



Saskatchewan First Nations Suicide Prevention Strategy

Prepared by the Federation of Sovereign Indigenous Nations

May 24, 2018

We have become experts in dealing with crises.

Now we have to become experts in preventing crises from happening.

– Participant in the community engagement in La Ronge, March 15, 2018

Vision of Saskatchewan First Nations:

First Nations will always live on this land as we have since time immemorial, where our people will be self-determining and economically independent, where we will walk in health and happiness with strength, unity, balance and according to our oral traditions as bestowed on us by the creator.

FSIN Health and Social Development Commission Mission Statement:

Through the full implementation of Treaty, Treaty First Nations powers, laws and jurisdictions, we will develop a sound and responsive traditional, social, economic and environmental infrastructure for the health benefit of our children and families and to deliver good quality services to all Treaty First Nations citizens, both on and off reserve.

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Appendix A: Actions to be Taken Under the Saskatchewan First Nations Suicide Prevention Strategy

Appendix B: Motion passed by the FSIN Health and Social Development Commission, May 8, 2017

Appendix C: Resolution #2049 passed by the FSIN Legislative Assembly, May 17, 2017

Appendix D: Community Engagement – Results Section (Prepared by Dr. Kim McKay-McNabb)

Forward by FSIN Vice-Chief David Pratt



The large numbers of suicide threats, ideations, attempts, and deaths by suicide among the First Nations population in Saskatchewan, particularly among northern youth, have brought national attention to the need for more coordinated and collaborative efforts to provide increased mental wellness supports, services and capacity for Saskatchewan First Nations.

The lack of a provincial or federal First Nations-specific suicide strategy prompted the Chiefs in Assembly to call for a First Nations specific suicide strategy with resolution # 2049 directing the Vice-Chief responsible for the Health & Social Development portfolio to develop and release the strategy by May 31, 2018.

As Second Vice-Chief of the Federation of Sovereign Indigenous Nations (FSIN) responsible for the Health & Social Development Secretariat (HSDS) portfolio, I am proud to say that with profound diligence we have met the May 31, 2018 deadline. It is with great pleasure that I present the Saskatchewan First Nations Suicide Prevention Strategy (SFNSPS) – developed by First Nations for First Nations.

The first-of-it's-kind Saskatchewan First Nations Suicide Prevention Strategy (SFNSPS) was collaboratively developed from the concerns and feedback from community engagements, the expertise of the Mental Health Technical Working Group (MHTWG; including the FSIN youth representatives), two of the FSIN Health & Social Development Secretariat (HSDS) technicians and our two technical advisors.

The statistics in the report are alarming and continue to increase. It is time for a transformed First Nations Health Care system that is based on Inherent and Treaty Rights. We call on government to work collaboratively with First Nations to reduce First Nations lives lost to suicide. Federal and provincial policies contributing to the lack of mental health supports for First Nations must be addressed. Supports and resources must also be included as part of any implementation plan.

The Federation of Sovereign Indigenous Nations is fully committed and ready to tackle the pressing issue of the challenges and causes of suicide.

Our Communities Have Spoken

It is imperative to have implementation of the SFNSPS developed and delivered by First Nations and First Nations communities to be effective. Land-based healing models must be developed and delivered in communities to address the reconnection to the land and ones' self. Traditions and culture must play a role in the healing journey. Youth are hurting but also have answers and solutions. We will support our youth and communities on their endeavours to reclaiming culture and traditions and to build strength-based approaches from a grassroots level.

We must also ensure First Nations and individuals are able to choose their method of healing whether it be land based healing, family/individual healing lodges, Elders, Ceremonies, Social Workers, Addictions Counsellors or Mental Health Therapists. What is offered now is not working.

Thank you to all those who have contributed to the Saskatchewan First Nations Suicide Strategy and those who continue to support this very important journey.

Thank you to the members of the Mental Health Technical Working Group for all their hard work on this important project, and to the FSIN staff who supported them – Charmaine Pyakutch, Special Projects Researcher/Analyst, and Cheryl Thomas, Mental Wellness Project Co-ordinator.

I am grateful for the contribution made by the First Nations communities who participated in the community engagement sessions. Our First Nations communities are clearly committed to sharing their lived experiences, which have guided the strategy development process along the way. I am grateful also for the Elders, the Knowledge Keepers and the ceremony that has also supported and guided this work.

Thank you to our technical advisor Jack Hicks (Adjunct Professor of Community Health & Epidemiology at the University of Saskatchewan) and our clinical technical advisor Dr. Kim McKay-McNabb (an Indigenous clinical psychologist in private practice) for a job well done.

And finally, my appreciation to the members of the Peer Review Committee who followed the project as it progressed, and who offered many thoughtful expert comments and suggestions: Drs. Allison Crawford (University of Toronto), Brian Mishara (Université du Québec à Montréal), Laurence Kirmayer (McGill University), Joseph Gone (University of Michigan) and Mary Cwik (Johns Hopkins University).

Respectfully,

Vice-Chief David Pratt

1. Introduction and Mandate

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 suicidal 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. There is, however, 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 strategy, the Chiefs-in-Assembly directed the Federation of Sovereign Indigenous Nations (FSIN) to address suicidal behaviour among First Nations people “with high priority”.

The Mental Health Technical Working Group (MHTWG) was established by a detailed motion passed by the FSIN’s Health and Social Development Commission (HSDC) on May 8, 2017. The motion, which is appended to this strategy (as Appendix B), provided clear direction regarding the manner in which the First Nations Suicide Prevention Strategy was to be developed and what the priorities were to be. It was very clear that the strategy was to “address the well-documented background risk factors for suicide behaviour” and propose evidence-based suicide prevention, intervention and postvention measures in addition to encouraging ‘life promotion’ initiatives.

The HSDC motion was ratified by a resolution – also appended to this strategy (as Appendix C) – passed unanimously by the FSIN Legislative Assembly on May 18, 2017. The Chiefs-in-Assembly specified that the First Nations Suicide Prevention Strategy was to be released by May 31, 2018.

2. Statistics on death by suicide in Saskatchewan

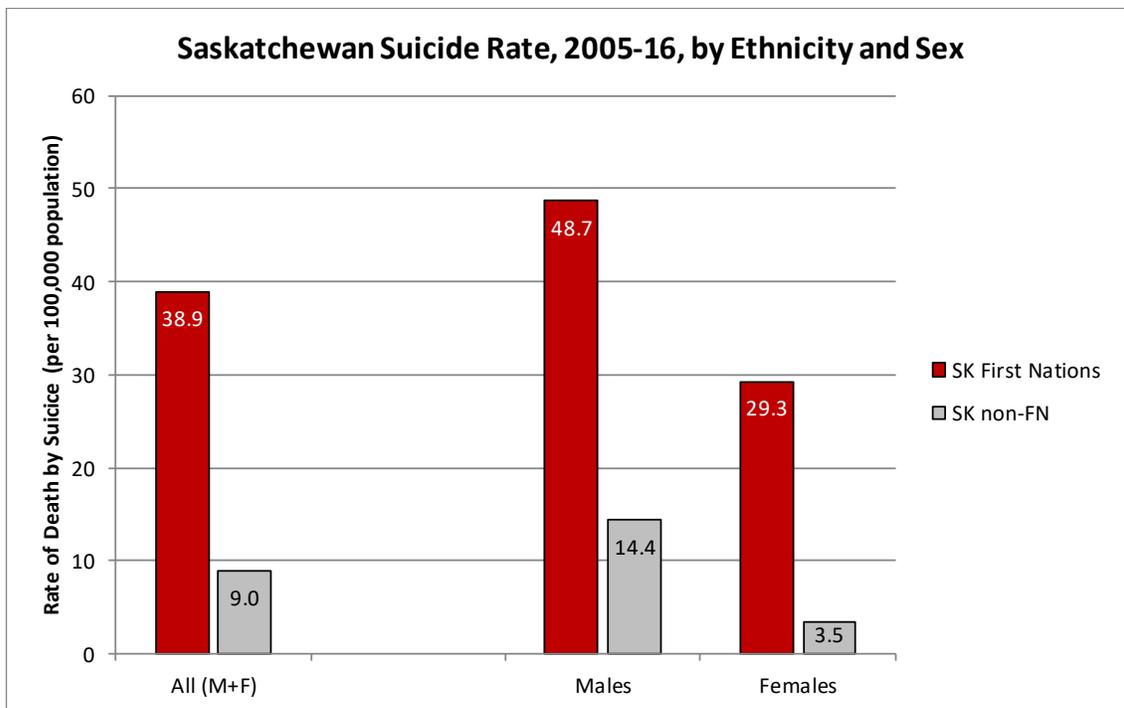
Data on the number of deaths by suicide among First Nations people in Saskatchewan has been provided by the Office of the Chief Coroner. From 2005 (when SK death certificates began being coded by ethnicity) to 2016, 508 deaths by suicide have been recorded by First Nations people.

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 is unable to code by ethnicity are coded as “Unknown”.

First Nations people make up between 30% (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.

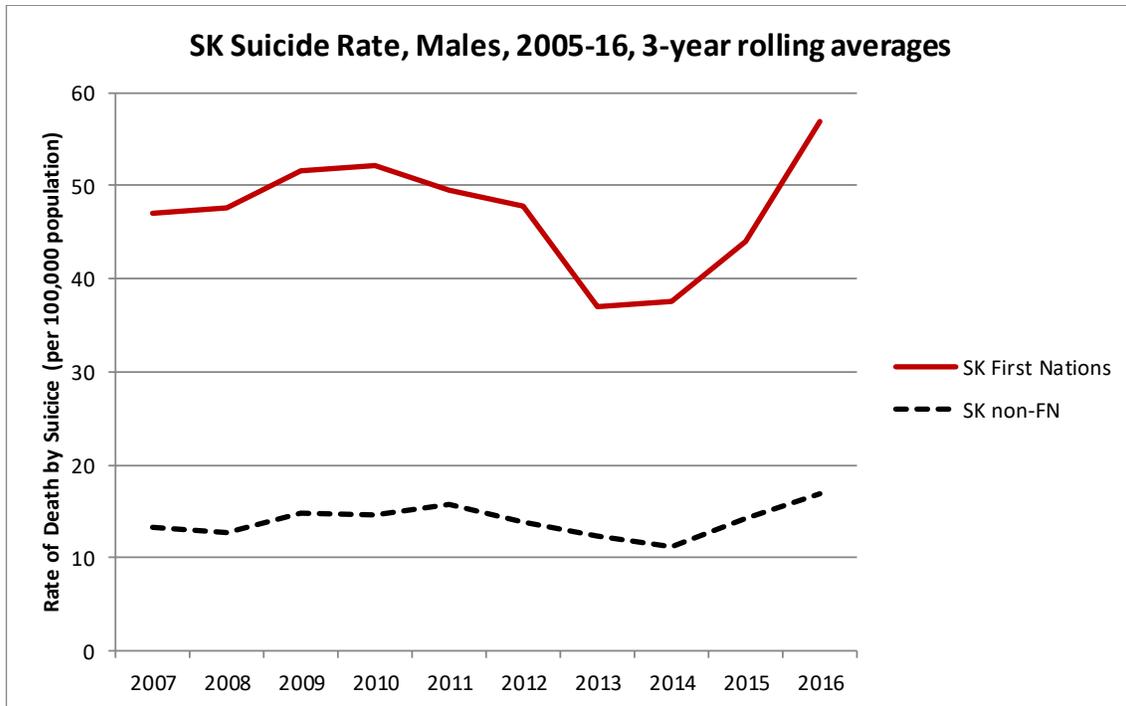
The following graphs exclude suicides coded as “Unknown” ethnicity. Rates were calculated using demographic data from *Covered Population*, a detailed breakdown of the population prepared annually by eHealth Saskatchewan.

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.

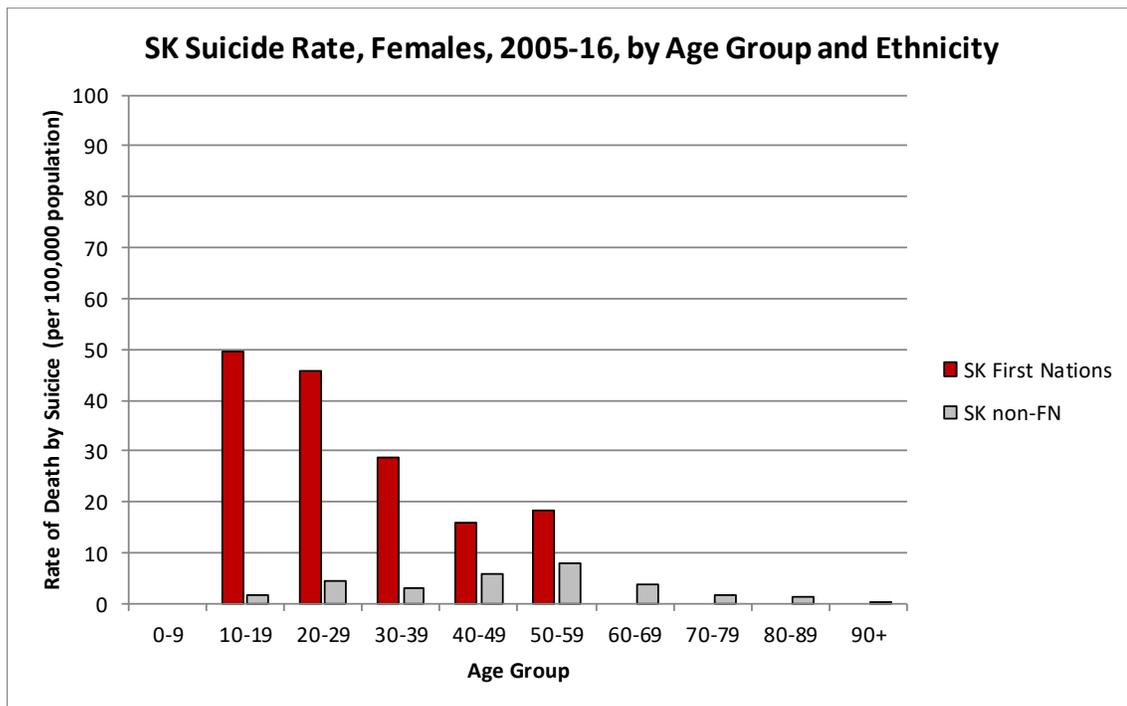
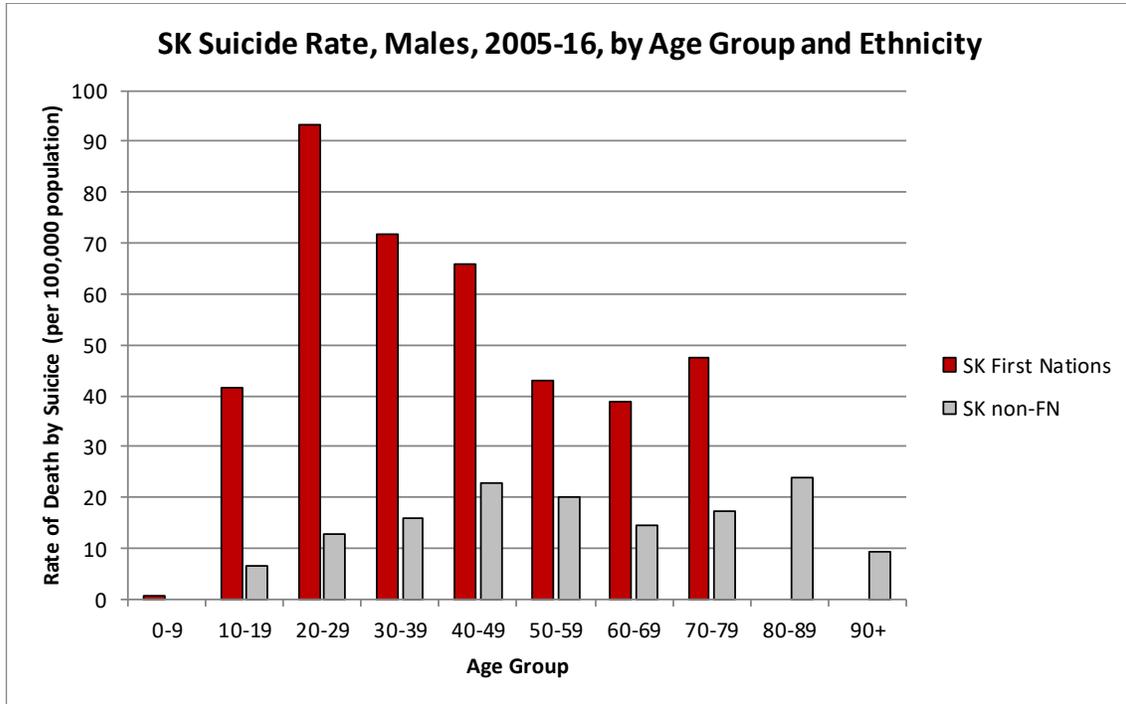


It should be noted that these data are slightly different than those presented in the Discussion Paper released on September 22, 2017. The reason for that is that Coroners always have a number of ‘open’ cases that they are still working on – i.e. cases for which the cause of death has not yet been determined. We asked the Office of the Chief Coroner to provide us with updated data in mid-March of 2018, and they kindly did so. During the months since our initial data request a number of previously-open files had been ‘closed’ – meaning that a determination had been made as to the cause of death. For this reason, the totals are slightly higher and the rates and the ratios are slightly different.

These charts show the differing rates of death by suicide for men and women in the province over time, broken out by SK First Nations people and SK non-First Nations people:

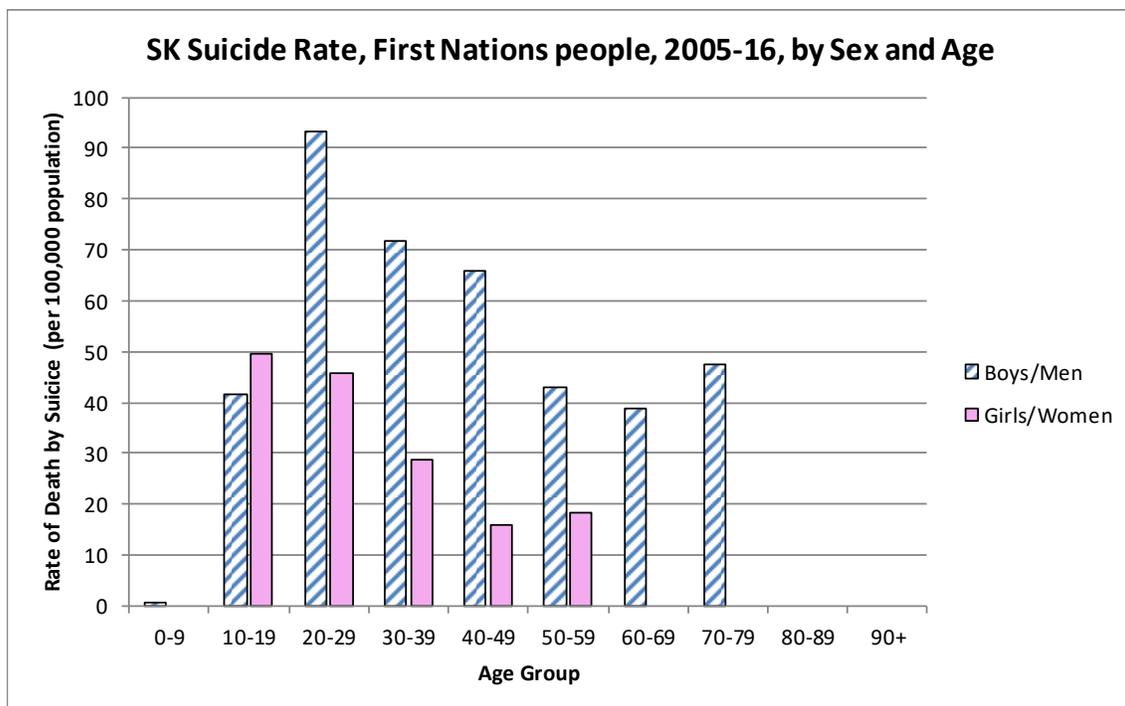


These charts show the differing rates of death by suicide for men and women in the province by age group, again broken out by SK First Nations people and SK non-First Nations people:



These graphs raise as many questions as they answer:

- Most fundamentally, why is the suicide rate so much higher among First Nations people than among non-First Nations people?
- Why is the suicide rate so much higher among men than among women?
- What factors resulted in the number of suicides by First Nations men falling from 27 in 2012 to 13 in 2013? Was it just the random distribution of a small number of events?
- What factors resulted in the number of suicides by First Nations men increasing from 13 in 2013 to 36 in 2015? The number of suicides by non-First Nations men also increased, from 56 in 2013 to 109 in 2015. Could the economy – job losses in particular – have been a factor for this spike in suicides by men?
- Why is the suicide rate for teenaged First Nations girls higher than the rate for teenaged boys (see below)? This is quite unusual. What happened in the lives of the teenaged First Nations girls who have died by suicide in recent years?



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 29.7 times higher** than that of non-First Nations women in that age range, and for First Nations women in their 20s the rate is 10.1 times higher.

- **The rate for First Nations men aged 10 to 19 is 6.4 times higher** than that of non-First Nations men in that age range, and for First Nations men in their 20s the rate is 7.3 times higher.

25% of all suicides by First Nations people are by teenagers, compared to 6% among persons of other ethnicities.¹ As Saskatchewan’s Advocate for Children and Youth has noted, “This picture is appalling” (Advocate for Children and Youth 2017).

62% of all suicides by First Nations people are 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.

In May of this year the Minister of Health tabled statistics in the Legislative Assembly indicating 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’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, which uses a broader definition of ‘First Nations’.² 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. This is essentially identical to the national rate for the period 2005 to 2013 (the latest year for which Canada-wide data is currently available).

Data were also broken out by Health Region.³ 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

¹ This is in part a reflection of the relative youthfulness of the First Nations population.

² 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).

