Lifenotes
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Mental Health, Addictions and Suicides – A Likely Partnership?

Pat Konkin, MSW

Is it an addiction that causes one to have a mental health problem or is it a mental health problem that causes one to misuse substances where, in either case, some people contemplate suicide as a way out of the pain they are suffering?

Seasoned clinicians in both fields of mental health and addictions will confess that the answer to this seemingly "chicken-egg" question is not best suited to an either-or response. As a mental health and addictions therapist it has been my experience that most people with a mental health issue misuse substances in an attempt to manage the psychosocial impact of a mental health problem.

HOW HAVE I COME TO THIS CONCLUSION?

It has been useful in my work to find a repetitive scenario from which I can build confidence in any hypothesis I have constructed that can assist me with an explanation of why a specific community of people behave in a certain way. One such scenario that lends credence to a proposition that compromised mental health leads to substance misuse, which can in turn lead to a contemplation of suicide, is the scenario of today's First Nations people in Canada. Their alarming poor health and psychosocial status is exemplified within contemporary statistics and research. The statistics compliment my direct clinical observations in the fields of addictions and mental health which direct me toward the conclusion that mental "ill-health" and substance misuse can have a disastrous outcome for a community of people.

I recently had an opportunity to discuss the connections between mental health, substance misuse and suicide when invited by the Inter Tribal Health Authority to attend a

First Nations "Mental Health and Wellness Gathering" on Vancouver Island. I was one of a number of panel members who were asked to speak about the future needs and directions for mental health services to First Nations people and communities. I discussed the topic from two perspectives – through my experience as a clinical service provider and through what I have learned from First Nations students as a college instructor. I thought it useful to combine these two areas as my assumptions obtained from direct practice become validated through the testimonials of the students I have had the opportunity to learn within an academic environment.

After confessing to not being an "expert" in the field of First Nations mental health, I began my discussion by making reference to the work of Dr. James Thompson, Professor of Psychiatry at the University of Maryland in Baltimore who spoke of his experience about the help-seeking behavior of First Nations people in the United States. He states that, "As with any minority group, there are variations within the group. But in my experience, Native Americans are usually very pragmatic in seeking help for mental health problems; they want to find something that works. They often have a built-in distrust of the mainstream system, so they tend to be wary. I have also found that Native American men, more so than women, associate mental health problems with weakness, and therefore may feel ashamed of seeking help."[1]

It has also been my experience that non-First Nations initiated and provided mental health services have been underutilized by First Nations people – perhaps for the reasons Dr. Thompson describes (distrust of the mainstream system – for a number of reasons, including lack of cultural relevancy in service delivery).

I went on to describe initiatives currently under way at the Culture and Mental Health Research Unit at the Institute of Community and Family Psychiatry in Montreal, where they are finding that work in Aboriginal communities raises issues of the relevance of professional concepts of problem definition and therapeutic efficacy[2]. This spoke of the need to have First Nations people highly involved in services that respond to the mental health needs of First Nations people. The Culture and Research Unit began *Continued on Page 8*

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

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The Powerful Allure of Stories: Personal and Professional Tales in Suicide Prevention

Jennifer White, Director, SPIRC

. . . we see ourselves in the middle of a nested set of stories – ours and theirs (Clandinin & Connelly, 2000)

We all lead "storied lives." No matter where we are located on the human landscape our stories are *always* in progress – unfinished, organic, unpredictable – and our stories are of course inevitably bound up with other people's lived experiences. When we listen to other people's stories, we invariably look for themes and patterns that resonate with our own experiences, but we also notice the discordant notes as well. We often learn profound lessons about ourselves when we listen to other people's stories of joy, sadness, heartbreak, tragedy and triumph and it is through the telling (and re-telling) of our own stories that we come to know and experience ourselves in relation to others and our communities.

The suicide prevention field is replete with stories: survivors' personal stories of grief and loss, professional caregivers' stories of clinical case management, researchers' scientific accounts of the problem, policy-makers' stories about how resources will be allocated and justified, public portrayals of suicides through the media, and community stories of healing, hope, and renewal in the aftermath of suicide. In other words, there are multiple story lines that we must attend to – and position ourselves within – as we attempt to take effective action to reduce the tragedy of suicide in our communities. Each of these renderings provides a unique and valuable contribution to advancing our understanding of the phenomenon of suicide and we must be prepared to *really listen* to both the public and private, as well as the official and unofficial, stories that comprise the field of suicide prevention. There are also many silences, gaps, and "stories not told," that warrant our attention as well.

By granting certain voices greater legitimacy and power to "author the stories" of suicide prevention (e.g. credentialled researchers and caregivers) we run the risk of silencing the valuable contributions to be made by others who have a uniquely qualified perspective to share with us, including survivors, concerned community members, and mental health consumers. In our zealous pursuit of best practices and evidence-based decision-making, we may become unwittingly complicit in perpetuating the belief that only scientists, researchers, and professional caregivers have something worthwhile to say about what needs to be done in our communities to reduce the risks of youth suicide and suicidal behaviour. I think we need to guard against this tendency to surrender our knowledge over to experts and specialists and we must actively support the inclusion of other community voices and perspectives in all of our suicide prevention efforts. There is indeed a special place for expert, professionalized knowledge in the field of suicide prevention, and without it we would surely waver, however we will be in a much better position to take effective action against this troubling and complex social problem, if we learn how to create a more democratic space for a broader range of voices to be heard.

I believe that this newsletter provides an important vehicle for sharing multiple and overlapping stories about suicide prevention and community health. It is a space where a range of perspectives can be heard, including the personal, professional, and political. Based on the feedback we received in response to our recent readers' survey, it is just these types of stories that our readers find most relevant and captivating. I am very committed to maintaining this emphasis on broad stakeholder participation in all of our suicide prevention efforts and I hope that our readers will continue to share their rich and textured stories with us in future issues to come. ■

Realizing a Project for the Prevention of Aboriginal Youth Suicide

Cheryl R. Matthew, Continuum Consulting,
Communication & Leadership Workshops, Aboriginal Youth Advocacy

Last summer I was a participant in a Mental Health Workshop that was put together jointly between the Mental Health Promotions Department of Health Canada and the Assembly of First Nations (AFN). This gathering brought together the National Youth Council of the AFN which are 20 Aboriginal youth from across Canada, one male and one female representative for each of the ten regions.

