Discussion Paper regarding a

Saskatchewan First Nations Suicide Prevention Strategy

Released by the Federation of Sovereign Indigenous Nations'
Mental Health Technical Working Group

September 22, 2017

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1. Introduction

Death by suicide is a tragedy for the individual and their families, friends and communities. Each suicide results in intense grief, loss and trauma, and has ripple effects throughout society.

There is no evidence that First Nations were historically 'high-suicide' societies. On the contrary – the evidence we do have tells us that until relatively recently, perhaps five decades ago, First Nations had relatively low rates of death by suicide. Additionally, there is no reason why some First Nations must suffer from high rates of suicide behaviour now, or into the future, if we can effectively address the underlying issues. We know that we cannot prevent all suicides – no society on earth has ever done that. However, as this Discussion Paper will demonstrate, there is compelling evidence that many more lives could be saved than are being saved today. And further, that people impacted by suicide can go on to live a good life.

In the absence of either a federal or provincial suicide prevention, the Chiefs-in-Assembly have directed the Federation of Sovereign Indigenous Nations (FSIN) to address suicide behaviour among First Nations "with high priority". Accordingly, this Discussion Paper marks the beginning of a process that will result in release of a multifaceted, evidence-informed First Nations Suicide Prevention Strategy. **This strategy will emphasize capacity-building at the community level** so as to strengthen the ability of First Nation Tribal Councils and individual First Nations to take constructive action to address suicide behaviour.

We urge you to read this Discussion Paper carefully. At the end you will learn how you can contribute to the process. We want to reduce the number of lives – especially young lives – lost to suicide, and the number of families who have to suffer pain, grief and trauma of losing a loved one to suicide. ***We urge you to join us on this important journey.***

2. Mandate

The Mental Health Technical Working Group (MHTWG) was established by a motion passed by the FSIN's Health and Social Development Commission on May 8, 2017. The motion, which is appended to this Discussion Paper, provided clear direction regarding the manner in which the First Nations Suicide Prevention Strategy is to be developed. Two additional persons were later added to the MHTWG, bringing the membership to 11.

The above motion was ratified by a resolution – also appended to this Discussion Paper – passed unanimously by the FSIN Legislative Assembly on May 18, 2017. The Chiefs-in-Assembly specified that the First Nations Suicide Prevention Strategy is to be released by May 31, 2018.

3. Statistics on death by suicide in Saskatchewan

Data on the number of deaths by suicide among First Nations people in Saskatchewan has been provided by the Office of the Chief Coroner. Since 2005, when death records began

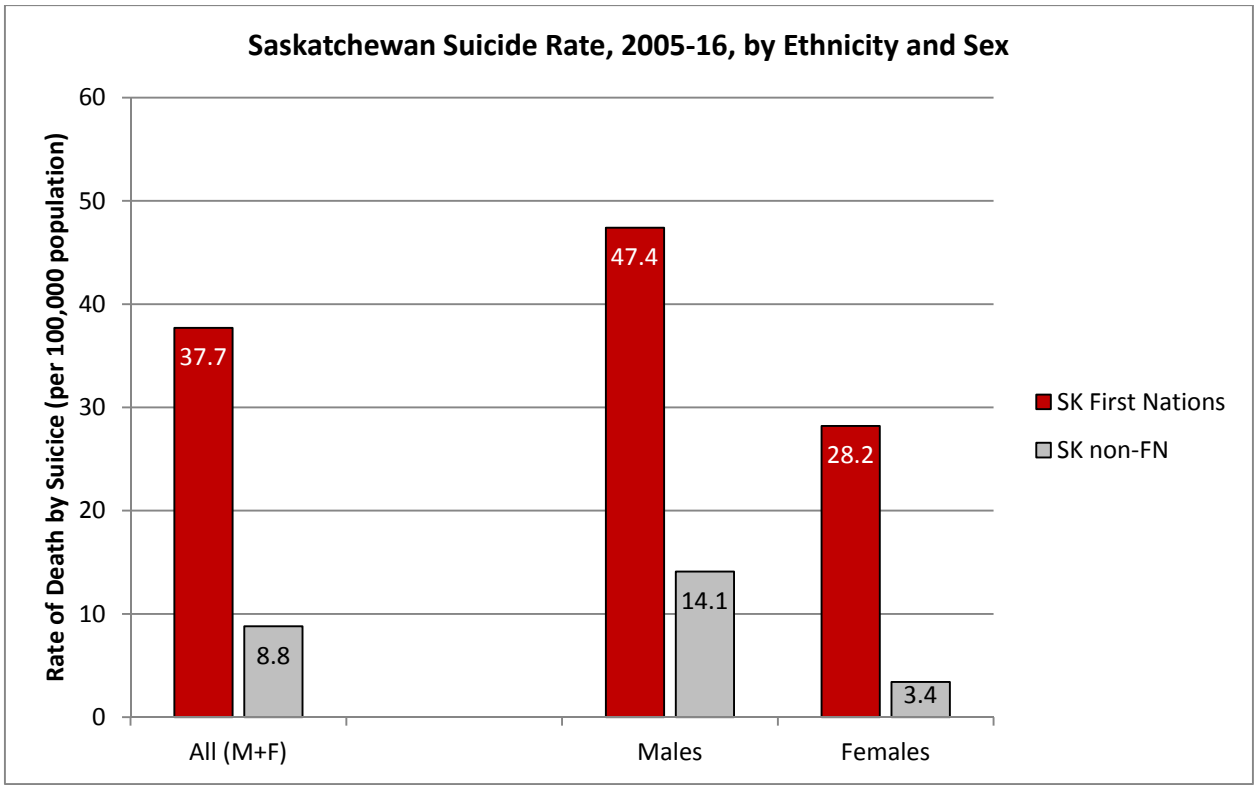
being coded by ethnicity, **close to 500 completed suicides have been recorded by First Nations people.**