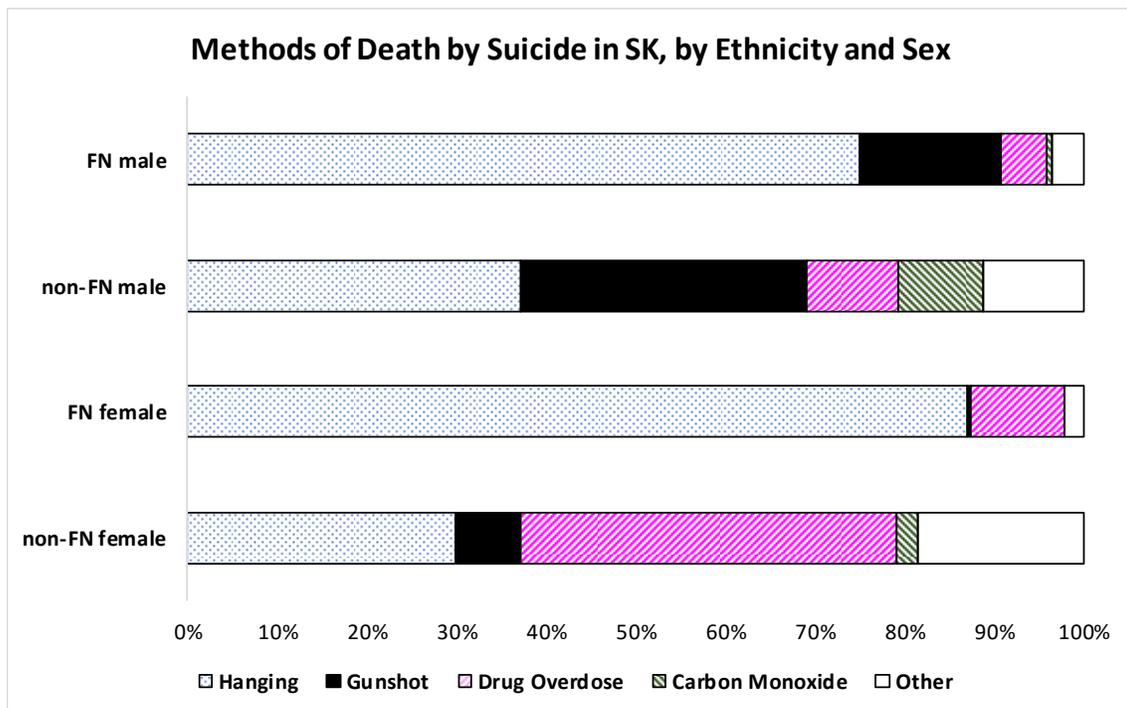
³ The Health Regions have since been amalgamated into one, with the exception of the Athabasca Health Authority in the northwest of the province – which is unique in that it is funded by federal, provincial and First Nations sources.

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.

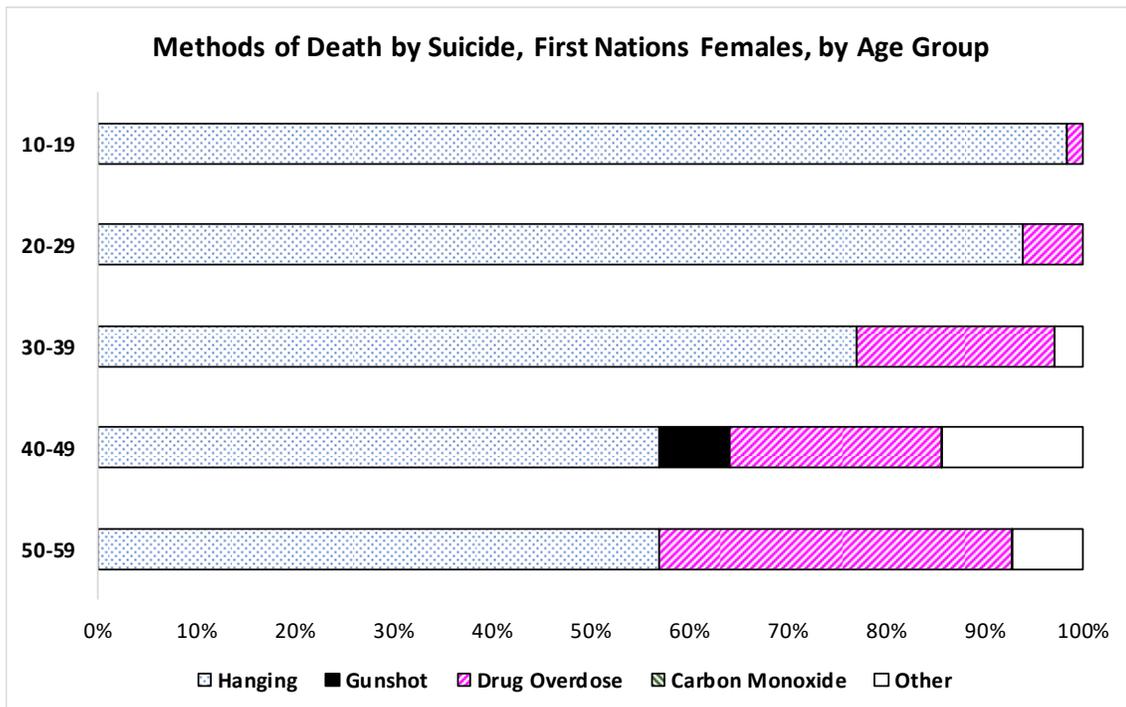
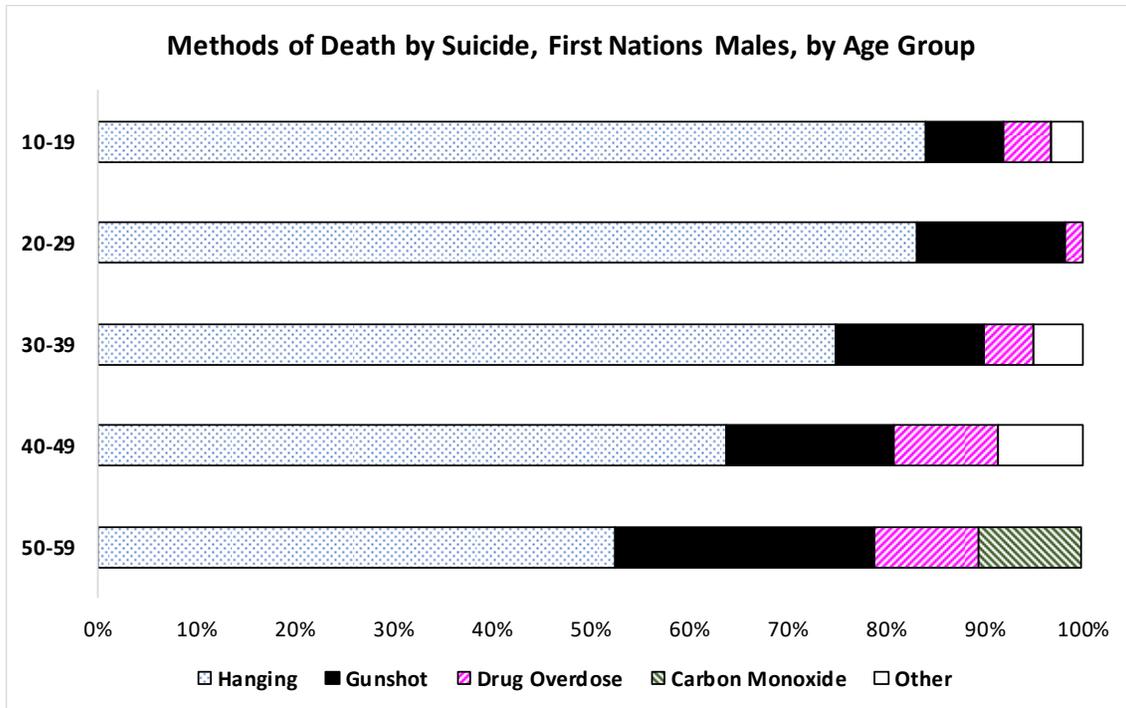
DATA GAP: These rates are for *all* residents of each Health Region – we do not have suicide data for First Nations people broken out by Health Region.

The suicide statistics presented above are shocking, but no less troubling is the fact that public health authorities have thus far taken only limited action to address the suicide crisis in First Nations communities in Saskatchewan.

The Office of the Chief Coroner was able to provide us with data on the rate of different methods of death by suicide. Here we can see the differences between men and women, by First Nations status and non; and among First Nations men by age group:



We can also see how the pattern changes as people of both sexes grow older, with suicides by gunshot becoming more frequent among men and suicides by drug overdose becoming more frequent among women.



In other jurisdictions it is possible to examine the patterns of alcohol, cannabis and other drug use at the time of death by suicide.⁴ This allows people working on suicide prevention to better understand the dynamics at work in society – for example, whether or not ‘hard’ drugs such as crystal meth are playing an increasing role in suicides – and target their prevention efforts accordingly. The Office of the Chief Coroner is currently unable to provide us with those data.

DATA GAP: We have no data on substances in the body at time of death, so we have no idea of the patterns of alcohol, cannabis and other drug use at the time of death by suicide.

It should also be noted that we appear to have essentially no data on rates and patterns of suicide attempts by First Nations people in Saskatchewan.

We know that in terms of deaths by suicide, Saskatchewan is in the mid-range of Canadian provinces. But data reported by the Canadian Centre for Health Information (CIHI) shows that Saskatchewan has the second highest rate of hospitalization due to “attempted suicide and self-inflicted injury” of any province. Why the difference between the suicide rate and the suicide attempt rate? How do the rates vary across the province? Who are these ‘extra’ suicide attempters? How many of them are children, youth and young adults? How many of them are First Nations women?

Given that teenaged First Nations girls in Saskatchewan have a sharply elevated rate of death by suicide, might they also have a sharply elevated rate of attempted suicide? If so, what might be the implications for these young women over their life courses? What might be the implications for the health system – what are these attempts costing the system? And fundamentally, what are the implications for society? At this point we have no idea.

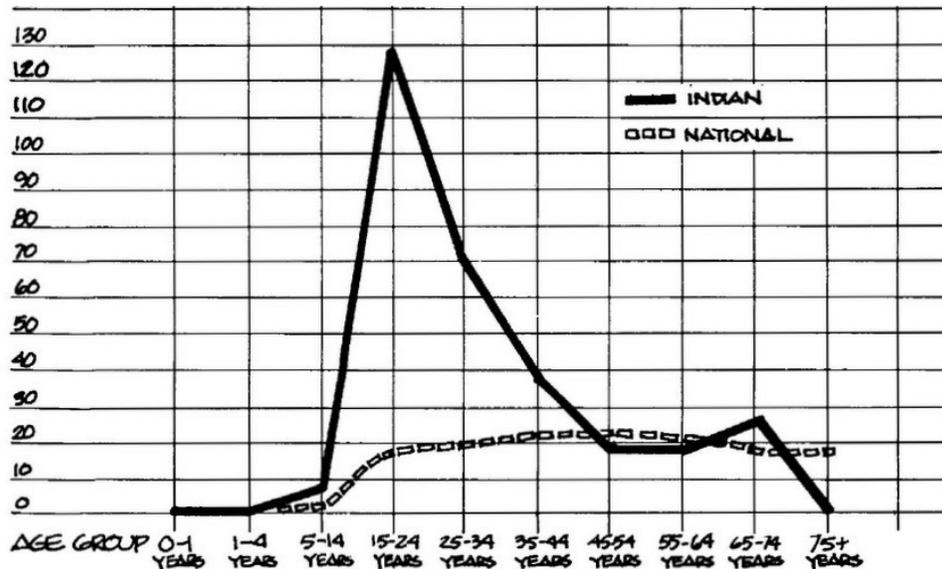
DATA GAP: We have no data on the rates or the ethnicity/sex/age patterns of suicide attempts in the province.

⁴ It should be noted that substances in the body at time of death is a different thing than a person’s lifetime history of substance use. To understand the latter one requires a suicide follow-back (or ‘psychological autopsy’) study.

The high rate of suicide among young First Nations people has been known for decades. See, for example, this graph from a federal government document (Canada, Indian and Northern Affairs 1980) based on data from 1978 – exactly 40 years ago:

SUICIDES

Per 100,000 Population at Each Age Level
1977



sources:

- (1) Annual Report, 1978: Medical Services Branch, Health and Welfare Canada
- (2) 1977, DIAND (Indian Population)
- (3) 1976, Statistics Canada (National Population)

What's more, an internal Health and Welfare Canada document from 1979 shows that the federal government was aware at that time that First Nations people in Saskatchewan had the highest suicide rate of First Nations people in any province in the country (MacLean 1979).⁵

The logical conclusions that can be reached after a review of the data presented above include:

1. The rate of death by suicide by First Nations people in Saskatchewan today constitutes a public health crisis;
2. We need more data about deaths by suicide by First Nations people in the province today;
3. The failure of the federal and provincial governments to take actions commensurate with the high burden of suicide-related loss and suffering among Saskatchewan First Nations communities since at least the 1970s – which they were very well aware of – is a powerful example of systemic racism.

⁵ It is also noteworthy that in 2018 there are no comparable current data for suicide rates of First Nations people across Canada.

3. What we know about suicidal behaviour

The members of the Mental Health Technical Working Group brought to the table many decades of experience working with people in suicidal crisis. Participants in the community engagements also spoke powerfully of their experiences and insights – as summarized in Appendix D. We combined this first-hand knowledge from Saskatchewan First Nations communities with the broader evidence base, built up over decades from research conducted around the world.

We know a lot about how and why people may find themselves in a suicidal crisis. Because upwards of 800,000 people die by suicide world-wide each year, a great deal of work has gone into understanding suicidal behaviour – so there is an enormous research base. There are numerous books which summarize what we know about suicidal behaviour. One concise and particularly clearly-written example is psychiatrist Robert D. Goldney’s *Suicide Prevention (2nd ed.)*, which can be purchased online through the usual vendors.

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

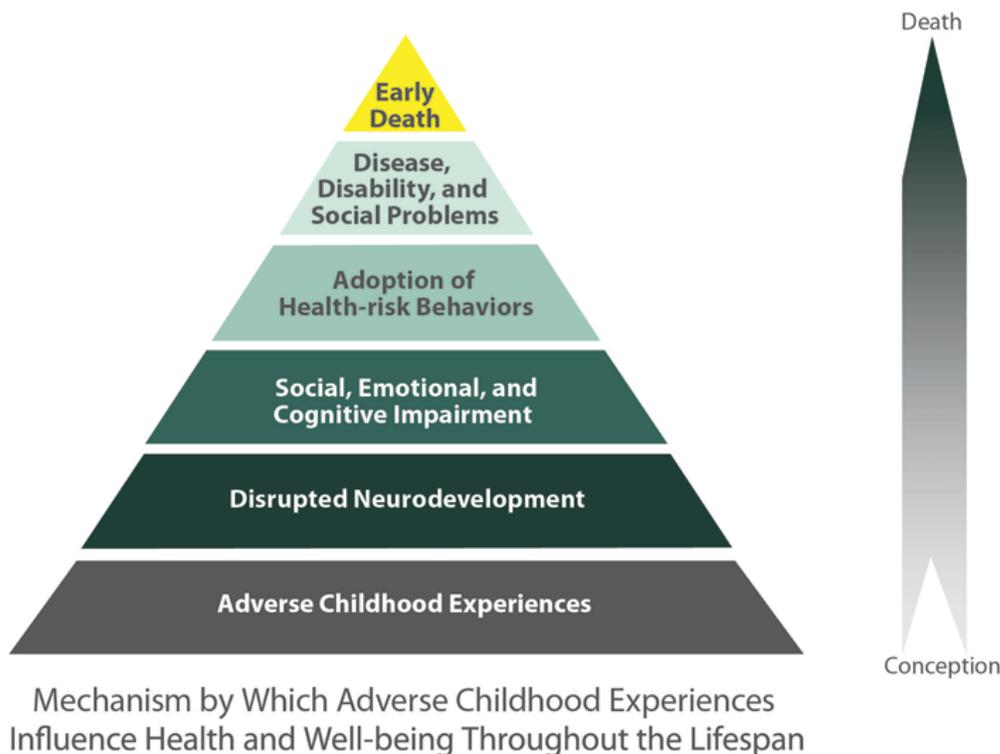
- People whose first suicide attempt occurs as adults are likely to be suffering from major depressive disorders (single or recurrent).
- People whose first suicide attempt in their teenage years or their 20s are more likely to have cumulative risks including more frequent comorbid (occurring at the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

There is a big difference between (A) a middle-aged person suffering from adult-onset depression brought on by a recent job loss, and (B) a 15-year-old who has suffered household instability and food insecurity as a child, is being bullied at school, smokes cannabis on a regular basis, exhibits emotion dysregulation, and has just received news of the death of a friend or relative to suicide. The prevention strategies for those two people will have to be quite different.

When discussing suicide, many people reflect on the stories they know of people who have died by suicide. While those stories may well be accurate, they may also have limitations – starting with the fact that people often focus on (and may only have knowledge about) the period of time immediately prior to the death (perhaps including the ‘triggers’ the person may have experienced) but not the person’s developmental trajectory. To phrase it differently: how was it that the person came to be in emotional pain to the point of suicidal distress? We know that to understand the deaths of people who die by suicide we also have to understand their lives – and the developmental trajectory which brought them to a point of suicidal distress. We need to understand their childhoods in particular, because of the significant role that our childhoods have on how healthy, resilient and productive we are as youth and as adults.

There is a significant body of research on the impact of adverse childhood experiences (ACEs) on people’s health outcomes. A path breaking study at the Centers for Disease Control (CDC) 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 most damaging form of adverse childhood experiences is child sexual abuse (Hu et al 2018).

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 suicidal 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.⁶ At the same time, people with early onset mental health disorders are at risk for chronic problems throughout their lives (Mishara and Chagnon 2016). The following graphic was developed by the researchers at the CDC:



⁶ Further information on ACEs and the association between ACEs and a wide range of negative physical and mental health outcomes over the life course can be found on the CDC’s website at https://www.cdc.gov/violenceprevention/acestudy/about_ace.html

One Indigenous population for which we have considerable historic and current data on mental health and unhealth 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).

First Nations people in Saskatchewan may have undergone a similar health transition brought on by colonialism and its aftermaths, but we don't yet have the historical data required to prove or disprove this hypothesis.

There is a story that is common to many, if not most, Indigenous peoples. It is a story of colonization, of loss, of suffering, of gradual mobilization and ethnopolitical mobilization, and now of a strong push for self-determination and decolonization. Here is one telling of this story:

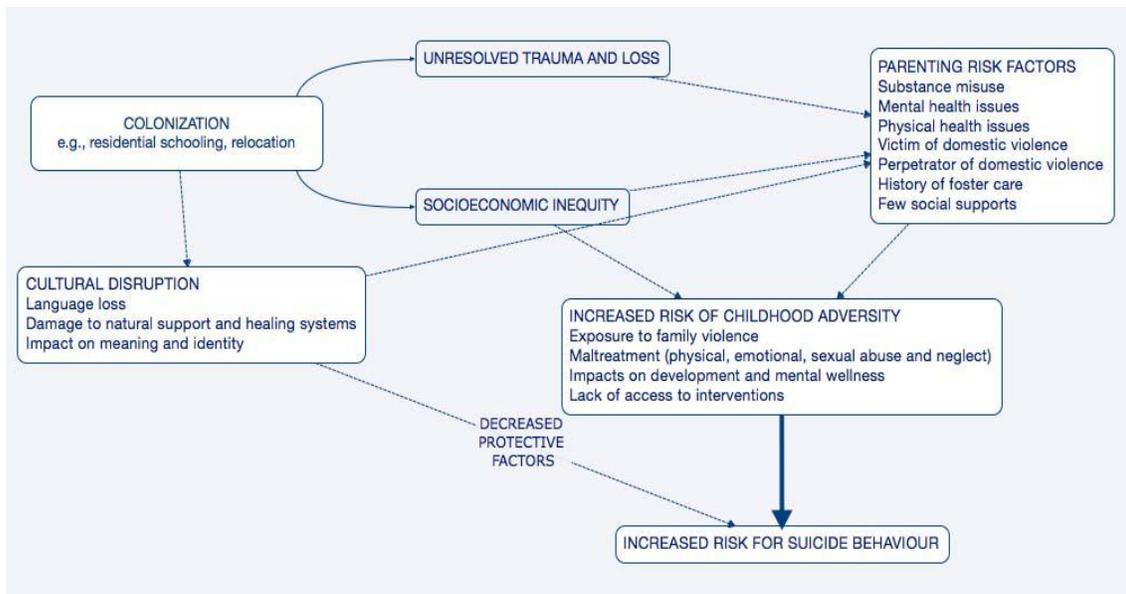
The rate of death by suicide among [Indigenous peoples] rose above the national rate in the 1970s among the first generation of young people to grow up in settlements. The rise in deaths during this time coincides with social and economic upheavals in our society that were largely engineered by the federal government after World War II. These changes included families being relocated by the federal government off the land into permanent settlements, where they faced crowded and inadequate housing. Traumatic experiences followed that are associated with residential schooling, the loss of loved ones to epidemic diseases, and the rapid social transitions that accompanied these events.

Social and economic upheaval ... created the conditions under which suicide risk factors multiplied and, within some families, were passed from one generation to the next. Substance abuse, family violence, and poor mental health became more prevalent in [Indigenous] society as a result of these changes within a country that, based on past social inequities still evident today, sees [Indigenous people] as unworthy of the basic services, supports, and infrastructure taken for granted in most other parts of Canada (Obed 2018).

As Gabor Maté, a retired B.C. physician who specializes in addiction, tries to communicate to Canadians:

At the core of the suicide pandemic is unresolved trauma, passed ... from one generation to the next, along with social conditions that induce further hopelessness. The source of that multigenerational trauma is this country's colonial past and its residue in the present. The march of the history and progress Canada celebrates, from which we derive much pride and national identity, meant catastrophe for natives: the loss of lands and livelihood and of freedom of movement, the mockery and invalidation of their spiritual ways, the near-extirpation of their culture, the corruption of their intrafamilial and intracommunal relationships, and finally, for nearly a hundred years, the state-sanctioned abduction, rape, physical abuse and mental torture of their children. (Maté 2016)

But how does this trauma pass from one generation to the next? Canadian researchers have recently tried to explain a key factor in understanding elevated rates of suicidal behaviour in Indigenous communities. Crawford and Hicks (2018) propose that “early childhood adversity is a key risk factor for later suicide behavior over the life course. Further, early childhood adversity may be understood as a key mechanism by which disruption and loss related to colonization is mediated into [in other words, brings about or results in] suicidal behaviour.” This chart presents proposed pathways through which factors related to colonization increase suicidal behaviour by youth:



“One legacy of colonial disruption is elevated levels of traumatic stress in many Indigenous households, which may manifest in biological dysregulation as well as disrupted relationships, including caregiving relationships. We suggest that related traumatic stress and loss is linked to increased risk for suicide, and that this risk is transmitted through generations by disrupting parenting relationships, which exposes children to higher levels of stress throughout childhood

while also impairing their optimal development. Capacity for parenting is impacted by parental substance misuse, mental and physical disorder, being the perpetrator or victim of domestic violence, and having been through foster care.” (Crawford and Hicks 2018)

Elevated rates of early childhood adversity are not the ‘fault’ of First Nations people. They are, in large part, a result of colonialism. But they are very real, they have devastating impacts in our communities, and they have to be addressed as a matter of the highest priority.