It was at this workshop that we began discussions around Aboriginal youth and suicide. At the time I had not realized how intense and how pertinent an issue this would become for me. I realized how important my personal experiences with suicide could be in affecting the delivery programs and services aimed at Aboriginal youth by the final report put together at this workshop for Health Canada.

At the workshop I was able to share my personal experience with suicide when I was 19, the circumstances that lead up to it, and recommendations that I had for finding a relevant healing process. As well, I shared my feelings and thoughts around the suicide of my Uncle that had happened a few years back. In sharing these experiences, not only did I feel a sense of relief but a sense that I had contributed something of great significance. It wasn't until December of last year that these intense emotions would re-surface. I was at a Confederacy of Nations meeting in Ottawa and I was listening to Peter Kelly as he addressed the youth. The message that Peter Kelly brought was a plea for the Assembly of First Nations to address the issue of suicide amongst Aboriginal youth. Peter Kelly had lost both his children at age 19 to suicide. It was at that moment that

I knew I had to do more, that I had to do something, and that it was within my means to contribute somehow.

I spent the next month or two talking to people about suicide, doing research on how it has impacted the Aboriginal community. I found myself telling many people that I was working on a proposal that would take a grassroots approach to suicide prevention by getting recommendations directly from youth. People were very interested in this idea, this project and wanted to see the proposal. It was at this time that I had realized that I had hit some type of mental block on the subject. I had written a short article describing my experiences and some recommendations for communities to look at when confronted with suicide of an Aboriginal youth in the community. The article brought back those same torrid emotions that for so many years I had held back. One of the main messages in that article is found in it's title "Taking the Shame Out of Suicide" as I had realized that all those years I was hiding the fact that I was indeed a suicide survivor. I had tried to take my own life, and I had hidden it for so long because there is so much shame that is associated with the subject in our society. I remembered when I woke up after three days in the hospital the first thing the doctor said to me was that I had done something that was "socially unacceptable." I carried that guilt for so many years and felt ashamed of what I had done. In reliving my experience I came to accept it and I realized that I would not be ashamed anymore. The longer that we continue to sweep this issue under the carpet, when we have real experiences and solutions that could help to prevent it the higher the suicide rates will become amongst our First Nations young brothers and sisters. When I finished writing my article I had this great uplifting feeling, an epiphany: I realized that if I could draw on the personal experiences of fellow Native youth, we could collectively come up with community solutions that were relevant to our people.

Finally, after much inner reflection and research I wrote that proposal which I called "A Healing Journey: An Aboriginal Youth Approach to Suicide Prevention." The concept of the proposal was accepted and supported by Health Canada, who have contributed money for the completion of the project. The purpose of the project is to bring Aboriginal youth together from different parts of Canada who are suicide survivors and come up with recommendations and insight into what helped us through our time of need. Another key element is finding out what had gotten us there in the first place and what could have been done to prevent it. The project would use Aboriginal youth similar to *Continued on Page 14*

Youth Suicide Prevention Community Initiatives: Phase Two

Jennifer White, Director, SPIRC

BACKGROUND

During the fiscal year 1998 - 1999, the Ministry for Children and Families announced that $200,000 would be made available to communities – through the Suicide Prevention Information and Resource Centre (SPIRC) – to support local action for youth suicide prevention. Following a competitive process and systematic, staged review organized by SPIRC, seven BC communities were chosen to serve as demonstration sites for the purposes of implementing a best practices approach to youth suicide prevention. The projects were selected based on their interest, readiness, and capacity to implement approaches that were consistent with the "before-the-fact" mental health promotion and early intervention strategies articulated in the Manual of Best Practices in Youth Suicide Prevention (White & Jodoin, 1998). These seven projects were funded for one year starting in late April, 1999 and awards ranged from $10,000 to $40,000. The overall purpose of the provincial demonstration project initiative was to learn which youth suicide prevention strategies work best in communities of different sizes, representing different regions of the province. All seven projects were required to generate matching funds (or contributions-in-kind) as one strategy for optimizing sustainability beyond the formal project term.

CURRENT STATUS

The majority of the demonstration site communities have expressed a keen interest in continuing their community efforts, and each is at varying stages of readiness in terms of "institutionalizing" their program

efforts in their own community. A final evaluation report will be complete by November, 2000. Key learnings at both the local level and the provincial level will be highlighted. Organizational considerations (e.g. committee structures, leadership, involvement of key partners) as well as specific program outputs (e.g. learning outcomes, community attitudes, and public awareness) will be noted in the final report.

NEW OPPORTUNITIES

Recognizing the strength of a community-wide approach to youth suicide prevention, the Ministry for Children and Families recently announced that an additional $200,000 would be made available to support further local action in youth suicide prevention. These funds will be used to build on the current efforts in the original sites, but will also be used to enable additional communities to begin the work of developing comprehensive youth suicide prevention strategies. This staggered approach to funding and project startup and implementation will result in a series of youth suicide prevention projects being implemented around the province, each at varying stages of development. Those community projects that are funded later (i.e. 2000-2001) will be able to benefit from the wisdom gained from the earlier funded efforts. More information about this new initiative will be made available to communities throughout the province in coming months. ■

"Recognizing the strength of a community-wide approach to youth suicide prevention, the Ministry for Children and Families recently announced that an additional $200,000 would be made available to support further local action in youth suicide prevention."

BC Council for Families, Community Partners, and Provincial Government Collaboration – A Success Story!

Cheryl Jeffs, Program Director, BC Council for Families

Collaboration. The BC Council for Families (BCCF) was built on collaboration. Incorporated as a Society in 1977 the Council was established through the work of community and government. These partnerships have endured through the development and implementation of projects and programs troughout the province. Provincial funding has been a mainstay – first from the Ministry of Health and in more recent years from the Ministry for Children and Families (MCF). In addition, several federal government contracts have helped our mission to strengthen, encourage and support families of British Columbia. Our mission is met through information, education, research and advocacy by working with and through family-serving organizations and government agencies.

COLLABORATING ON SUICIDE PREVENTION EFFORTS

One example of government and community collaboration is the suicide awareness and intervention project that began in 1990. The Ministry of Health offered BCCF a contract to develop a suicide prevention curriculum for grades 8 - 12. *Let's Live! A School-Based Suicide Awareness and Intervention Program* was developed. An advisory committee of community and government, including teachers and school counsellors, guided the direction and development for this provincial program. A Ministry of Education recommended resource, *Let's Live!* weathered Ministry changes to curriculum including the revision of Learning for Living to the current Career and Personnel Planning Curriculum (CAPP). A commitment from government will ensure a newly revised version in the future.