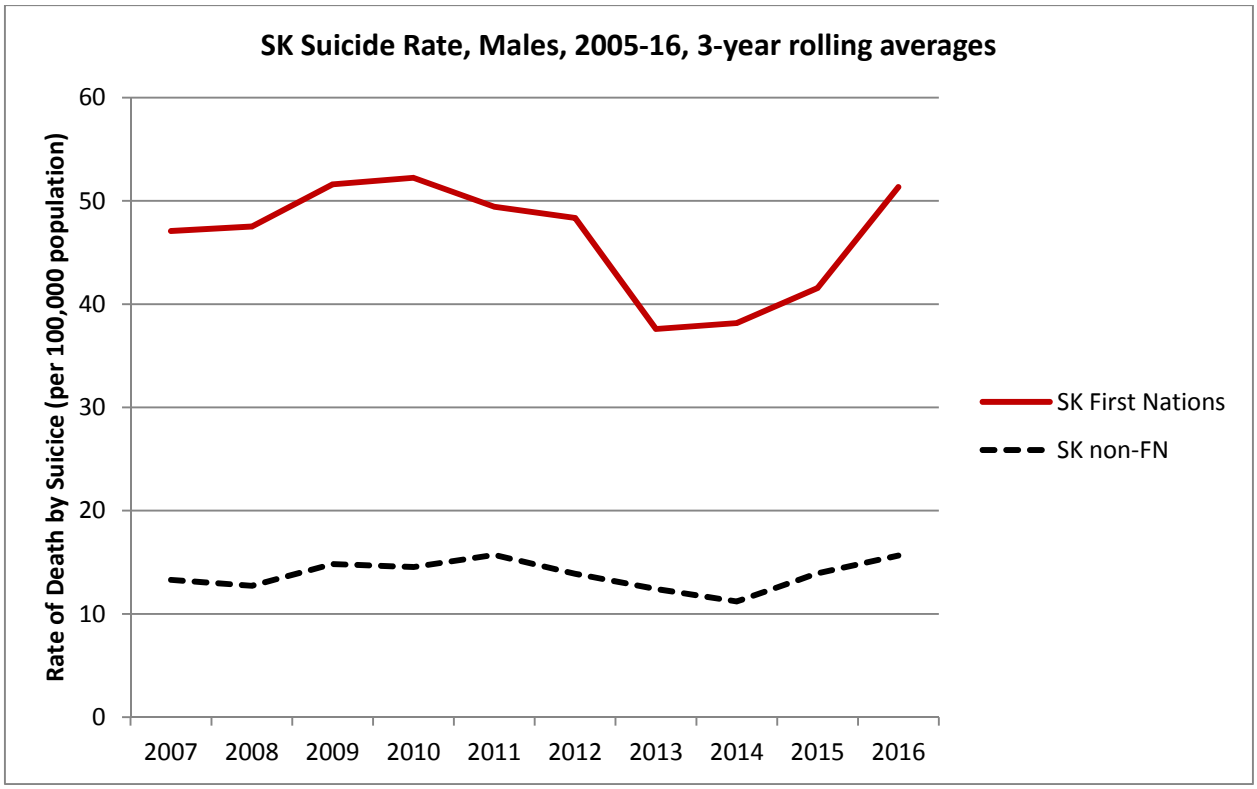
The Office of the Chief Coroner codes death records by one of six ethnicities: Caucasian, North American Indian ("Includes Status and Non-Status"), Asian, Black/African American, Metis, and "Other Specified Race". Death records which the Office of the Chief Coroner are unable to code by ethnicity are coded as "Unknown".

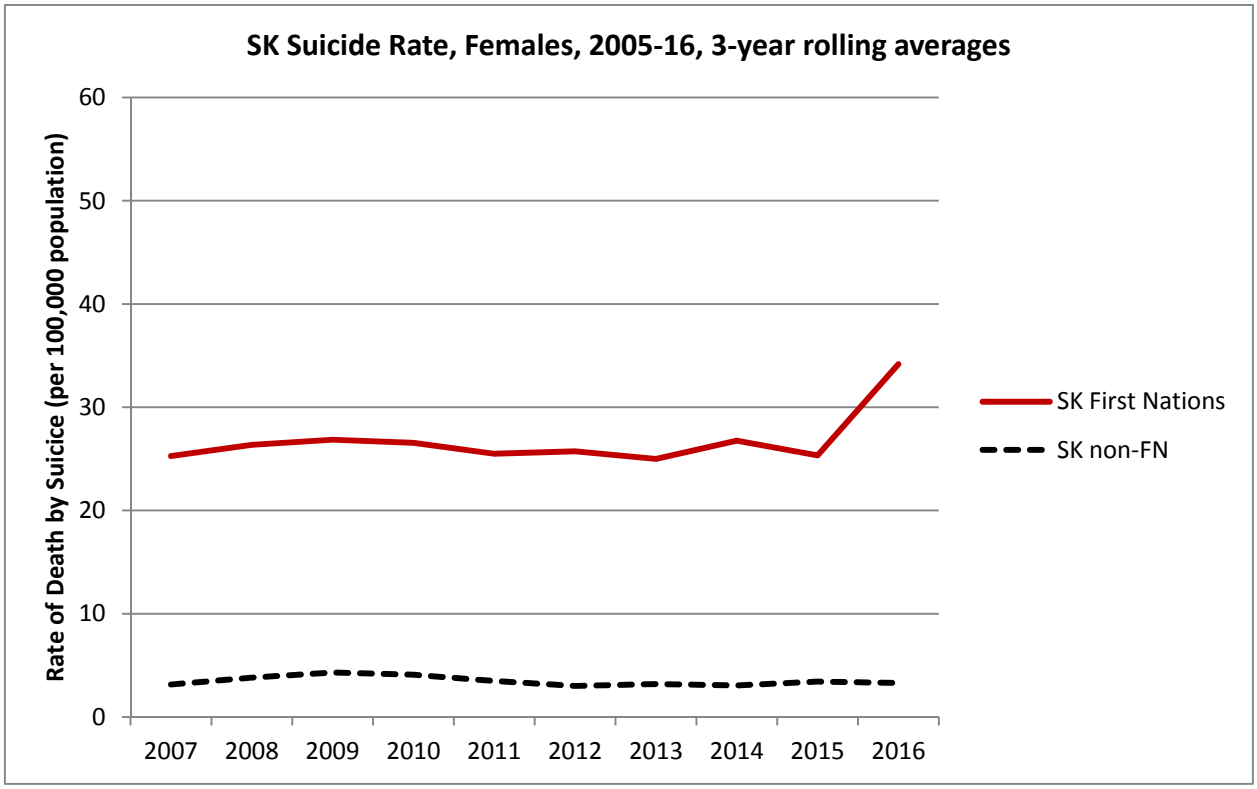
Over the 11-year period 2005 to 2015, 493 suicides were coded "North American Indian (Includes Status and Non-Status)", 1,025 were coded for other ethnicities (including Métis) , and 189 were coded unknown. First Nations people therefore made up between 29% (if none of the "Unknown" were First Nations people) and 40% (if all of the "Unknown" were First Nations people) of the deaths by suicide in the province over this decade.