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.” (Bombay 2016, McQuaid et al 2017)

Most research focuses on risk factors that make someone more likely to be suicidal and engage in suicidal behaviours. However, although the likelihood of suicidal behaviors is increased by exposure to risk factors, most people who have suicide risk factors, even multiple risk factors, do not attempt suicide. This is because ‘protective’ factors can effectively compensate from exposure to important risk factors and prevent suicidal behaviors.

The three most important protective factors are:

- 1) social support – having a person or people you can tell about your troubles and who will be there to help you when you are experiencing difficulties;
- 2) having good coping skills – suicide is a tragic way of coping with problems people think they cannot deal with, being able to use a range of effective coping skills when confronted with difficulties can avert looking to suicide as a way to end the anguish in a person’s life;
- 3) help seeking and having help available – people who seek help for their problems, particularly help with psychological, mental health and addiction difficulties, are more likely to get help and reduce symptoms and problems associated with high suicide risk. (Of course, if we encourage children and youth to seek help then we have to ensure that the helping resources they need are in place...)

Communities can take measures to increase the social supports available to vulnerable community members. For example, programs that promote emotion regulation and reduce aggression and behavior problems can be incorporated into school curricula.⁷

⁷ The programs *Zippy’s Friends* (for 6-7-year-olds) and *Passport: Skills for Life* (for 9-12-year-olds) are taught in schools and have been shown to improve emotional and social competencies, and coping abilities. They have been successfully used and appreciated in the Kitigan Zibi Kikinamadinan school in an Algonquin First Nations community north of Ottawa, as well as in many other locations around the world. See Sloan et al 2017.

One made-in-Saskatchewan success story is the culturally-based, semester-long high school mental health curriculum developed by Mental Health Technical Working Group member, mental health nurse and educator Marlene Mirasty in collaboration with the then-Principal at Beardy's & Okemasis Cree Nation, the school Elder and a mental health therapist. The curriculum has three parts. The first part covers basic mental health information (e.g. depression and anxiety), including everything taught in Mental Health First Aid. In the second part students develop a 'skills toolbag' to assist themselves and others. The third part consists of visits to three different mental health facilities, to meet people living with mental health disorders and professionals who work with them. Several other schools and school districts have expressed interest in the program.

4. What we know about suicide prevention

The members of the Mental Health Technical Working Group also brought to the table many decades of experience with suicide intervention, prevention and postvention, and participants in the community engagements also spoke powerfully of their experiences and insights. Again, we combined this first-hand knowledge from Saskatchewan First Nations communities with the broader evidence base, built up over decades from research and practice from around the world.

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

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 requires significant new resources if effective implementation is to take place; and,
- the impact of an SPS can be evaluated over time.

Suicide prevention strategies are usually government-led initiatives (e.g. Quebec's provincial SPS, discussed below, which is recognized by suicide prevention specialists world-wide) which address the risk and protective factors for the general (i.e. non-Indigenous) population.

But as Alaskan Inuk Tim Argetsinger has noted,

Unlike in the non-Indigenous population ... suicide among Indigenous populations still tends to be viewed by policymakers and researchers as a unique phenomenon rather than a public health problem warranting evidence-based, public health solutions. As a consequence, suicide is now a multigenerational problem that too many of our families and communities are still struggling with today. ...

It often seems like Indigenous peoples have been confined – and often confine ourselves – to an alternative reality when it comes to suicide prevention, one in which we are expected to combat this challenge without access to many of the basic tools and resources available in non-Indigenous communities. For decades we have too often settled for the mental health equivalent of home remedies instead of the evidence-based public health measures that have successfully reduced suicide rates elsewhere (Argetsinger 2018).

In recent years, however, a number of Indigenous-specific SPS have been developed, led by Indigenous organizations: by Aboriginal Australians; by Sámi in the Scandinavian countries, and by Inuit in Nunavut – as well as the 2016 National Inuit Suicide Prevention Strategy.⁸

These are all minority Indigenous populations within advanced industrial societies that have experienced profound trauma and dislocation in the wake of colonization and colonialism. Both Aboriginal Australians and Inuit suffer deep poverty and poor living conditions, and as a result their Indigenous-led suicide prevention strategies place emphasis on social inequality and suicide risk.

Another key common element is a focus on intergenerational trauma, traumatic stress, early childhood adversity and the need to nurture healthy children alongside suicide prevention measures targeting youth and adults. To quote Australia's National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, 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; emphasis added).

Existing models of suicide risk and prevention typically focus on proximal (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). Social determinants such as poverty, poor living conditions, violence and racism impact suicidal behaviour rates as well.

Persistent inequities and lack of access to services and supports also contribute to suicide risk and suicidal behaviour.

⁸ Respectively, Australia, Department of Health and Ageing 2013; Sámi Norwegian National Advisory Unit on Mental Health and Substance Abuse (SANKS), and Saami Council 2017; Nunavut, Government of, Nunavut Tunngavik Inc., Royal Canadian Mounted Police V Division, and Embrace Life Council 2010; and, Inuit Tapiriit Kanatami 2016.

Claims that variations in suicides rates at the community level can be explained solely on the basis of measures of ‘cultural continuity’ fail to take into consideration varying degrees of unresolved historical trauma embedded in different communities, and the accessibility, cultural appropriateness and quality of the mental health care available to the residents of the different communities (Hicks 2018). Community-level action on suicide prevention can make a big difference in the lives of individuals at risk, however claims that suicidal behaviour can “stop” or decline sharply for a significant period of time *solely* as a result of community-level ‘life promotion’ activities appear to be exaggerated, or simply made up (Hicks 2018).

A recent article by Janet Gordon and Kimberly Matheson documented a “holistic, multi-pronged approach to suicide prevention [which] recognizes the multi-layered world in which youth live” (Gordon and Matheson 2018):

After several years of partnership-building across disciplines, universities, and sectors working with children and youth in northwestern Ontario, in 2016 the Indigenous Youth Futures Partnership (IYFP) was launched. The IYFP brings together tools and approaches rooted in local Indigenous knowledge and Western science to work together with First Nations communities in the Sioux Lookout First Nations Health Authority (SLFNHA) zone in northwestern Ontario to articulate each community’s vision for the future. This vision will guide the co-development, implementation and evaluation of multiple, interdependent pathways to foster youth resilience and create the conditions for youth to thrive.

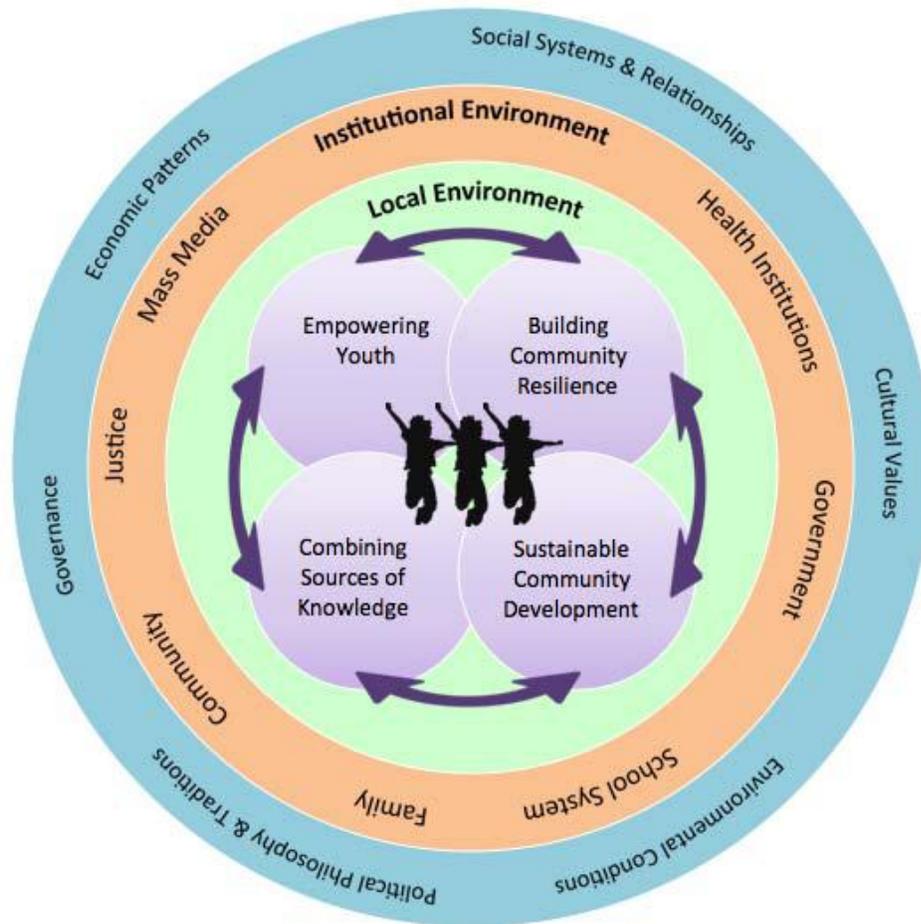
The need for an interconnected approach to suicide prevention reflects the IYFP’s early discussions with First Nations youth who pointed to the importance of “being balanced physically, emotionally, mentally, and spiritually,” “having and being a good role model and being a leader”, “community gatherings” and especially “family.” Elders further underscored the need for youth to understand the history of First Nations peoples that has led to their current circumstances. Such an understanding would help youth to appreciate that their difficulties are not about their own shortcomings, or those of their family or community. By recognizing the pervasive effects of colonizing practices and policies, there is a basis for moving forward in the healing process.

As depicted in [the following graphic], the IYFP framework takes a systems-based approach to suicide prevention that places youth at the centre, and recognizes the influences of the local community, the institutions that affect how communities operate, and in the values, norms, and social relationships that are at the core of community life. This framework is consistent with theoretical perspectives that argue that resilience operates within the ‘ecosystem’ in which youth reside.

In line with this, the IYFP approach focuses on activities that target four elements:

- Empowering youth by fostering their hopes and goals for the future, strengthening coping skills, enabling a view of themselves as having something to contribute, and engaging them as decision-makers.

- Providing a positive socio-cultural context for youth development.
- Encouraging the aspirations of youth by enabling them to contribute to, and benefit from, the development of their communities.
- Finally, local values and traditions are a source of strength, and many communities have retained or are reclaiming traditional teachings, connection to the land, language, and ways of relating to one another. Ensuring youth have a voice in shaping cultural identity and strategies of resistance and empowerment can contribute to their resilience.



In effect, our approach to suicide prevention encourages multiple pathways to youth wellness. It is aligned with various strategies that encourage a culturally relevant, holistic, and community-engaged framework, including the 2015 *First Nations Mental Wellness Continuum Framework* that highlights the need for youth to feel a sense of belonging, purpose, hope, and meaning in life. These factors are key to youths' capacity to cope with the challenges that they face, and to protect them against depression, despair, and ultimately suicide.

Sustained and real change requires holistic, multi-faceted and culturally appropriate interventions. Indigenous-driven projects such as the Indigenous Youth Futures Partnership in northwestern Ontario are making a significant contribution to the global evidence base and practice of suicide prevention, which is constantly evolving:

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).

We feel strongly that since adverse childhood experiences are known *developmental precursors* to suicidal behaviour, particularly by teenagers and young adults, we need to find culturally appropriate ways of constructively intervening in the lives of First Nations children and youth in order to lower their risk factors and increase their protective factors. 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.

We also feel strongly that our suicide prevention efforts must emphasize *both* developmental precursors to suicidal behaviour over the life course *and* risk and protective factors specific to First Nations histories and current social contexts.⁹

A recent report from the House of Commons’ Standing Committee on Indigenous and Northern Affairs stressed the need to improve the underlying 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).¹⁰ To do that effectively, we will

⁹ See for example the work of Les Whitbeck and his colleagues on perceived stigma/discrimination and association with depression (Whitbeck et al 2014, Greenfield et al 2017).

¹⁰ Its recommendations harkened back to those made by the Royal Commission on Aboriginal Peoples in 1995.

need a plan – a strategy. It must reflect First Nations culture, realities and community priorities, it must be evidence-based, and it must be something that can be implemented starting as soon as additional resources are made available. Resources must be made available on the basis of the principle of ‘proportionate universality’: “... programs, services, and policies that are universal, but with a scale and intensity that is proportionate to the level of disadvantage” (Sir Michael Marmot, cited in Human Early Learning Partnership 2015).

We will now examine first what the World Health Organization (WHO) and the United Nations (UN) have to say about suicide prevention strategies, then review three examples.

4.a 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. For each adult who died of suicide there have been many more (some research suggests more than 100) others who have attempted suicide.
- Suicides are largely 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.

We reiterate the last message: the WHO recommends that community-specific and culturally-specific needs be addressed in national suicide prevention strategies, which should not consist of ‘one size fits all’ approaches.

The UN has called on all governments to develop and implement evidence-based 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-sectoral 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 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, that is, it 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 followed WHO recommendations by developing and implementing national strategies for suicide prevention.¹¹ Canada is the only G8 country *not* to have done so (Matsubayashia & Ueda, 2011). Developing countries such as Bhutan and Namibia have followed WHO recommendations and developed national strategies for suicide prevention, but Canada has not.¹²

There does not appear to be national strategy for suicide prevention in Canada's short-term future – at least not under the current government. Neither the mandate letter given by the Prime Minister to Minister of Indigenous Services Jane Philpott (Canada, Prime Minister 2017a) nor the mandate letter given Minister of Health Ginette Petitpas Taylor (Canada, Prime Minister 2017b) mention suicide at all.

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 Federation of Sovereign Indigenous Nations is of the view that the WHO's recommendations that every country should adopt a national strategy for suicide prevention apply to the *provincial* level as well – especially in the absence of a national strategy. All 50 states in the U.S. have state-level suicide prevention strategies, but only a few Canadian provinces do. Saskatchewan has no provincial suicide prevention strategy – and apparently no plans to develop one.

4.b 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 are 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 ... also dropped ...”

¹¹ http://www.who.int/mental_health/suicide-prevention/en/

¹² The federal government's National Aboriginal Youth Suicide Prevention Strategy (NAYSPS) is not really a suicide prevention strategy, but rather a framework to allow funding of community-based projects. The federal government's 'suicide prevention framework' is not a strategy either (Eggertson 2017).

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. We believe that the suicide prevention measures undertaken by the White Mountain Apache can and should be replicated in Northern Saskatchewan.

4.c The Inuit experience

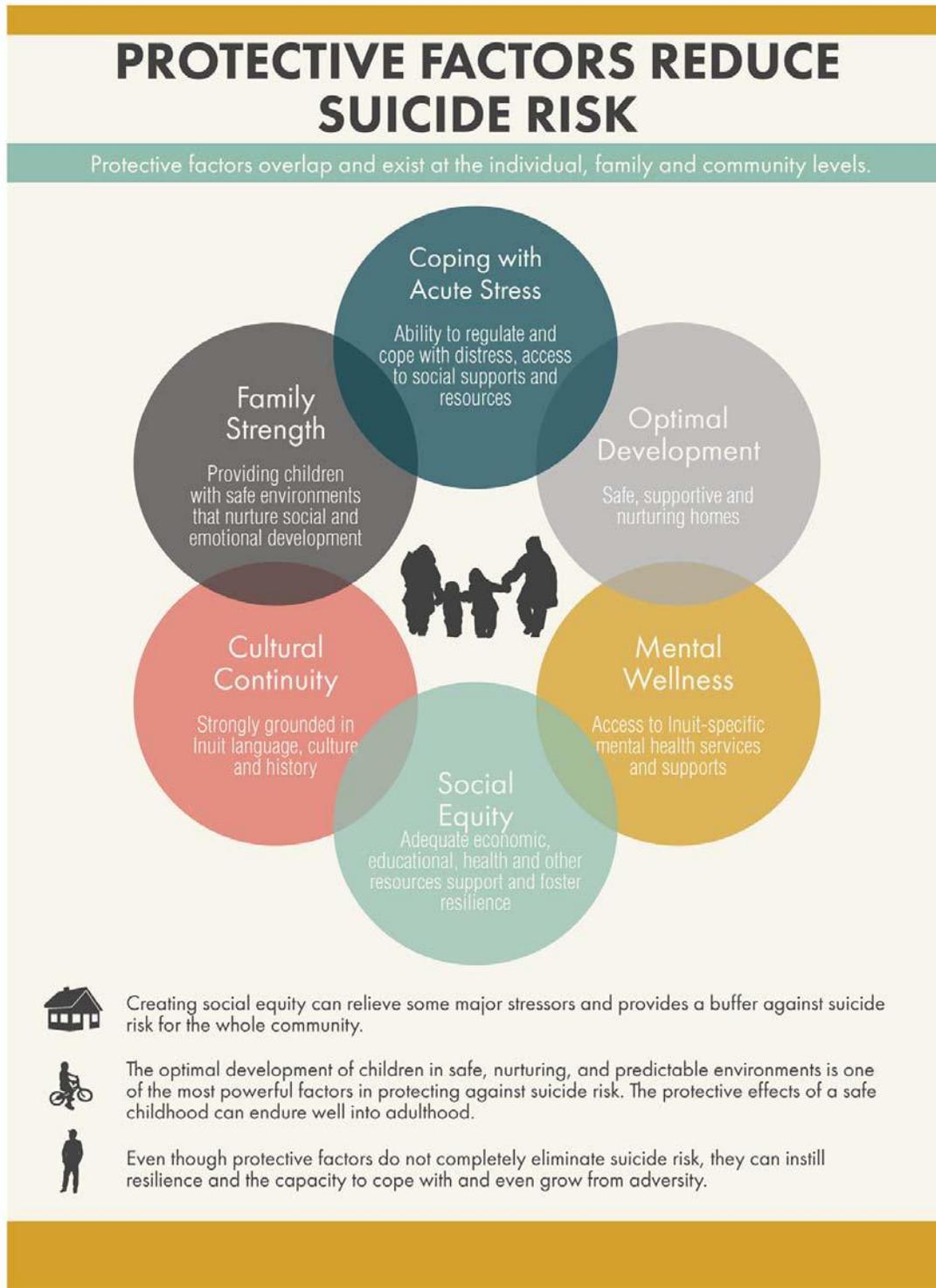
Inuit populations across the Arctic experienced a devastating increase in their suicide rates beginning in the 1970s, from rates lower than the national average to one in Nunavut (since 1999) that is 9.8 times higher than the national rate – and a staggering 40 times higher the national rate among males 15 to 24. Public health authorities only began to take evidence-based action to address the Inuit suicide crisis in 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 sufficient 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 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, please see the document at <https://tinyurl.com/ydgxej6v>.

Inuusivut Anninaqtuq shows unparalleled commitment by a public government to work in partnership with Indigenous and other organizations to support 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 transformed from ‘not our problem’ to ‘let’s work hard together to bring the rates down.’

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

The NISPS contains striking graphics which communicate effectively about risk and protective factors in an Inuit context. One example is:



The Nunavut Suicide Prevention Strategy and the National Inuit Suicide Prevention Strategy are cutting-edge documents in that they locate elevated rates of suicidal 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. The Inuit suicide prevention strategies are too new to have had any measurable impact on suicide rates, but they have succeeded in focusing attention and funding in ways which should make a difference in the coming years.

As a review of the NISPS in *The Lancet* noted:

the NISPS considers the full breadth of risk and protective factors for suicide, from historical, social, developmental, and mental health factors, affecting the individual, family, and community. NISPS promotes a multi-level strategic approach to suicide prevention, with six key strategic priority areas aiming to: create social equity, through addressing social determinants of health; create cultural continuity, through approaches that connect Inuit with their land, culture, and language to foster healing; nurture healthy Inuit children; ensure access to a continuum of mental wellness services; heal unresolved trauma and grief; and mobilise Inuit knowledge for resilience and suicide prevention. (Crawford 2016)

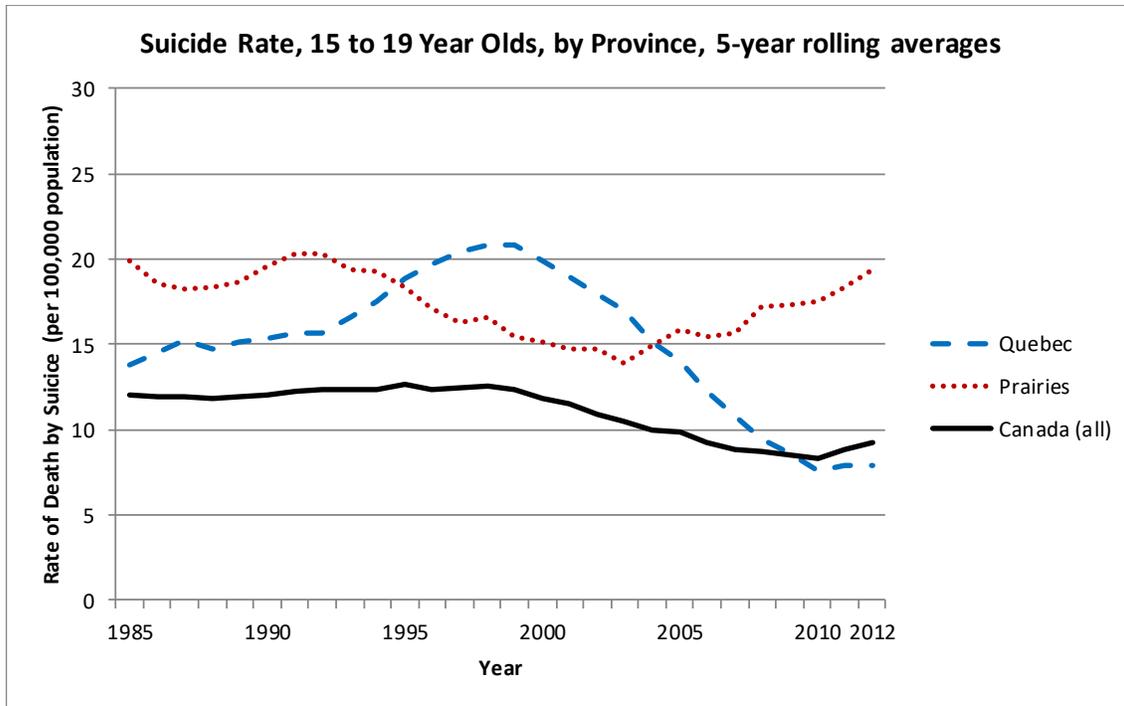
4.d The Québec experience

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 (Québec, Ministry of Health and Social Services 1998). The strategy was adequately funded, and aggressively, thoughtfully and effectively implemented.

