Report of the Workshop on

Best Practices in Suicide Prevention and the Evaluation of Suicide Prevention Programs in the Arctic

Held in Iqaluit, Nunavut
March 14 and 15, 2003

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NOTE: This report and copies of all presentations made at this workshop are available on the GN EIA Evaluation and Statistics website -- www.stats.gov.nu.ca

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1) Introduction

From March 12 to 14, 2003, approximately 40 people from Nunavut, Greenland, Nunavik, the Northwest Territories and Alaska gathered in Iqaluit to discuss the progress of suicide prevention programs in the circumpolar world. These delegates were joined by health care professionals and researchers from southern Canada, England and Australia. Funded by Nunavummit Kiglisiniartiit (the Evaluation and Statistics division of the Government of Nunavut's Department of Executive and Intergovernmental Affairs), the workshop was intended to:

- bring together practitioners from within the circumpolar world who had experience with suicide prevention;
- summarize existing suicide prevention programs in the circumpolar world;
- discuss issues surrounding the administration and evaluation of culturally appropriate suicide-prevention programs;
- identify 'best practice' from suicide prevention programs that might be appropriate for Nunavut; and,
- identify appropriate methods of evaluation for suicide prevention programs.

1.1. Suicide in Nunavut

Since the creation of Nunavut on April 1, 1999 there have been 105 deaths by suicide. At present Nunavut lacks both a comprehensive suicide prevention program and a method to evaluate the effectiveness of existing efforts. This workshop was intended to help correct this gap. In the weeks immediately preceding the workshop six young people had died by suicide in Nunavut. By holding the event, and by gathering people from around the circumpolar world, the workshop was intended to identify a best step forward and provide hope to the young people and suicide prevention practitioners working in Nunavut. Results of the workshop will be presented at the Canadian Association for Suicide Prevention annual conference that will take place in Iqaluit, May 2003.

1.2. Workshop Report

This is not a verbatim transcript of the proceedings -- such a document would be several times the length of this one -- but rather an edited version of the proceedings of the workshop based on notes, tapes and documents. It highlights the main points made by participants during the workshop and the points on which there was disagreement.

Information contained within this report draws on the formal sessions of the workshop and the speeches made during the dinner on March 15. It does not include detailed information on the breakout sessions, in part because groups presented the results of these discussions to the workshop.

2. An Overview of the Main Sessions and Speakers at the Workshop

Wednesday March 11

Participants from Greenland were prevented from arriving due to a blizzard in Nuuk. It was decided that the free day, originally designated for Saturday, would be changed to Thursday. This would allow the conference to be held on Friday and Saturday. Participants who had arrived successfully assembled for a brief dinner and informal reception at the 'By the Sea' Bed and Breakfast.

Thursday March 12

This was supposed to be the first day of the conference. Weather conditions improved in Nuuk and the Greenlanders were able to travel to Iqaluit. For all other participants this was a free day, allowing them to explore Iqaluit. On Thursday evening workshop participants assembled for a dinner at the Frobisher Inn. They were welcomed by Jack Hicks, Nunavut's Director of Evaluation and Statistics, and Anne Crawford, Deputy Minister of Nunavut's Department of the Executive.

The Greenlandic delegation arrives in Iqaluit

Friday, March 13

The workshop formally convened on Friday. Most of the day was devoted to presentations from the various representatives of the circumpolar world. The day began with brief introductory remarks from the two co-chairs -- Jack Hicks and Alexina Kublu.

Before the formal presentations began the workshop participants were led in prayer by Cathy Towtongie, President of Nunavut Tunngavik Inc. After a brief discussion of the day's agenda Ms Towtongie made a keynote address to the participants, which was followed by a brief trip to the Legislative Assembly of Nunavut where the visitors were welcomed by Speaker Kevin O'Brien.