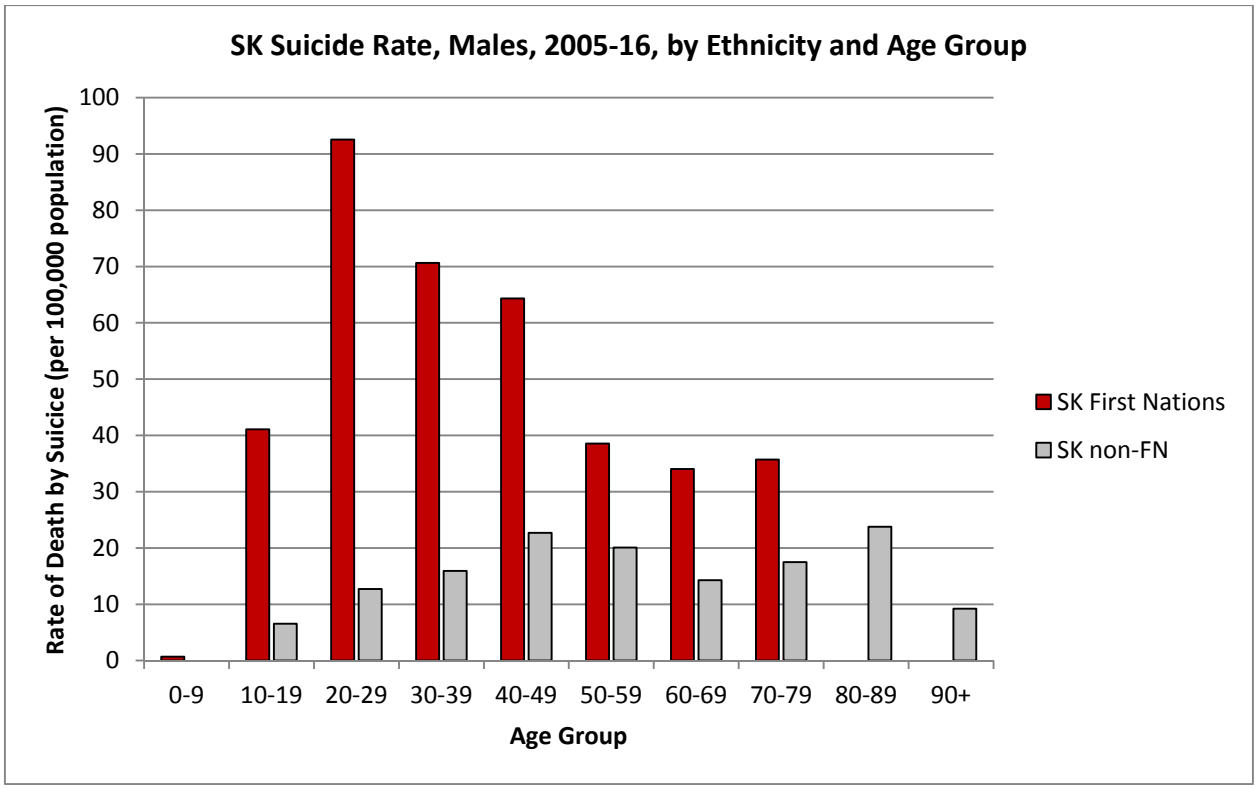
The following graphs exclude suicides coded as "Unknown" ethnicity. Rates were calculated using demographic data from *Covered Population,* a detailed breakdown of the population prepared annually by eHealth Saskatchewan.

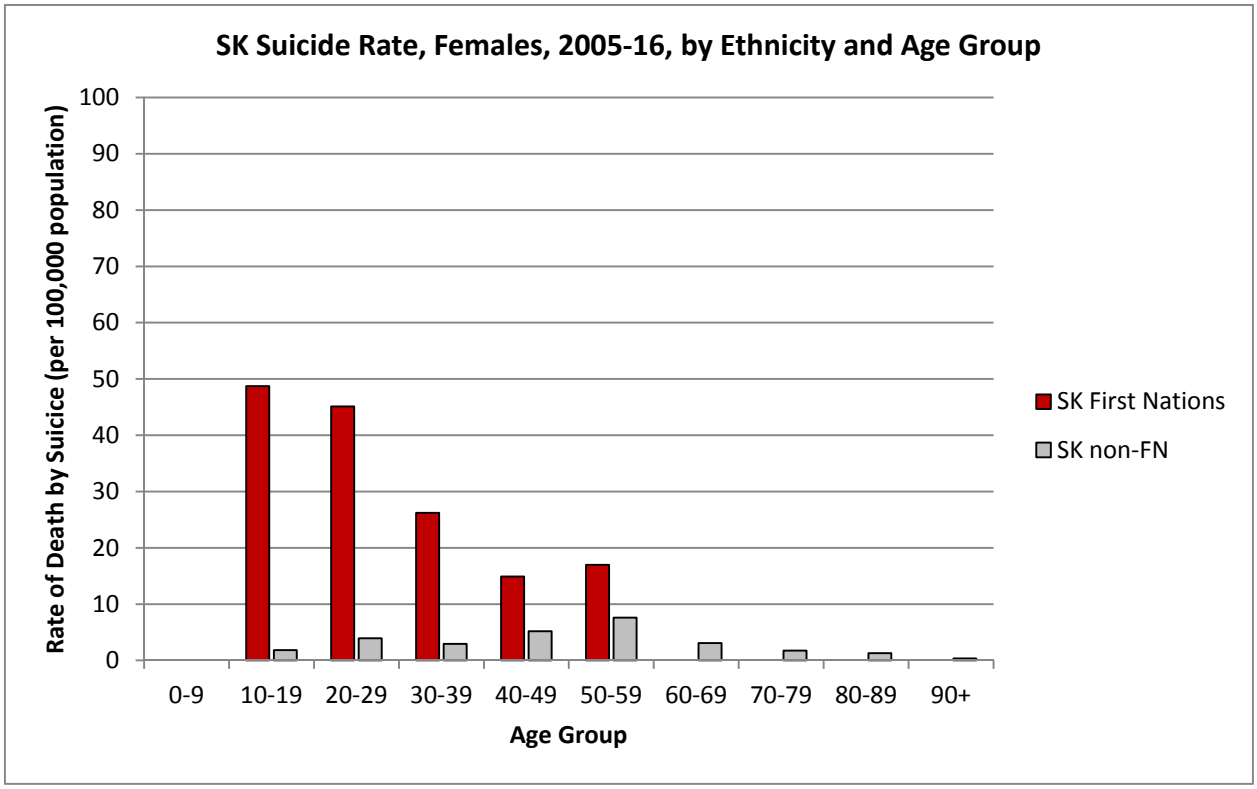
The graphs presented below highlight some of the differences in the suicide rates of First Nations people and other residents of the province. They also point to a spike in suicides by both First Nation males and females beginning in 2014. Finally, they draw attention to variations in rates by age and sex.




SK Suicide Rate, Males, 2005-16, 3-year rolling averages
Rate of Death by Suicice (per 100,000 population)
60
50
40
30
20
10
0
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
SK First Nations
SK non-FN


SK Suicide Rate, Females, 2005-16, 3-year rolling averages
Rate of Death by Suicice (per 100,000 population)
60
50
40
30
20
10
0
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
SK First Nations
SK non-FN


SK Suicide Rate, Males, 2005-16, by Ethnicity and Age Group
Rate of Death by Suicice (per 100,000 population)
100
90
80
70
60
50
40
30
20
10
0
0-9
10-19
20-29
30-39
40-49
50-59
60-69
70-79
80-89
90+
Age Group
SK First Nations
SK non-FN


SK Suicide Rate, Females, 2005-16, by Ethnicity and Age Group
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30-39
40-49
50-59
60-69
70-79
80-89
90+
Age Group
SK First Nations
SK non-FN

Overall, the rate of death by suicide among First Nations people in Saskatchewan is 4.3 times higher than the rate among non-First Nations people in the province.

