments and communities. Health Canada, for example, is interested in partnerships between health care system and Inuit communities (Inuit Health Initiatives 2000). This section deals with two types of partnerships: between formal and informal support systems, and between elders and youth.

There is a sense in Nunavut that individuals access their informal support networks more than the formal health system. In their review of psychological autopsies Davidee et all suggested "When people are suicidal, they don't seek out or have any use for support systems" (Davidee et al, 2003). This is supported by existing research on youth behaviour in Nunavik. In a 1992 study of 100 young people, Malus et al found that youth were generally unable to identify who they would go to for help if they needed it (Malus et al 1998: 5). The same survey asked individuals if they were depressed who they would talk to first. None of the respondents suggested they would speak to a doctor (Malus et al, 1998 : 44). There were, however, important differences in behaviour according to gender. If they suffered from physical abuse none of the female respondents indicated that they would speak to a doctor, while approximately one third of men said they would contact their doctor or nurse. The trend is reversed for sexual abuse. None of the male respondents said they would go to a doctor if they were sexually abused but over 80% of females said they would contact their doctor. This suggests that the formal system is underused, but that different people approach medical professionals under different circumstances. This is perhaps both an access issue and a relevance issue. It is also worth noting that the same survey suggested that individuals are not more likely to discuss their problems with a community helper or elder. None of the respondents said they would consult a community helper first if, for example, they were physically abused. This suggests we should be careful assuming that all people feel more comfortable talking to community-trained volunteers rather than the formal system. Many individuals are more likely to contact their friends. Malus et al asked respondents if they had any of eleven problems who they would talk to first. For seven of the eleven items, individuals would go to their friends first. We must combine this information, admittedly from a small sample, with what we know from investigations of coroners reports and RCMP records. According to this information, many of those who committed suicide have been seen by a health professional shortly before their suicide attempt. MacAulay's investigation of Keewatin suicides shows that 20% of individuals had visited a health centre in the week before their suicide attempt. Partnerships with medical professionals and community workers must acknowledge that some individuals may be trying to access the help they need but might not be able to find it from the person, group or service with whom they feel most comfortable. This is related to the issue of partnerships between elders and youth.

One recent workshop report indicates that when asked for their ideas on suicide prevention youth recommended that the names of support persons and clinics be distributed to each home. They also recommended teen talk clinics and activities that involved sports, land skills, and traditional skills (Brackenbury 2003). Youth appear to want youth centres and are not interested in strangers or stress managers descending on their family or community after a suicide. Instead, they want to be surrounded by family and friends before dealing with others. The report suggests that youth need to mingle with other youth and to escape their "overcrowded" homes (Brackenbury 2003). Youth are interested in peer counselling and seeking support from their friends. This confirms the shift from vertical families to horizontal families mentioned earlier. The transition from traditional to contemporary society has created stronger bonds among those of similar age cohorts in part because the pressures facing each cohort are so different. Youth clearly see elders as repositories of traditional skills. They see them as a way to get in touch with their culture and identity. They do not necessarily see them as a source of advice for

the issues facing their navigation through contemporary society. Elders want youth to improve their land and language skills. Young people often want activities that allow them to interact with elders but do not want them at the expense of activities that allow them to interact with other youth. In the minds of youth there is a clear division between suicide prevention, something they see resolved through the formal system and in peer groups, and the sense of cultural distance, which they see resolved in more frequent activities with elders. For the most part, these two approaches, suicide prevention and cultural regeneration, are united in the minds of elders. Any strategy must acknowledge that elders and youth do not necessary want the same things out of their partnership with each other. Two further examples speak to the different types of partnerships that are possible between governments and communities.

Example 1: Injury Prevention Resources
As part of a partnership between Health Canada and Inuit communities, the First Nations and Inuit Health Program Directorate has developed three injury prevention resources to help communities cope with risk-taking behaviour and their resulting injuries. The partnership includes suicide in its definition of risk-taking and injuries. The resources include an injury prevention guide, a guide to resources and funding for injury prevention programs and an Aboriginal Injury Surveillance Tool that allows communities to gather and analyze information on risk and injuries.

Example 2: Aboriginal Corrections Unit
Based within the office of the Solicitor General the Aboriginal Corrections Unit is a partnership between the Government of Canada and Aboriginal communities. It focuses on community justice and advocates connecting with people rather than directing their lives. The unit community activity report contains a list of resources and programs used in Manitoba and Quebec that seek to provide alternatives to the court system. In addition, the unit has provided a community development resource package that provides guides on how to do research, how to establish committees of community members and how to establish community programs. The unit aims to empower communities by encouraging them to establish partnerships amongst themselves and with the government. The resource package also contains information on government funding to which communities can apply.