At this point, MCF began to collaborate with BCCF and to provide funding for the next phase of suicide awareness and intervention. The Council was also just one community agency funded by MCF in its commitment to suicide prevention. Development on a new training program began as it was apparent that one of the needs of school personnel was suicide intervention training. It is essential to train school faculty and staff as they are in a position to detect potentially suicidal students.

An advisory committee consisting of community and government representatives, including MCF and Ministry of Education, guided the Council in the development, field testing, implementation and evaluation of a new suicide intervention training program for school personnel called ASK • ASSESS • ACT. The program has been delivered throughout BC and two years of evaluation data indicate ASK • ASSESS • ACT has met its objectives of increasing suicide intervention knowledge and skills, and influencing attitudes favourable to suicide intervention.

A NEW SUICIDE INTERVENTION TRAINING INITIATIVE

A recent initiative in collaboration with BCCF, the Ministry of Education and MCF was launched in October 2000. Representatives from each school district, including independent and Aboriginal, and each MCF region were invited to attend a training for trainers event. The objective of the initiative was to train school counsellors and mental health clinicians to deliver a revised version of the ASK • ASSESS • ACT program and a newly developed (one and two hour) awareness modules to school personnel in their school districts. MCF supported the development of the trainers edition of ASK • ASSESS • ACT, and the Ministry of Education supported the travel and accommodation of delegates. This initiative is just a beginning. It is expected that the school districts in turn will collaborate with MCF regions and other community partners to deliver suicide intervention training throughout the province.

THE CHALLENGES AND REWARDS OF COLLABORATION

Perhaps this success story sounds too simple. Collaboration is a challenging and complex process. Hours, days, months and years are spent on building and nourishing relationships. Change is a constant including new ministries, new policies, and new staff. Some days it seems like we have gone in a circle and are back where we started. Other days and events are more rewarding as we meet a benchmark and continue moving forward. Meetings and every electronic means of communication assist the process. Financial contributions are extremely important and provide the foundation for the *Continued on Page 14*

Bridging the Gap
Youth Net, Courtenay, BC

Joyce Austin, Program Director

Implementing a new program generates many challenges. In its earliest stages, Youth Net was faced with the initial challenge of gaining local support and then as a proposed satellite program, we had to secure funding before being selected as a satellite. The main obstacle for funding was the fact that in the Youth Net model of mental health promotion "youth" are seen as the experts in defining what their issues are. Initially we established a Youth Council by asking interested parties to come to a community meeting and out of this meeting, the youth committee was formed. This committee was involved in the initial stages of the program networking, fundraising and training. After several requests for funding were rejected, we gained the support of The Vancouver Foundation and the Children's Hospital of Eastern Ontario (CHEO), where the program originates. With the incredible support of these funders, we officially started to build the program.

The first step was to offer training workshops to the fifteen core youth facilitators. This session was lead by Dr. Simon Davidson, cofounder of the Youth Net project, and Lynn Chiarelli and Edouard Kodsi of the Ottawa Branch of Youth Net. We took the model developed by CHEO and adapted it to fit the needs of a semi rural area. Youth Net supports the talking circle format for meetings which allows for the equality of all participants. We have Aboriginal youth facilitators working in Aboriginal communities. The program is available to youth of all cultures.

The philosophy of having the youth facilitators created some challenges within the local community. We constantly have to reassure professionals that the youth facilitators are not working as counsellors, crisis intervention workers or social workers, and that their primary goal is to lead focus groups to initiate youth into talking about what mental health is, and to find out who, and where the youth feel comfortable turning to when they are in crisis. If the team of facilitators encounters a situation, where there is a youth in crisis, the facilitators are required to refer the youth to the crisis intervention worker who is on call during the focus groups. The facilitators, youth committee and I are working as a bridging agent for the youth to the community resources. We encourage youth to become active in the process of developing services that fit their identified needs and to work as advocates for other youth.

Our biggest success to date is our Youth Net Newsletter. These newsletters are produced by the youth committee on a monthly basis and are delivered to coffee shops, schools and recreation centers and anywhere else that youth are found. Included in each issue are researched articles pertaining to different mental health issues: stress, school, parents, jobs relationships, etc. No subject is barred. Included in these newsletters are pieces of art and poems created by local youth. On the last page of every newsletter is a list of resource numbers that are youth friendly. The service of offering resources and referrals are in high demand. Our staff is in the process of developing resource materials designed especially for the youth to read and use.

As we look ahead to our upcoming year we are looking forward to continuing the focus group work, increasing the production of our newsletter, producing youth friendly resource materials, working on establishing a Youth Mental Health Rescue Centre and continuing to seek out funding for the continuation of our program. We are optimistic about the continued growth of the program and look forward to increased support from both the Aboriginal and mainstream communities. ■

"Youth Net Getting Connected is a satellite program of the parent Ontario based Youth Net/Réseau Ado"

For more information about
Youth Net/Réseau Ado
visit www.youthnet.on.ca

For more information on the Courtenay satellite specifically, please call Joyce Austin at (250) 334-9591.

GUEST ARTICLE *continued*

Mental Health, Addiction and Suicide – A Likely Partnership? . . .

planning a series of meetings and workshops designed to train First Nations students and health and social service workers in culturally responsive methods of clinical intervention and evaluation research.

Is there some urgency to develop mental health services by and for First Nations people? Certainly social and health statistics indicate an urgent need to begin planning a range of mental health services, including crisis intervention services.

Annually reported disproportionate rates of incarceration, suicide, alcohol and other drug addictions, HIV and AIDS, family violence, and the resultant number of First Nations children in the care and custody of Provincial Directors of Child Welfare and First Nations bands and Tribal Councils, point to a culture under a great deal of pain.

More than one third of all new HIV cases diagnosed in Edmonton are Aboriginal – in Saskatchewan, 47.6% were Aboriginal in 1997, compared with only 10.5% in 1993. The scenario is much the same in BC where, "Aboriginal people in urban areas represent a disproportionate number of people infected with HIV."[3]

Between 1994 and 1995 there were 24 completed suicides by First Nations young people and 135 completed suicides by young persons of all other ethnic origins. This means that of all suicides completed by young persons under age 24 in 1994 and 1995, 17.7% were attributed to First Nations young people. When examining suicides by all ages, 6% of the suicides in BC in 1994 and 1995 were Aboriginal and yet only 3% of the total British Columbia population identifies themselves as Aboriginal[4].