The ratios among younger people is higher still:

- **The rate for First Nations women aged 10 to 19 is 26 times higher** than that of non-First Nations women in that age rate, and for First Nations women in their 20s the rate is 11 times higher.
- **The rate for First Nations men aged 10 to 19 is six times higher** than that of non-First Nations men in that age rate, and for First Nations men in their 20s the rate is seven times higher.

25% of all suicides by First Nations people were by teenagers, compared to 6% among persons of other ethnicities.

62% of all suicides by First Nations people were by persons less than 30 years of age, compared to 19% among persons of other ethnicities.

Just 8% of all suicides by First Nations people were by persons 50 years and older, compared to 45% among persons of other ethnicities.

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In May of this year the Minister of Health tabled data in the Legislative Assembly stating that over the 11-year period 2005 to 2015 there were 1,432 deaths by suicide in Saskatchewan, which is 110 less than the number of suicides counted by the Office of the Chief Coroner.

The Minister of Health wrote that "Data pertaining to First Nations is based on individual's self-declaration as Registered Indian and the provision of their Treaty number. First Nations status does not take into account those who may identify as First Nations" (emphasis in the original). On that basis, the Minister's data indicated that over the 11-year period 2005 to 2015 there were 265 suicides by First Nations people – a figure which is 40% lower than the count provided by the Office of the Chief Coroner using a different definition of 'First Nations'.

The data tabled in the Legislative Assembly by the Minister of Health allows calculation of an overall rate of death by suicide for Saskatchewan of 11.3 per 100,000 over the time period 2005 to 2015 (using population data for 2015). This is identical to the national rate for the period 2005 to 2013 (the latest year for which Canada-wide data is currently available).

Those data were also disaggregated (broken out) by Health District. Using those statistics we can calculate suicide rates (per 100,000 population) by Health Region for that time period:

Athabasca	60.1	Prairie North	13.0
Keewatin Yatthé	44.7	Prince Albert Parkland	14.7
Mamewetan Churchill	24.2	Kelsey Trail	13.4
		Heartland	10.9
Saskatoon	9.3	Sunrise	10.8
Regina Qu'Appelle	9.8	Cypress	7.5
		Five Hills	12.1
		Sun Country	11.0

Taken together, the three northern Health Regions, which have the largest proportion of First Nations people among the populations they serve, had a suicide rate of 32.9 per 100,000 population – which is **3.1 times** the rate for the ten other Health Regions. Saskatoon and Regina Qu'Appelle, the two largest health regions, had a combined rate of 9.6, while the rest of the province had a rate of 12.0.

Again, these rates are for *all* residents of each Health Region – we do not have suicide data for First Nations people broken out by Health Region.

4. What we know about suicide behaviour

We know a lot about how and why people may find themselves in a suicidal crisis. Because upwards of 800,000 people a year die by suicide world-wide, a great deal of work has gone into understanding suicide behaviour – so there is an enormous research base.

There are numerous books which summarize what we know about suicide behaviour. One concise and particularly clearly-written example is psychiatrist Robert D. Goldney's *Suicide Prevention (2nd ed.),* which can be purchased online.

One useful way to understand risk factors for suicide behaviour is through the prism of 'age of first suicide attempt':

- People whose first suicide attempt occurs as adults are likely to be suffering from major depressive disorders (single or recurrent).
- People whose first suicide attempt in their teenage years or their 20s are more likely to have cumulative risks including more frequent comorbid (occurring at the same time) anxiety disorders, cannabis misuse and personal history of emotional and sexual abuse (Slama et al 2009).

There is a significant body of research on the impact of adverse childhood experiences (ACEs) on people's health outcomes. A pathbreaking study in the United States examined abuse (emotional, physical and sexual) during childhood, witnessing domestic violence, parental separation or divorce, and living with substance-abusing, mentally ill, or criminal

household members (Anda et al 2006, Stevens 2012). The US study revealed that 80% of suicide attempts during childhood and adolescence are attributable to ACEs – as are a majority of suicide attempts among adults. The impact of ACEs on suicide behaviour over the life course is "of an order of magnitude rarely observed in epidemiology and public health data" (Dube et al 2001). Higher rates of early childhood adversity put people at greater risk for stress and negative health outcomes – including psychological distress, suicidal thoughts and suicide attempts – over their entire life course. At the same time, people with early onset mental health disorders are at risk for chronic problems throughout their lives.

One Indigenous population for which we have considerable historic and current data is the Māori of New Zealand (Beautrais and Fergusson 2006):

- Māori have transitioned from having lower rates of death by suicide than Pakeha (White) residents of New Zealand to having higher suicide rates than their non-Māori counterparts.
- Māori youth now have higher overall rates than their non-Māori counterparts of many mental disorders including depression, anxiety, conduct disorder, suicidal ideation and attempts, and alcohol and cannabis abuse.
- Māori are more likely to be socioeconomically disadvantaged in childhood, and more likely to have experienced childhood adversity, than their non-Māori counterparts.
- Significant ethnic differences in rates of mental disorder amongst New Zealand youth can be largely explained by the higher rates of exposure amongst Māori to socio-economic disadvantages during childhood, childhood family adversity, peer influences, etc (Marie, Fergusson, Boden 2011).

A key factor in understanding elevated rates of suicide behaviour in Indigenous populations *with recent experiences of colonization* may be how colonialism is mediated into risk factors for suicide behaviour among children and youth, in part by the intergenerational transmission of historical trauma (e.g. trauma associated with Indian Residential Schools) resulting in elevated rates of early childhood adversity. As First Nations psychologist Amy Bombay recently told a House of Commons Standing Committee investigating suicide in Indigenous communities, "past collective effects can actually accumulate across generations, so really, if we do nothing to address these intergenerational cycles, we can expect that the effects are only going to get worse."

5. What we know about suicide prevention

Suicide behaviour is complex and multi-causal, but understandable – and, to a certain degree, preventable. According to the World Health Organization (WHO) (2004), suicide is best understood as a "largely preventable public health problem."

Suicide prevention strategies (SPS) are multifaceted approaches to reducing the rate of death by suicide in a society. It is generally agreed that:

- an SPS should address prevention, intervention and postvention;
- an SPS should address both proximal (immediate) and distal (background) risk factors for suicide behaviour;
- an SPS requires resources if effective implementation is to take place; and,
- the impact of an SPS can be evaluated over time.

SPS are usually government-led initiatives (e.g. Quebec's provincial SPS, discussed in section 7, which is recognized by suicide prevention specialists world-wide). In recent years, however, a number of Indigenous-specific SPS have been developed, led by Indigenous organizations: by Aboriginal Australians; by Māori in New Zealand, by Sámi in the Scandinavian countries, and by Inuit in Nunavut – as well as the 2016 National Inuit Suicide Prevention Strategy.

Existing models of suicide risk and prevention typically focus on proximate (immediate) risk factors. They do not adequately explain elevated rates of suicide in some (but by no means all) Indigenous communities, as they do not adequately take into account distal (background) risk factors: larger-scale social and community factors such as colonialism, intergenerational trauma, and socioeconomic and other inequities (see, for example, Samaritans 2017).