The remainder of Friday was devoted to five hour-long presentations by delegations from Alaska, the Northwest Territories, Nunavut, Nunavik and Greenland. Each of the presentations was followed by a discussion period. The six presentations were made by:

Alaska:	Chris Aquino, Associate Coordinator, Alaska Community-Based Suicide Prevention Program
	Teresa Perry, Counsellor, Shaktoolik
Northwest Territories:	Sandy Little, Mental Health Consultant, Department of Health and Social Services
Nunavut:	Don Ellis, Director, Health and Social Services Programs, Department of Health and Social Services
Nunavik:	Johnny Naktialuk and Richard Kouri, Nunavik Regional Board of Health and Social Services
	Louisa Brown, Kativik School Board
Greenland:	Anne Cathrine Lefèvre, PAARISA
	Regitze Nyeland Castsensciold, Practitioner, Nuup Kommunea
	Greenlandic Youth (Nitta Lyberth, Petrine Hansen, Upaluk Poppel)

On Friday afternoon Nunavut's Minister of Health and Social Services Ed Picco visited the workshop and addressed participants on the issue of suicide prevention in Nunavut. Mr Picco was accompanied by Jack Anawak, Member of the Legislative Assembly for Rankin Inlet North. That evening participants assembled for a formal dinner at the Discovery Lodge. Dinner was followed by speeches from Nunavut Premier Paul Okalik and Inuit Circumpolar Conference Chair Sheila Watt-Cloutier.

Saturday, March 14

Saturday was divided between presentations from practitioners and researchers who had addressed the issue of culturally appropriate suicide prevention programs and discussion among participants. The following presentations were delivered Saturday morning:

- Dr Laurence Kirmayer, Director, Division of Social and Transcultural Psychiatry, McGill University: "Best Practices in Suicide Prevention in First Nations Communities"
- Dr Tracy Westerman, Managing Director, Indigenous Psychological Services: "Best Practices in Suicide Prevention Among Aboriginal Australians"
- Chris Aquino, Associate Coordinator, Alaska Community-Based Suicide Prevention Program: "The Evaluation of Alaska's Community-Based Suicide Prevention Program"

Each of these presentations was followed by a discussion period. In the afternoon, participants were divided into two groups where they could discuss recommendations for the administration and evaluation of a culturally appropriate suicide prevent program in Nunavut. Recommendations were then presented to the group as a whole. This was followed by a discussion period.

Proceedings ended late Saturday afternoon. At the conclusion of the conference participants from Greenland treated the workshop to songs. Participants were later joined by drum dancers from Iqaluit.

3. Summary of the Proceedings of the Friday Session

3.1 Friday, March 14, 2003, 0830-1700

On Friday workshop participants assembled at the 'By the Sea' Bed and Breakfast for the first day of the formal proceedings. Participants were welcomed by co-chairs Jack Hicks (the Government of Nunavut's Director of Evaluation and Statistics) and Alexina Kublu (Kamatsiaqtut Crisis Line volunteer and a member of the organizing committee for the 2003 Annual Meeting of the Canadian Association for Suicide Prevention).

Mr Hicks explained that he hoped this workshop would be seen as a sign of hope because it demonstrated that practitioners throughout the circumpolar world were working together to develop suicide prevention programs that would stem the tide of deaths by suicide. He noted that a report on the workshop would be delivered at the Canadian Association for Suicide Prevention conference that will be held in Iqaluit in May.

After opening remarks participants introduced themselves. Participants included government workers and community activists from Nunavut, Greenland, Nunavik, the Northwest Territories and Alaska. Representatives from Nunavut included members of the departments of Culture, Language, Elders and Youth, Education, Executive and Intergovernmental Affairs, Health and Social Services and Justice in addition to participants from Nunavut Tunngavik Inc. and the Kamatsiaqtut Crisis Line. The Greenlandic delegation included youth representatives and three members of the *Landsting* (the Greenlandic legislature) in addition to community workers. In addition to representatives of the circumpolar world, participants included researchers from McGill University, London, England, and Australia.