Suicide prevention programs

> "Of immediate need are tools, methodologies and training opportunities that will help to identify currently vulnerable individuals, the situations or conditions that heighten their vulnerability at any one time and their risk behaviours, so that professionals as well as immediate friends and family can be alerted to the imminent danger of suicide"
>
> Isaacs et al, 2000

In the early 1990s participants in regional suicide prevention forums argued that the lack of suicide prevention resources gives the impression that it is not a high priority. Following these forums the NWT created a territorial suicide prevention strategy. Nunavut, however, has not yet created a comprehensive suicide prevention program and much of the research suggests that one is needed. Research in Australia and New Zealand suggests that comprehensive programs give the impression that suicide is a community responsibility and not something to be left to individuals (Ferry 2000). When they articulated what a program for Inuit communities would look like, Pauktuutit argued for increased training of Inuit suicide prevention counsellors, the involvement of elders who would assist these counsellors, the creation of support groups and workshops on suicide provide (Pauktuutit 1991). Pauktuutit stressed the importance of providing the public with an opportunity to voice their concerns and of encouraging individuals to talk. Suicide prevention programs usually focus on three approaches, the prevention of suicidal behaviour, intervention in the event of suicidal thoughts or attempts, and postvention following a suicide. This section explores current activities in Nunavut and provides examples of successful activities in other jurisdictions.

Suicidal prevention normally focuses on the underlying attitudes and behaviours of the population and seeks to reduce the sense of hopelessness and helplessness while increasing resilience and ability to deal with stress. Suicide prevention can also involve such activities as means reduction, reducing the availability of things used in suicide attempts. In the north this

often means reducing access to firearms although in Qikiqtarjuaq closet bars were removed during a recent increase in suicides. In southern Canada this can mean reducing access to high bridges. Many reports encourage the government to shift away from crisis response, which is by definition too late, and move more towards suicide prevention (Brackenbury 2003, Henderson 2003, Stout and Kipling 1999)

In 1999 very few communities had anything resembling a suicide prevention program, even if defined broadly as a workshop or conference. By 2003, however, most communities were participating in some form of suicide prevention program although it is worth noting that there were no programs operating in the Kitikmeot, which tends to have a lower suicide rate. In the Baffin and Kivalliq, some activities involved the Whitestone Aboriginal Youth Suicide Program. Funding available through Brighter Futures/Building Health Communities made it possible for individuals from seven communities to attend the training workshop in Iqaluit. Operated by the RCMP the Whitestone project is designed to educate youth about risk factors and aims to increase their levels of self confidence and leadership. The goal is for individuals who complete the program to return to their home community to exercise leadership and encourage others to engage in suicide prevention activities. Communities who benefited from Brighter Futures/Building Healthy Communities funding for the Whitestone program included Clyde River, Hall Beach, Pangnirtung, Qikitarjuaq, Coral Harbour, Rankin Inlet and Repulse Bay. Other activities included a four day camp for youth in Coral Harbour. Forty youth from around Nunavut were accompanied by elders, parents, volunteers and counsellors. Following a 20 kilometre hike the young people established a camp and discussed suicide prevention. In addition to the event, Pangnirtung made additional counselling available for those from Pang who attended the event. Other examples of suicide prevention activities include a workshop in Cape Dorset to facilitate healing and recovery and encourage people to communicate their sense of grief over suicide. No doubt these are just a sample of the suicide prevention activities taking place in Nunavut. Events not directly funded by the Brighter Futures/Building Healthy Communities have not been listed. At present there is no comprehensive list of current suicide prevention activities in Nunavut.

Two examples from Australia suggest different suicide prevention strategies. The first involves screening high risk individuals to identify those at risk, while the second focuses on increasing awareness of risk factors and increasing access to existing resources.

Example 1: WASC-Y Screening Tool, Western Australia
Tracy Westerman in Australia has implemented a culturally-relevant screening school that she administers to young people in Western Australia. The screening tool determines if individuals are suffering from depression, anxiety or suicidal behaviour and also measures cultural resilience. Dr Westerman then uses the screening tool to identify youth at risk and ensures that they are referred to appropriate treatment programs. Young people are given the opportunity to rely on traditional healing techniques or mainstream medical approaches. The intervention activities following the introduction of the screening tool have been very effective in reducing the number of suicides in Western Australia.