Québec is an internationally-renowned suicide prevention success story – perhaps the best example yet of what a government and society can achieve in the way of suicide prevention if it really tries.

The graph on the next page shows the sharp decline in Québec’s youth suicide rate after the introduction of their provincial suicide prevention strategy in 1998 – from well above the national rate to just below the national rate (data from Renaud et al 2018).

In comparison, the youth suicide rate for the three prairie provinces has remained well above the national rate, has risen 40% since 2003, and is now more than twice the national youth suicide rate. (It should be noted that these rates are for the general population. The rates for First Nations youth would be many times higher.)



One important question is whether the suicide rate in the majority Indigenous parts of the province fell as much as it did in the majority non-Indigenous parts of the province. This question cannot be answered using Coroner’s records, because in Québec (as in Manitoba, and in other provinces as well) death certificates are not coded by ethnicity. The question may be answered by the fact that the Health Boards in the majority-Indigenous parts of the province decided not to implement the ‘mainstream’ SPS in their jurisdictions. Eggertson and Patrick (2016) concluded that “The strategy did not ... reduce rates among Québec’s indigenous populations, which had opted out of the provincial strategy.” It would matter greatly to us if the ‘standard basket’ of suicide prevention measures recommended by the WHO and called for in Québec’s SPS failed to have an impact in First Nations and Inuit communities in the province, but this does not appear to have been the case.

5. A suicide prevention strategy which meets the needs of all Saskatchewan First Nations people

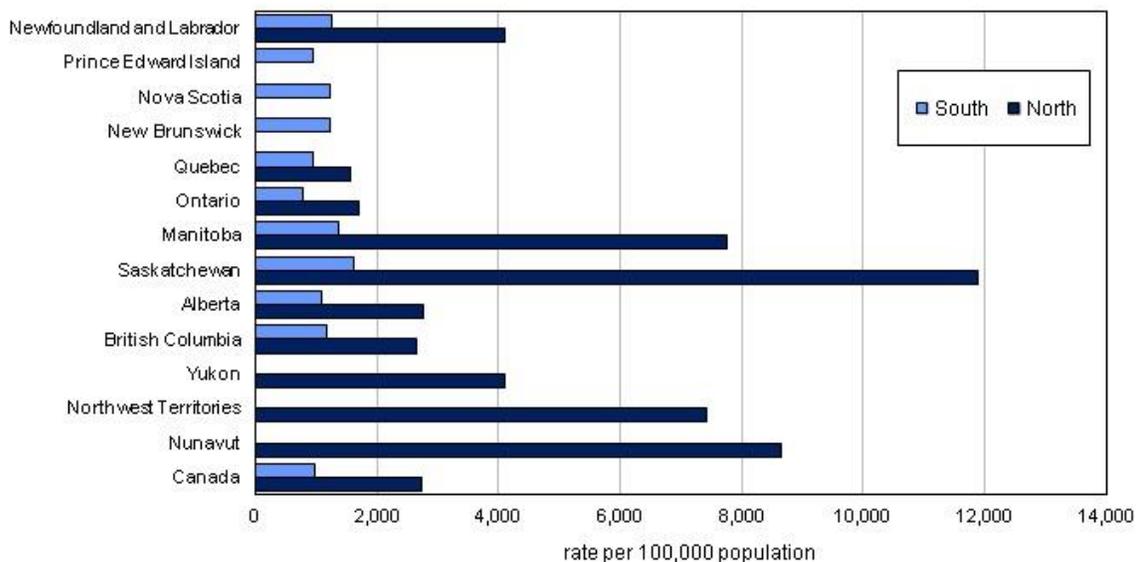
The destruction of Indigenous systems in combination with the chronic underfunding of contemporary human services has resulted in the First Nations people of Canada ranking 63rd or lower in the world on the United Nations Human Development index, far below the overall Canadian ranking of 9th. According to the federal government’s own data, the gap in well-being between First Nations and non-First Nations communities is substantial – and has remained stable or in some instances widened in the three-plus decades since the 1980s. Change is long overdue. It

is time for a transformed First Nations health care system that is based on Inherent and Treaty Rights and fulfills Treaty commitment to realising the true spirit and intent of the Medicine Chest.

Social determinants such as poverty, poor living conditions and racism impact suicidal behaviour by people of all ages. And we must be clear: substantial reduction in the rate of death by First Nations peoples in Saskatchewan will not occur without multifaceted targeted suicide prevention measures *and* fundamental and profound improvements in social and economic conditions.

Northern Saskatchewan in particular is in a state of ‘suicide crisis’, in large part because of *negative social determinants, poverty and poor living conditions*: it is one of the most dispossessed, marginalized and oppressed parts of Canada, with the worst physical and mental health outcomes (Elliott 2014a, Elliott 2014b, *Sask Trends Monitor* 2015) and by far the highest police-reported violent crime rate and Crime Severity Index (CSI) values in the country – higher even than the territories (Allen and Perreault 2015):

Chart 3
Police-reported violent crime rate, by province and territory and north-south region, 2013



The goal of the Saskatchewan First Nations Suicide Prevention Strategy is to achieve equality of health outcomes between First Nations and non-First people, and to lower the rate of death by suicide of First Nations people to that of non-First Nations people in the province.

Imagine if youth in Saskatoon had a suicide rate twice that of youth in Regina. Imagine the effort that would be made to close that gap... The suicide rate of First Nation youth (boys and girls ages 10 to 19) is ten times that of non-First Nations youth. Equal health outcomes for suicidal behaviour are a long way off, but we’ll never get there if we don’t start trying – really hard and smart.

As directed by a detailed and unambiguous motion by the FSIN's Health and Social Development Commission (Appendix B), the SFNSPS has been developed by the FSIN Mental Health Technical Working Group (including the FSIN Youth Representatives) with support from FSIN's Health and Social Development Secretariat and two technical advisors. Drafts were reviewed by a Peer Review Group of internationally-respected experts in suicide prevention.

The challenge given to the Mental Health Technical Working Group (MHTWG) was to develop a trauma-informed Saskatchewan First Nations Suicide Prevention Strategy which:

- Addresses the needs of all First Nations people living on and off reserve, with a special focus on Northern Saskatchewan; and,
- Address the needs of First Nations men and women of all ages, with a special focus on children, youth and young adults.

Community engagements were held in La Ronge, Meadow Lake, Prince Albert, Regina and Saskatoon. (See Appendix D for a summary of the results of the engagements.) Both Working Group members and community engagement participants emphasized the critical role that First Nations cultures and traditions play in fostering resilience and healing. **We must ensure that First Nations communities and individuals are able to choose the healers they are most comfortable with and confident in** – be they Elders, Social Workers, Addictions Counsellors or Mental Health Therapists. Currently the federal government's Non-Insured Health Benefits (NIHB) program and the provincial government will only pay for services delivered by Mental Health Therapists.

MHTWG members feel that the province's current mental health action plan, *Working Together for Change* (Stockdale Winder 2014), is clearly not meeting the needs of First Nations peoples. The strategy is not the result of *engagement* with First Nations peoples; instead, only a select small group of First Nations people were *consulted* as it was being developed. Furthermore, sources within the government have told us that the strategy has been only minimally implemented – and that no evaluation has been released of whatever implementation has taken place to date.

FSIN asserts that First Nations people in Saskatchewan have a Treaty right to a culturally appropriate continuum of trauma-informed mental health care, with no break in service when people turn 18 and when people move off (or back onto) reserve.

Working Group members and community engagement participants also stressed the importance of obtaining additional resources to build suicide prevention capacity in the communities, and of supporting persons bereaved by suicide and communities that need help in the aftermath of suicide.

In addition to the knowledge and recommendations drawn from the Mental Health Technical Working Group and the community engagements, research was conducted to document measures that have had a positive impact on suicide rates in other jurisdictions.

The Mental Health Technical Working Group believes the following to be self-evident truths:

- A. First Nations people can experience suicidal crises for a wide variety of reasons, just as non-Indigenous people can;
- B. The elevated rate of suicidal behaviour in First Nations is, in part, a legacy of colonial experiences and practices (including, but not limited to, intergenerational trauma and gendered violence resulting from Indian Residential Schools);
- C. The elevated rate of suicidal behaviour in First Nations is also, in part, a result of persistent inequities such as poor living conditions, joblessness and poverty, and limited access to culturally appropriate mental health services; as well as violence and racism; and,
- D. First Nations people have a right to the same health outcomes as non-Indigenous people. Focus, interventions and additional resources are required to overcome historical trauma and achieve equality of health outcomes in terms of rates of suicide attempts and rates of death by suicide. Funding should be allocated on the basis of need (i.e. the social burden of suicide-related suffering in the communities) rather than on population.

With regard to the third point, we are aware of cases of parents driving their children from the northern communities in which they live south to Prince Albert in the hope of obtaining mental health services that are not available at home – at least not in a time frame that they can bear.

The Advocate for Children and Youth has commented:

Saskatchewan children and youth are facing immense pressure and risks resulting in an increase in mental health concerns for our young people. Saskatchewan’s mental health system is failing our children, and this is particularly true in our northern and remote communities ... The recommendations of the Mental Health and Addictions Action Plan developed four years ago has made little impact in addressing the barriers and access issues cited in the report. Timely services that include a broad scope of supports to ensure that our young people’s overall health needs are met must be provided. The lengthy wait times for psychiatric and psychological services must be rectified. Waiting several months and, at times, years for these services is simply unacceptable. Accepting the current standards of mental health care not only compromises our young people’s rights, but our children and youth are literally dying while waiting for service. (Saskatchewan, Advocate for Children and Youth 2018, p. 14.)

In comments to the media, the Advocate for Children and Youth called the wait times “shameful”:

Saskatchewan’s children’s advocate says wait times for youth mental-health services in the province are unacceptable. Corey O’Soup says young people shouldn’t have to wait for up to two years to see a psychiatrist. “The wait times for mental-health services experienced by children in this province are shameful,” O’Soup said Tuesday as he released his annual report. “Those are the children that end up in our reports. Those are the children that we want to stop from dying.” (*Globe and Mail* 2018)

The provincial government clearly disagrees. On May 10, 2018, after a judge called the mental health services available to people in La Loche a “travesty,” an opposition MLA tabled this motion:

That this Assembly take action to further supports for mental health and addictions in the province, but particularly in northern Saskatchewan where the rates of suicide are alarming and services are extremely limited.

Government MLAs refused to support the motion, with one member stating that “Our northern communities have not been overlooked.” (Saskatchewan, Legislative Assembly 2018)

FSIN agrees with the Advocate for Children and Youth, and notes that:

- A. The First Nations suicide rate is highest among children and youth.
- B. Younger people tend to have different ‘baskets of reasons’ for suicidal crisis than do older people. Depression plays a key role in suicidal behaviour by middle-aged and older people, whereas more common reasons for suicidal behaviour by children, youth, and young adults. Are (1) adverse childhood experiences; (2) psychological difficulties which develop as a result of early childhood adversity; and, (3) comorbid substance abuse.
- C. Early childhood adversity may be understood as a key mechanism by which disruption and loss related to colonization results in suicidal behaviour over the life course.

For these reasons, FSIN proposes a three-track approach:

1. A full range of culturally appropriate mental health care services, including land-based healing services that reflect First Nations culture and traditions;
2. The application of targeted suicide prevention, intervention and postvention measures that have been demonstrated to be effective in other jurisdictions; and,
3. A strong focus on ending the cycle of intergenerational transmission of historical trauma by reducing the rates of early childhood adversity among First Nations children and increasing coping skills of youths.

With regard to the first approach, FSIN’s Health and Social Development Commission directed the Working Group to “Respect and reflect the cultures of Saskatchewan Indigenous First Nations.” In our discussions regarding utilizing culture as healing/intervention we have been guided by FSIN’s 2014 *Cultural Responsiveness Framework* and the Assembly of First Nations’ 2015 *First Nations Mental Wellness Continuum Framework* (Health Canada 2015).

If we are to turn the suicide situation around, EVERYONE must do more and better – families, communities, the First Nations leadership, the public governments... everyone. It is imperative that all three political leaderships – First Nations, federal and provincial – agree to place great emphasis on suicide prevention, and that additional resources are provided *to the communities* allow for a

multifaceted effort both to provide better services to people at risk today, and to tackle the *developmental precursors* of suicidal behaviour among children and youth.

Saskatchewan's Advocate for Children and Youth has already urged "The Government of Saskatchewan work in partnership with the Federation of Sovereign Indigenous Nations to support a Saskatchewan First Nations Suicide Prevention Strategy ... supported and implemented in a way that increases the capacity of communities; [involving] partnerships, where needed, with provincial ministries such as Health, Education, and Social Services; ... financially supported by the provincial government, as required, as the lives of our children and youth are everyone's responsibility (Saskatchewan, Advocate for Children and Youth 2017, p. 2).

It is also imperative that the jurisdictional overlaps and the bureaucratic obstacles that contribute to differential access to services by First Nations people living on and off reserve are eliminated. Jordan's Principle should apply to all First Nations children regardless of whether they live on or off reserve and should ensure there are no gaps in service to those children. A 2017 decision by the Canadian Human Rights Tribunal stated that the federal government's failure to fully implement Jordan's Principle may have contributed to the suicides of two teenagers in Ontario earlier that year.

We will now summarize the 75 Action Items we expect to see undertaken as a result of full implementation of the Saskatchewan First Nations Suicide Prevention Strategy. The Action Items are organized into nine commitments:

1. We will take a focused and active approach to suicide prevention

Central to the success of the SFNSPS will be political agreement on the first Action Items:

- 1.1 Seek a joint commitment by the Minister of Indigenous Services, the Premier of Saskatchewan and the Chief of the Federation of Sovereign Indigenous Nations to prioritize delivery of targeted suicide prevention measures until such time as the rate of death by suicide of Saskatchewan First Nations people has been reduced to that of non-First Nations people in the province.

It will be critically important to obtain the commitment of government partners to intervention over the long term (i.e. not just short-term, crisis-driven interventions) due to the complexity of the issue and the need to address the underlying social determinants, including elevated rates of early childhood adversity. Inter-sectoral collaboration between First Nations, Tribal Councils, FSIN, all levels of government, and interagency groups will be essential to ensure full and energetic implementation of the SFNSPS.

The MHTWG holds that the complex and difficult challenges of tackling elevated rates of suicidal behaviour warrant the creation of a small, efficient and effective Saskatchewan First Nations Suicide

Prevention Secretariat. The Working Group further proposes that the Secretariat should be housed at the FSIN for an initial period of six years and then, following careful review, a decision should be taken on its permanent institutional ‘home.’

Further, we will seek federal and provincial funding for an initial period of one year, during which time the Secretariat’s priorities will be to (A) develop and cost-out an energetic five-year implementation strategy; and, (B) to launch a Community Initiatives Grant Program (CIGP) to support community-led action and build on cultural and community strengths, in addition to tackling selected other Action Items as time and resources permit. This must be ‘new funding’ that does not impact on the ability of Saskatchewan First Nations to access the NAYSPS program.

It will also be important to create Suicide Prevention Co-ordinator positions in the each of the Tribal Councils and Independent First Nations (in addition to the existing Mental Wellness Teams) to ensure full community participation in the overall planning and implementation process. This will help ensure that youth and Elders are full participants in the decision-making processes regarding implementation of the SFNSPS, and that all parties act in ways that are sensitive to, and respectful of, religious and spiritual difference between and within regions and communities. There are excellent suicide prevention and intervention curricula in use, including the ‘Your Life is Sacred’ program (Health Canada 2013), Mental Health First Aid, ASIST and safeTALK. Delivery of these courses should be enhanced and co-ordinated to ensure cost-effectiveness.

At the same time, Elders and Knowledge Keepers should be supported in the research, development, implementation and evaluation of culturally responsive activities which hold promise as a resource to prevent suicide.

We will need to take evidence-based approaches to the design and delivery of ‘upstream’ interventions (including family-based/parenting interventions, emotion regulation interventions, school-based training of the development of coping skills, programs to reduce bullying and violence, and approaches to trauma and loss) and to the design and delivery of selective/indicated interventions for those who self-harm or have attempted suicide, including regular follow-up with persons who have attempted suicide.

It will be important to develop information packages for non-Indigenous education and health workers on (A) the history and cultures of First Nations people in the province; (B) the concept of historical trauma and trauma-informed suicide prevention; and, (C) the approach and contents of the SFNSPS.

In all we do, we must ensure that additional resources are provided to the Athabasca Health Region – which has the highest rate of death by suicide in the province, as well as the highest costs.

Saskatchewan universities and polytechnics should take suicide more seriously by (A) offering at least a 'survey' course on suicidal behaviour (especially to medical, nursing and education students); and, (B) by making ASIST widely and affordably available to students and staff.

2. We will support community-led action and build on cultural and community strengths

It will be essential that communities feel empowered and supported to take the actions they feel will contribute to the prevention of suicide. Who knows what creative solutions may be proposed and tried? We will therefore create a Community Initiatives Grant Program (CIGP) to fund local suicide prevention initiatives. The Saskatchewan First Nations Suicide Prevention Secretariat will provide advice and assistance re: both proposal writing, and the evaluation of activities undertaken.

We will conduct an inventory of all relevant programs delivered in First Nations communities and ensure that all programs which are supposed to be delivered *are actually being delivered* in all communities.

Elders and Knowledge Keepers will be engaged to share oral stories about sacred teachings and life and to share protocols of process and meanings related to spiritual teachings, with goal of having this wisdom included in curricula. In addition, Engage Elders and Knowledge Keepers will be engaged to help develop culturally responsive curricula to reduce stigma related to suicidal behaviour.

3. We will invest in the next generation by taking actions to support healthy early childhood development

The research, design, piloting and evaluation of interventions designed to prevent the intergenerational transfer of historical trauma – for example early childhood home visits by trained staff (e.g. nurses) to connect with and provide support and education to expectant/new mothers – will address one of the key mechanisms identified in this strategy.

We will also research, design, implement and evaluate interventions to address early childhood adversity and other *developmental precursors* of suicidal behaviour over the life course.

At the same time, we will strive to support universal programs and initiatives to heal and support parents, including reducing maternal stress and intimate partner violence, to foster optimal home environments in which children can thrive.

4. We will better equip children and youth with skills to cope with adverse life events and negative emotions

We can better equip children and youth with skills to better cope with adverse life events and negative emotions by taking behaviours that put them at risk (e.g. poor school attendance) seriously, and by ensuring that effective school programs and training opportunities are available to foster coping skills.

A wide range of mental and suicide prevention programs and additional resources are needed in our schools. Communities should be able to choose whether they wish these such programs to be mandatory, recognizing that people (and especially youth) who are traumatized by suicide should never be forced into a program they don't feel they can handle.

We need to support the engagement of youth through community-based arts programming (including digital storytelling), increase opportunities for youth to access Elders, Knowledge Keepers, medicine people and traditional supports from within their First Nation (or nearby), and support the creation of dedicated youth centres in all First Nations communities which do not currently have one.

And while it will undoubtedly be a long process, we will investigate the feasibility of establishing a Child Advocacy Centre to provide 'best practice' care and services to young victims of sexual abuse.¹³

5. We will strengthen the continuum of culturally appropriate mental health services

The MHTWG places high priority on the availability of, and access to, the full range of culturally appropriate mental health services.

Given that the provincial government's existing mental health strategy is not meeting the needs of First Nations peoples, we will lobby for development a new mental health strategy. We will require that First Nations organizations be fully engaged in the process, from the outset up until consent is given to the final product. There should be a clearly defined evaluation framework put in place to ensure that First Nations communities are aware, at any point in time, of the degree to which the strategy has actually been implemented.

¹³ For a systematic review of the evidence for the efficacy of the CAC model, see Herbert and Bromfield 2016.

We will ensure that First Nations communities and individuals are able to choose the healers they are most comfortable with and confident in – be they Elders, Social Workers, Addictions Counsellors or Mental Health Therapists. Currently the federal government’s Non-Insured Health Benefits (NIHB) program and the provincial government will only pay for services delivered by Mental Health Therapists.

This Section of the strategy includes a commitment to implement a system of regular follow-up and support contacts with suicide attempters, as per the World Health Organization's SUPRE-MISS program. This project focuses on people who have been seen in a medical facility for a suicide attempt. People who attempt suicide are at greater risk of repeated attempts, and of dying by suicide. Many studies in different cultures have found that simple, non-professional follow-up after an attempt can prevent repeated attempts. The SUPRE-MISS program, tested by the WHO in eight general hospitals in five low- and middle-income countries, involved regular follow-up contacts over 18 months, and found that the participants were less likely to die by suicide than control groups that did not receive the follow-up. This program should definitely be replicated in Saskatchewan. What possible reason is there not to?

This Section includes a commitment to investigate the feasibility of adapting the White Mountain Apache suicide screening and prevention model, described in Section 4.b of this strategy, to Northern Saskatchewan.

Health care staff at all levels can benefit from training in suicidal behaviour and suicide prevention and intervention (National Action Alliance for Suicide Prevention 2014). In the State of Washington, “Every healthcare provider ... is required to be trained in suicide prevention” (Hurst 2017). Given the scale of the crisis in First Nations communities in Saskatchewan, what reason could the be for not adopting a similar policy here?

Finally, this Section contains a total of 19 commitments, too many to list here. We urge readers of to consult Appendix A and review them.

6. We will strengthen the continuum of care for substance use and addiction services

This Section seeks a joint commitment by the Minister of Indigenous Services, the Premier of Saskatchewan and the Chief of FSIN to prioritize improving access, services and support for First Nations people with trauma and substance-related disorders.

It commits to developing best practices for working with First Nations people who have dual diagnoses related to trauma and substance abuse, and culturally appropriate resources for treatment centres which serve First Nations people in the province.

7. We will develop a strategy aimed at reducing our high rates of violence and of child sexual abuse

The MHTWG feels strongly that violence in all its forms – beginning with young children being sexually abused or witnessing violence in the home, resulting in developmental traumatology – is a significant, and too often overlooked, contributor to elevated rates of suicide in the province, especially in the North.

This Section makes a general commitment to development of a strategy to reduce the high rate of violence in First Nations communities that recognizes (A) different causes and consequences for men, women and children of gender-based violence, youth violence and gang-related violence; and, (B) the impact on young children of witnessing violence between adults they love. This will be a huge undertaking.

This Section also makes a general commitment to development of a strategy to (A) reduce the rate of child sexual abuse in our communities; and, (B) to establish a culturally-based Child Advocacy Centre to provide 'best practice' care and services to young victims of sexual abuse and their families.¹⁴

8. We will communicate about prevention and our progress

The MHTWG is committed to ensuring that First Nations youth are educated about risk factors for suicidal behaviour, for themselves and for those they love. A website will be developed with information on the SFNSPS, and information on available resources for First Nations, Tribal Councils, interagency groups, other stakeholder groups, and individuals.