In their introductions participants from various countries expressed appreciation for being invited. Through an interpreter representatives from Greenland indicated that they would be interested in building a network of suicide prevention specialists who could help to combat suicide in ways that are culturally appropriate to Inuit. Many of the participants indicated that they had been touched by suicide, by the loss of friends or family. Pierre Kolit from the Department of Health and Social Services in Rankin Inlet requested that the workshop begin with a moment of silence for his departed sister.

3.2 President of Nunavut Tunngavik Inc. Cathy Towtongie

Following introductions the workshop was addressed by Cathy Towtongie, President of the land claim organization Nunavut Tunngavik Inc. Ms Towtongie led the workshop in a moment of silence and a brief prayer. She noted that Nunavut Tunngavik Inc. would provide partial funding for the forthcoming annual meeting of the Canadian Association for Suicide Prevention.

Ms Towtongie noted that suicide is relevant to Nunavut and to the circumpolar world and that all of us have been touched by its devastating effects. She highlighted the culture of survival that had characterized Inuit culture, a culture that had to survive on the land and in a harsh climate, and compared this to the rising youth suicide rate since the 1970s.

Ms Towtongie also noted that geography and isolation have prevented Nunavummiut from realizing that the rest of the country does not have suicide rates anywhere near as high as Nunavut's. Furthermore, the rest of the country doesn't appear to be aware that Nunavut is coping with such a high rate of death by suicide. A lack of knowledge and the pace of deaths have taken their toll on Nunavummiut. Pointing out that it is almost always Inuit who kill themselves, Ms Towtongie stated that Nunavut Tunngavik Inc. is concerned both for the victims and their families. She suggested that our behaviour right now is purely reactive, that we are struggling to cope with the effect of suicide on siblings, marriages, parents and colleagues but are doing little in the form of prevention.

Nunavut Tunngavik Inc.'s president pointed out that children whose lives should be easier are surrounded by so much suicide that they begin to see it as a legitimate option. The clustering of suicides suggests that young people see suicide as a way to end the helplessness and hopelessness of their lives. Ms Towtongie dubbed the lack of a concerted action plan the 'northern leaders' great silence'.

Ms Towtongie stated that standard approaches to suicide prevention won't work here. The situation is so advanced in Nunavut that 'textbook techniques' are inappropriate. Throughout her address she noted that standard programs won't appeal to Nunavummiut. She noted that elders tended to think that southern professionals would know what to do and talked of the frustration that elders felt when they realized that the professionals in fact didn't have all the answers.

She recommended a hard-hitting curriculum in the schools. Such a curriculum would help to develop an emotional vocabulary that would enable young people to communicate the stressors in their lives, would help to develop skills in conflict resolution and problem solving. Inuit pride campaigns that showcase values and beliefs that emphasize survival would help young Inuit to find strength in their culture.

Ms Towtongie also supported conducting a process of psychological autopsies (or 'follow-back studies') which would allow Nunavummiut to better understand the circumstances of suicides in Nunavut. She indicated that research would be useful but that guidelines for research were necessary. The goal, for Ms Towtongie, is to provide young Inuit with an understanding of how resilient their culture has been, how it rests on the ability to survive, and how young Inuit should find pride and strength from this.

3.3 Alaska: Chris Aquino and Teresa Perry

Chris Aquino began his discussion with a brief outline of the demography of Alaska. As of 2001 there are 634,892 residents in Alaska. The state contains many different Native groups including Inupiat, Yupik, Tlingit, Haida, and others. The cities of Anchorage, Fairbanks and Juneau are home to more than half of the entire population of the state. Alaska has several regional hubs, such as Bethel, Nome and Kotzebue, but most villages are very spread out, isolated and small. The cost of delivering health care programs in such circumstances is high. Teresa Perry noted that the cost of a Medevac from her home village of Shaktoolik to Anchorage is approximately US $11,000.

Mr Aquino explained that there are approximately 125 suicides per year, which works out to a rate of 21 per 100,000. This rate is double the suicide rate for the United States as a whole. He noted that within Alaska the suicide rate for Natives is three times the rate for non-Natives. Native males aged 18 to 29 have one of the highest rates of suicide in Alaska, with the highest suicide rates occurring in regions in Western Alaska (i.e. Northwest Arctic, Bering Straits, Yukon-Kuskokwim).