As a recent journal article from the US observes:

> What suicidologists have recommended for quite some time, but has yet to be systematically achieved, is a truly comprehensive approach to suicide prevention – one that occurs across the social ecology (i.e., at the individual, family/relationship, school/community, and societal levels) in schools, workplaces, and healthcare settings, and includes both "downstream" prevention efforts (i.e., secondary and tertiary prevention efforts that focus on treatment and interventions for at-risk individuals or groups to decrease the likelihood of future suicide attempts) and "upstream" prevention efforts (i.e., primary prevention efforts that focus on preventing suicidal ideation, behavior, and risk before they occur). …
>
> [Adverse childhood experiences] are a well-documented and understood risk factor for suicidality, but in practice, the field of suicide prevention has yet to focus in earnest on this connection. Given the increasing rates of suicide, the growing empirical evidence linking ACEs and suicide risk, and the mounting discourse for comprehensive suicide prevention, the importance of partnering across disciplines to adopt strategies that impact early in the life course and that continue across the lifespan has never been clearer. Together, enhanced coordination to prevent exposure to ACEs, and subsequently reduce suicidal ideation, behavior, and death, is possible (Ports et al 2017).

Adverse childhood experiences are known *developmental precursors* to suicide behaviour, particularly by teenagers and young adults. We need to find culturally appropriate ways of constructively intervening in the lives of children and youth in order to lower their risk factors and increase their protective factors. As Australia's National Aboriginal and Torres Strait Islander Suicide Prevention Strategy notes:

> There is growing evidence that, in order to reduce rates of suicidal behaviour and suicide over the longer term, measures should also be put in place to address the *developmental precursors* of suicide and suicidal behaviour. … There needs to be a shift towards collaborative, cross-sectoral approaches to treatment and prevention to treat both current risk and its *developmental precursors* (Australia, Department of Health and Ageing 2013).

A report by Lechner, Cavanaugh, and Blyler (2016) provides a useful review of interventions to address trauma in American Indian and Alaska Native youth in the US.

A recent report from the House of Commons' Standing Committee on Indigenous and Northern Affairs also stressed the need to improve the social determinants of health as an 'upstream' approach to suicide prevention, especially among Indigenous youth (Canada, House of Commons- Standing Committee on Indigenous and Northern Affairs 2017).

6. Recommendations by the World Health Organization and the United Nations

In 2014, the WHO released a landmark document entitled *Preventing Suicide: A Global Imperative.* Among its key messages (on page 9 of the report):

- Suicides take a high toll. Over 800,000 people die due to suicide every year and it is the second leading cause of death in 15-29-year-olds. There are indications that for each adult who died of suicide there may have been more than 20 others attempting suicide.
- Suicides are preventable. For national responses to be effective, a comprehensive multi-sectoral suicide prevention strategy is needed.
- Restricting access to the means for suicide works. An effective strategy for preventing suicides and suicide attempts is to restrict access to the most common means, including pesticides, firearms and certain medications.
- Health-care services need to incorporate suicide prevention as a core component. Mental disorders and harmful use of alcohol contribute to many suicides around the world. Early identification and effective management are key to ensuring that people receive the care they need.
- Communities play a critical role in suicide prevention. They can provide social support to vulnerable individuals and engage in follow-up care, fight stigma and support those bereaved by suicide.

The United Nations (UN) has called on all governments to develop and implement evidence-informed national strategies for suicide prevention. In 1996 the UN published guidelines to

assist and stimulate countries to develop national strategies aimed at reducing morbidity, mortality, and other consequences of suicidal behaviour. These guidelines emphasised the need for inter-sectorial collaboration, multi-disciplinary approaches, and continued evaluation and review. The UN identified several elements that should increase the effectiveness of suicide prevention strategies, including:

- support from government policy;
- a conceptual framework;
- well established aims and goals;
- measurable objectives;
- identification of organisations capable of implementing objectives; and,
- ongoing monitoring and evaluation.

The WHO followed up in 2012 with a document entitled *Public Health Action for the Prevention of Suicide: A Framework.* In the section 'The Need for Taking Action' the WHO answers the question "Why is a national suicide prevention strategy necessary?":

- a national strategy not only outlines the scope and magnitude of the problem, but more crucially, recognizes that suicidal behaviours are a major public health problem.
- a strategy signals the commitment of a government to tackling the issue.
- a cohesive strategy recommends a structural framework, incorporating various aspects of suicide prevention.
- a strategy provides authoritative guidance on key evidence-based suicide prevention activities, i.e. identifies what works and what does not work.
- a strategy identifies key stakeholders and allocates specific responsibilities among them. Moreover, it outlines the necessary coordination among these various groups.
- a strategy identifies crucial gaps in existing legislation, service provision and data collection.
- a strategy indicates the human and financial resources required for interventions.
- a strategy shapes advocacy, awareness raising, and media communications.
- a strategy proposes a robust monitoring and evaluation framework, thereby instilling a sense of accountability among those in charge of interventions.
- a strategy provides a context for a research agenda on suicidal behaviours.

To date 28 national governments have developed and implemented national strategies for suicide prevention. Canada is the only G8 country *not* to have done so (Matsubayashia & Ueda, 2011). It should be noted that the Grand Chief of the Assembly of First Nations, Perry Bellegarde, has called on the federal government to develop and implement a national strategy for suicide prevention (*Globe and Mail* 2016) – as has the Canadian Association for