With the imminent legalization of cannabis, it is imperative that a creative and energetic public awareness campaign be launched about the impact of cannabis use on the still-developing adolescent brain. The brains of young people do not fully develop until they reach their mid-20s. Regular cannabis use during the early years of life can lead to harmful psychological changes in the brain. Research shows that when youth use cannabis their memory, learning, problem-solving skills and attention are harmed. Some studies suggest a permanent impact as well. Mental health problems may include anxiety, depression, suicidal behaviour, and schizophrenia. Cannabis use increases the risk of psychosis in people with certain vulnerabilities.¹⁵

¹⁴ For a systematic review of the evidence for the efficacy of the CAC model, see Herbert and Bromfield 2016.

¹⁵ Resources include Canadian Centre on Substance Abuse 2015, Canadian Centre on Substance Abuse 2016, Canadian Paediatric Society 2017, and Canadian Research Initiative in Substance Misuse 2017.

The SFNSPS calls for the contracting of an independent consultant to prepare an annual report on implementation of the Saskatchewan First Nations Suicide Prevention Strategy, to be submitted for review by both the Chiefs-in-Assembly and the provincial Legislative Assembly. This will be an important way to keep all parties to the strategy, as well as First Nations people across the province, well-informed about the progress (or not) of implementation.

9. We will support ongoing culturally-relevant research, monitoring and evaluation

It will be important to fill the data gaps identified in Section 2. This includes obtaining additional resources for the Office of the Chief Coroner and establishing a direct relationship between the Office of the Chief Coroner and the Saskatchewan First Nations Suicide Prevention Secretariat. It will also be important for the provincial Ministry of Health to commit to recording and sharing detailed data on rates of suicide attempts in the province.

We need to better understand gender dimensions of suicidal behaviour. We can do so by (A) planning and conducting research on the causes and consequences of gender-based differences in suicidal behavior; and integrating a sex and gender disaggregated approach to all research conducted in order to discern causes and consequences of gender-based differences in suicidal behavior and to develop interventions accordingly.

While our primary concern is the loss of life and the pain and trauma inflicted on loved ones, suicidal behaviour is also extremely expensive to society – especially if one includes the value of lost productivity over the deceased individual’s life course.¹⁶ There are aspects unique to Saskatchewan as well: How many suicide-related medivacs take place each year, and at what? What is the cost of a community shutting down for several days for collective grieving? What was the cost of the ‘fly in’ response of government to the crisis in La Ronge, spending that left nothing behind in the community? All these questions need to be researched, as Northern Saskatchewan in particular may be an example of a situation where money spent on suicide prevention measures may pay for itself in lower costs to the public system, savings that could be reprofiled for investment elsewhere.

¹⁶ One recent study from Australia calculated the average cost per youth suicide at just under C\$ 2.8 million, and the total annual economic loss to the country from youth suicide at C\$ 21.3 billion (Kinchin and Doran 2018). A study in California found that the state’s investment in ASIST training “a positive financial benefit for the state government (Ashwood et al 2015).” For a thorough review of the economic case for investing in suicide prevention, see McDaid 2016. He concludes: “It will always be highly uncomfortable to think about suicide in monetary terms, but from an ethical and moral perspective, it is important to consider these issues so that the case for suicide prevention can be considered on a level playing field with other potential health promotion and injury prevention investments.”

A suicide follow-back (or ‘psychological autopsy’) study of deaths by suicide by First Nations people in the province will provide currently unavailable detailed data on risk factors, use of services by people in suicidal crisis, cohorts, developmental trajectories and so on that will be invaluable to help improve planning in the future.¹⁷

¹⁷ For a description of, and results from, the only suicide follow-back study conducted on an Indigenous population, see Chachamovich et al 2013 and 2015, and the commentary by Crawford (2015).

6. Conclusion

In this document, the Federation of Sovereign Indigenous Nations (FSIN) has made the case for a vigorous, multifaceted, culturally appropriate suicide prevention strategy to address the suicide crisis in First Nations communities in Saskatchewan. It respects and reflects the cultures and traditions of the First Nations of the province and calls for new and additional resources flowing to Tribal Councils and Independent First Nations, so they can implement their responsibilities under the strategy. It absolutely requires an unprecedented commitment and collaboration between the federal and provincial governments, and the First Nations leadership.

The statistics on the rates of death by suicide by First Nations people in the province are truly shocking. Equally shocking is the fact that government has known about these sharply elevated suicide rates for at least four decades yet has taken essentially no targeted suicide prevention measures. This failure to take appropriate measures in the face of a devastating public health crisis in First Nations communities in the province is a powerful example of systemic racism.

Without the kind of vigorous, multifaceted, and culturally appropriate suicide prevention measure spelled out in this strategy, there is no reason to believe that First Nations suicide rates will decline by themselves. In recent years they have been increasing.

The current anaemic patch work of measures undertaken by the federal and provincial governments, with jurisdictional overlaps and the bureaucratic obstacles that contribute to differential access to services by First Nations people living on and off reserve, is part of the problem – not part of the solution.

The failure of governments to meaningfully address our “largely preventable” suicide crisis is, at the end of the day, a matter of fundamental human rights and social justice. An American scholar (Button 2016) has recently made penetrating comments about suicide as a social justice issue:

To make suicide a subject of collective responsibility about which the members of a political society can and should be responsive, we should acknowledge that suicide is not simply a “naturally” occurring social bad that is randomly distributed within a population but is something for which human agency (or the lack of human agency) plays a causal role.

[Conventional approaches to suicide prevention are] a form of collective bad faith wherein we [citizens and public officials alike] presume that a collective political response to suicide as a matter of social justice is not possible because one has never been imagined or tried before. ...

the properly political question about suicide today is not only why certain identifiable groups are persistently haunted by higher rates of suicide than others, but how it is that these concentrations of suicide can coexist alongside widespread beliefs about the dignity and moral equality of all persons without raising an acute sense of existential and institutional crisis in

need of a collective political response. An organized political approach to suicide would not allow a society and its major institutions (legislative bodies, the health care industry, schools and universities, the mass media, etc.) to characterize suicide as a strictly personal or family problem because such an approach would start with the acknowledgment that suicide is also a collective burden of social justice tied to the distribution of primary goods within a political system. ...

A social justice approach to suicide prevention

[looks] at rates and distributions of completed suicides as a form of sociopolitical critique for the living, one that challenges the acceptance of what counts as normal. ...

FSIN has produced Canada’s first provincial-level, First Nations-driven suicide prevention strategy. It calls for a trauma-informed, community-focussed, decolonized, First Nations-led approach to suicide prevention, intervention and postvention.

The public health authorities have shown themselves unable to develop an evidence informed approach to suicide prevention that respects and reflects First Nations cultures and addresses the realities of our lives. We have therefore done that work ourselves, and we offer it to the federal and provincial governments.

It is imperative that the Saskatchewan First Nations Suicide Prevention Strategy be acted upon. We must improve living conditions, address the intergenerational transmission of historical trauma, reduce our elevated rates of early childhood adversity, and take a wide range of evidence-based targeted suicide prevention measures.

Full and effective implementation of this strategy is imperative. The First Nations of Saskatchewan demand that all necessary measures be taken to cut our rate of teen suicide in half in a decade, as Québec has done. This is not just a call for resources to allow the proposed Saskatchewan First Nations Suicide Prevention Secretariat to fulfill the role we have proposed for it, it is also a call for the federal and provincial governments to embrace and act on the suicide prevention vision we have articulated. As soon as humanly possibly, the suicide rates of First Nations people must be reduced to the rates of non-First Nations people in this province. It must be done because it *can* be done.

Let us not wait another day to act, for many young lives are at risk.

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Actions to be Taken Under the Saskatchewan First Nations Suicide Prevention Strategy

1 WE WILL TAKE A FOCUSED AND ACTIVE APPROACH TO SUICIDE PREVENTION

- 1.1 Seek a joint commitment by the Minister of Indigenous Services, the Premier of Saskatchewan and the Chief of the Federation of Sovereign Indigenous Nations to (A) prioritize delivery of targeted suicide prevention measures, until such time as the rate of death by suicide of Saskatchewan First Nations people has been reduced to that of non-First Nations people in the province; and, (B) fully implement the recommendations of the Truth and Reconciliation Commission (TRC) and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP).
- 1.2 Obtain commitment of government partners to intervention over the long term (i.e. not just short-term, crisis-driven interventions) due to the complexity of the issue and the need to address the underlying social determinants, including elevated rates of early childhood adversity.
- 1.3 Create a small, efficient and effective Saskatchewan First Nations Suicide Prevention Secretariat (to at least initially be located at FSIN) to (A) serve as a knowledge hub, and provide information and referrals to appropriate resources; (B) promote, coordinate, manage (when appropriate) and evaluate suicide prevention measures; (C) manage a Community Initiatives Grant Program (CIGP); (D) if/as desired by all partners, co-ordinate delivery of ASIST and other training programs; and, (E) generally seek to ensure the fullest possible implementation of the Saskatchewan First Nations Suicide Prevention Strategy (SFNSPS).
- 1.4 Seek federal and provincial funding for an initial period of one year, during which the priorities of the Saskatchewan First Nations Suicide Prevention Secretariat will be to (A) develop and cost-out an energetic five-year implementation strategy; and, (B) to launch a Community Initiatives Grant Program (CIGP), in addition to tackling selected other Action Items as time and resources permit. This must be 'new funding' that does not impact on the ability of Saskatchewan First Nations to access funding from the NAYSPS program.
- 1.5 Build intersectoral collaboration between First Nations, Tribal Councils, FSIN, all levels of government, and interagency groups to ensure full and energetic implementation of the SFNSPS.

- 1.6 Create Suicide Prevention Co-ordinator positions in the each of the Tribal Councils and Independent First Nations (in addition to the existing Mental Wellness Teams).
- 1.7 Ensure that sufficient and sustainable resources are in place so that culturally adapted suicide alertness and intervention training (ASIST and SafeTALK) can be delivered on a consistent and comprehensive basis to First Nations people across the province, with mental health supports provided as required.
- 1.8 Ensure that the 'Your Life Is Sacred' program (Health Canada 2013), developed by the Youth Solvent Addiction Committee, is delivered on a consistent and comprehensive basis to First Nations people across the province.
- 1.9 Ensure that youth and Elders are full participants in the decision-making processes regarding implementation of the SFNSPS.
- 1.10 Act in ways that are sensitive to, and respectful of, religious and spiritual difference between and within regions and communities.
- 1.11 With Elders and Knowledge Keepers, research, develop, implement and evaluate culturally responsive activities which may contribute to suicide prevention.
- 1.12 Take evidence-informed approaches to the design and delivery of 'upstream' interventions, including: family-based/parenting interventions, emotion regulation interventions, school-based training of the development of coping skills, and approaches to trauma and loss.
- 1.13 Take evidence-informed approaches to the design and delivery of selective/indicated interventions for those who self-harm or have attempted suicide, including regular follow-up with persons who have attempted suicide.
- 1.14 Implement 'means restriction' programs re: firearm storage, medicine storage, etc.
- 1.15 Develop information packages for non-Indigenous education and health workers on (A) the history and cultures of First Nations people in the province; (B) the concept of historical trauma and trauma-informed suicide prevention; and, (C) the approach and contents of the SFNSPS.
- 1.16 Develop media guidelines re: reporting on suicides, and regularly review them with media in the province.
- 1.17 Ensure that sufficient resources are provided to the Athabasca Health Region, which has the highest rate of death by suicide in the province (as well as the highest travel and living costs).

- 1.18 Urge Saskatchewan's universities and polytechnics to take suicide more seriously by (A) offering at least a 'survey' course on suicidal behaviour (especially to medical, nursing and education students); and, (B) by making Mental Health First Aid and ASIST widely and affordably available to students and staff.

2 WE WILL SUPPORT COMMUNITY-LED ACTION AND BUILD ON CULTURAL AND COMMUNITY STRENGTHS

- 2.1 Create a Community Initiatives Grant Program (CIGP) to fund local suicide prevention initiatives – Saskatchewan First Nations Suicide Prevention Secretariat to provide advice and assistance re: proposal writing and the evaluation of activities undertaken under the CIGP.
- 2.2 Conduct an inventory of all relevant programs delivered in First Nations communities, and ensure that all programs which are supposed to be delivered are actually being delivered in all communities.
- 2.3 Engage Elders and Knowledge Keepers to share oral stories about sacred teachings and life and to share protocols of process and meanings related to spiritual teachings, with goal of having this wisdom included in curricula.
- 2.4 Engage Elders and Knowledge Keepers to help develop culturally responsive curricula to reduce stigma related to suicidal behaviour.

3 WE WILL INVEST IN THE NEXT GENERATION BY TAKING ACTIONS TO SUPPORT HEALTHY EARLY CHILDHOOD DEVELOPMENT

- 3.1 Research, design, pilot and evaluate interventions designed to prevent the intergenerational transfer of historical trauma, for example early childhood home visits by trained staff (e.g. nurses) to connect with, and provide connection, support and education to expectant/new mothers.
- 3.2 Support universal programs and initiatives to heal and support parents, including reducing maternal stress, to foster optimal home environments in which children can thrive.
- 3.3 Research, design, implement and evaluate interventions to address early childhood adversity and other developmental precursors of suicide behaviour over the life course.

4 WE WILL BETTER EQUIP CHILDREN AND YOUTH WITH SKILLS TO COPE WITH ADVERSE LIFE EVENTS AND NEGATIVE EMOTIONS

- 4.1 Support children demonstrating indicators of behaviours that put them at risk, e.g. poor school attendance.
- 4.2 Provide effective school programs to foster the development of better coping strategies in young children, starting in elementary school.
- 4.3 Provide training opportunities for youth in the areas of coping skills, anger management, healthy living, suicide prevention and general health and wellness.
- 4.4 Support development of culturally responsive educational materials related to developmental milestones.
- 4.5 Provide strength-based programs to foster self-esteem and developing goals for future orientation.
- 4.6 Provide mental health programming and resources to all First Nations schools, for example curricula which teach emotion regulation.
- 4.7 Collaborate to address suicide prevention within school curricula.
- 4.8 Support the development of youth programs that are gender-sensitive, to take into consideration the different life experiences, expectations and trajectories of girls and boys.
- 4.9 Support engagement of youth through community-based arts programming, including digital storytelling.
- 4.10 Increase opportunities for youth to access Elders, Knowledge Keepers, medicine people and traditional supports from within their First Nation (or nearby).
- 4.11 Support the creation of dedicated youth centres in all First Nations communities which do not currently have one.
- 4.12 Investigate the feasibility of establishing a Child and Youth Advocacy & Protection Centre to provide 'best practice' care and services to young victims of sexual abuse.

5 WE WILL STRENGTHEN THE CONTINUUM OF CULTURALLY APPROPRIATE MENTAL HEALTH SERVICES

- 5.1 Lobby the provincial government to develop a new mental health strategy, with full engagement with First Nations organizations from the outset – up until consent is given to the final product. There should be a clearly defined evaluation framework put in place to ensure that First Nations communities are aware, at any point in time, of the degree to which the strategy has actually been implemented.
- 5.2 Ensure that First Nations communities and individuals can choose the healers they are most comfortable with and confident in – be they Elders, Social Workers, Addictions Counsellors or Mental Health Therapists – as currently NIHB and the province will only pay for services delivered by Mental Health Therapists.
- 5.3 Develop and/or culturally adapt interventions to address individual, family, and community trauma.
- 5.4 Establish a list of First Nations Mental Health Therapists.
- 5.5 Establish a full-time Mental Health Nurse position in each First Nation which does not currently have one.
- 5.6 Establish a full-time Mental Health Navigator position in each Tribal Council and Independent First Nation which does not currently have one.
- 5.7 Increase capacity of primary care and mental health providers to address suicidal behaviour.
- 5.8 Implement a system of regular follow-up and support contacts with suicide attempters, as per the World Health Organization's SUPRE-MISS program.
- 5.9 Investigate feasibility of adapting the White Mountain Apache suicide screening and prevention model to Northern Saskatchewan.
- 5.10 Improve the ability to respond quickly and effectively to suicidal behaviour by children.
- 5.11 Increase support available in high schools for youth at risk of suicide.
- 5.12 Provide greater support to communities and front-line workers in the event of a 'cluster' of suicides (several suicides in a relatively short period of time) in a community or region.
- 5.13 Ensure that Help Line services are available to all First Nations persons in the province, including online help by chat, and by responses to text messages.

- 5.14 Develop and implement best practices for monitoring and engaging with online indications of suicide risk.
- 5.15 Develop collaborations with social media (Facebook, Microsoft, Apple, etc.) for referrals and interventions with at-risk persons identified by their postings and online behaviours.
- 5.16 Develop educational resources for primary care workers, both about the history and cultures and traditions of Saskatchewan First Nations and about suicidal behaviour and suicide intervention.
- 5.17 Develop a 'community of practice' among front-line workers using Project ECHO, which links expert inter-professional teams at an academic hub with front-line workers in local communities. Front-line workers (including primary care providers), the spokes in the model, become part of a learning and support community where they receive mentoring and feedback from a team of experts.
- 5.18 Develop self-care and support resources for workers who are involved in suicide prevention activities.
- 5.19 Promote the development and implementation of actions a community can take after a suicide, to reduce the risk of contagion and to help communities heal.
- 5.20 Ensure that culturally adapted, age-appropriate grief counselling is available in all First Nations communities.

6 WE WILL STRENGTHEN THE CONTINUUM OF CARE FOR SUBSTANCE USE AND ADDICTION SERVICES

- 6.1 Seek a joint commitment by the Minister of Indigenous Services, the Premier of Saskatchewan and the Chief of the Federation of Sovereign Indigenous Nations to prioritize improving access, services and support for First Nations people with trauma and substance-related disorders.
- 6.2 Develop best practices for working with First Nations people who have dual diagnoses related to trauma and substance abuse.
- 6.3 Develop culturally appropriate resources for treatment centres which serve First Nations people in the province.

7 WE WILL DEVELOP A STRATEGY AIMED AT REDUCING OUR HIGH RATES OF VIOLENCE AND OF CHILD SEXUAL ABUSE

- 7.1 Initiate development of a strategy to reduce the high rate of violence in First Nations communities that recognizes (A) different causes and consequences for men, women and children of gender-based violence, youth violence and gang-related violence; and, (B) the impact on young children of witnessing violence between adults they love.
- 7.2 Initiate development of a strategy to (A) reduce the rate of child sexual abuse in our communities; and, (B) to establish a culturally-based Child Advocacy Centre to provide 'best practice' care and services to young victims of sexual abuse and their families.

8 WE WILL COMMUNICATE ABOUT PREVENTION AND OUR PROGRESS

- 8.1 As a matter of priority, prepare a plain-language document which provides practical information about suicide and suicide prevention to First Nations individuals, families and communities, and which presents an overview of the SFNSPS.
- 8.2 Create public awareness campaigns targeting youth on issues identified as risk factor behaviours that have an impact on the suicide rate.
- 8.3 In addition to existing educational campaigns on alcohol and drugs, create a public awareness campaign specifically on the impact of cannabis use on the still-developing adolescent brain.
- 8.4 Create a website with information on the SFNSPS, and information on available resources for First Nations, Tribal Councils, interagency groups, other stakeholder groups, and individuals.
- 8.5 Contract an independent consultant to prepare an annual report on implementation of the Saskatchewan First Nations Suicide Prevention Strategy, to be submitted for review by both the Chiefs-in-Assembly and the provincial Legislative Assembly.

9 WE WILL SUPPORT ONGOING CULTURALLY-RELEVANT RESEARCH, MONITORING AND EVALUATION

- 9.1 Obtain additional resources for the Office of the Chief Coroner, sufficient to allow for the collection and transmission of (A) data on the distribution of deaths by suicide by community; and, (B) data of substances in the body at time of death by suicide.
- 9.2 Establish a direct relationship between the Saskatchewan First Nations Suicide Prevention Secretariat and the Office of the Chief Coroner to receive 'real time' notification of deaths by suicide by First Nations people in the province.
- 9.3 Develop and implement a plan to obtain data on rates of attempted suicide by First Nations people in the province.
- 9.4 Plan and conduct research on the causes and consequences of gender-based differences in suicidal behavior.
- 9.5 Integrate a sex and gender disaggregated approach to all research conducted, in order to discern causes and consequences of gender-based differences in suicidal behavior and to develop interventions accordingly.
- 9.6 Prepare an analysis of the economic cost of current rates of suicidal behaviour by First Nations people – deaths by suicide, suicide attempts and suicidal ideation – and the savings which could be made (and reallocated elsewhere in the Health envelope) if the rates were to be reduced by 50%.
- 9.7 Conduct an omnibus Saskatchewan First Nations Youth Survey, to provide youth-specific data needed to help improve planning in the future.
- 9.8 Plan and conduct a suicide follow-back study of deaths by suicide by First Nations people in the province, to provide currently unavailable data needed to help improve planning in the future.
- 9.9 Participate in provincial, national and international research networks regarding suicide prevention among Indigenous peoples.

Appendix B

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 prevention 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 Seesequasis (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:** **DEFEATED:**



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.

**SUPPORT FOR FIRST NATION SUICIDE PREVENTION STRATEGY
REFERENCE NUMBER: 2049
PAGE TWO**

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

Appendix D

Community Engagement Results Section

1. Community Engagement Acknowledgements

Extending many, many thanks to those First Nation communities who participated in the community engagement sessions and provided the content in the following sections. The results of the engagement sessions appear in the following section from their lived experiences as shared in the sessions and shall provide options for care, treatment and support for First Nations within Saskatchewan who review the results. This section would not have been possible without the voices of those who participated and shared in the community engagements.

The First Nation communities described an urgent need within their communities for suicide prevention, substance use challenges and limitations in mental health and wellness options. Communities also expressed time and time again that the answers lay within their First Nation communities through their own people, culture and land based options. They also stated that they do not want to solely rely on outside western-based resources and outside professional people coming into their communities. As many communities reported they are left with more harm once the professionals leave their communities, after the crisis. The communities have the answers through the diverse culture and traditions, Elders/Knowledge Keepers, languages and land based options. Many First Nation communities expressed their readiness for change and developing strategies within their communities to address the crisis that are affecting and impacting their communities. Many suggest that their communities are ready and willing to develop their own interventions and desperately want to assist their community members and families to improve their quality of life. As well, First Nation community members described their need to get on the land, using natural laws and teachings and over time prove that this way of being may be looked at as their 'best practice' for suicide preventions, mental health care, treatment and support.

