PREVENTING YOUTH SUICIDE: DEVELOPING A PROTOCOL FOR EARLY INTERVENTION IN FIRST NATIONS COMMUNITIES

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Abstract / Résumé

Aboriginal youth suicide is a complex problem with culturally specific risk factors identified by Coulthard (1999). The development of a suicide risk management tool is proposed for gathering culturally sensitive, First Nations' data. The implementation of a tool useful in reducing attempted suicides for Aboriginal youth populations is also suggested.

Le suicide chez les jeunes autochtones est un problème complexe relié à des facteurs de risque spécifiques conformes à leur culture, identifiés par Coultard (1999). Le développement d'un outil de la gestion du risque du suicide est proposé afin de rassembler des données concernant les Premières Nations qui tiennent compte de leur culture. L'application d'un outil aidant à réduire les tentatives de suicide chez les jeunes autochtones est également suggérée.

Introduction

In Canada, there have been 52,500 deaths as a result of suicide since 1986 (Weir & Wallington, 2001). According to Dr. David Eden, Regional Coroner, and Dr. James Young, Chief Coroner of Ontario, suicide – the 'silent epidemic,' is the leading cause of death in Canadian youth as evidenced by the Emergency Centres across the country as (personal communication, September 23, 2002). According to Weir & Wallington (2001) "Among Canada's First Nations, suicide rates are 3 to 4 times higher than the rate in the general population" (p. 634). In Penashue, the Aboriginal community of Pikangikum, located in Northwestern Ontario, has a suicide rate of 470 deaths per 100,000, which is one of the highest in the world, and 36 times the national average. Ellroy (1999) reports that in the case of Aboriginals 8-24 year olds, there are on average 6-8 suicide attempts before each completed suicide.

According to Ferry (2000), the suicide rate of the Innu in Davis Inlet, Newfoundland, is 178 per 100,000 people, as compared to an overall rate of 12 per 100,000 in the rest of Canada. Ferry (2000) also acknowledges that, "In British Columbia, Aboriginal boys and girls aged 10-19 are 8 and 20 times more likely, respectively, to commit suicide than their non-Aboriginal counterparts; the suicide rate for Aboriginals in their 20's is even higher" (p. 906). These statistics have increased since 1995 when the Royal Commission on Aboriginal People (1995) reported, "an Indian adolescent aged 10-19 is 5.1 times more likely to die from suicide than a non-Indian adolescent" (p. 13).

Wide variations in reporting local and regional suicide rates further conceal an accurate suicide rate since data collection tools are either unavailable or inadequate. The evaluation tool presented in this paper has been developed to be a culturally sensitive, suicide risk assessment tool. Given the reactive nature of the reporting of suicides, this tool is proactively aimed at gaining a true prospective insight into suicidology. The results of such an approach would be as Eden (personal communication, September, 2002) suggests a solid and epidemiologically sound assessment of the predictive value. Present tools that evaluate suicide risk are based on expert opinion, which according to Eden, make prospective studies methodologically difficult. Statistical reliance on retrospective data has created a serious under-reporting of suicide, so rates may even be higher.

Suicide is a complex problem and has a number of risk factors that are culturally specific. Suicide is an important community problem where the number of completed suicides in the Native population is higher in all categories. A study that occurs in real time before the event rather than relying on retrospective data is needed (Eden). In First Nations

communities, therefore, the need to identify and assess suicide risk management strategies is urgently required.

Cultural Factors in Suicide Assessment

Social, historical, economic, psychological, and cultural stressors have been identified in the literature as causal factors for Aboriginal suicide (Coulthard, 1999). The National Aboriginal Health Organization and the Canadian Institutes of Health – Institute of Aboriginal People's Health recognize the need to address cultural, social and emotional issues using research methods that promote health in the individual Aboriginal, the family and community (NAHO, 2002; IAPH, 2002).