During the Mental Health and Wellness gathering I made reference to my experience as a College instructor. I asked students in my social work practice course, "What is the explanation of these elevated statistics in the First Nations population – suicide, addictions and mental health problems?" A First Nations student responded by saying "maginalization." I asked, "what causes marginalization?" She responded by saying that historical social injustice has contributed to marginalizing First Nations people – mandatory attendance at residential schools, enfranchisement, the inability to vote, loss of Indian status by First Nations women and racism. She spoke about the erosion of self – self esteem and self concept.

I asked, "What does marginalization look like?" She said, "unemployment, suicide, alcoholism, lack of appropriate child care practices, desperation and other issues."

We know that Aboriginal people in other countries are experiencing similar health and social issues. The Torres Strait Island communities in New Zealand, which have a high Aboriginal population have shown a disproportionately high rate of death and illness. The Royal Australian and New Zealand College of Psychiatrists state that, "a large part of this is due to psychiatric illness." They state that "International studies show that a secure identity is critical to the mental health of indigenous people." They also believe that the "current divisive debate about land rights will worsen the mental health problem of indigenous people (in New Zealand)."[5]

A recent study completed by Michael Chandler and Christopher Lalonde at the University of British Columbia titled, "Cultural Continuity as a Hedge Against Suicide in Canada's First Nations," points to the need for the attainment of what Chandler and Lalonde call "cultural continuity."[6] Their study which examined self-continuity and its role as a protective factor against suicide, suggests that "communities that have taken active steps to preserve and rehabilitate their own cultures are shown to be those in which youth suicide rates are dramatically lower." They identify five "markers of cultural continuity" factors that resulted in a percentage reduction in the relative risk of suicide within the group of communities in which the factor was present. The factors were: self-government, land claims, education, health services, cultural facilities and police and fire services. Those communities that enjoy some measure of self-government appear to provide the greatest protective value with the least amount of completed suicides, followed by communities that have band controlled schools, then communities with long standing effort at exerting effort over control of traditional land base, control over health services, the presence of cultural facilities and, finally, control of their own fire and police services.

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Would having control over much of what you are taught (in schools), control over economic destiny (with an economically viable land base), health services, police services and so on provide a secure identity by enhancing self esteem and self concept?

It makes sense that if we were to arrive at a synthesis of the statistical and empirical research reported from contemporary practice and research, the road to First Nations mental wellness points strongly towards empowerment for the First Nations community. A useful definition of empowerment for this purpose can be found in a definition put forth by Moncrieff Cochran, " . . . (empowerment is) an interactive process involving mutual respect and critical reflection through which both people and controlling institutions are changed in ways that provide those people with greater influence over individuals and institutions which are in some way impeding their efforts to achieve equal status in society, for themselves and those they care about."[7] The influence Cochran describes can be the vehicle (described by Rappaport) as "the means by which people, organizations and communities gain mastery over their lives. Empowerment implies that new competencies are required in a context of living life rather than being told what to do by experts."[8]

A discussion paper released by Health Canada in conjunction with the Atlantic Health Promotion Research Centre in 1977 speaks exhaustively about the links between substance misuse and mental health and its effect on the First Nations community. The authors stated that, "Among Canada's Aboriginal peoples, multiple mental health and substance misuse problems are profound. Suicide is the most extreme manifestation of these problems. The suicide rate is much higher on reserves than in the general population and has been linked to drug use, low self-esteem, isolation, a history of child abuse and lack of educational opportunities or meaningful employment. These same conditions contribute to frequently reported family violence, drug abuse, depression and anxiety. Increased empowerment of Aboriginal peoples within their own communities could serve as a positive mechanism to protect and enhance health and well-being."[9]

The paper also identifies the unfortunate philosophical differences that exist between the mental health and addictions fields. Unfortunate because, in my opinion, these two fields need to work much closer to address dual occurrence/diagnosis. Perhaps this is why numerous jurisdictions (in the United States and some of the provinces in Canada) have moved toward a single authority in the management of mental health and addictions.

In summation, mental health and addictions services must include a walk "upstream." Upstream, to determine what predisposing, precipitating and maintaining conditions create mental ill-health for individuals or a community of people – before we can construct those protective factors that enhance mental wellness and mitigate against those factors contributing to mental ill-health and substance misuse where suicide appears the only option for some. The First Nations experience described in this article only serves to demonstrate the connections between addictions, mental health and suicide and the importance of systematic inquiry into prospective causal factors – prior to embarking on a plan of action. ■

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The comments and views in this article are those of the author and do not necessarily reflect those of the Ministry for Children and Families.

RESEARCH SPOTLIGHT

The Facilitation of Healing for American Indian Youth Who Are Suicidal: *An Exploratory Study*

Rod M. McCormick, Ph.D., Mohawk Nation, Assistant Professor, Dept. of Educational and Counselling Psychology and Special Education, University of British Columbia

The following text is comprised of excerpts from the above stated paper (in press): For more information call (604) 822-6444.

BACKGROUND Suicide amongst American Indian youth has become a critical problem as is indicated in even the most conservative of statistics. A conservative estimate is that American Indian people in general are at least 3.6 times more likely to commit suicide than non-Indian people (Tuk & Macdonald, 1995). The suicide statistics for American Indian youth (between the ages of 10-19) are even higher. American Indian males in Canada between 10-19 years old are 8.3 times more likely to commit suicide than non-Indian males of the same age. American Indian females between 10-19 years of age are 20 times more likely to commit suicide than their non-Indian counterparts. (Tuk & Macdonald, 1995).

In examining the causes of suicide and suicidal ideation amongst Aboriginal youth it is necessary to examine the effects of colonization on American Indian communities. Although empirical research has not yet been conducted to show the direct link between suicide and colonization we do know that factors such as family violence, substance abuse, alcoholism, and child abuse have been found to be related to both colonization and to suicidal risk in American Indian youth (Berlin, 1987). Assimilationist government practices such as the residential schools resulted in a breakdown of the nuclear and extended family, loss of traditional values, and a loss of personal and cultural identity and meaning. (Berlin, 1987; Hodson, 1986; Duncan & Duncan, 1995; Chrisjohn and Young, 1997). Brant (1986) links this loss of meaning to American Indian people by virtue of the loss of cultural connection due to colonization.