2. Brief Background Information

The Mental Health Technical Working Group (MHTWG) was formed in May 2017 through a motion at the Chiefs In Assembly by the Federation of Sovereign Indigenous Nations (FSIN) to support the Health and Social Development Commission by effectively implementing the motion passed on May 8th, 2017. The MHTWG is the advisory body to the Health and Social Development Commissions (HSDC) and has guided and assisted in the development of the Saskatchewan First Nation Suicide Prevention Strategy document. The MHTWG guided the consultants on aspects of the community engagement sessions that occurred with First Nations communities. One of the first tasks of the MHTWG was to draft a Terms of Reference to effectively implement the motion passed for the Saskatchewan First Nations Suicide Prevention Strategy. This was completed on May 31st, 2017. Following this, the consultants researched, identified relevant best practice suicide prevention strategies from other Indigenous populations, compiled statistical information on rates of suicide within Saskatchewan through the Coroners office and Saskatchewan Health and included case examples from First Nation people in the Discussion paper.

The Federation of Sovereign Indigenous Nations' and the Mental Health Technical Working Group released the Discussion Paper entitled *The Saskatchewan First Nation Suicide Prevention Strategy* on September 22nd, 2017. This document was sent to all First Nation communities in Saskatchewan through email and facsimile by the FSIN. The document was also available on line through the FSIN website <https://www.fsin.com/wp-content/uploads/2017/09/SK-FN-SPS-Discussion-Paper-FINAL.pdf>. At each of the community engagement sessions the Discussion Paper was provided prior to the session by email and a printed copy was provided to each participant in attendance. There were also extra copies provided to take back to their First Nation communities. The Discussion Paper included statistics on death by suicide in Saskatchewan, what we know about suicide behaviours and suicide prevention, recommendations by the World Health Organization and the United Nations and inclusion of empirically validated suicide prevention strategies that have occurred throughout North America and had an

Indigenous focus, such as the White Mountain Apache Intervention and the National Inuit Suicide Prevention Strategy (NISPS) with examples of challenges in mental health supports and service for First Nations people in Saskatchewan.

3. First Nation Community Engagement Process

In response to the suicide crisis within First Nations communities the Saskatchewan First Nations Suicide Prevention Strategy dedicated resources and time for engagement with the First Nations communities to gather lived experiences from those communities most impacted by the suicide crisis. The Federation of Sovereign Indigenous Nations (FSIN) requested that the Mental Health Technical Working Group (MHTWG) guide the community engagement process for gathering and documenting the lived experiences of the First Nations community members. The MHTWG identified community engagement as a significant next step in the process of identifying the needs within their First Nations communities following the results described in the Discussion Paper that was written by the consultants in the fall of 2017.

The MHTWG recommended that the FSIN staff and consultants coordinate community engagement sessions in the North and in the South regions of Saskatchewan. The FSIN staff members that worked along side the consultants are employed as a Special Projects Researcher Analyst and as the Mental Wellness Project Coordinator. The FSIN staff members facilitated contact with First Nation communities and organized the details for the community engagement sites. The consultants did not partake in the process of selection of the First Nations communities. Invitations to all First Nations communities occurred through emails and facsimile from the FSIN staff member employed in Special Projects and letters of invitations were distributed written by Vice Chief Heather Bear and Vice Chief David Pratt. The First Nation community engagement sessions occurred throughout the months of November 2017 to March 2018. The FSIN staff informed the consultants when and where the community engagements would take place. The Mental Wellness Coordinator compiled the notes taken during the breakout sessions as well as the anonymous written responses provided through the engagement process. The results

of the lived experiences of the First Nations communities appear in this section written by the First Nation consultant. There were also two male First Nation interns from the Mental Health and Wellness Program through the Saskatchewan Indian Institute of Technologies that were completing their internships at FSIN and they assisted in setting up the engagement session's sound equipment, co-facilitating sessions and were a part of the community engagement team for the engagement session process.

The First Nation Suicide Prevention Strategy community engagement sessions occurred over the fall of 2017 to the winter of 2018 included numerous recommendations from the First Nation communities about what they thought may work to reduce the incidents of suicidality. Many First Nation community members identified the loss of life to suicide as being a direct result of historical traumas and colonization. In Saskatchewan, especially in the North, there has been a significant rise in deaths of First Nation community members by suicide, which has warranted a state of emergency within many of those communities.

The FSIN staff and consultants collaborated to develop the community engagement session agenda, breakout group questions and anonymous sticky note response activities. The sessions started with a Knowledge Keeper/Elder from the community providing opening prayers for the day. Following this, the FSIN Staff provided opening remarks, introduced the agenda, introduction of the team members working on the SFNSPS. In some communities, leadership and staff provided opening comments. Following these remarks, the PowerPoint presentation "*Overview of the development of a Saskatchewan First Nation Suicide Prevention Strategy*" was presented, prepared by the consultants. Breakout sessions occurred in two phases throughout the morning and afternoon, where community members who participated received a number from one to four to partake in a group breakout session. The consultants numbered the participating individuals to ensure that the breakout groups were made up of members from different communities and organizations. Once individuals were in the breakout groups they were advised to select a member to take notes while in their breakout group and another member to report their findings back to the whole group when we reconvened. Once the breakout sessions were

completed each group selected a reporter to present their groups findings to the whole group at the front of the room. Following this, they provided the FSIN with their notes from their breakout sessions. The sessions were also digitally reordered by FSIN to assist in the note taking process. Morning coffee, lunch and breaks were provided by the local community organizations and often included traditional foods. Following the groups reporting back, the FSIN staff reviewed the day and reported next steps. The Knowledge Keeper/Elder provided a closing prayer/travelling prayer from the community.

Community Engagement Questions

The following nine questions developed by the FSIN staff and the consultants guided the engagement sessions for all five First Nations community locations:

- 1.) What are the mental health resources in your community to support the youth members?
- 2.) What types of actions do you feel have made a difference re: suicide prevention in your community?
- 3.) What types of actions do you feel have made a difference re: Intervention support activities?
- 4.) What types of actions do you feel have made a difference re: treatment options (Institutions, land, etc.) ?
- 5.) What type of actions do you feel have made a difference re: After Care supports: healing, cultural and clinical?
- 6.) What do you believe are the specific issues as to why young people are ending their lives?
- 7.) How does your Community encourage you to feel a sense of belonging? What activities are done with families and/or the community to support this?
- 8.) Actions you would like to see included in the Saskatchewan First Nations Suicide Preventions Strategy?
- 9.) In your community, when crisis is seen occurring, what intervention worked and what did not?

Breakout Group Questions:

Breakout group questions included the following ten questions:

- 1.) What works in your community?
- 2.) What has not worked in your community?
- 3.) What are the mental health resources in your community to support the youth/community members?
- 4.) What types of actions do you feel have made a difference re: suicide prevention in your community?
- 5.) What do you believe are the specific issues as to why young people are ending their lives?
- 6.) How does your community encourage you to feel a “sense of belonging”?
- 7.) What activities are done or have been done with families and/or the community to support this?
- 8.) What programs are in place to address the issue of bullying?
- 9.) Actions you would like to see included in the Saskatchewan First Nations Suicide Preventions Strategy?
- 10.) When communities were experiencing crisis – what worked and what did not?

Locations of the First Nation Community Engagement Sessions

The first of the five First Nation community engagement sessions occurred in Prince Albert on December 4th, 2017. The second session occurred in Meadow Lake on December 5th, 2017. The third engagement occurred in Saskatoon on December 6th, 2017. Following this was an engagement session on December 7th, 2017 in Regina and Lac La Ronge on December 12th, 2017. There were requests by First Nation communities at the MHTWG meeting on January 16th, 2018 to return to the North for another session and this final session occurred on March 15th, 2018 in Lac La Ronge. The following sections include results from the community engagement sessions from First Nation community members using qualitative analysis with theming to highlight the results of the First Nation community engagement sessions.

4. Results Section

“Teachings need to come back for a more healthier successful life.”

“Old teachings: sacredness of life.”

Culturally driven, land based, family centered and community-based approaches were identified from the First Nations who participated in the community engagement sessions as being the foundation to build the strategy from. The First Nations community members also identified recommendations that emerged through the sessions (see Section 5) and assisted in the development of the suicide prevention strategy documents with the intention to reduce the rates of suicide within the First Nation communities. The following sections describe the lived experiences of those who attended the sessions and have been integrated into some of the Actions Items listed in the SFNSPS.

Community Voices

“We need a proper environment, like youth centres that encourage this that’s inviting, warm and accepting, clean humour, how they learn, how they open up.”

Findings from the engagements identified that there were some services and programs provided within their communities at one point that were helpful. Although, many First Nation reported the programs ceased to exist often due to the end of a funding agreement(s). They reported that when a program, service or position was no longer funded that often the service or support could not operate effectively, as it was an additional responsibility for often times an over worked position. *“Government funding is cut short and services end.”* The participating community members identified some of these previous programs and services have made a difference within their communities for suicide prevention and are discouraged when the programs end due to limitations in the funding. *“Funding cut short sets us up for failure.”*

The First Nation community members identified the following resources that they currently have access to or have had within their communities to support youth members. There were ninety-five responses documented within the engagement sessions from the community members. Themes identified that worked and were helpful related to cultural

and traditional supports such as Elders/Knowledge Keepers, Natural Laws and Land Based teachings. Examples included fishing, outdoor survival, recreation, and overnight camps, for tracking, hunting and trapping. *“Traditional teachings using natural laws, traditional music to rediscover yourself and utilizing Elders PHD (Positive Holistic Developers).”*

Community members identified other supports that were helpful which included identifying specific positions that focused on mental health, such as Mental Health Therapists, Social Workers, Community Youth Workers, Youth Peers, Family Support, Wellness Workers, NNADAP Workers, Health Centre, Health Staff, Nurses, Addiction Worker, Community Health Nurse, Community Health Representative, Indian Child and Family Services and Crisis Teams.

Programs identified by the participating First Nation community members as assisting within their communities were those that offered opportunities to leave this knowledge within their communities. Some examples included providing educational and training opportunities such as Train the Trainer, where they could enhance their knowledge and education related to mental health awareness and suicide prevention. Programs that have been offered within their First Nations included Mental Health First Aide, ASIST, Safe Talk and access to Help Lines.

Potential interventions within the community for the youth included themes related to where they spent much of their day, within their school environments and after school hours. They reported that First Nation youth should be supported and engaged outside of the school hours three to four times a week to assist in building and strengthening their identities, achieving developmental milestones, such as self esteem, self worth, identity, independence, etc. The participants identified the following themes as options for support: Education Staff, Teachers, Educational Assistants, Teaching Staff, School Counselor, Boys and Girls groups, Rink Staff and recreation. *“Youth need to be validated and we need to work more with youth, meet, have sessions, build trust and provide a safe environment.”* Some First Nation community members reported that there is stigma in

regards to acknowledging the word suicide in their communities. Many First Nation community members stated, “We do not talk about suicide.”

Many of the First Nation community members identified that there continues to be a significant disparity in basic mental health care compared to other Saskatchewan residents. They recommended urgent and immediate changes, as there should not be a difference for the First Nation members to access mental health supports over other options that Saskatchewan residents may receive. Another challenge identified by numerous community members as a barrier was the approved mental health therapists coming in only on the therapist’s availability, not the communities need. They also identified limitations when calling the list and having to phone all of the therapists in their area only to find out that therapist were not taking on new clients. Also, the mental health therapists make their own schedule and hours, not based on the First Nations needs. This was identified as a significant barrier for care, treatment and supports for basic mental health needs. Another challenge identified, was First Nations communities know the people in their own communities who can provide help, yet these individuals are not available to assist, as they are not on the approved mental health list. *“There continues to be jurisdictional issues – allow First Nations to help our own people rather than outside brought in.”* The themes that emerged in this section were: challenges for Mental Health on and off reserve. Most First Nation community members identified having to travel for healthcare and mental health needs, which often results in people not accessing supports until they are in crisis. Some First Nation communities reported having to travel great distances to access mental health supports and this is not feasible when living with low income. A significant challenge identified was First Nations individuals who may have an undiagnosed mental health disorder and cannot access basic mental health care whom will be at greater risk for self-harm and possibly suicide ideation.

First Nation community members identified the lack of youth focused resources as a result of funding cuts. These included options for support and interventions to First Nation youth members. *“ We need to work more with our youth.”* Currently, many First

Nations communities reported not having: recreation workers, youth focused programs, land based options such as fishing, trapping, outdoor survival and recreation. Another challenge identified was an urgent need for Teachers and other trusted adults who can listen to the youth when they are in crisis. Another challenge that members recognized was youth or community members may not go to see qualified counselors/therapists on their own and may need a support person to assist in this, like a mental health advocate or liaison to provide this support.

Suicide Prevention Supports

The First Nation communities identified actions through the community engagements that they believe have made a difference in suicide prevention. These interventions were provided through services and programs they currently have or have had in their communities regarding suicide prevention. Through the community engagement sessions it became clear that programs and services often relied on year to year funding which frequently ended and communities were challenged in how to continue to provide these services and supports without sustainable funding. The First Nation community members identified one hundred and twelve responses to this question. These responses were themed into the following: Culture, Education, Youth Programs, Family Programs and Need for more Staff.

Culture

All First Nation community members identified cultural connections and cultural activities as options for intervention in suicide prevention. Responses from the First Nations community members included cultural activities such as: “Sweats, Round dance, cultural days, Sundance, medicine picking, cultural support, family camps, healing circles, bible camps, natural laws, values and customs, youth support worker take youth to sweats and other ceremonies, recreation activities and cultural based youth activities”. These activities were highlighted, as what the communities believe will assist in the de-colonized approach to rebuilding the cultural losses from generations of youth and families impacted by colonization.

Education

As well community members reported that interventions such as education and awareness, prevention workshops, training workshops, programs, culture, spiritual, educational and personal development would all have an influence on reducing the rates of suicide within their First Nations communities. “Awareness of the different mental health concerns, more knowledge is needed – who, what, where, when and how?” Community members identified requiring more opportunities to gain education and awareness from workshops, to suicide information packages and on going educational opportunities. There were recommendations that interventions include opportunities for personal development, as this has a great impact on building up a persons self esteem and self worth. Some communities stated that many of their members do not know the history of colonization and are unsure of the impacts, as this is not talked about openly. There is also a great need for gaining a better understanding of trauma and the impacts of historical trauma. They recommended presentations and workshops about Indian residential schools, impacts of colonization and the resulting trauma.

Youth Programs

All five of the locations of First Nations communities who participated in the engagements sessions identified youth programs as being the first significant step in building a strong foundation of support. Many identified that youth programs have the potential to thrive with peers supporting peers, which may have the potential to reduce the suicide rates within the First Nation communities. The First Nation community members suggested intervention and prevention options such as having access to their own local First Nation youth supports, peer to peer supports, young adult mentors as supports and encouraging these healthy relationships would assist in building capacity and strengths within their own communities. They also identified having options for mentorship from healthy adults within their communities, such as Knowledge Keepers and Elders would enhance the strengths that their communities have from within. As well, having options for programs for youth being accessible to the youth and driven by the youth. For educational purposes for prevention and intervention community members

identified youth conferences as a way to build capacity within their communities with the youth. One on one and group counseling within the school is needed and comments were made about these supports being available after school hours in efforts to enhance the supports for youth outside of school hours. Other youth programs recommended by community members were: youth action council, safe grad walk, access to sports, cultural-based youth focused programs, after hours programs, train the youth, train the trainer/peers and school workshops. As well, First Nations community members identified the urgent need for education, awareness and intervention for bullying and cyber bullying.

Family Programs

First Nation community members identified a need for family oriented programming to combat the impacts of historical trauma and colonization. These programs include varying levels of family supports, access to traditional parenting, develop and implement programming for educating parents about how to identify red flags in their children and risks for self harming behaviours. The community members suggested integrating traditional land based programs that encourage positive emotional growth, health, and wellness. Some examples of land-based programs include Mother/Daughter Father/Son camps in ways that will bring families together that encourage developmental milestones, building self-esteem and growth. Community members reported that there is a significant need for community involvement, discussions, circles, communication and building trust to enhance their mental wellness within their communities. Most importantly, there is significant gap in after care support following crisis and when the crisis teams leave the community, they are left with a sense of loss. Sadly, some communities reported further feelings of abandonment and loss. After care supports are required within the communities to assist the families when there has been a mental health crisis to cope and adapt with the trauma from the crisis and better equip the communities for when the crisis teams leave.

Youth Programs

First Nation community members identified that youth programs are needed within their communities for suicide prevention. They reported requiring youth specific positions in their communities for full time youth workers, for one on one counseling as well as a good grief camp for youth. Some examples of programs that have been offered within their communities included the following: Hot Program, CISM, ASIST, SafeTalk and Grief Programs. The call for crisis support in some of the northern communities “brought out more supports, especially in the schools.” “The fact that it happened, wake up call.” “Listen to the youth, talk to youth and plan events that include them in all aspects”. Most importantly, the majority of participants identified that youth have the potential to engage in positive ways when provide with culturally relevant supports such as: connections with Elders to youth, and with Elders speaking with the youth.

Need for more Staff

First Nation community members identified that there are significant gaps in dedicated supports for suicide prevention within their communities. They expressed a great need for more staff in all areas related to mental health and wellness of the First Nations communities. They reported that one way to assist in building supports for suicide prevention within their communities is to educate and empower with tools and strategies for all staff living on the First Nation. They suggested by providing education to improve the quality of life within their communities included interventions from leadership and potentially all staff members. Providing a safe space with the intention to listen to youth and their needs as they are made up of diverse youth from every community. Pay close attention to the community members who have lived experiences of mental health challenges, as they are the most knowledgeable about potential supports needed. Have a collective response of community voices to the suicide crisis within their First Nations.

All communities identified that they do not have the number of staff needed within their communities for front line supports and services for mental health. They urgently require more staff that are dedicated to mental health such as therapists and psychologists. They indicated requiring additional supports for mental health providers, as there have been

instances of unqualified individuals coming into their communities and those do not have the dedication needed to provide services. They highlighted to prioritize their needs for hiring qualified, caring compassionate people, as there have been many examples of individuals “not keeping up with the changes and complacency at job so long just doing it.” Need more success for staff to provide prevention training and options for counselor interventions. There is a significant need for supporting community members and “that “I am going to find a therapist, mental health assessment.” Overall, the message of unconditional support kept emerging from the communities and some examples included “to assure the person(s) that need support and reach out.” And most importantly to “Be there for them!”

In many of the engagement sessions the community members identified having access for suicide prevention, support, intervention and guidance from their local Elders and Knowledge Keepers. They reported one of the challenges for providing this, as an option for services within their communities was Elders not receiving any payment or even an appropriate payment for cultural and traditional knowledge’s. They want to acknowledge the Elders and Knowledge Keepers for their teachings and support them financially by paying them for their sharing of knowledge, teachings, support and services. This theme was highlighted in many of the communities where it was stated that if they are not on the approved mental health list they could not be compensated at all and often since there was not a budget for this support, they receive low rates of pay. Examples included, “payments for services of Elders be at an appropriate pay rate.” The community members identified having access for mental health and suicide prevention options that include culturally responsive care, treatment and support through Elders and Knowledge Keepers. They requested mental health supports to include the following: “Elders sharing knowledge, Connections with Elders to youth, Community involvement, Elders speaking with the youth and Elder language teaching.”

First Nation community members identified in the community engagements sessions that not all communities are prepared to engage and talk about suicide. There were many members who stated, “be careful where you discuss suicide”. Many First Nations

communities throughout the engagement sessions reported that there are natural laws and teachings passed on through generations, which caution using the term suicide, and also about attending sessions or presentations about suicide. Other concerns were not everyone who is in the helping profession are well suited to these positions and this may result in emotional impacts on their community members. For example, “attitudes and approaches used make a difference in how programs and services are delivered.” Also, workshops and activities for building capacity, relationship building and communication between front line workers and community members would be a helpful addition in the strategy. Communities suggested ceremony as a process of developing a foundation of prevention of suicide by building on their strengths related to natural laws, culture and traditional teachings. For example, “*school ceremony, feast at they start of school, Elder involvement, Elders going to school to talk to youth and cultural camps.*” First Nation community members suggested that encouraging engagement of the youth to access supports within their own communities such as Elders and Knowledge Keepers. Community members highlighted to focus on what works within their communities and move away from what does not work approach. Using the strengths within their communities and leave behind the deficit focus, which emerged through the impacts of colonization. The answers lay within the communities and they know what is best for them, not from the outsiders coming in with preconceived notions about what should work. Most importantly, the First Nations expressed an overwhelming need to build their own capacity from within based on the natural laws and teachings. “*Community based and own plans, listen to the youth, love them.*”

Intervention Supports and Activities

“More awareness is needed! More presentations provided free or low cost.”

“Provide opportunities to engage with one another in the community.”

“Celebrate Successes”

Throughout the engagement sessions community members reported actions that they felt have made a difference in suicide intervention that they have currently within their

communities or have had in their First Nation communities. Again it was identified that programs and services often end due to lack of sustainable funding. Although, many communities stated that they try to sustain the programs and services that are cut which often lead to staff burnout, as they end up doing more in their jobs because of the cuts. Some communities mentioned that one person may take on the responsibilities of two, three or more jobs to try and continue to provide the care, treatment and supports when cuts occur. The First Nation community members identified eighty-eight responses to this question about interventions, supports and activities through the community engagement. These responses were themed into the following: Land Based Teachings and Traditional Knowledge, Education and Training, Family Supports, Youth Focused Interventions, Other options for Interventions and Need for more staff.

Land Based Teachings and Traditional Knowledge

First Nation community members identified that Traditional Knowledge was important for suicide prevention and interventions. They reported that there is a great need for community members to develop ways to improve their mental health and wellness by infusing it with Traditional Knowledge. One such intervention would be options for communities to infuse the process of intervention with options for Land Based teachings. *“Connect with identity and language and spirituality.”* As well as enhancing the community members knowledge of culture by providing programs and supports that integrate this such as, “traditional teachings, drumming, singing, dancing, music, feasts and cultural activities.” The First Nations communities stated that land based options for mental wellness would enhance their quality of life in ways that connect them to their diverse cultural teachings. Examples included “Land based healing such as sweats, ceremonies and healing circles.” As well they reported strengths based supports that are inclusive of Land Based Teaching and Traditional Knowledge would have a great impact on the suicide and mental health crisis. They reported providing these options has been effective in building on their strengths. They requested options for “Land Based teachings such as fishing, hunting, camping and trapping.” These Land Based teachings and activities have many benefits of learning, connecting and building capacity in regards to Traditional Knowledge. Most importantly, they reported having the strategy highlight the

importance of access to Elders and Knowledge Keepers as they are the strength of the communities and this is greatly needed in the suicide crisis. They suggested having options for the communities to access Elders and Knowledge Keepers as intervention and support where they can plant the seeds of knowledge within their youth and community members. “Elders’ supports through sharing teachings, talking circles, humour, helping and getting involved.”