Example 1: Australian National Youth Suicide Prevention Strategy
From 1995 to 1999 the National Youth Suicide Prevention Strategy received $31 million (Australian) to prevent suicide, reduce rates of self-harm, reduce suicidal ideation and "enhance resilience, resourcefulness, respect and inter-connectedness for young people, their families and communities" (Tatz 1999: 129). Over that four-year period the strategy funded 88 different projects. The strategy has successfully raised awareness of the issues relevant to suicide prevention among health care professionals, educators and youth. It has identified the factors that inhibit individuals from accessing the formal health care system and has encouraged greater accessibility through one-stop resource centres and assertive follow-up programs with those who seek help. A recent review of the program suggested that the strategy should incorporate parenting programs, increase its data collection on suicide attempts and pursue more projects that empower communities.

Intervention is the second possible focus of suicide programs. Here, individuals intervene for those who are feeling suicidal or under considerable stress. One of the earliest activities of volunteers in Nunavut was the creation of a crisis telephone. Following a 1989 conference and initial fundraising activities by the CBC, a crisis line opened in Iqaluit in 1990. What began with fourteen volunteers who received 20 hours of training is now a large operation with over 100 trainees. The Iqaluit line spurred the creation of similar lines in Yellowknife and Rankin Inlet. In their description of the crisis line Levy and Fletcher note that most of the calls focus on relationships and loss. The 1994 Suicide in Canada report suggested that existing intervention programs need to be integrated so that they represent a seamless network of resources for people (Health Canada 1994). It also emphasised the development of hospital-based services and encouraged mental health

professionals to remain in contact with those who appear to be at high risk. The most comprehensive investigation of suicide prevention strategies is *Acting on What we Know: Preventing Youth Suicide in First Nations* (Advisory Group on Suicide Prevention 2002) . The final report of the advisory group on suicide prevention, the document highlights short, medium and long-term goals in suicide intervention, in addition to highlighting prevention and postvention strategies. It argues that an integrated network of mainstream medical professionals and traditional carers will provide for the most effective suicide intervention. It suggests that funding based on need, and a resource bank of mental health practitioners will help to focus efforts and provide advice. It argues that even one day of additional suicide intervention training can help professionals to better identify those in psychiatric distress or those suffering from suicidal ideation. This is supported by academic literature on the experiences of doctors and nurses who deal with young people (Anderson, Standen and Noor 2003)

The third focus of any suicide strategy is postvention. Dealing with suicide after it has occurred involves meeting different needs. For survivors, postvention is associated with the need to talk. For suicide prevention workers, postvention includes the collection of additional information about the circumstances of suicide. Gathering such information allows suicide prevention workers, whether professionals or volunteers, to better identify risk factors and better focus their efforts. Last, postvention also includes gathering data on the success of existing programs. Without evaluation, it is difficult to know whether suicide prevention programs are working. Each of these issues is worth discussing.

For survivors, suicide raises issues of guilt, shame, loss and grief. The high suicide rate in Nunavut means that many individuals and entire communities are dealing with an overwhelming amount of sadness. Talking is seen as one way of dealing with the pain and beginning to heal. The discussion of regional suicide prevention forums in the NWT pointed out that individuals must deal with their own grief issues, indeed they must be healed, before they can reach out to others. Healing is important for individuals themselves but also for healthy communities. But knowing when to talk, and who to talk to, are difficult issues. Much of the research suggests that there is resistance to grief counsellors or professionals descending on a family following a suicide. Instead, families need time to grieve with friends and relatives. Afterwards, individuals may need to continue to talk in order to continue healing. In Nunavut, there are plans for Andrew Tagak to travel to communities to engage individuals who wish to talk about suicide. Mr Tagak plans to announce his arrival on local radio, and provide individuals with a chance to communicate. Research from other jurisdictions discusses how best to meet the need of community members to talk. It warns, however, about the use of those who have experienced suicide in their families. Such research suggests that while this might make them more emphathetic or more wise as individuals, it does not necessarily make them more beneficial for those who have survived. Much of this research suggests that a combination of those with personal experience of loss, and those who have not been touched personally by suicide, works best.