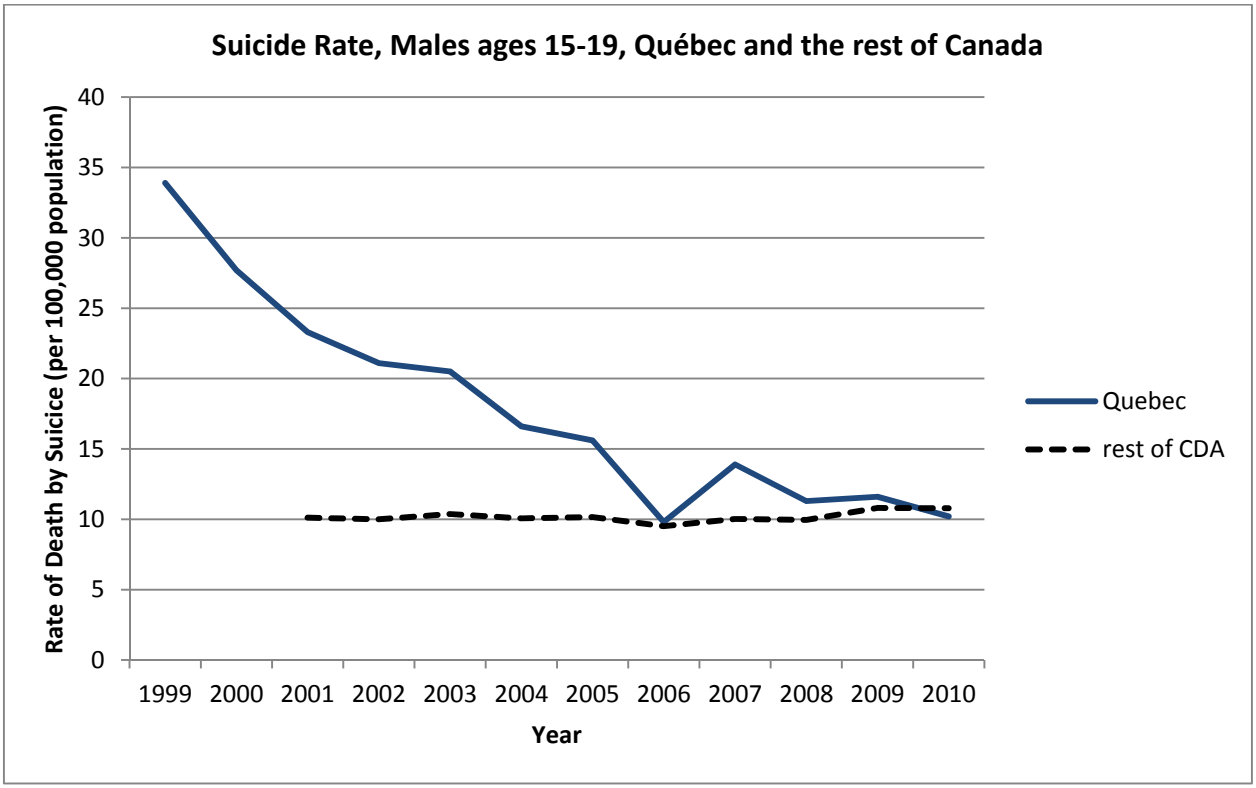
Suicide Prevention (2009), the Calgary-based Centre for Suicide Prevention (2016), and an editorial in the *Canadian Medical Association Journal* (Eggertson & Patrick 2016).

The Mental Health Technical Working Group believes that the WHO's perspectives apply to the need for suicide prevention strategies at the *provincial* level as well – especially in the absence of a national strategy.

7. The Québec experience

From the 1960s to the 1990s Québec had by far the highest rate of death by suicide of any province in Canada. Alarmed by the rates rising even higher in the 1990s, the provincial government released the multifaceted Québec Strategy for Suicide Reduction in 1998. The strategy was adequately funded, and aggressively thoughtfully and effectively implemented.

The results have drawn international attention to Québec as a suicide prevention success story – perhaps the best example yet of what a government can achieve in the way of suicide prevention if it really tries. This graph shows a sharp decline in the rate of male youth suicide in Québec between 2000 and 2010, from triple the national rate in 2000 to a little lower than the national rate a decade later.



Saskatchewan, on the other hand, is one of several Canadian provinces which has no provincial suicide prevention strategy – and apparently has no plans to develop one.

8. The Inuit experience

Inuit populations across the Arctic experienced a devastating increase in their suicide rates beginning in the 1970s, from rates lower than the national average to one in Nunavut (since 1999) that that is 9.8 times higher than the national rate – and 40 times higher the national rate for men 15 to 24.

Public health authorities did not begin to take evidence-informed action to address the Inuit suicide crisis until 2008, when a working group of officials from the Government of Nunavut, the Inuit representative organization Nunavut Tunngavik, the RCMP, and the community-based Embrace Life Council began developing the Nunavut Suicide Prevention Strategy (NSPS), which was released in 2010.

Implementation of the strategy was crippled by the Government of Nunavut's failure to allocate funding to support the workplan that it had agreed to. It took until 2016, and public anger after the jury at a Coroner's Inquest issued recommendations highly critical of the Nunavut government, for the situation to be corrected. The Premier declared a state of suicide 'crisis' in the territory, named the world's first Minister Responsible for Suicide Prevention, and created and funded a secretariat to coordinate implement of the NSPS. In June of 2017 the four partner organizations released a detailed five-year implementation plan, called *Inuusivut Anninaqtuq* ('United for Life'), backed by $35 million provided by the territorial government – $16 million of which is earmarked for community programs that support suicide prevention. To see the range of activities that will be undertaken, review the document at http://inuusiq.com/wp-content/uploads/2017/06/Inuusivut_Anninaqtuq_English.pdf.

In 2016 the national Inuit organization, Inuit Tapiriit Kanatami (ITK), released the National Inuit Suicide Prevention Strategy (NISPS), which covers all four Inuit regions in Canada.

The Nunavut Suicide Prevention Strategy and the National Inuit Suicide Prevention Strategy are cutting-edge documents in that they locate elevated rates of suicide behaviour by an Indigenous population in the context of high rates of unresolved historical trauma, high rates of adverse childhood experiences, poor living conditions, and limited access to culturally-appropriate mental health services.

Inuusivut Anninaqtuq shows unparalleled commitment by a public government to work in partnership with Indigenous and other organizations to fund a wide range of suicide prevention measures in Indigenous communities. It took a decade for the Nunavut government's approach to suicide prevention to be completely transformed, from 'not our problem' to 'let's work hard together to bring the rates down.'

The Inuit suicide prevention strategies are too new to have any measureable impact on suicide rates, but they have succeeded in focusing attention and funding in ways which should make a difference in the coming years.

9. The White Mountain Apache experience

A 2016 article in the *American Journal of Public Health* reported on how a team of suicide prevention researchers and practitioners "evaluated the impact of a comprehensive, multi-tiered youth suicide prevention program among the White Mountain Apache of Arizona since its implementation in 2006" (Cwik et al 2016).

The results were impressive: "The overall Apache suicide death rates dropped from 40.0 to 24.7 per 100 000 (38% decrease), and the rate among those aged 15 to 24 years dropped from 128.5 to 99.0 per 100 000 (23% decrease). The annual number of attempts White Mountain Apache also dropped from 75 (in 2007) to 35 individuals (in 2012) in a population of 17,500 enrolled members.

The conclusion was that "the overall Apache suicide death rates dropped following the suicide prevention program. The community surveillance system served a critical role in providing a foundation for prevention programming and evaluation." This is another excellent example of what a society can achieve in the way of suicide prevention if it really tries.

The Mental Health Technical Working Group will be investigating the suicide prevention measures undertaken by the White Mountain Apache to see if their approach can be replicated in Saskatchewan.

10. Challenges in mental health supports and services for First Nations people in Saskatchewan – prepared by Dr. Kim McKay-McNabb

First Nations communities in Saskatchewan are burdened with many mental health disparities, and suicide is an urgent health care need for First Nations people within the province. The existing programs and services do not provide adequate access and support. Many First Nation individuals who attempt to seek supports and/or servies for crisis mental health supports are often disappointed when they cannot access a First Nation therapist. At the present time, there are very few options for mental health supports. The following are examples of the barriers that exist, and of the lived experiences of individuals who have mental health challenges.