The Alaska Community-Based Suicide Prevention Program is an attempt to empower local communities. The program is based on the idea that physical, mental and cultural health are all related and that active, healthy communities will have active, healthy residents. The program offers non-competitive two-year grants of up to US $20,000 per year for each community that applies. Communities must submit a proposal that outlines plans for suicide prevention activities. The proposal is reviewed by the community council and then reviewed by the staff of the Department of Health and Social Services' Division of Alcoholism & Drug Abuse. The program staff has attempted to make the process of applying for the grant as non-threatening as possible. The total cost of the program is estimated at US $800,000 to 900,000.

Chris Aquino and Teresa Perry

The average award is approximately US $14,000 per year. The money normally covers salaries, stipends, supplies and travel to workshops in addition to any activities that the community intends to hold. Communities must reapply if they want to receive a second year of funding, and can continue to reapply again once the second year of funding has been used. Of the sixty communities currently operating programs, two-thirds re-

apply for continued funding after the two-year cycle. Mr Aquino noted that while they haven't had a community 'graduate' from the program, they find that occasional problems with deadlines, a lack of time, or interest in other funding opportunities prevents some communities from re-applying.

There are four requirements for any application. The community must hold a meeting to discuss the strengths of the community, its goals and the activities it wants to hold. The community must designate a half-time coordinator. The application must contain a very clear description of how the coordinator will spend his or her time and money and how he or she will cooperate with the community council. The coordinator might wish to work closely with elders, youth, counselors, village safety patrol officers, or other members of the community when administering programs. Groups and individuals must support the application by writing letters indicating that they hope to work with the coordinator. The application must also contain a budget.

Mr Aquino noted that a typical project would contain a crisis response team, plans for wellness counseling and suicide prevention workshops, teen centers, newsletters and various cultural activities. By helping to reinvigorate culture the program is based on the belief that suicide is tied in part to the sense of dislocation that individuals feel within a community, and that the community may feel within the State. By re-emphasizing cultural values, traditional values, cooperation and sharing the program aims to empower communities and individuals.

Discussion

Dr Sam Law, a psychiatrist who until recently worked at the Baffin Regional Hospital, asked whether in addition to the council and counselor there were also social workers in the community. Ms Perry explained that there are village-based wellness counselors who do work on self-esteem. There used to be school counselors for kindergarten to grade eight but the program for these has since been cut. There is also a suicide prevention worker and an Indian Child Welfare Act officer in most villages.

Dr Laurence Kirmayer from McGill University asked whether there was a mechanism for identifying communities that aren't asking for money but should, given their suicide profiles. Mr Aquino indicated that they make a special effort to invite communities with high suicide rates to apply for the program, and that community members from these villages have been asked to participate in the annual Coordinators Conferences where they can learn more about the program.

In response to a question from Margaret Joyce of the Nunavut Department of Education about the names of the programs, Mr Aquino noted that each community decides what to call their list of activities and that the word 'suicide' need not be in the name. Ms Perry noted that in Shaktoolik the program is called the 'fun club' while others employ phrases such as 'choose life' or 'community wellness' in their titles. Mr Aquino noted that this reflects the fact that communities have different foci and different marketing needs.

3.4 Northwest Territories: Sandy Little

Sandy Little began her discussion with a summary of suicide statistics in the Northwest Territories. The suicide rate in the Northwest Territories is twice the national average. The rate increased in the late 1980s and early 1990s, but dropped in the mid 1990s when it approached the national average. After division in April 1999, however, there was an increased number of suicides to 16 per year. That rate has now halved to approximately eight per year. Ms Little explained that people with a history of addictions, loss, and trauma are at risk, as are the victims and witnesses of violence. Inuit and Inuvialuit are at a higher risk, as are young men. In addition, Ms Little noted that there is an increased incidence of men aged 30 to 44 dying by suicide.