Risk factors and suicidal ideation need to be assessed in the Aboriginal population to determine culturally sensitive and appropriate solutions to this serious endemic (Boothroyd, Kirmayer, Spreng, Malus & Hodgins, 2001). The literature suggests that if data collection is designed to combine the theoretical concepts of support, caring, empowerment, and acceptance, the spirit at the heart of the Native culture will be enhanced and the hope generated will be transmitted to potential suicide victims (Health & Welfare Canada, 1996; Johnson, 1999; McKeon, 2000; Stout & Kipling, 1999; Tatz, 1999). According to the Royal Commission on Aboriginal People (1995), successful intervention must "reflect the Native perspective and nurture cultural pride" (p.115). This approach would require training of people in the field of research to open lines of communication and provide networking among Aboriginal youth, their elders, and the First Nations communities, particularly in emergency settings, counseling and crisis centers.

Development of a Suicide Risk Management Protocol

There must be a partnership for research between Aboriginal communities and non-Aboriginal health care professionals, which supports cultural values. This partnership will generate new knowledge and can improve the overall health status of the Aboriginal people (NAHO, 2001; Smye & Browne, 2002).

Evident from the body of knowledge surrounding suicide risk management tools is that a tool should be user-friendly, clear, concise, and contain questions that are culturally significant and appropriate (Fogarty, 1997). The tool should provide information that is easily integrated through repeated use and have specific markers that indicate the imminence of the act of suicide (Abraham & van Parjas, 1994; Kerr, 1999a; McNamee & Oxford, 1999; Tomaszeski, 1999).

Few suicide risk management tools currently exist, and there does not appear to be any such tool with content that is specific to the Ab-

original culture. The majority of data collection tools have been based on hospital admission policy and criteria from the Mental Health Act, which states that an individual must be admitted to a psychiatric facility if they are at risk of harming themselves or others (Ministry of Health, 2000).

When a suicide risk management tool (see Appendix A), combines theoretical concepts of support, caring, empowerment, and acceptance, a support system will be created for potential suicide victims (Health & Welfare Canada, 1996; Johnson, 1999; McKeon, 2000; Stout & Kipling, 1999; Tatz, 1999). According to the Royal Commission on Aboriginal People (1995), successful intervention must "reflect the Native perspective and nurture cultural pride" (p. 115).

The literature also indicates that Aboriginal clients require a culturally sensitive tool that is delivered in a way that fosters dignity and hope, and values the individual (Health & Welfare Canada, 1987; Kerr, 1999b; Tatz, 1999). According to the CIHR-IAPH (2002) research studies on the health of Aboriginal people need to be presented "in a way that is accessible, appropriate and easily understood" (p. 4). Research indicates that the use of an appropriate data collection system could significantly reduce attempted suicides in Aboriginal youth (Robinson, 2001; Coulthard, 1999).

Aboriginals in Canada, have a suicide rate of 470 deaths per 100,000, which is one of the highest in the world and is 36 times the national average. According to the Ontario Chief Coroner, Dr. James Young, innovative methodology, as proposed in the protocol suggested here, must be used to accurately determine suicide risk, provide prevention and decrease suicide rates. A semi-qualitative methodology, with a pre-test – post-test design, should be developed to test this protocol.

A sample should consist of a non-random, relatively homogeneous population of Aboriginal youth, who have attempted suicide. All Aboriginal youth clients who present to Emergency settings and Aboriginal crisis and counseling centers, would be evaluated using this culturally sensitive suicide risk management tool. Due to the serious nature of this problem, there would be no exclusion criteria or control group in such a study. According to the Aboriginal culture, the concept of exclusion is unacceptable and in this case would be unethical (Smith, 1999).

An appropriate sample size would be derived from the number of attempted suicide clients that access emergency settings, Aboriginal crisis centers, and counseling centers. This initial measure of the dependent variable would be considered as a baseline measure.