Education and training

First Nation community members identified that they are in urgent need of options for education and training for intervention for mental health and suicide. Dedicated opportunities for communities to receive educational materials, workshops and training will encourage capacity building within their communities for knowledge about mental health, suicide and mental wellness. There was a significant gap identified for culturally responsive educational materials for suicide prevention and mental health. Communities suggested student and youth led workshops where the youth could develop culturally responsive materials for their peers based on their own strengths within their First Nation communities. Examples of educational and training activities that they would like more of within their communities were “health promotion events, health fairs, student workshops, health topics, suicide intervention, prevention, awareness, education and information supports.” As many communities identified that secrets and shame are often part of the historical trauma imprinted for generations and reasons for stigma and misconceptions about mental health and suicide. They stressed the need for building capacity from within their own communities by developing culturally responsive educational opportunities and training. As all agreed that education and training would provide a foundation to build up their knowledge base and build their own capacity from within.

First Nation community members highlighted training as process of building capacity from within. Especially when provided with options for obtaining skills and knowledge from train the trainer workshops. The communities stated they wanted more training where the knowledge is left within the First Nation communities and for them to share it.

As well as having training occur with certification and to follow best practices. Examples included “Training with proper certification, ASIST, Safe Talk, CISM, and Mental Health First Aide.” The community members again requested that they be empowered through training and workshops to enhance their own community’s abilities to provide care, treatment and support in crisis. For example, “Train everyone in the communities.” They also identified opportunities for gaining a better understanding through training would enhance their abilities to possibly reduce the tragic rates of suicide within their communities. They requested culturally responsive care treatment and supports that include “Training, workshops and education for cultural and spiritual.” Strengthening capacity by building healthy relationships and healthy boundaries through training and workshops with all members from youth to old people. They stated, “need for more real communication between age groups.” Most importantly, to reduce incidents of transference and burn out amongst staff to provide opportunities for “personal and professional development training.” The First Nation communities expressed great need within their communities and their hope is to ensure that there are more opportunities to build up the knowledge related to suicide intervention and mental health.

Family Supports

The First Nations community members highlighted the need for family supports for interventions. It has been documented that childhood adverse events result in childhood adverse conditions and may impact an individual throughout their lifetime. Family supports were identified as a need for building capacity within their communities by providing support to the families, rather than the previous historical challenges, of apprehending the children. The communities stated having access to supports for improving conditions in the families by providing options for “home visit supports, parental guidance programs, involve families and parents, traditional parenting, connect with families as a whole, parenting, family retreats and sharing circles. “ Impacts of colonization has taken a toll on families and it has resulted in generations of families that are limited in their parenting skills. Recently, there have been programs developed by First Nation people to assist in re-introducing the traditional parenting roles and responsibilities that are culturally responsive. These family parenting programs should be a support within every First Nation

community and developed, adapted to their own diverse communities and provided as a priority through this strategy.

Youth Focused Interventions

First Nations communities have always stated that the “youth are our future leaders.” First Nations communities also have had many generations that have lived through diverse challenges as youth themselves. At the present time, many youth in First Nations communities are struggling emotionally and mentally. The First Nations community members recommended providing intervention programs that engage the youth and build capacity. Examples included “youth groups, youth support groups, access to sports, exercise, youth centre, fitness centre and team based approaches such as soccer, basketball, volleyball, hockey and baseball.” It has been well documented that for children who play sports have a better chance of coping with the emotional changes throughout developmental milestones from children, adolescence to adulthood. There were recommendations to have opportunities for youth to have access to interventions that build their capacity through “community activities, high school student peer support groups (i.e. SRC), school presentations and to engage and involve youth in committees” such as “Big Brother/Big Sister awareness and mentoring Programs.” Most importantly, the community members stated that they would like to see the youth in every First Nation become advocates for the future by engaging in youth leadership groups. For example “youth empowerment strategies, suggestions to start a climate change Guardian project for youth and Elders mentorship.” This would enhance the knowledge base and build relationships between youth and the Elder/Old people, as there are very few organized opportunities to do so.

Other Options for interventions

The First Nation community members identified that youth of today have been born with digital technology and this is a viable option to develop a strength-based approach to enhancing their First Nations community’s knowledge. Recently, Kawacatoose First Nation wrote a song, recorded and filmed it within Asiniw-Kisik Educaiton Comlex, the digital song is called Many Paths (<https://youtu.be/Qpbw6UvB21U> (March, 2018)). The

First Nations community members identified that there are many ways that their youth may be able to access that are strengths based. They suggested “use technology, multimedia designed programs by youth for youth, text apps, inbox message, social media such as a Facebook page being friendly, positive, encouraging, etc.” Other options for interventions included “Art therapy, coping skills and express themselves through art-based activities.” Again, First Nations communities expressed concern for the historical issues of children being removed from the parents and communities care. They stated “reduce apprehensions from Child and Family Services and if apprehension is required find safe homes.” Most importantly, “talk about suicide in a trustful way!”

Need for more staff

There continued to be a theme for the need of more staff dedicated to mental health and suicide prevention that emerged for the majority of the questions that were asked at the engagement sessions. Historically, there was greater access to having a dedicated position for a First Nations staff member through the National Native Alcohol and Drug Abuse Program (NNAPAD). Although over the past decade, these positions have been reduced and many do not have a dedicated position. Though, many of those positions were transferred over to mental wellness staff positions, addiction workers, mental wellness teams and dedicated crisis teams. These staff members have the capacity to provide dedicated support, care and treatment and there are many more of these positions required. The First Nations community members suggested increasing and improving the numbers of staff members within their communities dedicated to mental health and suicide prevention. For example “*The NNADAP program, have a NNADAP worker in every community.*” Other needs that they requested for more staff included having more dedicated to prevention and crisis positions for “*Crisis response team, Mental Health Therapists, Health wellness team.*” Most importantly, they identified having options for qualified, trained and reliable workers in order to provide intervention and prevention supports rather than after the crisis, to be proactive. Specifically, they stated having “*support workers with professional training for them and require them to be proactive.*”

Some suggestions made from the First Nations communities included reducing the stigma, shame and misinformation related to mental health and suicide. *“Talking out, being open about teachings and consequences of what happens to families when a situation such as this (suicide) happen in a community.”* As well as a community members suggested providing strength-based supports by *“sharing to the youth that you are there for them and available whenever they need someone to talk to.”* Another suggested that a program be developed with options for an intervention that has potential to build trust and healthy relationships within their communities such as *“Check in programs with individuals who may be in danger of self-hurt.”* This has been proven to be effective in regards to enhancing quality of life and life promotion programs.

Communities Identified Treatment Option Examples

First Nation community members provided suggestions about future treatment option examples that they would like to have within their communities. Many First Nation community members described options that they felt might have potential to make a difference within their communities for suicide treatment and intervention. These include examples from treatment options they currently have or previously had. Again, the First Nations communities identified lack of sustainable funding for treatment options, which in turn impacts their abilities to provide best practice and treatment. In some cases, where there are wait lists for access to mental health interventions and treatment centres many of their community members do not receive the much needed care, treatment and support that they deserve. The First Nation community members identified eighty-three responses to this question about treatment option examples through the community engagement. These responses were themed into the following: Land Based Teachings and Traditional Knowledge, Programs, Education, Community Treatment Options and Need for more staff.

Land Based Teachings

The majority of First Nations community members identified through the engagement sessions that youth and community members would benefit from options such as Land

Based Teaching and Land Based Treatment. These recommendations from the First Nation communities encourage building strengths within an individual as well as having great benefits to the community. They stated, *“having access to ceremonies and teachings, strong support system, listening to youth needs, following through and on going care.”* Other suggestions were specific to their First Nation and highlight the culturally responsive care, treatment and support that they are requesting for inclusion in the strategy. Examples include *“land based teachings, year rounds, seasonal, taking traditional medicines and learning from that/those experiences.”* They reported having options to use the land and their Knowledge Keepers for teaching the community members and especially the youth this knowledge. Have options for treatment include *“on the land family healing activities and treatment on the land. Land based activities involving Elders about culture. Teaching youth about the land, hunting, fishing, surviving, etc. Cultural programs for individuals and families, cultural camps, medicine wheel teachings, self identity, healing on the land, sweats, talking circles, a holistic approach to self care/healing mental, spiritual, physical and emotional.”* Most importantly they identified having trauma informed wrap around care, treatment and support to encourage long term healing, such as *“Hub wrap around.”* Land based teachings and knowledge hold many benefits to the communities and it is a option for best practice for re-introducing the traditional knowledge’s that have been impacted by the Indian residential schools and impacts of colonization. Community members want access and support for Land-Based options, such as *“Medicine practice with Elders and parents.”* This would provide culturally responsive care, treatment and support that the First Nation communities have identified as their best practice in suicide prevention.

Traditional Knowledge

First Nation community members identified that there are numerous benefits to health and wellness when their communities can access their Traditional Knowledge. A limitation reported by communities in providing these options for Traditional Knowledge is aging. It is well known that as the Elders/Old people age the First Nation’s may loose this important knowledge if it has not been passed on to someone within their community. More importantly when they pass away so may their teachings. It is urgent

that the traditional knowledge and teachings be provided as a process to revitalize the traditional knowledge within the First Nations communities. They stated, “*Very few cultural and spiritual based programs, we need more. Youth being taught to be the healers and going on the land. Elders teachings from specialized locations and specific teachings in communities with Elders*” Community members expressed urgency for having options that include Traditional Knowledge, as if this were integrated into programs and services within the community, many benefits could result. Examples included “*Intervention circles on the reserve, Traditional ceremonies and oskâpêwis (Elders Helper). Traditional songs, powwow dancing, spiritual naming and stories.*”

Programs

Community members identified through the community engagement session that there is an urgent need for culturally responsive and culturally appropriate options for programs related to treatment. In the southern part of Saskatchewan, there are currently very limited options for treatment centres available that include options for culture. Currently, there are three treatment centres within Sk that have included some cultural options. Although, there are significant wait lists for these spaces. Travelling was also listed as a challenge; especially for those who want to attend treatment and have little to no income and they have to find ways to travel there. Community members in the south identified that their band members have to travel to northern cities to access treatment for substance use. As well, in the North, their community members are required to travel down south. As substance use disorders are often a direct result of historical trauma, there is a significant need for treatment centres located on First Nations with a focus on providing culturally responsive long-term support and treatment for First Nation community members. They identified having options such as a “*treatment centre on their First Nations and providing their own treatment in community level.*” They further identified having options for integrating best practices with land based options for treatment. For example providing options for “*Alcohol Treatment Centres and Family Treatment Centres with Holistic long-term addictions treatment (up to 2 years) using therapeutic community model of care.*” Another gap reported for treatment was very limited options for people with disabilities, as there are very few centres available for physical disabilities and cognitive

disabilities for treatment. For example “*centres for people with disabilities, wellness centre, residential support facility and other options for therapy besides talk therapy.*”

Education

First Nations communities suggest that not all of their membership know about the impacts of colonization and more importantly the direct impacts of historical trauma. For some community members, they stated that they learned this information as adults about Indian Residential schools and colonization. They report wanting to be taught this earlier in life through education opportunities and gain knowledge to assist with healthier coping strategies and dealing with the impacts of colonization. Many of these adults reported accessing substances to avoid the emotional trauma from the impacts of colonization and historical trauma. They requested “teaching about colonization, self-governance, community planning and teaching connection to land.” This process of education has the potential to provide knowledge to reduce the lack of information about historical trauma and colonization. As well, there is great need for efforts for education about stigma, shame, misinformation about mental health and suicide. As First Nations communities are smaller in size, it is often more difficult for access to anonymous care and this causes people to access services outside of their home community which may result in potential stigmatization effects in social situations.

Community Treatment Options

Community members reported that they would like to have options for treatment include holistic focus in life promotion and validating the experts from within their communities. Responses included treatment as being community driven and guided by ceremonies. Community gatherings being inclusive of culturally responsive support and adapted to use with the diverse First Nation communities throughout Saskatchewan. Some options suggested were talking/sharing circles, ceremonies, traditional medicines, Elders, Knowledge Keepers and traditional supports. There should also be accessible treatment centres that focus on families and include ceremonial spaces designed that are inclusive of traditional healing practices and medicines, as well as inclusive of traditional foods with teachings about gardening and connections to the land. Elder supports should be a

community treatment option as a first response to care, treatment and support of First Nation community members.

Need for More Staff

There continued to be a theme for need of more funding for more staff that emerged for treatment options by the First Nations community members at the engagement sessions. They requested a policy and process for providing each and every community with access to funding to enhance their number of staff positions dedicated to providing mental health and wellness on their First Nation. If staff members and resources increases this may have a positive influence on reducing the rates of suicide attempts, more staff for focusing on improving mental health and wellness. As well as requiring more staff for providing interventions for substance use disorders. They suggested having access to more staff for numerous health care areas, such as *“Elders, mental health therapists, have access to a wet house, detox programs, addiction programs, family addiction counseling, hospital liaison and school liaison.”*

Some suggestions were made from the First Nations communities about options for addressing the suicide challenges in their communities from previous reports that were completed. They indicated that the SFNSPS would benefit from previous historical reports that included recommendations for the need of preventative measures made by the Aboriginal Justice Implementation Commission Report in that it mandated healing in ceremony from historical traumas (1991). As well as the original report on the Culturally Responsive Health Care: A Literature Review and Environmental Scan (2012) where culture was identified as an intervention. *“Culture is good medicine.”* A report from FSIN in 2012 stated that *“the response flowing from many of these reports was a call for health care providers and the system to collaborate with Indigenous communities to design services and become more sensitive to Native Canadian culture and communication behaviours as a means of reducing the gap in health status and improving care standards.”* A community member stated *“ceremony as an option for healing, as well as healing lodges.”* Another suggested *“Opening one’s self to any treatment or help whether they are white or First Nations.”* They expressed a need for more cultural and spiritual based

programs “*not many available, need more of both cultural and spiritual based programs.*”

After Care Supports

First Nation community members provided suggestions about potential after care supports that they would like made available within their First Nation communities. Some members stated, “*There is very little after care supports and more prevention programs are needed.*” As well, the First Nations community members identified that it is up to the individual when they attend treatment to continue on their path for recovery, as there is often little to no follow up after treatment. This is unacceptable, after care supports have been proven as a best practice for reducing relapse and prevention. Most importantly, “*have supports remain in place until the youth feels safe to try to live life on their own. We all rush to the hospital then when they get home, we leave. No more of this!*” The following section includes themes developed from the eighty-nine responses that the First Nation communities would like to have in their communities. These responses were themed into the following: Land based, Traditional Knowledge, Education, After Care, Self Care, and Need for More Staff.

Land Based

After care supports suggested by the First Nation community members included options for Land Based therapies, Land Based teachings as well as using ceremonies for healing. They suggested that through their experiences they would like to use Traditional Land Based teachings as options for mental health, suicide prevention and crisis interventions. They reported not all community members feel comfortable with accessing therapist and psychologists and by having an option for Land Based interventions in tandem with appointments to see psychologists for mental health challenges may benefit the overall intervention process. They stated, “*use traditional healings and not only psychologists.*” As well, the community members continued to request Land Based family options for care, treatment and support. They suggested having options made available for “*Family camps and family counseling.*”

Traditional Knowledge

Over the course of the community engagements, community members continued to highlight a need for traditional knowledge to assist in providing after care supports. There is a significant need for these teachings to be offered within their communities, as there is potential after care supports should develop programs around using traditional knowledge. The community members requested options for after care that includes “*cultural teachings, invitations to attend ceremonies, talking circles, cultural training, cultural camps, Sweatlodge and Sundance.*” Another significant need is to utilize their diverse language and re-introduce language into their First Nation communities that do not use their language presently because of the impacts of colonization. The community members suggested language as a way to rebuild their communities using traditional knowledge to “*train our First Nation people to regain their language.*” Other after care options were suggested that include traditional knowledge, besides the “go to” for the mental health therapist that provide talk therapy. Examples included using other means to provide interventions including traditional knowledge such as “*arts, music, dance and purposeful entertainment.*” Passing down the old ways and stories was identified as a process of bonding and rejuvenation of traditional knowledge.

Education

In most aspects of providing care, treatment and support for individuals struggling with mental health challenges, is the concept of psycho-education and talk therapy. Through these western identified best practices, individuals may change their thoughts by accessing positive thoughts over the automatic negative thoughts, changing their perspectives through educational activities and interventions. First Nation community members identified that they would like to have more options for education related to after care. Examples included education about how to build trust “*trusting relationships education and options for building trust workshops.*” One of the themes that continued to emerge throughout the sessions was lack of identity that many children, adolescents and adults have. They suggested having educational workshops and training that would enhance knowledge such as “*training for adults and youth to have identity, finding*

purpose, personal development, strength driven, mentorship, family education and communication strategies.” Many First Nations identified that they lack the finances in their overall budgets that prevent them from providing best practice and reported they need more financial support to employ more staff within their First Nation communities for *“jobs and education options.”* On Reserve and urban members are limited in their knowledge about systemic racism and colonization, efforts need to be made to educate all First Nation people to ensure that they know about the historical impacts that being First Nations has, such as the impacts of not knowing *“why we are the way we are”*. They suggested providing insight into the institutional impacts related to generations of families who have had to attend the Indian residential schools, the sixties scoop and the apprehension of children. They requested options for educational session to include, *“Urban and First Nation members require more support and information about systemic racism.”*

After Care

Research suggests that after care is a part of western best practice in treatment for substance use, mental health challenges and attempts of suicide. Although, after care is often missed due to the cost related to follow up and after care for First Nation people who return to their communities after treatment or intervention. If it is done, it is an afterthought. Community members reported many instances of after care not occurring with their community members and stated *“people end up falling between the cracks, relapsing or self-harming.”* They requested urgent needs for options for after care in hopes to prevent future mental health impacts, substance use relapses or even loss of lives. They stated requiring treatment programs and after care services as a part of the process to ensure after care occurs that will assist in providing follow up care, treatment and support, such as: *“follow up, home visits, support groups, after care supports and community support groups.”* After care was also identified as needing *“cultural integration”* options, based on the land and with Knowledge Keepers.

Self Care

The First Nation community members identified that self-care often does not occur, especially when they are the ones providing the front line support and services. They recommended providing education, activities and opportunities for self care as an after care requirements for enhancing their overall health as First Nations staff and communities. They suggested options for after care include enhancing their knowledge about self-care, self-esteem, self-worth and group wellness activities. Building healthy teams and healthy families by highlighting the importance of self-care, which would also benefit their overall quality of life. They requested supports such as *“inner healing teachings, promote self care and consistency, youth wellness and group wellness.”*

Need for More Staff

There continued to be a theme for need of more staff that emerged from the engagements for after care options by the First Nations community members. They requested need for more staff such as *“suicide support workers, on call people available on weekends, Healthy Elders, family supports, 24 hour support lines all needed for all communities with options for Elders and Family supports, therapists available 24/7, youth workers, NNDAP workers, Hospital Liaison Worker, School Liaison workers and access to Rape/Date Crisis line.”* In regards to more staff in the area of mental health and mental wellness staff positions requested included *“Elders, counselors, mentorship, peer parenting, mental health therapists for youth and adults and Elder mentorship program.”* The following were identified as options for after care that a few Northern communities have access to and have provided supports *“the La Ronge Medical Clinic, Women’s Centre Piwapan and JRMCC brings people together.”*

Sense of Belonging

Community members provided examples of activities that encourage a sense of belonging with their families or communities throughout the community engagement sessions. For developing and maintaining an individuals well being we need to pursue activities that give us purpose or meaning and that engage aspects of ourselves holistically: physically, mentally, emotionally and spiritually. Some First Nations communities reported, *“This is*

non-existent in my community!” Some mentioned discourse within their communities due to community divisions related to politics, family relationships and lateral violence/bullying. Other suggested “*no more community separations and honour our traditional ways.*” Building and maintaining a strong community foundation and sense of belonging included risks related to potential burnout for leadership, staff and community members. For example, “*leaders need to support, always the same ones supporting which results in burnout.*” Strength based supports for building and developing a sense of belonging included “*Hearing you’re from this beautiful community to be provided with love from one another and loving yourself.*” First Nations communities identified one hundred and eleven responses about encouraging, developing and having a sense of belonging. These responses were themed into the following: Land Based, Strength Based Approaches, Supports, Education, Therapy and Interventions.

Land Based

In order to provide healthy opportunities to enhance quality of life and build strength-based approaches for a sense of belonging First Nation community members included recommendations for options of land-based therapies. These Land Based teachings can have a direct impact and positive influence while using ceremonies for healing when developing identities, building up individuals strengths, self esteem and self worth. Examples from the First Nations communities included “*Land based activities, Elders sweats, traditional ceremonies, cultural camps, cultural days, summer/winter camps, fish derby’s, traditions, language, stories, spirit, medicine wheel teachings, holistic health, Round dances, sewing classes, beading classes, tipi set up, storytelling, smudging, healing, sharing medicines, basket making, honor our traditional ways, powwows, Cultural gatherings at the urban reserve more than once a year. Feast for the four seasons occurs at their school.*” Land Based options have emerged in the mainstream recently in academic settings, as well as within treatment centres. First Nation communities recently have developed and use Land Based interventions for substance use programs and mental health interventions as options for healing within First Nation communities. Some of these options will soon be recognized as a best practice for working with First Nation communities once the results are evaluated and published.

Strength Based Approaches

Many First Nation community members requested strength based approaches and therapies to engage with communities. This approach aligns well with the culturally responsive framework where it was identified to access the strengths from within the First Nation communities (FSIN, 2012). Culturally Responsive health care was identified as a First Nation best practice approach for care, treatment and support for First Nation communities by the Elders and Knowledge Keepers within Saskatchewan. In the past, often there was shame-based approaches used such as in the residential school, foster care and sixties scoop experiences. This ultimately has had great negative impacts on individuals' self-worth, self-esteem and identities within First Nations communities lasting for generations. Historically, First Nation people have carried negative experiences that include fear, shame that resulted from historical trauma. Currently, there is much work to be done to re-direct the shame and focus on strengths in the individual and the community. The communities suggested that through their experiences they would like to see their members have options for *“equality for all, healthy leaders, empowerment by having input on planning and most importantly mentoring and not blaming.”*

Supports

First Nation community members identified that there are limitations financially as well as limitations in coordinating events within their communities for supports and healthy gatherings. They suggested that there is a great need for more community building and capacity building as a way to continue to build a foundation for healthier communities. They recommended having options for directed activities within the suicide prevention strategy that encourage building self esteem, bonding activities and developing trust from within their communities, They suggested options that they would like to have access to for supports such as *“community gatherings and events, free activities, transportation, invite everyone by invitation, suppers, games nights, church suppers, healthy family activities, community recognition awards, encourage happiness, strength based supports,*

phone calls, home visits, posters, bingo, workshops, healthy activities Job opportunities Recreational programs, sports, keeping active, summer games and winter games.”