The Northwest Territories strategy on suicide prevention began with a series of regional forums. The results of these forums are recorded in the 1992 document *Working Together Because We Care.* The resulting suicide prevention program focuses on the training of community workers. It is based on the idea that if you fly southern experts to a community following a suicide that it will be too late for the victim and not necessarily culturally relevant to the community. The program is designed as a northern solution that targets community members because northern communities house sufficient knowledge and caring individuals to address the issue.

The program offers three weeks of training and is an improvement, according to Ms Little, on the previous two-day workshop that only dealt with suicide in principle. The current program includes one week on understanding suicide, grieving and healing. Ms Little explained that both individuals and communities need to deal with their grief. The small population of many northern communities means that one suicide will very often affect the entire community on a personal level. The devastating effects of suicide which can result in lower self-worth for community residents would not necessarily develop in southern Canada, where suicides tend not to be clustered within small communities. Week two attempts to develop intervention skills such as active listening, while week three deals with leadership and community development. This last week helps people to look at what they bring to the process, and helps to identify skills that may help the community and empower the individual.

The program operated both before and after division in 1999. Thus far it has operated in Fort MacPherson, Hay River, Fort Good Hope and Deline. It has also been conducted in five Nunavut communities. The program costs approximately $35,000 per three-week workshop and requires approximately three months to screen participants and prepare.

Ms Little pointed out that because the program is intended to have community-based people take over the training in their own communities evaluation of the program focused on the views of these participants. Those who participated indicated that they liked the content and learning style and felt that three weeks was an appropriate length. They felt, however, that follow-up training and support were necessary.

And finally, Ms Little noted that the Northwest Territories has now set up a steering committee composed of representatives from the government, non-governmental organizations and elders to deal with broader prevention issues such as mental health and addiction, early childhood development, residential school awareness and healing.

Discussion

Louis Tapardjuk, a Nunavut Tunngavik Inc. staff member from Igloolik, asked about the distribution of suicides throughout the territory and the production of workshop materials. In response Ms Little noted that some communities are hit harder than others but that there aren't constant geographic predictors of suicide. Suicides tend to be clustered, and then the problem tends to disappear for a while. Some of the larger communities such as Inuvik, Hay River and Yellowknife are magnets for persons with social problems. This has an effect on the suicide rate of these communities. In addition, some communities that experienced oil and gas exploration have been left reeling by the massive influx of money and the tremendous change in the community. She added that the workshop materials took years to create and that the Dene Cultural Institute completed the initial draft.

Elisapi Davidee, a counsellor in Iqaluit, asked about the selection of participants. Ms Little noted that some individuals became involved in the program because they themselves felt suicidal. She stressed the need for a rigorous screening process, as the program shouldn't be seen as way of healing individuals but of training them. The program now has a seven-page application process that helps to identify appropriate participants. Ms Little added that of the initial 19 who participated, 12 were from Nunavut and many since then have been from communities in the Baffin region. This reflects both the higher suicide rate in Nunavut and the high risk for Inuit but also the efforts of Nunavummiut to address suicide.

Sandy Little (left) and Elisapi Davidee (right)

3.5 Nunavut: Don Ellis

Like other participants Don Ellis began his presentation with a description of Nunavut's population and suicide profile. At present Nunavut has a population of 29,000 in 25 communities, many of them isolated. Since April 1, 1999 there have been 105 suicides. Of these suicides the overwhelming majority have been Inuit, male and under the age of 25. The rate is variable across the territory, with the highest rate in the Baffin region. He noted, however, that individuals who are visiting or temporarily residing in a community and commit suicide there are counted as a suicide in that community -- and not in the community in which they normally reside. Mr Ellis noted that most suicides are not the result of psychiatric episodes, and that the suicides often occur as clusters.

Mr Ellis indicated that while there is no comprehensive suicide strategy in Nunavut, there is much appropriate activity in some areas but none in others. He explained that a typical community in Nunavut has a variety of health care professionals including nurses, social workers, and visiting specialists such as physiotherapists. In addition, there is sometimes a psychiatric nurse or mental health worker, and an addictions or wellness counselor. The nurses are aided by interpreters and community health representatives -- all of whom are Inuit.