The pretest data should be gathered by Aboriginal health care professionals, who could handle triage, describe the nature and scope of

the project; and obtain informed consent. The adolescents should be greeted upon arrival, in their First Nations language and the teachings of the Eagle Feather would open the sharing of information. The questions that appear on the tool would be explored between the health care professional and the adolescent. In three months time, post-test data could then be collected. This measure of the dependent variable would be referred to as the outcome measure for the supportive component of the tool.

The post-test follow-up would consist of a face-to-face interview with each adolescent, one adolescent at a time to determine suicide risk. A final outcome measure would be obtained, one year later, through follow-up information provided through records of admission.

This paper proposes the use of a culturally sensitive suicide risk management tool that would be accessible and useful to First Nations populations. The tool would be administered to Aboriginal youth, who have attempted suicide in emergency settings, and Aboriginal crisis and counseling centres. The development of an effective suicide risk management tool is essential not only to capture Aboriginal clients at risk before they commit suicide, but also to provide an opportunity for early intervention by supplying culturally-based support from members within their own community. The use of this traditional network strategy provides support that could affect future suicide rates among this population.

Conclusion

Statistically, it is apparent that Aboriginal suicide is an endemic problem, worldwide (Weir & Wallington, 2001). According to the Institute of Aboriginal People's Health (2002), there remains minimum research and development of Aboriginal health care issues, including data on attempted suicide, using a team approach. According to Tatz (1999), Aboriginal suicide is different, and requires a specific data collection methodology that addresses the "nature of Aboriginal suicide by reflecting social factors and community values" (p. 2).

According to Dussault et al. (1995) "any tool that improves the community by helping the people within it will serve to prevent suicide" (p. 67). Tatz (1999) also acknowledged that the development of appropriate assessment must exclude, "racism, contempt denigration, and disempowerment [and remove the] mental disorder model" in the assessment process (p. 8). The tool proposed in this paper is based on these tenets.

Aboriginal mental health research is necessary to develop appropriate strategies for addressing the endemic problem of suicide in First

Nations adolescent populations. The development of a culturally sensitive suicide risk management tool would empower, value, and allow youth to maintain dignity.

References

Abraham, B., & van Parjas, L. G.
 1994   A Search For Literature on Teaching Tools For Health
               Professionals. *Medical Teacher 16*(2), 237-252.
Boothroyd, L. J., Kirmayer, L. J., Spreng, S., Malus, M., & Hodgins, S.
 2001   Completed Suicides Among the Inuit of Northern Que-
               bec, 1982-1996: A Case-control Study. *Canadian Medi-
               cal Association 165*(6), 749-756.
CIHR – IAPH
 2002   *Annual Report of Activities, 2001-2002.* Retrieved Sep-
               tember 3, 2002 from http://www.cihr-irsc.gc.ca/insti-
               tutes/iaph/publications/annual_report_2001-02_e.pdf
               http://www.cihr-irsc.gc.ca/institutes/iaph/publications/
               annual_report_2001-02_e.pdf
Coulthard, G.
 1999   *Colonization, Indian Policy, Suicide, and Aboriginal
               People.* Retrieved September 3, 2002 from http://
               www.ualberta.ca/~pimohte/suicide.html
Davis, M.
 2000   *McGill University Division of Social and Transcultural
               Psychiatry. Culture and Dental Health Research Unit.*
               Retrieved November 27, 2000 from http://
               www.ctfphc.org/full_text/ch40full.htm
Dussault, R., Erasmus, G., Chartrand, P., Meekism, J., Robinson, V.,
Sillett, M., & Wilson, B.
 1995   *Community Solidarity and Support—Cultural Programs
               and Activities.* Ottawa, ON: Minister of Supply and Ser-
               vices Canada.
Ellroy, J.
 1999   *Crime Wave: Reportage and Fiction From the Under-
               side of L.A.* London, England: Century.
Ferry, J.
 2000   No Easy Answer to High Native Suicide Rates. *The Lan-
               cet 355,* 906.