At present, we rely on information gathered by the coroner for insight into the circumstances of suicides in Nunavut. Psychological autopsies, or 'follow-back studies' are seen as a way of gathering additional information that would allow for a better understanding of suicidal behaviour. Individuals would talk with the friends and family of those who died, to determine, for example, if the individual had contacted a health professional, if they were experiencing problems with bullying, if they were adopted or had ever been incarcerated. The Evaluation and Statistics recently commissioned a report on the feasibility of psychological autopsies. The report concluded that the undertaking would be a positive one but should be careful with the issue of grief. In many cases, discussing suicide, even ones that occurred years ago, brings back feelings of shame, stress, and sadness. Interviewers conducting psychological autopsies must be aware that they are discussing difficult topics. The activities would also have to ensure that a sufficient time had elapsed. The report recommended that having the first contact made by a member of a family who had already been interviewed might alleviate some of the anxiety over studies. Concern over the invasiveness of psychological autopsies has prompted some researchers to conduct reviews of medical charts instead (Boothroyd et al 2001).

The final postvention activity involves evaluation. In 2003 EIA's Evaluation and Statistics Division held a workshop on the evaluation of suicide prevention programs. At present, the considerable effort put towards suicide prevention is having an unknown impact on suicide rates. The effectiveness of the various programs is not clear. Accurate evaluation of program success requires an evidence-based assessment of what works and what doesn't. The US National Strategy for Suicide Prevention emphasises the importance of research and data collection. The lack of evaluation is seen as a barrier to identifying effective prevention and intervention strategies. A 1994 report on Suicide in Canada suggested that the lack of evaluation data is both lamentable and understandable, given the complexity of the issue (Heath Canada 1994).

Summary of recommendations in existing literature

The final section in this report presents a summary of recommendations issued by the various conferences, workshops, training meetings, commissioned research and government activities that have been published in the past fifteen years. Many of the recommendations are similar across reports. They have been grouped together here as themes. The over-riding recommendation is that suicide prevention programs must be multidimensional. No one approach, whether prevention, intervention or postvention, will work on its own. Traditional and contemporary knowledge is essential, as are the formal and informal support networks that surround people. A combination of, for example, crisis intervention, peer groups, bereavement training, support groups, life skills workshops, traditional activities and mental health counselling would address the diverse list of issues surrounding suicide in Nunavut.

Culturally specific programming
The first recommendation is for culturally specific programming. Strategies designed in the south, for southern residents, will be of little use in the north. Materials must be created by northerners. This is of particular importance in the development of a screening tool. In addition, programs should encourage Inuit methods of counselling, should seek to provide Inuit volunteers with training and support and should orient non-Inuit workers to dominant values and beliefs. If the uneasy interaction between two cultures is seen as important contributing factor to suicidal behaviour, then these two cultures must be addressed in suicide prevention strategies. This includes Inuit volunteers and traditional healers in addition to Inuit mental health professionals.

Combination of mainstream medical care AND community care
The second recommendation is for a combination of mainstream medical care and community care. Malus et al note that young people are often hesitant to consult the formal health system and are more reliant on peers for advice (Malus et al 1998). We know that rates of depression are high in the north but that access to mental health services is limited. A broader emphasis on mental and family health must acknowledge the importance of traditional counselling approaches and mainstream medical approaches. For many individuals, the medical services are seen as remote because positions are not staffed by Inuit and there is a high turnover in professionals. It would not be particularly useful to have a layer of Qallunaat medical doctors and psychiatrists and a layer of Inuit volunteer counsellors. The goal is to have Inuit doctors, Inuit psychiatrists and Inuit traditional healers, each of whom would approach the issue from different perspectives but would always relate to those in their care. More locally-trained counsellors, and greater Inuit representation within the mainstream medical system are seen as ways to reduce obstacles to seeking resources. Research from the NWT also suggests that it is essential to involve more men in counselling. At present the majority of suicide prevention volunteers are women and while approximately half of all suicide attempts are made by women, the absence of male volunteers cannot but have an impact on the sizeable number of men who exhibit suicidal behaviour. Suicide prevention strategies that seek to expand access to resources must acknowledge that some individuals may benefit more from traditional approaches, while some will benefit more from mainstream medical approaches.