Psychiatric services within the territory are limited to two to four visits per year to each community. There are 15 psychiatric nurse positions although not all positions are currently staffed. These nurses are linked to the visiting psychiatrists and are connected with community networks that include volunteers, school counselors and social workers, among others, depending on the community. There are also five new positions for child and youth outreach workers.

Mr Ellis explained that whatever suicide prevention strategy exists is based in part on the legacy from the pre-division Northwest Territories. The relevant documents, including the 1992 report mentioned by Ms Little, stress themes of awareness, mutual aid, community services, crisis intervention and institutional care. Mr Ellis linked suicide prevention to empowerment.

Since 1999 Nunavut has emphasized program leadership, and has created three regional health promotion positions. The department opened the first facility for the mentally ill (and those at risk of homelessness) in December 2002. Other developments include basic critical incident stress management training for 140 people that is funded by three departments, a federally funded peer counseling video created by Nunavut Tunngavik Inc., a Nunavut-adapted peer-counseling manual, and workshops initiated by the Royal Canadian Mounted Police.

Mr Ellis also described the file review process that follows any death by suicide. He noted that many of the people who take their own lives have been 'seen' by someone in the system, for example a nurse or social worker, within the 24 hours preceding the suicide. Recently, access to telehealth services has been made available and is starting to be used for mental health/illness services.

Mr. Ellis noted that research has shown that whether a caregiver demonstrates *caring* is more predictive of good health outcomes than right diagnosis. While social workers and nurses have important roles, a network (like family) that can demonstrate love for an individual is obviously more important. Nunavut needs to provide practical support and tools to those who are important to youth.

> "People will go to someone that they trust, and we have to help them identify that person and those who might be capable of helping even if they're not a social worker or a nurse"
>
> -- Don Ellis, Nunavut Department of Health and Social Services

Mr Ellis indicated that Nunavut's communities receive more than $3 million annually from the federal government for work on mental health issues, and that money *per se* is not the problem. Less clear, Mr Ellis noted, is a vision of what needs to be done. He stated that we need to know "the things that trouble grows out of". He noted that there are conflicting views of suicide: some would argue that you shouldn't talk about suicide otherwise more will occur, while others are clear that talking is absolutely necessary to healing and prevention. Mr Ellis lamented the limited link between formal and informal support systems in some communities, and noted that the not-for-profit sector in Nunavut is underdeveloped. He suggested that the formal system -- schools, health and social services, and the police -- should see themselves as a support network for the primary, informal system of family and community. He concluded by pointing out that Nunavut needs targeted programs that protect people from the impulse to commit suicide and the impact of suicide once it occurs.

Discussion

Mr Louis Tapardjuk asked how many of the suicides since 1999 have been by Inuit, and how much of the existing support is delivered by Inuit workers. Mr Tapardjuk suggested that not having Inuit in professional positions has a negative impact on self-belief. Mr Ellis responded that 103 of the 105 suicides have been by Inuit, and that many front-line workers are Inuit. Margaret Joyce indicated that almost all of the 21 school counselors in the 47 Nunavut schools are Inuit. Mr Ellis also described a workshop for elders in Pangnirtung that was designed to bring together 'natural helpers' to find out how the elders feel they can help individuals who are at risk. He noted that people will go to someone that they trust and we have to help them identify that person .

In response to a question from Ms Asii Chemnitz Narup, a member of the *Landsting* and a former Minister of Family and Health, Mr Ellis explained that suicide statistics come from the Coroner, the person responsible for determining the cause of death. He added that the Department doesn't track the number of attempts because it doesn't feel that it can provide reliable counts. Attempted suicides are both difficult both to define and to record consistently. He added that those who have attempted suicide are referred to the health center, are sometimes seen by a general practitioner and usually seen by a psychiatrist the next day. Over the longer term the individual will be seen by wellness workers. He acknowledged, however, that counseling available to an individual depends very much on the community in which the individual resides.