Fogarty, R.
1997   *Problem-Based Learning and Other Curriculum Mod-els.* Arlington IL: Skylight Training.
Health and Welfare Canada
1987   *Health, Healing, and Cultural Values for Aboriginal Com-munities in Canada. Indian and Inuit Health Services.* Ottawa, ON: Ministry of Health.
Health and Welfare Canada
1996   *Suicide in Canada: Update of the Report of the Task Force on Suicide in Canada.* Ottawa, ON: Minister of National Health and Welfare.
IAPH
2002   *Institute Overview.* Retrieved September 3, 2002 from http://www.cihr-irsc.gc.ca/e/institutes/iaph/9109.shtml
Johnson, M.
1999   *Ontario Aboriginal Patient Advocacy Initiative. Medical Services.* ON, Canada: Ministry of Health.
Kerr, R.
1999a   First Nations and Suicide. *In Suicide and Education Centre Information Kit.* Ottawa, ON: Za-geh-do-win.
Kerr, R.
1999b   *Ontario Aboriginal Patient Advocacy Initiative.* Ottawa, ON: Ministry of Health.
Ministry of Health
2000   *Mental Health Act Admission Policy.* Ottawa, ON: Au-thor. November.
McKeon, C.
2000   *Suicide in Ireland. A Global Perspective and a National Strategy.* Retrieved November 2, 2000 from http://www.webireland.ie/aware/suicide.html
McNamee, J., & Oxford, D.
1999   *Canadian Task Force on Preventive Health Care.* Hamilton, ON: McMaster University Press.
NAHO
2001   *About the National Aboriginal Health Organization (NAHO).* Retrieved September 3, 2002 from http://www.naho.ca/nahowebsite.nsf/pages/0FCEF99D03BC8F7D825256A6A0046215B
Robinson, B. A.
2001   *Suicide Among Canada's Native People.* Retrieved Sep-tember 3, 2002 from http://www.religioustolerance. org/sui_nati.htm

Royal Commission on Aboriginal People
   1995   *Choosing Life: Special Report on Suicide Among Ab-
                 original People.* Ottawa, ON: Author.
Smith, T.
   1999   Decolonizing Methodologies: Research and Indigenous
                 Peoples. New York: Palmgrave Macmillan.
Smye, V., & Browne, A.
   2002   'Cultural Safety' and the Analysis of Health Policy Af-
                 fecting Aboriginal People. *Nurse Researcher 9*(3), 42-
                 57.
Stout, M., & Kipling, G.
   1999   *Emerging Priorities for the Health of First Nations and
                 Inuit Children and Youth.* Ottawa, ON: Health Canada.
Tatz, C.
   1999   Aboriginal Suicide is Different. A Report to the Crimi-
                 nology Research Council. *The Criminal Research Coun-
                 cil 25*(7), 25-96.
Tomaszewski, S.
   1999   *Elements of Instructions.* New York, NY: Instructional
                 Services Department, Professional Development Cen-
                 ter.
Weir, E., & Wallington, T.
   2001   Suicide: The Hidden Epidemic. *Canadian Medical As-
                 sociation 165*(5), 634-636.

Appendix A
A Suicide Risk Management Tool

Date of Referral: _____ Time of Referral: _____

Referred By: _____

Introduction – Eagle Feather Teachings

Interviewer/Translator greets client in Native tongue (speak slowly, wait after each question)

Preferred Language: First Nations: _____

                                  English: _____

                                  French: _____

                                  Other - specify: _____

History

Patient Name: _____

                 surname   given name   initials

First Nation Name: _____ Clan: _____

Address: _____ Postal Code: _____

First Nations Community: _____ Location: _____

Local Town: _____ Affiliation: _____

Band Leader or Chief: _____ Support: _____

Community Health Care Worker: _____ Religion: _____

Date of Birth: _____

Significant Other: _____ Sex: • M   • F

OHIP #: _____ Métis: _____ Status: _____

Non-Status: _____ Canada Works Program: _____

Training Program: _____ Old Age Pension: _____

Employed By: _____• Full time • Part time

Unemployed: _____

Family Physician: _____Traditional Healer: _____

Environment of Interview

Appearance of client:_____

Living Conditions: Lives with: • Alone • Family • Adopted • Traditional
• Friends • Group or Commune • Other