Family Treatment Centres: This is a significant need for family treatments centers that can provide mental health supports to families, ranging from early childhood, adolescence and adults across the life span. The impacts of intergenerational trauma has had significant mental impacts on families and generations of families lack the ability to identify that they are experiencing mental health issues that may have been the direct result from intergenerational trauma.

Client #1 – This First Nation individual was the head of the household and was struggling with substance abuse disorder (SAD), co-morbid with post-traumatic stress disorder (PTSD). They also had attended residential school in southern Saskatchewan. This individual knew

that they had been struggling with symptoms since suffering the abuses while attending an Indian Residential School, and required intensive treatment. However, they did not want to leave their children with anyone and also wanted their partner to attend treatment as a family unit. Phone calls and emails were made by the client and their mental health therapist. All family treatment centers in Saskatchewan were contacted, and all had waitlists at the time of contact. As well, as a requirement, the majority of the family treatment centers required the client to attend detox prior to their application being accepted. Eighteen months later, this individual finally received approval from the waitlist. Unfortunately, at the time of the contact from the treatment centre, this individual was homeless, did not have their children in their custody any longer and at the writing of this has not been located by their mental health therapist to inform them of finally being accepted on the waitlist.

Shame, Stigma and Mental Health: Historically, there is stigma attached to mental health issues and generations of First Nations people have suffered with symptoms without accessing mental health supports. There are many theories about why this is occurring. However, as an experienced clinician who has worked within First Nation communities over the past few decades, I would suggest that efforts to engage with psychoeducational sessions to assist in understanding symptoms would greatly benefit individuals suffering with untreated/undiagnosed mental health disorders and challenges.

Client #2 – This First Nation individual had been told all her life that only 'crazy' people need mental health supports. She reported that from a young age she had lived in numerous foster homes and eventually attended Indian residential school. By the time she was an adult she had significant symptoms of anxiety and depression. The first attempt on her life was in early adolescence and continues regularly into to the present time. She has been hospitalized numerous times over the past decade, where she reported that the mental health care providers medicate and stabilize her and then refer her to the community for mental health services. She reported that during the periods after she had been discharged she continued to have challenges with day-to-day functioning. She indicated that it was due to the high dosage of the mediation prescribed by the psychiatrist on staff in the psychiatric ward. Further, she reported feeling lethargic, no affect and "not myself". At this time, there are limited mental health supports available and since she remains in consistent crisis with suicidal ideation, she has a difficulty in securing/accessing mental health supports due to in some cases therapist not agreeing to treat her mental health disorder. She decided to access this writer/therapist when she learned of a First Nation woman who opened her own practice and was an Non-Insured Health Benefits (NIHB) Approved Mental Health Therapist. Previously, she had called the NIHB list and left messages on numerous occasions to therapists on the list, whom she stated failed to return her calls. She reported that was very frustrating and at times, felt like she was being abandoned. She stated that she had also requested cultural supports to assist with the mood disorders and was informed by mental health staff that it was not an appropriate method to treat her illness. We need to develop a model of care for First Nation individuals to assist in treating mental health disorders.

Why is there not a list of First Nation Psychologists and Therapists?

Client #3 – A First Nations youth who is attending an equine therapy environment to deal with childhood trauma and adverse childhood experiences requested to attend a First Nation psychologist located in their city. At the present time, there is no listing of First Nation psychologists in Saskatchewan. This was a challenge that prevented the youth from accessing psychological supports and the caregivers indicated that they were at a loss of how to proceed with providing mental health supports specifically in regards to a First Nation psychologist.

Client #4 – A First Nation young woman diagnosed with depression in adolescence and further diagnosed in young adulthood as a dual diagnosis of Major Depressive Disorder and Substance Abuse Disorder. At the age of thirteen she had her first suicide attempt and continues to the struggle with suicidal ideation. She reported that she should not be here today, as a number of her attempts she had medically died and machines and medications brought her back to life. Over her life course she has been hospitalized on numerous occasions. She reported adverse childhood experiences, and had reported witnessing a parent attempt to take their life as a child. She reported that she has tried numerous medications to assist to manage her symptoms, which have not alleviated the suicidal ideation. At the writing of this report, this individual continues to struggle with day to day functioning, cannot attend a job regularly (she reports when she can stabilize, she enjoys working – although she has not been able to do so in two years), has been denied disability (she has appealed and lost) and cannot live on her own due to financial challenges. All of these later compounded into more mental health challenges as she was raised by parents who had attended an Indian Residential School and were struggling themselves. She reported that attending a First Nation mental health therapist was beneficial to her treatment and care. Although, when her therapist closed her practice in the winter of 2017, she reported that she could not locate a First Nation therapist on the NIHB list to assist her with crisis support and long-term therapy – which resulted in another mental health challenge.

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The MHTWG's initial discussions have identified significant gaps and barriers in the existing mental health programs and services available to First Nations people in Saskatchewan:

1. The most significant gap relates to the approved Mental Health Therapist (MHT) list maintained by Health Canada's First Nations and Inuit Health Branch (FNIHB). There are currently few clinicians on this list who are taking on new clients. Individuals seeking supports often call the entire listing of clinicians and leave messages in an attempt to access a MHT. What if this individual is in significant mental health distress? Where does that leave a person who is in need of mental health support, who is in crisis? Who can advocate for them? How many individuals will continue to reach out for help when they do not reach a MHT by phone?

2. There are significant gaps and limited supports and services for the broad range of psychological treatment, interventions, and limited access to addiction and family treatment centers, especially in Northern Saskatchewan.
3. There are very few options currently available for individuals who are experiencing the intergenerational trauma and effects of the Indian Residential Schools.
4. There are currently very few treatment options that focus on the devastating impacts on children and youth who witness intergeneration trauma, family violence and abuse. There are very few therapy and treatment models to work specifically within the First Nations communities to prevent mental health impacts. This gap suggests that specific supports and services need to be developed within First Nation communities to help children and youth heal from intergenerational trauma.
5. There is a need for programs and services for men and women who may be struggling with addictions and substance abuse disorder. There are a few programs that encourage men and women to participate in programs that assist in building stronger parenting skills and developing healthier relationships. Most focus on a deficit not on their strengths.
6. There is a lack of youth programs for mental health, healthy relationships, support groups, etc.
7. There is a need for programs and services addressing bullying and lateral violence, which occurs across the age span from children, youth, adolescents, adults and older adults.
8. There is a need for integrating traditional/ceremonial options for First Nation individuals who may want to access this as an option for treatment,

We are aware that the Government of Saskatchewan released a ten-year Mental Health and Addictions Action Plan for Saskatchewan (Saskatchewan, 2014). We have not found information on the degree to which the Action Plan has actually been implemented, or evaluated.

The recommendations contained in the Saskatchewan First Nations Suicide Prevention Strategy will be aligned with those already made by the Mental Health & Addictions Task Team (Mental Health & Addictions Task Team 2010), by FSIN's *Cultural Responsiveness Framework* (Federation of Saskatchewan Indian Nations 2014), and by the *First Nations Mental Wellness Continuum Framework* (Health Canada 2015).