Provide youth with traditional AND contemporary skills
At present, there is some evidence that youth feel caught between two worlds, between traditional and contemporary society, and feel that they fit in to neither. Often, improving the traditional skills of individuals, particularly by increasing their contact with elders, is seen as a way to solidify their cultural identity and restore self-esteem. Evidence from other jurisdictions demonstrates, however, that prioritizing traditional skills over contemporary skills, or vice versa, does not address the fundamental sense of displacement among young people. Research from Australia suggests that young people with a mix of Aboriginal and non-Aboriginal friends are most resilient to social problems (Henderson 2003). Research in New Zealand and Greenland suggests that competency in both traditional and contemporary societies is the best protection against suicidal behaviour (Lawson Te-Aho 1998, Bjerregaard and Curtis 2002, Langford, Ritchie and Ritchie 1998). This suggests that a comfort level with both societies, traditional and contemporary, increases the sense of empowerment than young people feel. Addressing both would include a curriculum in schools that deals with self-esteem and anger management. In addition to traditional activities and skills, the education system must work to increase graduation rates and ensure that individuals feel that their education leads them to something. Stout and Kipling argue that the absence of a university in the north may lead some to believe that post-secondary education is not important, and thus that high school education need not be completed (Stout and Kipling 1999). They suggest that the creation of an Arctic university that offered courses relevant to northern residents would allow young people to see the value in education and establish a clear link between success in school, further training and employment later in life.

Address cultural norms that may be exacerbating the problem
Traditional Inuit society was seen as more cohesive. It has also been described as a society in which interfering in other people's lives was not welcome. A 1986 report on suicide in the Keewatin argued that traditional society did not encourage

individuals to express anger or negative emotions as small social units made it necessary for individuals to get along (Kivalliq Consulting 1986). In addition, the vision of suicide as a taboo topic inhibits some from discussing its impact. Former NWT MLA Goo Arlooktoo once suggested that the reluctance to talk has less to do with traditional society and more to do with Christian notions that suicide is a sin (Tilden 1997a). In either case, young people must be encouraged to discuss their mental health.

One controversial 'norm' that might be addressed is the existence of suicide in traditional Inuit culture. There are three main arguments on this point. Some literature argues that suicide was completely absence from traditional Inuit society. As a result, the current suicide rate is seen as an obvious result of the clash of two cultures. In the review of a recent forum of suicide Brackenbury reports that one participant maintains suicide was not heard of before 1968 (Brackenbury 2003). Still further literature suggests that suicide took place but that it was largely suicide by elders who did not want to be a drain on the social unit. A quick death was seen as preferable to a lingering one. Kirmayer et al suggest that social problems such as homicide, child abuse and suicide existed in traditional society but that they were not necessarily prevalent (Kirmayer et al 1998: 41). Last, there is anthropological research that suggests suicide was much more frequent in Inuit traditional society and that it dropped off *after* the arrival of missionaries. Leighton and Hughes say that elders in the community they visited were able to identify 44 separate suicides (Leighton and Hughes 1955). Rasmussen reported three suicides in the one winter he spent with Inuit in Igloolik in the 1920s (Rasmussen 1929, cited in Kirmayer, Fletcher and Boothroyd 1998). Research conducted by the Igloolik Research Centre suggests that suicides were "common" among the elderly but were a form of euthanasia (Tilden 1997b). None of the literature suggests that youth suicide was prevalent. Kirmayer et al argue that there is an obvious difference between the suicide as an altruistic act for the good of the community and disaffected youth. (Kirmayer et al 1998). This is obviously true. At the same time, cultural norms that see respect as the result of altruistic self sacrifice, in whatever form, could be contributing to the perception of suicide as a viable option for youth. Respect should be clearly associated with healthy lives rather than premature death.

Increase public education

A final recommendation concerns public education. This deals with education about mental health, stress management and life skills. Communities must be informed about the resources and programs at their disposal, including the sources of funding for programs they may wish to develop (Katt, Kinch, Boone and Minore 1998). Often this requires greater publicity of existing repositories of knowledge. In Iqaluit, the Nunavut Artic College library contains a few books on suicide, none of which deal directly with the Canadian North and many of which are more relevant to urban settings in the United States. It does, however, have a video collection that contains sources relevant to Canada and to Aboriginal populations. The creation of suicide prevention resource centres in communities would allow for improved access and, hopefully, education about suicide prevention. Public education is also important for the justice system. Approximately one fifth of suicide victims in some studies have been waiting for court dates, suggesting that the justice system is seen as a considerable source of stress and shame. Individuals must receive better education about their legal rights and the workings of the justice system. Long delays between charges and court dates have been credited with elevating stressors for young people. One solution is the use of court-workers who would meet with incarcerated individuals and ensure that they have a realistic expectation of the court process (Kivalliq Consulting 1986)

Bibliography and Resources

The following bibliography contains a list of references and resources mentioned in this report. The resources are grouped together as themes. Items that are relevant to more than one theme are listed in each section to which they are appropriate.