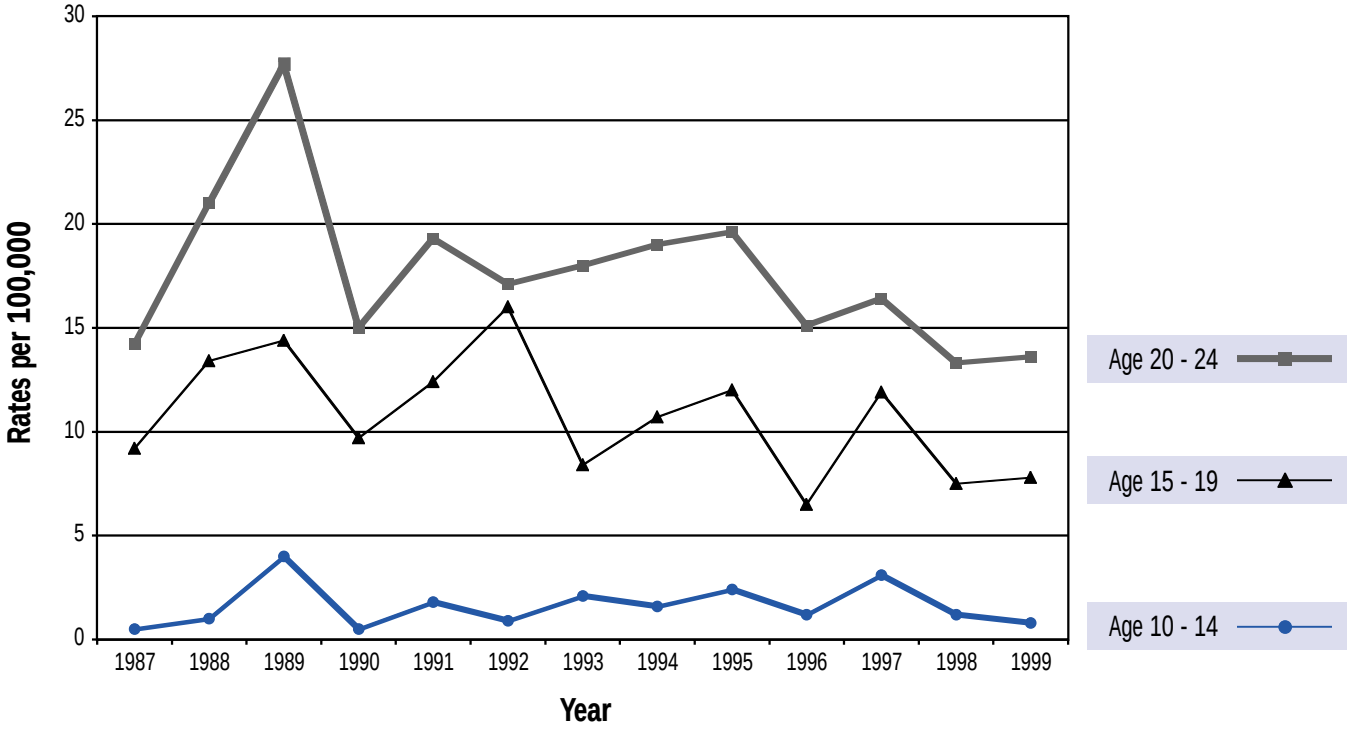
Suicide is causally linked to the oppressive effects of colonization and resultant cultural change and acculturation stress for American Indian people (Kirmayer, Malus, & Boothroyd, 1996). American Indian people have suffered a substantial loss of their culture and spirit (Hammerschlag, 1993). Duran (1995) alikens this loss as a form of intergenerational post-traumatic stress disorder suffered by all American Indian people. The effect of this loss on Aboriginal youth is the development of fragile personal and cultural identities (Wilson & Wilson, 1995). This absence of identity and sense of alienation experienced by American Indian youth leads to increased suicidality (Hodson, 1986).

Very little research has focused on solutions to the problem of suicide amongst American Indian people. Literature on youth suicide that can be found recommends teaching self esteem, communication skills, knowledge on how to handle grief, a sense of community, a sense of one's own value, and how to deal with emotions (Hafen & Frankness, 1986). Limited recommendations for American Indian suicide reduction include: teaching positive self image, exploration of traditional healing practices, and the re-introduction of traditional cultural activities (Cooper, Carlsberg, & Pelletier-Adams, 1991).

DISCUSSION Through gathering reports from American Indian youth, the purpose of this project was to develop a set of categories that describe what facilitates healing for American Indian youth who are suicidal. Although millions of dollars have been spent on developing and delivering programs to address the problem of suicide amongst these youths, researchers have not explored the insights and experiences of American Indian youth themselves in order to obtain information to determine the best way to facilitate healing. This research has been unique in that it explores healing processes that work as reported by American Indian youths themselves.

IMPLICATIONS FOR THEORY AND RESEARCH
The results of this study suggest that it is necessary to understand the belief system and worldview of American Indian culture before applying theories and techniques of healing. Belief systems, decision making strategies, models of problem solving, assumptions about how problems arise, and how change occurs are all connected to how we see the world (Torrey, 1972; Ibrahim, 1984). It is hoped that this research will generate a belief in the value of mobilizing the belief system and healing resources of the clients that we serve in order to facilitate healing for them. To ignore these belief systems or to impose a contrary one is to potentially overlook important healing resources and undermine the working relationship between ourselves as therapists and our clients. *Continued on Page 14*

1987 - 1999 Youth Suicides in BC (Females & Males)