11. The next steps, and how to contribute

The Federation of Sovereign Indigenous Nations (FSIN) represents 74 First Nations in Saskatchewan. The Federation is committed to honouring the spirit and intent of the Treaties, as well as the promotion, protection and implementation of the Treaty promises that were made more than a century ago.

The Saskatchewan First Nations Suicide Prevention Strategy initiative was announced on World Suicide Prevention Day, September 10, 2017. "We need the world to know that Indigenous people are taking action on their own," Vice-Chief Heather Bear said at the announcement. "We don't have to wait for government. If we wait for government, it will never happen… so we need to take action ourselves."

A sweat and feast were held one week later, to launch the project in a good way according to protocol.

FSIN has retained two Technical Advisors to assist with development of the Strategy: Jack Hicks, Adjunct Professor of Community Health & Epidemiology in the College of Medicine at the University of Saskatchewan; and, Dr. Kim McKay-McNabb, a First Nations therapist in her own private practice.

Over the next few months the FSIN's Mental Health Technical Working Group will be preparing an evidence-informed, multifaceted draft Suicide Prevention Strategy, conducting consultations about it throughout the province, reviewing the comments and suggestions received, and then releasing a final Suicide Prevention Strategy by May 31, 2018.

The final Strategy will implement the detailed motion passed by FSIN's Health and Social Development Commission and Resolution 2049 passed by the FSIN Legislative Assembly, both of which are appended to this Discussion Paper.

We invite your comments on what should be included in the Saskatchewan First Nations Suicide Prevention Strategy.

What are your thoughts on the information contained in this Discussion Paper?

What actions do you feel could be taken to reduce the rate of suicide behaviour in your community, both in the short term and over the long term?

Comments and suggestions need to be received by November 15, 2017.

Please send your submissions to mental.wellness@fsin.com. For further information, please contact Charmaine Pyakutch, FSIN Special Projects Researcher/Analyst at 306.665.1215; Jack Hicks at 306.262.4735; or, Dr. Kim McKay-McNabb at 306.533.2299.

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Health and Social Development Secretariat
Health and Social Development Commission
MOTION RECORD

MOTION NUMBER:

PURPOSE: **Saskatchewan Indigenous First Nations Suicide Prevention Strategy**

MEETING DATE: **May 8, 2017**

BE IT RESOLVED THAT the Federation of Sovereign Indigenous Nations (FSIN) shall develop and release a Saskatchewan Indigenous First Nations Suicide Prevention Strategy by May 30, 2018 as a matter of highest priority; and,

BE IT FURTHER RESOLVED THAT THIS STRATEGY SHALL:

A. Respect and reflect the cultures of Saskatchewan Indigenous First Nations;

B. Acknowledge, celebrate and learn from the good work that has been done, and is being done, in many of our communities;

C. Support capacity-building at the community level so as to strengthen the ability of Tribal Councils and individual First Nations to take whatever actions they feel are required to address suicide behaviour locally;

D. Improve the resources available to implement suicide preventions measures at both the provincial and the community level;

E. Implement 'best practices' and lessons learned from the suicide prevention strategies of other Indigenous peoples, and of governments both nationally and internationally;

F. Address suicide prevention, suicide intervention and suicide postvention;

G. Have a particular focus on suicide behaviour among children and youth, but address the needs of all age groups;

H. Address the needs of both Indigenous First Nations people living on reserves and Indigenous First Nations people living in cities and towns;

I. Focus on both the provision of a broad range of culturally-appropriate mental health services (commensurate with the burden of suffering in the communities) as well as the other measures which address the well-documented background risk factors for suicide behaviour, including unresolved historical trauma, poor living conditions; high rates of early childhood adversity, high rates of violence, and high rates of substance abuse;

J. Require both the federal and provincial governments to acknowledge the Treaty Rights of Saskatchewan Indigenous First Nations people to health and social services of capable of addressing the burden of social suffering in our communities;

K. Establish an evaluation framework capable of measuring whether public health and other authorities deliver on commitments made, and whether the measures outlined in the strategy are making a positive impact on the rates of suicide behaviour by Saskatchewan Indigenous First Nations people; and,

L. Set out a research program to strengthen work on both immediate and background risk factors for suicide behaviour over the coming decade.

M. Strike a Mental Health Technical Working Group to assist in guiding the work of the Suicide Prevention framework with representation from a provincial perspective with the following members:

Shirley Bighead (PAGC)
Flora Fiddler (MLTC)
Angie Tanner (Cowessess First Nation)
Dawn Sinclair (YTC)
Penny Constant (PAGC)
Joanne McKay (NITHA)
Jeremy Seeseequasis (Beardy's & Okemasis First Nation)
Linda Barclay (STC)
Stephen Neapetung (STC)

MOVED BY: Chief Gilbert Ledoux, STC

SECONDED BY: Councillor Richard Aisaican, Independent

All in Favour

OPPOSED:		**ABSTENTIONS:**		**CARRIED:**	X	**DEFEATED:**	

FSIN

LEGISLATIVE ASSEMBLY RESOLUTION

MAY 18, 2017 **REFERENCE NUMBER: 2049**

SUPPORT FOR FIRST NATION SUICIDE PREVENTION STRATEGY

WHEREAS the *United Nations Declaration on the Rights of Indigenous Peoples* states that Indigenous people shall take effective measures to ensure continuing improvement of their social conditions and have the right to determine and develop priorities and strategies; and

WHEREAS the *Truth and Reconciliation Commission of Canada: Calls to Action* states that the gaps in health must be assessed and closed in collaboration with Indigenous people and specifically references the indicators of suicide; and

WHEREAS First Nations have recently faced a state of crisis with numerous suicides in their communities; and

WHEREAS the rate of death by suicide is higher among the First Nations population than among the non-First Nations population of Saskatchewan, and it is significantly elevated among First Nations children and youth; and

WHEREAS the rate of death by suicide by First Nations persons in Saskatchewan will not decrease without multifaceted suicide prevention measures being implemented; and

WHEREAS there is no regional First Nations suicide prevention strategy in Saskatchewan.

THEREFORE BE IT RESOLVED the Chiefs-in-Assembly direct the Federation of Sovereign Indigenous Nations to address suicide with high priority; and

FURTHER BE IT RESOLVED that the Chiefs-in-Assembly direct the Executive Member holding the portfolio for Health and Social Development to develop and release a First Nations Suicide Prevention Strategy, with inclusion of the FSIN Youth Representatives, by May 31, 2018.

MOVED BY: Chief Cadmus Delorme, Cowessess

SECONDED BY: A/Chief Paul Ledoux, Muskeg Lake

CARRIED

It is HEREBY CERTIFIED by the undersigned that the foregoing is a true copy of a resolution unanimously passed by the Chiefs of the Legislative Assembly at a meeting duly called and regularly held on the 18th day of May, 2017, and the said resolution is now in full force and effect.

CLERK OF THE LEGISLATIVE ASSEMBLY