For the most part, resources are listed as:

Author(s) (Year published) *Title*. City of publication. Publisher.

If the document is an article in a journal, it is listed as:

Author Lat Name, Author First Name. (Year published) "Article Title" *Journal*. Volume Number (Issue Number): Pages.

This should allow members to find resources in libraries. Copies of all articles are available through the Government of Nunavut Department of Health and Social Services. Please contact the Department of Health for more information. Documents available through the internet have weblinks listed.

Topic 1: Information about suicides in NWT (until 1999) and Nunavut (since 1999)

Coroner's reports

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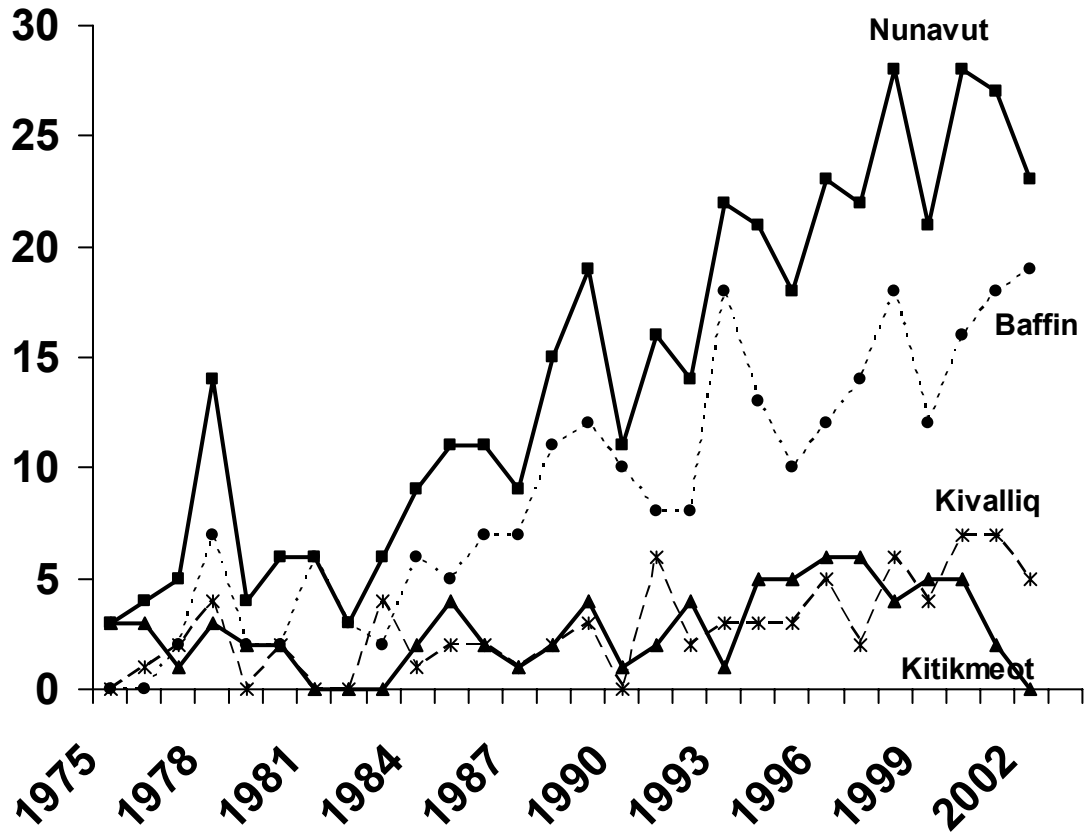
Appendices

Figure 1: Suicides in Nunavut, 1975-2003



Source: Data for 1975-1995 is from Stevenson 1996. Data for 1996-1998 is from Office of the Chief Coroner of the NWT 1999. Data for 1999-2001 is from Office of the Chief Coroner of Nunavut 2002. Data for 2002 is from Department of Health and Social Services, 2003.

Table 1: Number of suicides per 100,000 total population.

Jurisdiction	Suicide rate
Nunavut	80
NWT	40
Nunavik	44
Alaska	21
Greenland	88

Source: Henderson 2003.