BC Youth Suicides by Age & Gender 1994 - 1999

	YEAR											
	1994		1995		1996		1997		1998		1999	
Age Group	*f*	rate	*f*	rate	*f*	rate	*f*	rate	*f*	rate	*f*	rate
05 - 09							**1**	**0.4**				
M							1	0.8				
10 - 14	**4**	**1.6**	**6**	**2.4**	**3**	**1.2**	**8**	**3.1**	**3**	**1.2**	**2**	**0.8**
F	1	0.8	4	3.3			3	2.4				
M	3	2.4	2	1.5	3	2.3	5	3.7	3	2.2	2	1.5
15 - 19	**25**	**10.7**	**29**	**12**	**16**	**6.5**	**31**	**11.9**	**20**	**7.5**	**21**	**7.8**
F	9	8	6	5.1	2	1.6	9	7.1	6	4.7	5	3.8
M	16	13.2	23	18.4	14	10.7	22	16.4	14	10.2	16	11.7
20 - 24	**49**	**18.9**	**51**	**19.6**	**40**	**15.1**	**43**	**16.4**	**35**	**13.3**	**36**	**13.6**
F	10	8	9	7.2	7	5.5	5	4	3	2.3	5	3.8
M	39	30.1	42	32.2	33	25	38	28.4	32	24	31	23

f = annual frequency

rate = rate per 100,000 per year

Source: BC Coroners Service & BC Vital Statistics
Prepared by: SPIRC, MHECCU, Department of Psychiatry, UBC
September 2000

1-800-SUICIDE – Responding to the Challenge

Linda Stanton, Clinical Director, NEED Crisis and Information Line, Victoria, BC
BC Crisis Line Association Island Regional Representative
CASP 2000 Program Committee Member

HOW 1-800-SUICIDE WORKS

The USA's National Hopeline Network phone number 1-800-SUICIDE automatically connects callers in crisis – people who are depressed or suicidal, or those who are concerned about someone they love that may be depressed or suicidal – to an American Association of Suicidology (AAS) certified Crisis Centre nearest to where the call is placed. One of the strengths of this network is that it brings the knowledge, skill and resources of existing Crisis Centres under the safety net of a single, easy-to-remember, toll-free telephone number. This model allows centres to collectively respond to call volume and ensure that callers in crisis do not encounter busy signals or voice mail but instead are seamlessly rerouted to a person ready to assist them.

THE CANADIAN CONNECTION

Since the suicide of his wife Kristin, in April 1998, Reese Butler has been a tireless crusader for the establishment of the National Hopeline Network. In April 2000, I met Reese at the AAS Conference in Los Angeles. He was excited to assist Canadian Crisis Centres to set up a similar response network. At the recent Canadian Association for Suicide Prevention (CASP) conference in Vancouver, Karen Marshall from the American National Hopeline Network, gave a presentation to the CASP Board and met with Crisis Centres from across Canada. The CASP Board agreed to pursue the concept of a coordinated network in Canada.

THE CHALLENGES & POSSIBILITIES

While there are many challenges inherent in organizing a coordinated response to suicide

calls within Canada, I believe in the possibilities. All of us who are in the field of suicide prevention and crisis intervention must make a serious effort to bring this closer to reality.

People are probably already dialing this number in Canada and no one is answering their call for help. In the USA, as soon as they hooked up the number, 100 calls a day were forwarded to the certified crisis lines.

We have long struggled with the need to establish standards for crisis lines here in Canada, and I believe this could be the impetus for a national lobbying/fundraising effort to support all crisis lines to become certified. There are issues with certification, including the expense, and the fact that we do not have a Canadian certification process. 1-800-SUICIDE could be the catalyst to begin to address these issues.

IT CAN BE DONE

This toll-free service has been activated in the USA since May 1999. There are now over 40 AAS certified Crisis Centres responding to 1-800-SUICIDE calls in the USA and the network is expanding rapidly. By the end of 2000, over 100 Certified Centres will be connected to this 1-800 network. The USA Senate recently unanimously approved $3 million to support the certification of USA Crisis Centres thanks to a powerful lobby group. It is estimated that a majority of existing Crisis Centres in Canada could be certified but lack the financial resources to do so. The 1-800-SUICIDE telephone number should be one more vital link made available to people that need Crisis Centre services in Canada. ■

Information

To support this initiative
or for more information
please contact:
Linda Stanton at
lstanton@needcrisis.bc.ca
or Joan Wright,
Executive Director of CASP
at *casp@suicideprevention.ca*

Our Readership's Voice

Jessica Flores, SPIRC

Thanks to all of you who provided feedback about *Lifenotes* via the survey we distributed in our last issue vol. 5(2) June 2000. We are happy to report that the great majority of you find *Lifenotes* a worthy publication to browse through and share with your colleges and friends.

The goal of the *Lifenotes* survey was to see whether this newsletter is useful to you and is not an unwelcome piece of mail that clutters your in-box. Fortunately, we were pleasantly surprised with the survey's results.

SATISFACTION

We are delighted that 95.4% of you find the information in *Lifenotes* useful, 88.7% of you find it to be relevant to your community, 81.5% of you circulate it to your colleges and friends after reading it, 57% of you recommend to others that they subscribe to *Lifenotes* and, most importantly, 81.5% specified that you want to remain on the mailing list (13.2% left this question blank, 3.3% are neutral and only 2% preferred to be deleted). In addition, we received several phone calls and e-mails asking to be added to the *Lifenotes* distribution list. Thank you! This is a good report card!

DEMOGRAPHICS

Please refer to the pie chart.

AN EXAMPLE OF SOME OF THE THINGS YOU ASKED FOR AND WHICH WE CAN BRING TO YOU IN THIS ISSUE:

- "Listing of resources."
  Please find a listing of some web sites in the Notice Board section.
- "Issues surrounding youth addictions and suicide."
  Please see the Guest Article section.
- "More information on what crisis lines are doing."
  Please see the Crisis Centre News to learn about a possible new national initiative being spearheaded in BC.
- "Article from an Aboriginal psychologist."
  Please see the Research Update section to find excerpts from a paper (in press).
- "Information on what other communities are doing in the way of prevention/education."
  Please see the Regional News section to learn about the Youth Net Project in Courtenay, BC.

FUTURE ISSUES

We plan to introduce a new standing Round Table section in the next issue which will showcase a case consultation. For those of you who expressed interest in submitting an article for the Editor's consideration, please note that the deadline for the February 2001 issue submissions is Friday January 19th, 2001.