Education

First Nation community members identified that education opportunities would strengthen communities, encourage building knowledge and further developing a sense of belonging. Examples of educational and training activities that they would like more of with in their communities for developing a sense of belonging were *“Teaching about identity and roles, rights of passage, coming of age, father, son, mother daughter teachings, engage teaching from Elders with parents and from Elders with children.”* The First Nations community members also suggested that they would benefit from having opportunities to further enhance their knowledge for suicide prevention and mental health by *“having conferences, workshops and invitations to youth conferences.”*

Therapy and Interventions

Many of the First Nation community members identified that there continues to be a significant gap in basic mental health care compared to other Saskatchewan residents. They recommended urgent and immediate changes, as there should be options for access to therapy within their First Nations, options for mental health care and interventions. They suggested options for providing intervention and supports for developing a sense of belonging, re-introducing traditional parenting, coming of age, roles within families, mentoring, healthy relationships, etc. Suggestions include *“One on one counseling, parenting programs, attend parent meetings at the schools, school festivals and games brought into the community. Sober living and sober community events, AA, NA, very few options for non-drinkers.”*

First Nations communities identified examples of specific issues related to the suicide crisis

Community members were asked to provide examples of what they believed are the specific issues related to why young people within their First Nations communities may

be ending their lives. Some communities identified the clear link between the risk of suicide in their communities by the historical trauma and impacts from this. *“Families did not show feelings and were not affectionate due to the intergenerational trauma.”* Another example was *“lack of understanding roles and responsibilities in the home.”* Intergenerational impacts such as, *“Kids don’t have a reference point for feeling good.”* Other significant examples were *“Parents not liking themselves take things out on their kids.”* Gender was identified as having a potential factor. For example *“Males have too much pride too cool to go for help.”* Community members stated that the lack of emotional growth has been passed on for generations. Some community members were very animated with care and worry for their communities; they felt an urgent need for focus on the youth. They stated, *“Pay attention! ‘Listen!’ youth are crying for help!”* Numerous examples were shared about the significant impacts of poverty and intolerable living conditions. Statements were expressed such as *“Living in 3rd world conditions, no hope for the future, need opportunity!”* Some community members were concerned about individuals having nothing to do within their communities as a cause for concerns *“boredom creates a lot of time to think!”* This section includes one hundred and eleven responses from the First Nations communities throughout the community engagement sessions. These responses were themed into the following: Impacts and Effects of Colonization, Mental Health Challenges, Limited parenting skills, Limited coping skills, Self Esteem and Crisis.

Impacts and Effects of Colonization

First Nation community members identified that there continues to be significant mental health impacts that their community members experience due to colonization and historical trauma. Numerous examples included responses where they reported First Nation communities were forced to internalize the trauma, advised not to express or show emotion and not to trust people in power positions. They identified examples that included impacts on individual’s development milestones that were often stunted in growth due to the dysfunctional environments that they were exposed directly related to the impacts of colonization. Communities shared examples of what they would like to see included in the SFSPS as a priority. They included suggestions that would directly

improve their quality of life, to remove the historical shame and fear and embrace the ways of knowing from within their own First Nation communities. Provide options in care, treatment and support services that are inclusive of education about decolonization. For example, *“intergenerational trauma, residential schools, racism, lack of identity and Culture, Lack of cultural and spiritual identity, Belonging, identity loss, feel that they have no purpose, trauma, physical, sexual, emotional abuse, abuses, abandonment.”* Further impacts of colonization are the impacts of poverty and economic challenges as a direct impact of colonization. First Nation community identified not having enough personal space due to overcrowding, which may develop into substance use and mental health problems and impact quality of life. They stated, *“Poverty, not enough homes, overcrowding, economic control and joblessness.”*

Mental Health Challenges

Community members were asked to provide examples of what they believed are the specific issues related to why young people within their First Nations communities are ending their lives. This was a part of the community engagement session where we heard many lived experiences of challenges with access, limited support and services for mental health, especially when in crisis. Community members highlighted mental health challenges such as *“undiagnosed mental health problems, mental health issues, poor psychiatric care, depression, anxiety, social anxiety, bullying and loneliness.”* The communities recommend that the strategy highlight the disparities in mental health and highlight these challenges. There was an urgency to adapt and change to the needs that have emerged from within their communities for mental health challenges. Over and over again, the community members stated that the youth are lost and feel as though life is not worth living. Although, many communities identified if there were options for the youth to have a group to attend and to provide presentations and options for land based healing, that their communities would be able to have a positive impact on the mental health challenges. To de-stigmatize mental health disorders, where the youth can learn about ways to manage symptoms and access care, treatment and support that is also culturally responsive for mental health care needs.

Limited Parenting Skills

A continued theme that emerged from the community engagement session was limitations in parenting skills. This has been documented as a direct result of Indian residential schools and effects of colonization. Many community members identified that it has taken over 150 years of colonization to get this way and it will take decades to recover, relearn and rejuvenate their parenting skills. They reported instances of limitations in parenting by examples of “*Children not being heard, not being told I love you, youth not feeling connected, lack of encouragement, no support system, no coping skills, no healthy outlets, a response to emotional pain, a response to terrible pain, no one to turn to for help, lack of trust, lack of safe people to talk to, young parents, kids having kids, dysfunctional family and lack of parenting.*” Recently, there have been traditional parenting programs offered within the communities, where they the communities bring in the Elders and Knowledge Keepers to share in the traditional teachings and natural laws to re-build their strengths from within.

Limited Coping Skills

Community members provided examples of what they believed are the specific issues related to why community members might have limited coping skills. Challenges in coping skills emerged historically from generations of First Nations people being forced to attend Indian residential schools and being removed from their homes or communities to be raised in institutions. Over generations, First Nation people learned not to express themselves, to hold in their emotions and shame and fear was ingrained in them. Lack of development of coping skills is often documented in research as being a direct result of colonization and often results in emotionally avoiding the feelings and emotions by accessing unhealthy options for coping, such as substance use or physical and emotional violence. The communities identified the following challenges within their communities “*Drug and alcohol abuse, gambling addictions, relationship issues.*” Other concerns identified were community members not having a healthy relationship to model their relationships after and not knowing the emotions and concepts related to love. For example “*Dispel the myth that ‘sex is love’, not enough love and felling unloved.*”

Self Esteem and Crisis

First Nations members identified that their youth and community members have lived through generations of limitations in building healthy self-esteem. They reported that often the youth have modeled behaviours that are not healthy and this impacts their self-esteem, self worth and overall quality of life. As well, the traumatic losses and multiple losses within their communities result in challenges with expressing empathy and grieving loss. Community members reported that they have witnessed their youth searching for their sense of belonging and validation by getting into relationships before they are mature and ready for the emotions related to this. For example *“Crying out for help the wrong way. No one knows healthy ways to grieve and too much loss. Missing loved ones who have passed away. Not knowing how to deal with pain. Youth are not exposed to more opportunities, fulfilling purpose in school and work.”* Community members also identified challenges to building self esteem included *“imbalance in our medicine wheel, need a higher power, spirituality, media, cyber bullying and cell phones.”* There were many examples provided about youth and community members not feeling safe or being in crisis and frontline staff burnout because of *“bullying, not safe, bullying in schools and community big concerns and compassion fatigue.”*

A community stated, *“Have the youth create this strategy not the politicians.”* Another community indicated they believe the approach for the community engagements was helpful *“continue the approach you are doing now, getting input from youth/Elders/frontline workers.”* Another community stated, *“come to the communities with the strategy, then set the solutions for the people.”* Challenges related to the lack of mental health supports and services within the First Nations communities included limited access to assessments, interventions, and treatment. For example, *“There are barriers to mental health assessment”* and *“too much red tape to get youth assessed.”* Another community identified challenges related to assessment *“Stop sending our children down south for evaluations.”* Another concern about the strategy was the community expressing concerns about it not being sustained long term *“Once you start something like this, carry on and help in every way possible thereafter.”*

5. Recommendations and Action Items Community Members identified to be included in the Saskatchewan First Nation Suicide Prevention Strategy

First Nation community members were asked to provide examples of recommendations for actions to be included in the Saskatchewan First Nation Suicide Prevention Strategy. This section includes themes from one hundred and three responses from the First Nations communities about what they would like to have made available within their communities for mental wellness and prevention of suicide. These recommendations include taking a focused and active approach to suicide prevention will require commitment and partnerships. There was consistency when responding to this question about access to longer-term supports rather than short-term crisis driven interventions. Community members identified that they would like to see *“Partnerships that are continuous. Interagency and inter tribal council. Have all health regions come together and working together. Better leadership at the provincial level. Commitment from all leadership, Government, Federal, Provincial, urban and rural.”*

Other recommendations include ensuring that there are sufficient and sustainable resources in place so that they can be culturally responsive and adapted for suicide alertness and interventions training that can be delivered on a consistent and comprehensive basis to First Nation people across the province, with mental health supports provided as required. Community members identified training programs such as *“ASIST, Safe Talk, Life Skills, Crisis Response and Critical Incident Stress Management.”* Community members identified a new program that is currently being implemented within the Sturgeon Lake First Nation, the training program called *“ACCESS, Open Minds”* that will *“help identify and help initiate interventions designed to improve mental health outcomes of the communities youth.”* Other examples included access to *“cultural training and cross cultural training for staff members, police, emergency medical services, etc.”* As well as sustainable resources for *“cultural integration programming, cultural tradition teachings, prayer and ceremonial, sessions to experience love and belonging, bring love and talk about the sacredness of life, develop more traditional life skills in the bush, sweats and talking circles.”*

Support a community led scan by conducting an inventory of all relevant programs delivered in First Nations communities and document all programs that are being delivered on suicide prevention and mental health and wellness. The communities identified that conducting the scan would assist in identifying Land Based and culturally responsive services and programs that are validating this as a best practice. As well, it would provide a resource whether they are working or not in all communities.

Community members identified having options for “*land based programs and requested community owned and led by First Nation, grassroots, brainstorming, community involvement, options to go to schools to engage youth, engage leadership and engage families.*” Community led interventions and engage Elders and Knowledge keepers to share oral stories about sacred teachings and life and to share protocols of process and meanings related to spiritual teachings, with goals of having this included in curricula. Examples included community led actions such as “*organized structural response, multi-sector coordinated approach, community support and neighboring community’s support.*” Elder and knowledge keepers engaging and sharing their knowledge by leading “*Talking circles, family sharing circles and communities working together with neighboring communities support.*” Engaging Elders and knowledge keepers to help develop culturally responsive curricula to reduce stigma related to suicidal behaviours. Suggestions by community members included “*Having activities for youth. First Nation responders that are trained and training at the community level.*” Provide options for interventions to be “*First Nation Led, with First Nation Languages and skills*” integrated throughout the curricula.

Invest in the next generation by taking actions to support healthy early childhood development. Research, develop, design, pilot and evaluate interventions designed to prevent the intergenerational transfer of historical trauma with the communities not the academics. Programs such as early childhood home visits by trained staff to connect with and provide connection, support and education to expectant mothers. Other suggestions were providing “*age appropriate training to deliver programs and supports. As well as a specific focus on programs for example in Northern Sk, focus on 10-19, and focus on*

girls. “ Provide supports for universal programs and initiatives to heal and support parents to foster optimal home environments. Program options suggested were *“consistency, check in process, what works versus what does not work. A referral process for clients integrating back to the community for after care and parenting supports.”* Other suggestions included *“more cultural activities, utilize trap lines to help people learn about culture (i.e. medicine wheel teachings). Working together, partnerships, communication, and creating opportunities for dialogue on actions for healthy early childhood development.”*

Community members highlighted the need for focusing on the youth, as they are currently struggling emotionally, mentally, physically and mentally. Recommendations included education opportunities to assist the youth and encourage this education to be Land Based led by Elders and Knowledge Keepers. Suggestions included *“better equip children and youth with skills to cope with adverse life events and negative emotions.”* The fact that many of the programs that the communities identified related to the importance of sustainable and long term funding for programs. Comments included *“financial support provided for training the youth, sustainable funding, permanent youth workers, role models from the communities, permanent youth programs for all communities and educational in focus.”*

Community members identified recommendations to lead the strategy to be inclusive of the communities themselves, with focus on families, youth and their leadership. Suggestions included *“education and dedicated staff for the youth in schools, engage leadership, families and youth.”* The community members identified that there are significant gaps in current resources and that there is a significant need for more financial resources to ensure that the youth are engaged in the development of their programs and services, as well as opportunities for building and developing peer mentorship. They stated *“youth councilors in school, peer support, mentorship, more support services, involve the youth, Listen to the youth, suicidal youth survivors listening to their stories, trips, activities, football team, sports.”*

The communities identified a level of urgency with discussions in the engagement sessions about the continuum of care led by the culturally responsive framework. They suggested the strategy focus on strengthening the continuum of culturally appropriate mental health services aligned with: *“Traditional Knowledge, Elder mentorship, Elders Council to respond to the youth that are at risk to suicide.”* Other suggestions were specific to building up the strengths of the families in the communities by providing training, education and using the Natural Laws to guide this. They stated: *“training our families, education with ceremonies, traditional family systems developed and train all in each community, family structure, family units.”* Most importantly, the communities stressed urgency for integrating culture in all aspects of the strategy. They recommended the following: *“Culture driven funding and being Culturally Responsive Interventions, Elders support, Culturally appropriate interventions by local First Nations and First Nation intervention circles.”*

First Nation communities identified that there is a gap in the current structure and process of treatment centers. In the previous sections, there were many example shared about community members not receiving after care, long term care, treatment and support for substance use, especially when returning back to the community from a treatment centre. They suggested to *“strengthening the continuum of care for mental health and wellness, substance use and addiction services.”* A consistent recommendation was related to requesting funding for increased needs of the communities, as well as being sustainable. They stated, *“need more sustainable funding, financial support for cultural programming financial support for 24-hour crisis line, increased funding for mental health, mental health supports and addictions and self sustaining programs.”*

Most importantly from the community’s point of view was the lack of programs directly related to targeting the suicide crisis that communities reported currently struggling with. They requested more supports from within their communities, to be culturally responsive in providing their mental health care, as they state it is found within their communities and they are desperate to save the lives of their community members. They reported that there is a great need for a mental health advocate within each tribal council to assist in

coordinating services and supports for mental health. They indicated that this is currently done for early childhood development, and this is what they need for suicide prevention. They also need more staff to do this and suggested these positions, “*Suicide prevention workers, and increase of front line social workers, readily available counselors, permanent youth workers, and youth counselors in the school.*”

6. Interventions: Community Voices – What works for whom

First Nations community members were asked to provide examples that they have experienced when crisis occurs within their community’s and describe what interventions worked and what did not. They were asked to share these examples for the development of the Saskatchewan First Nation Suicide Prevention Strategy. This following section includes themes from ninety-four responses from the First Nation’s communities that were identified as working within their communities. These responses were themed into the following *Culturally Responsive Interventions, Positive Supports, Mental Health Supports and Community Led Interventions*

Culturally Responsive Interventions

Community members identified when there is a crisis they would prefer to have access to culturally responsive interventions. They suggested making mental health care services and supports culturally sensitive to their needs within their communities that are inclusive of their natural laws, values beliefs, traditions and inclusion of the guidance and stories from the Knowledge Keepers and Elders. They suggested options such as: “*Traditional therapy works and sweats.*” First Nation communities stated having interventions that are culturally responsive that include “*cultural supports, family camps, Elder Talks, Family circles and community coming together.*” Having options for the communities to provide from within “*traditional teachings, ceremony, being grounded, Elders engaging, traditional parenting respecting differing spirituality, building fishing shacks, land based teachings.*” Many communities stressed the importance of adapting and blending models of care that would enhance their community’s quality of life. They requested, “*culturally driven funding options, cultural integration programming, including language and more*

cultural activities.” The communities stressed that they have people within their communities who have the knowledge, it is their hope to be supported financially to provide these support from within their communities, and not to spend exorbitant amounts of money on bringing in the outside professionals (i.e. mental health therapists, psychologists, etc.). Why not invest in the communities to build their capacity to provide supports from within.

Positive Supports

First Nation communities expressed their preference in receiving and providing strength-based approaches within their communities. They reported impacts from intergenerational trauma that often resulted in systemic issues such as “lack of parental skills, no role models, lack of finances to provide programs and resources.” They suggested positive supports as options such as *“provide a safe place with food and love, be patient and be consistent and provide care with kindness.”* To address impacts of the historical trauma, use a strengths based approach that *“avoid blaming resentment and negative emotions, respecting the views of the people, comfort from others/love/support* and use approaches that include *“decolonizing, defusing and debriefing.”*

Mental Wellness Supports

The First Nations community members reported that they have experiences options for mental wellness, often related to crisis. They stated that community members are overwhelmed with mental health needs, as there are so many crisis, traumas, losses and serious events that may include physical violence. They stated needing to make efforts for mental wellness to be a part of their school curriculum, as well as within their community events. They stated that mental wellness options they have experienced were *“Crisis Teams, CISM, Mental Health Teams, ASIST training.”* Community members indicated that they need more financial supports to provide specific programs and services related to mental wellness, such as *“Trauma information workshops, access to more Indigenous mental health therapists”* and most importantly, that they are *“Qualified health front line workers and human intervention, showing that you care!”*

This following section includes ninety-six responses from the First Nation's communities that were identified as challenges that are not working within their First Nation communities: These responses were themed into the *following Limitations for Culturally Adapted Supports, Limitation of Programs and Service for Mental Health and Crisis, Lack of Trust and Limitations in Access to Staff*

Limitations for Culturally Adapted Supports

First Nation community members stated that they would like to have options for interventions that are culturally adapted, culturally responsive and land based. The communities reported that they have a preference for *“Train our own, Family circles, Elders and communities coming together.”* There was a consistent theme identified throughout all responses by the First Nations communities for suicide prevention was the need for integration of culture. They stated, *“need of culturally appropriate interventions by local First Nations.”* As well, the consistent theme of lack of funding for providing these much needed culturally relevant services and supports was *“Lack of funding for cultural programming.”*

Limitation of Programs and Service for Mental Health and Crisis

Community members provided consistent responses throughout the community engagements that there are significant gaps and limitations in programs and services for mental health care and crisis supports. The First Nation communities stated that they would like to see other options for care, treatment and support that are inclusive of cultural options and being culturally responsive. They provided numerous examples that they would like to see within their communities. For example, *“Need immediate support for crisis, lack after care, lack of addiction services, referrals, and defusing, debriefing, lack of education about how to deal with a crises.”* More importantly, they want to be inclusive of their own teachings. For example, *“Respecting the views of the people. Western options not working for our people.”*

Lack of Trust

Historically, there have been generations upon generations of First Nations people who have broken trust. This has resulted in a lack of capacity to develop trusting relationships and often results in challenges within an individual's ability to build trust. Some communities identified that since there has never been a process of education about why there are trust issues within the communities, that one of the areas of crisis is education about historical trauma and the resulting lack of trust within their communities. Some examples shared were *“lack of confidentiality, panic and fear, talking openly about the problem, blaming and ignorance.”* They suggested that they have options for choosing their mental health therapists from within that are healthy, positive supports as they have been impacted by therapists not being trusting, or feel abandonment when the therapists come and go. They stated wanting *“consistency, mental health therapists brought in are not engaged with the community, lack of lived experience in living on the First Nation. Mental health therapists can be educated but lack the experience of life on the First Nation and have options to evaluate the therapists.”*

Limitations in Access to Staff

There continued to be a theme for more staff due to lack of financial supports throughout all of the responses provided at the community engagements. The First Nation community members expressed significant need for trained staff from within their communities as well as the challenges that resulted from the limitations in staff. They reported restrictions in the support from overworked staff and limitations in commitment due to lack of resources. Some examples included *“Health Director and Leadership. All talk, no action, lack of structure for crisis management, lack of trained first responders, lack of access to medical services, lack of policies on crises protocol, no organized responses to crisis, no interventions, no follow up plans, need for more support for the helpers/workers, need for after care, lack of resources, support workers and limited to no police services.”*

7. Where can we go from here

The preceding results from the community engagement sessions provided a diversity of recommendations from First Nation communities for suicide prevention and improving the quality of life for First Nation communities. The communities came together to express their needs by sharing their lived experiences in hopes that they may receive acknowledgment of the importance for culturally responsive options for mental health, suicide prevention, crisis response and supports. A few quotes from the community engagements relays the urgent need for using their own people and build their capacity to provide supports *“We have become experts in dealing with crises. Now we have to become experts in preventing crises from happening.”* They stressed the need to focus on their strengths. *“If we are always bringing in experts from the outside – we are failing, as we have our own experts, in land based options, we have our language keepers, we have our own medicine people.”* Now is the time for assisting First Nation communities to develop innovative mental health approaches to suicide prevention and building their capacity from within. Our communities are in consistent crisis and urgently need culturally responsive interventions.

The recommendations that emerged throughout the community engagements from the First Nation communities highlighted throughout this document are the need to focus on the strengths that the communities have within. There will significant commitment required from all for these recommendations guided from the First Nations community’s voices for improved options for mental health, crisis supports, interventions and suicide prevention. Throughout their responses was the need expressed for land-based options, with guidance from their Knowledge Keepers and Elders. Each and every individual who participated in the engagement sessions came with such passion and strength, with motivation for change from within. Interventions were identified that are led and guided by First Nation healing philosophies and traditional approaches, such as the ACCESS Open Minds: Adolescent/young adult Connections to Community driven Early Strengths-based and Stigma-free services program, Your Life is Sacred and Roots of Hope were identified as options to adapt for First Nations Suicide Prevention. If First Nation communities can receive financial supports to provide land based options, their own

treatment centres using natural laws, and accessing their Elders and Knowledge Keepers by leading the interventions, there is a potential to make a significant difference in the lives of First Nation people by using the strengths they have from within. Historically, the “best practices” for mental health and suicide prevention are western focused and not considered a best practice for the First Nation communities. The answers lie within the communities; they are their own “best practice.”