Table 2: Basic facts about suicide victims, 1999-2001

Year	Number of suicides	% male	% Inuit	% youth (15-24)	%hanging
1999	21	95	100	90	100
2000	28	71	96	61	82
2001	27	89	96	74	70

Source: Office of the Chief Coroner of Nunavut (2002) Nunavut suicide completions by region, April 1, 1999 to December 31, 2001. Iqaluit.

Table 3: A Nunavut Suicide Prevention Chronology, 1990-2003

	Event
1990	✡ GNWT Executive develops plan 'Working Together: A Strategy for suicide prevention'
	✡ Grassroots forum on suicide prevention organized by DSS and NWT division of the Canadian Mental Health Associations in Rankin Inlet. An additional regional forum is held in Baker Lake
	✡ Iqaluit crisis line opens
	✡ RCMP in NWT begins keeping record of suicide attempts in the territory
	✡ Pauktuutit holds Inuit mental health workshop
1991	✡ NWT government releases Suicide Prevention Strategy
	✡ Additional regional forums on Suicide are held in Yellowknife, Fort Simpson, For Smith, Inuvik, Coppermine and Iqaluit
1992	✡ NWT government publishes 'Working Together Because We Care' a summary of the various regional forums on suicide prevention
1993	✡ Pauktuutit holds Inuit mental health workshop and creates recommendations on suicide prevention.
1994	✡ Canadian Association for Suicide Prevention (CASP) holds its annual conference in Iqaluit
	✡ Royal Commission on Aboriginal Peoples (RCAP) holds hearings to discuss suicide
1995	✡ RCAP releases its report on suicide among Aboriginal Peoples
1997	✡ GNWT creates suicide database with information on 343 suicides from 1981 to 1996
	✡ *Nunatsiaq News* publishes three-part series of articles on suicide in Nunavut
2001	✡ Department of Health and Social Services launches 'Strength from our past, Strength from each other' media campaign to reduce suicide
	✡ Department of Health and Social Services holds inter-departmental symposium to identify suicide prevention strategies in government departments
2003	✡ Department of Health and Social Services budgets $2.2 million for new mental health strategy
2003	✡ CASP holds its annual conference in Iqaluit
	✡ Department of Health hosts the Inuuqatigiisiaqniq workshop on suicide prevention, involving participants from throughout Nuanvut
	✡ EIA, Evaluation and Statistics holds a conference on the evaluation of suicide prevention programs
	✡ EIA, Evaluation and Statistics commissions report on the feasibility of 'psychological autopsies'
	✡ Nunavut Legislature passes motion to create Task Force on Suicide Prevention
	✡ Nunavut Tunngavik Inc releases suicide prevention video

Table 4: Community Wellness Activities and Suicides, By Community, 1999

Community	# suicides '99	# suicides '00	# suicides '01	# suicides '02	Total $	Total progs	SP co-ord	SP prog	CW co-ord	Nutrition	Traditional skills and activities		Contemporary skills and activities	
											Short	Ongoing	Short	Ongoing
Baffin														
Arctic Bay	1	1	0	1	260,043	10	•	•	•	•	1	1	2	3
Cape Dorset	0	1	0	2	313,592	8	•	•	•	•	3	1	1	1
Clyde River	1	0	2	3	181,000	13	•	•	•	•	3	2	1	2
Grise Fiord	0	0	0	0	17,243	5	•	•	•	•	2	0	0	1
Hall Beach	0	2	2	0	161,935	10	•	•	•	•	3	0	0	3
Igloolik	1	2	1	1	318,458	12	•	•	•	•	0	1	1	7
Iqaluit	6	8	4	3	414,310	21	•	•	•	•	2	2	5	6
Kimmirut	0	0	3	1	92,771	6	•	•	•	•	0	2	0	2
Pangnirtung	2	0	2	3	252,736	18	•	•	•	•	1	1	5	4
Pond Inlet	1	1	1	2	184,946	7	•	•	•	•	1	1	1	1
Qikiqtarjuaq	0	0	1	2	89,356	10	•	•	•	•	3	1	1	2
Resolute Bay	0	2	0	0	43,890	7	•	•	•	•	2	0	2	0
Sanikiluaq*	0	1	0	0	235,586	17	•	•	•	•	8	1	1	4
Kivalliq														
Arviat	1	2	1	0	902,046	15	•	•	•	•	2	2	1	3
Baker Lake	1	1	1	2	358,887	9	•	•	•	•	1	0	2	2
Chesterfield Inlet	0	1	0	0	35,372	2	N/a	N/a	N/a	N/a	N/a	N/a	N/a	N/a
Coral Harbour	1	0	3	0	297,698	9	•	•	•	•	1	3	0	1
Rankin Inlet	1	2	1	2	609,098	12	•	•	•	•	0	1	2	3
Repulse Bay	0	1	0	1	140,517	13	•	•	•	•	1	1	0	2
Whale Cove	0	0	0	0	54,885	5	•	•	•	•	0	0	1	2
Kitikmeot														
Bathurst Inlet	0	0	0	0	6,382	2	•	•	•	•	1	0	1	0
Cambridge Bay	0	2	0	0	227,289	15	•	•	•	•	0	7	1	3
Gjoa Haven	0	0	0	0	247,312	10	•	•	•	•	1	4	2	1
Kugluktuk	3	3	1	0	416,942	7	•	•	•	•	0	1	0	3
Kugaaruk	1	0	0	0	186,678	10	•	•	•	•	0	1	1	4
Taloyoak	1	0	1	0	267,227	4	•	•	•	•	0	1	0	1