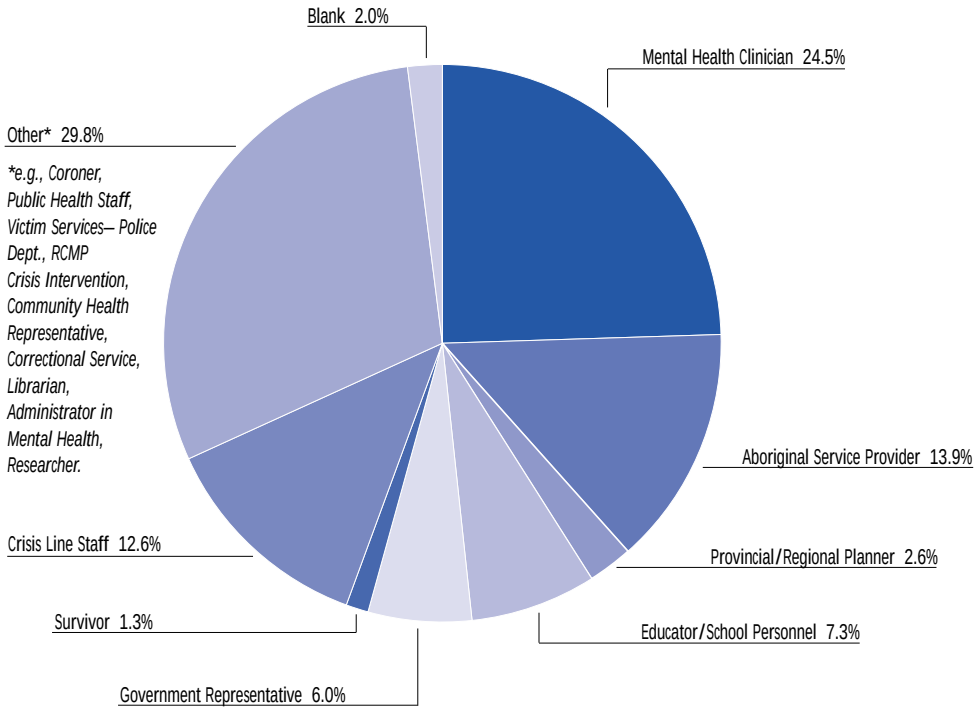
ACCESS

Did you know that anyone in the world has access to *Lifenotes* starting with the January 2000 volume? How? Just log on to the Internet and type in our net address *www.mheccu.ubc.ca/spirc* then go to the bottom of the page. The newsletters are in PDF format so you can download them easily.

P.S. For those of you who requested Aboriginal specific statistics, these were published in the "Graphic Issue" of the January 2000 issue; it is accessible via the Internet at our web site. This issue also includes other Aboriginal specific articles.

For those of you who requested more information on the adult and elderly populations, please note that this publication is funded by the Ministry for Children & Families and thus, the focus is on children and youth. For information on these populations go to *www.siec.ca*

Thanks again for your feedback! ■



NATIONAL NEWS *continued*

Realizing a Project for the Prevention of Aboriginal Youth Suicide . . .

myself between the ages of 20 to 29, who had suicide experiences when they were younger but have reconciled and gone on to be contributing, active members in the community.

I have spent the last year facilitating many youth empowerment, leadership development and communications workshops with Aboriginal youth and I discovered many things. The most important being that many Native youth have difficulty with written word, and how strikingly low literacy rates are. Therefore, I knew that my medium of communication for this project would have to be visual, I decided that this project would be a documentary film. The film will be aimed at prevention for high school youth by using the recommendations of reconciled youth. The project will help by letting youth know that there is support out there and what other youth, and communities can do to support an Aboriginal youth if they are thinking of attempting suicide. The film will be hopeful, uplifting and empowering to Aboriginal youth so they know they are not alone and that life does get better. Often the utter despair and loneliness that is felt by youth at their most desperate moments it can seem as if there is no one out there, no one that cares, and they can't think of living for another day. The film will show them that there can be another day, things do get better. The film could also be used in communities to identify strategies for prevention, and education.

The Provincial Residential School Project has supported me greatly in the development of this project and they are the host agency. The project is aimed for official start-up October 1, 2000 and it will be completed by the end of the fiscal year March 31, 2001. ■

If you are interested in getting a copy of the film after its completion please contact Michele Bourque, Project Officer, Mental Health Promotions Department of Health Canada at (613) 957-1477.

Also you can contact the Provincial Residential School Project at (604) 925-4464.

PROVINCIAL NEWS *continued*

BC Council for Families, Community Partners, and Provincial Government Collaboration – A Success Story! . . .

collaborative process. New ideas and vision, long term government and community relationships, credible programs, and information reaching farther than can be imagined are some of the benefits of collaboration.

The future of collaboration may look different. One of the key elements of the collaboration process is human resources and financial resources. Our current economy of fiscal constraint is threatening government and community collaboration. Some of the key changes already appearing are fewer community agencies involved, less time and staff – thus hurried projects, and fewer resources. Hopefully this is part of a normal cycle as community and government learn new ways, or adapt old ways, of working together to ensure the collaboration process in this new century. ■

RESEARCH SPOTLIGHT *continued*

The Facilitation of Healing for American Indian Youth Who Are Suicidal: *An Exploratory Study* . . .

IMPLICATIONS FOR PRACTICE There are two key points concerning this study that have implications for practice. Firstly, this research presents a map of what facilitates healing for American Indian youth who are suicidal. This map describes categories of healing and does so in an interpreted form that depicts how individuals go through the healing process. As this map did not exist previous to this research, it is now possible for practitioners to utilize this map in their practice of facilitating healing and recovery. The map has implications for counselling, counsellor training, program development, and community based initiatives.

Secondly, the map of healing presented in this research indicates that an abundance of healing resources exist for American Indian youth who are suicidal. This finding has the potential to change significantly the way American Indian communities view the nature and source of mental health services provided to them. In recognizing that the natural healing resources of youth themselves can be effective sources of healing, American Indian community leaders may feel empowered to start examining ways to utilize these methods of healing in addressing youth suicide in their communities. ■

NOTICE BOARD

INFORMATION / STUDIES

ICE beyond cool

"You are confused, fed-up, depressed and angry. Then, you're full of energy, fire and fun. You're a teenager – at the end of your rope. What do you do?" "Why do kids shut down and become cool?"

"ICE beyond cool is an Avanti Pictures Corporation production for national broadcast on CBC Television in the 2000/2001 season. The film is an adaptation of the DanceArts performace hit by groundbreaking choreographer Judith Marcuse. The film's young cast brings the story of a 16-year-old urban teen, her friends and the conflicting pressures on her, vividly to life [as a way to broach the topic of teen life experiences as they may relate to teen suicide]." The DanceArts/Judith Marcuse ICE beyond cool project developed from two years of intensive workshops with some 250 teenagers in Vancouver. The audience is invited to "talk-back" sessions after the live performances.