Type of Housing: • Reserve • Urban-Native Homes • Private Accommodation • Hostile/Shelter • Homeless • Other

Practices Cultural Traditions: • Yes • No
If Yes Describe: _____

Education: • Regular • Residential School • Traditional (no school)

Risk Profile
Reason for Referral:
• Assessment of Suicidal Risk
• Urgent (non-emergent) Consultation to Family
• Assessment of Homicidal Risk/Danger to Others
• Physician or Other Physician
• Assessment of Ability to Care for Self
• Assessment of Unusual/Bizarre Behavior Excluding Cultural Beliefs –
Visions, Dancing, Auditory Voices

Presenting Problem:
How can I help you? _____

Who sent you and why? _____

Describe your day. _____

_____

Suicidal Thoughts/Plans: (Describe in detail)   Not suicidal

_____

_____

Has Patient Made A Suicide Attempt Before:
• Yes   • No   • Not sure

If Yes, briefly describe attempt: _____

_____

Interrelationship Between Client and Significant Other:
Describe: _____

_____

Summary of Key Presenting Problems: (Please check all that apply)
- Suicidal
- Self Harm Behavior
- Danger to Others
- Self Care/Competency Issues
- Hx of Psychiatric Disorder
- Developmental Problem
- Alcohol Abuse Problem
- Drug Abuse Problem
- Family History
- FAS
- Behavior Problem
- Attention Deficit Disorder
- School Problem – Residential
- Work Related Problem

- Unemployment
- Housing Problem
- Financial Problem
- Marital Problem
- Divorce/Separation
- Parenting Problem
- Other Relationship Problem
- Social Isolation/Lack of Social Support
- Difficulty With ADLs
- Social Skills Problem
- Legal Problem
- Bereavement
- Head Injury
- Low Self-esteem

Current Alcohol/Substance Abuse: • Yes • No   • Unknown
• Inhalants • Herbs • Marijuana • Street Drugs • Prescription Drugs

Specify: _____

Discussion: _____

_____

Psychological Alteration in Well-Being:
Previous Admissions: • Yes   • No
If Yes, Date: _____   Where: • Lodge   • Hospital

Most Recent Admission: Date: _____
                             Where:_____

Severity of Psychological Trauma: _____
Special Needs: _____
Post Rehabilitation Efforts:
• Healing Circles   • Elder: When _____
                                 Who _____

Comments, Contacts, or Potential Supports: _____

_____

Legal Issues:
First Nations Advocate: • None   • Past • Current • Unknown
Specify: _____

Family: Suicide History
• Peers: • Attempted   • Complete   • Pact Commitment
• Family: • Attempted   • Complete   • Pact Commitment

Currently Receiving Support For Psychological Alterations:
• Yes   • No   • Unknown
• Family Physician Only
• Outpatient Psych Clinic : Name: _____
• Community Program: Name: _____
• Alcohol/Substance Abuse Program: Name: _____
• Private Psychiatrist/Therapist: Name: _____
• Traditional Healer
• Other Remedies/Ceremonies: Name: _____

Current Medications: • Yes   • None   • Unknown   • Herbs

Psychiatric: • Yes   • None   • Unknown   • Herbs
1. _____
2. _____
3. _____
4. _____
5. _____

Non-Psychiatric Medications: • Yes   • None   • Unknown
1. _____
2. _____
3. _____
4. _____
Herbal Remedies: • Yes   • No   • Unknown
1. _____
2. _____
3. _____

Traditional Healer Name: _____
Other Healing Ceremonies: _____

Comments/Client Sharing:

_____

_____

Social History: • Unknown

_____

_____

Current Social Functioning: • Unknown

_____

_____

_____

Administer By: _____

Date: _____

Signature: _____