Source: GN. Department of Health and Social Services (2003) *Nunavut Brighter Futures/Building Healthy Communities*. April 1, 2002-March 31, 2003 Year End Report. Iqaluit. * Sanikiluaq is included in the Kivalliq health region.

Table 5: Community Wellness Activities and Suicides, By Community, 2003

Community	# suicides '99	# suicides '00	# suicides '01	# suicides '02	Total $*	Total progs	SP co-ord	SP prog	CW co-ord	Nutrition	Traditional skills and activities		Contemporary skills and activities	
											Short	Ongoing	Short	Ongoing
Baffin														
Arctic Bay	1	1	0	1	92,504	8	•	•	•	•	5	1	1	0
Cape Dorset	0	1	0	2	137,443	4	•	•	•	•	0	0	1	1
Clyde River	1	0	2	3	105,514	7	•	•	•	•	0	1	0	4
Grise Fiord	0	0	0	0	47,416	2	•	•	•	•	0	0	0	0
Hall Beach	0	2	2	0	88,599	7	•	•	•	•	1	2	0	1
Igloolik	1	2	1	1	161,245	6	•	•	•	•	1	1	0	1
Iqaluit	6	8	4	3	348,766	17	•	•	•	•	3	1	3	6
Kimmirut	0	0	3	1	64,645	5	•	•	•	•	0	2	0	1
Pangnirtung	2	0	2	3	156,964	12	•	•	•	•	0	3	1	3
Pond Inlet	1	1	1	2	164,068	9	•	•	•	•	2	0	0	3
Qikiqtarjuaq	0	0	1	2	75,903	8	•	•	•	•	0	1	1	3
Resolute Bay	0	2	0	0	44,192	3	•	•	•	•	0	1	0	1
Sanikiluaq**	0	1	0	0	89,206	6	•	•	•	•	1	0	0	1
Kivalliq														
Arviat	1	2	1	0	199,140	12	•	•	•	•	1	0	2	7
Baker Lake	1	1	1	2	166,728	6	•	•	•	•	0	1	0	3
Chesterfield Inlet	0	1	0	0	58,564	3	•	•	•	•	0	0	0	1
Coral Harbour	1	0	3	0	103,194	11	•	•	•	•	2	2	1	3
Rankin Inlet	1	2	1	2	200,236	9	•	•	•	•	0	1	0	3
Repulse Bay	0	1	0	1	85,365	8	•	•	•	•	0	1	1	4
Whale Cove	0	0	0	0	51,607	7	•	•	•	•	5	0	0	0
Kitikmeot														
Bathurst Inlet	0	0	0	0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	N/a	N/a	N/a
Cambridge Bay	0	2	0	0	130,980	7	•	•	•	•	0	4	0	2
Gjoa Haven	0	0	0	0	125,400	11	•	•	•	•	0	4	0	6
Kugluktuk	3	3	1	0	141,528	8	•	•	•	•	4	2	0	1
Kugaaruk	1	0	0	0	89,694	8	•	•	•	•	0	1	1	3
Taloyoak	1	0	1	0	99,526	4	•	•	•	•	0	2	1	1

Source: GNWT. Department of Health and Social Services (2000) *Nunavut Community Wellness in Action 1998-1999: Summary Report of Community Wellness Initiatives*. Yellowknife: DHSS. * includes funding for Brighter Futures and Building Healthy Communities ** Sanikiluaq is included in the Kivalliq health region.