For more information about the film production you can call (604) 609-0339. For information about the ICE beyond cool Judith Marcuse project, visit the DanceArts web site at www.dancearts.bc.ca/ice.htm or call (604) 606-6425.

BOOKS / PUBLICATIONS

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

Who is it for?

This Manual was developed to meet the needs of anyone interested in developing or enhancing suicide prevention programs in their own organizations, schools and communities.

To order a copy:

Use the BC Government Publications virtual shopping-cart. Log on to **www.publications.gov.bc.ca** then

(1) click on the *'General Public'* button,

(2) click on *'Search the Entire Index,'*

(3) under *'Search Index For'* select *'Children and Families,'*

(4) type in *youth suicide prevention* in the *'Description contains'* box,

(5) click on the Manual's title,

(6) click on the *'Add to Shopping Cart'* button

and

(7) follow the ordering instructions.

You will need a valid Visa or Mastercard number. If you do not have access to the Internet then:

Fax in your request to BC Government Publications (250) 387-1120. Your fax cover sheet or letterhead is acceptable for ordering. Please be sure to include the following information:

- name of the publication
- your full mailing address
- your contact name
- your phone numbers
- a Visa or Mastercard credit card number with expiry date

The cost of the Manual is as follows:

- MCF staff: **no cost**
- other BC Government Ministries i.e., Ministry of Education: **$15.00 + shipping & handling**
- all others: **$22.00 + shipping & handling**

Questions regarding stock availability or ordering should be directed to Government Publications Services, PO Box 9452 Stn. Prov. Gov., Victoria, BC V8W 9V7, phone: (250) 387-6409, e-mail: Susan.Haskins@gems4.gov.bc.ca

CONFERENCES

American Association of Suicidology (AAS) 34th Annual Conference

Mind , Body & Soul: Three Dimensions of Suicide

April 18 – 21, 2001

Sheraton Colony Square Hotel – Midtown Atlanta, Georgia

For further information please contact the AAS at phone (202) 237-2280, fax (202) 237-2282 or visit www.suicidology.org/conferenceinfo.htm

Canadian Association for Suicide Prevention (CASP) 12th Annual Conference

Getting the Message Out

October 24th – 27th, 2001

St. John's, Newfoundland & Labrador

If you would like an advance notice, please call (709) 772-3189 or e-mail: mouellette@roadrunner.nf.net

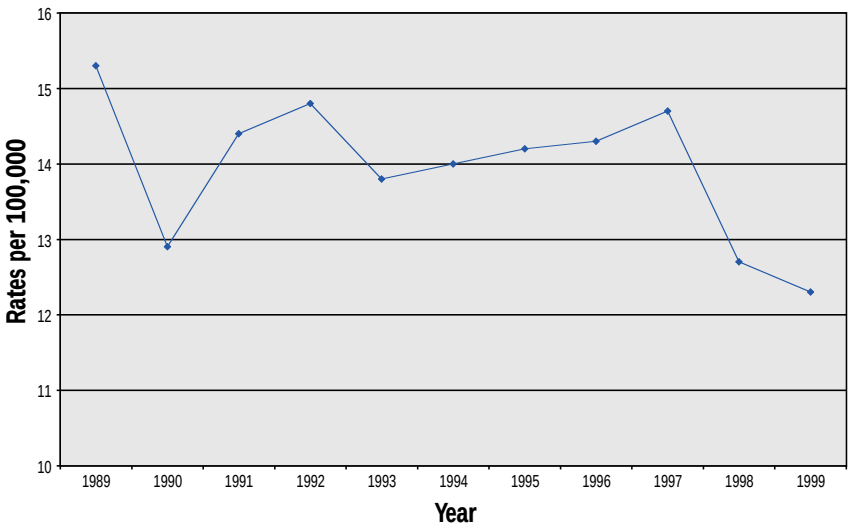
NOTICE BOARD *continued*

AGE-SPECIFIC SUICIDE RATES IN BC (1999): Females and Males by Age Group

Source: BC Coroners Service

AGE	NUMBER OF SUICIDES	RATE PER 100,000
10-14	2	0.8
15-19	21	7.8
20-24	36	13.6
25-29	31	11.0
30-34	44	14.2
35-39	64	18.0
40-44	56	16.3
45-49	56	18.0
50-54	54	20.4
55-59	34	17.0
60-64	25	15.3
65-69	14	9.3
70-74	21	15.8
75-79	15	13.5
80-84	17	25.0
85-89	5	13.0
over 90	1	5.8
Total	**496**	**12.3**

Suicide Rates in BC (1989 - 1999)



Source: BC Coroners Service
Produced by: Suicide Prevention Information Resource Centre (SPIRC), Mheccu, Dept. of Psychiatry, UBC

Some Internet Sites

Please note that these sites are provided for your information only and Mheccu assumes no responsibility for their content.

Ministry for Children and Families Offers a wide range of programs and services to children, youth, parents, families, people with special needs and those fighting addictions. **http://www.gov.bc.ca/mcf/**

Health Canada Encourages the health of Canadian children & youth through promotion and prevention activities, and supports the health system through research funding and the support of provincial/territorial health systems.
http://www.hc-sc.gc.ca/hppb/childhood-youth

Suicide Information & Education Centre (SIEC) A special library and resource centre providing information on suicide and suicidal behaviour. **http://www.siec.ca/**

Kids Help Phone, 1-800-668-6868 Canada's first national, toll-free, 24-hour, bilingual child and youth telephone counselling service and Web site.
http://kidshelp.sympatico.ca/

Youth Suicide Prevention Program Is dedicated to reducing youth suicide and suicidal behaviors in Washington State. Promotes youth voice, youth-generated media messages, peer advocacy. Provides resources for youth and those who work with youth 15-24 yrs of age. **http://depts.washington.edu/ysp/**

Australia's National Youth Suicide Prevention Strategy Communications Project A national government funded project to address the information and communication needs of those involved in youth suicide prevention. **http://www.aifs.org.au/external/ysp/**

Visit our Internet site at **www.mheccu.ubc.ca** for a more comprehensive list of web pages. Click on any of the icons on the left margin i.e., Consultation and then look for the LINKS button at the bottom of the web page. Happy e-surfing!