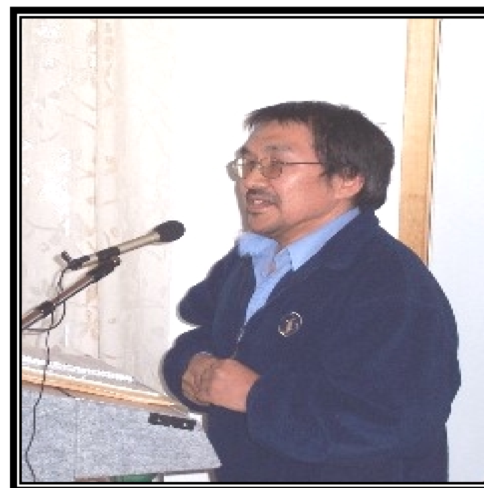
Mr Ellis's presentation prompted other participants to discuss the challenges of suicide prevention in Nunavut. Ms Davidee noted that one of the problems in Nunavut is that each group doesn't know what the other is doing. She added that it will take an entire community to help a community but this activity depends on cooperation among all actors. Pierre Kolit, an employee of the Department of Health and Social Services in Rankin, explained that when he lost his son to suicide that a professional person came to his home. He wondered whether it wouldn't be helpful to have a drama or theatre society to present shows that deal with suicide-related problem solving.

3.6 Nunavik

The Nunavik delegation provided a three-part presentation that dealt with culture, statistics and the practical application of training. The first two speakers were from the Nunavik Regional Board of Health and Social Services while the third speaker was from the Kativik School Board.

3.6.1 Johnny Naktialuk

Johnny Naktialuk began his presentation by apologizing to those who have lost love ones, and explained that he felt the only way to deal with the issue is to talk about it. He indicated that Nunavik had experienced 165 unexpected deaths in the region since 1972. He stated that like everywhere else in the circumpolar region the high suicide rate could be attributed to the legacy of colonization. The James Bay Agreement gave residents of Nunavik the tools to live life as they used to but that the people of Nunavik have forgotten about their elders. He suggested that the Nunavik education system needs more culture in it and that health and social services should stop trying to push the knowledge of elders away. The push to find 'qualified' people ignores the fact that for thousands of years it was the elders who kept the Inuit alive. A legacy of colonization and current treatment of the elders has contributed to a weakening of what had been a strong family system.



Johnny Naktialuk, Chair, Nunavik Regional Board of Health and Social Services

Mr Naktialuk explained that the two priorities of the Nunavik Regional Board of Health and Social Services are suicide and alcohol & drugs. The recent creation of a group to visit communities aims to discuss the issue of suicide and emphasizes the need to get back to the teachings of the elders. The group is composed of eight individuals: two elders, two social workers, two youth representatives, someone from education services and a residential school survivor. Of the 14 communities in Nunavik the group has visited ten so far. He notes that the group discusses statistics and then the residential school survivor talks about contact with the Inuit.

> "If we take back what our elders still hold today we will be so much stronger … work with your elders, they are the answer"
>
> -- Johnny Naktialuk, Chair, Nunavik Regional Board of Health and Social Services

Mr Naktialuk indicated that unlike the health system, which works within the colonial system, the group attempts to re-assert the 'missing link' between elders and youth. He noted that elders had accurately predicted both good and bad things in the future. The current period of hurt and pain that we are going through was 'as it was meant to be'. He ended by noting that although the intention of the group was suicide prevent it has turned out to have more to do with the promotion of life.

3.6.2 Richard Kouri

Richard Kouri explained the demography and patterns of Nunavik's suicide rate. The statistics, he explained, come from the Public Health authority of the Nunavik Regional Board of Health and Social Services. Nunavik's population is close to 10,000. The region has 14 communities; the four largest of which have more than 1,000 residents while the seven smallest have fewer than 500 residents. The communities are dispersed along 2,000 km of shoreline on the Hudson and Ungava coasts. Nunavik is part of the province of Quebec, which has a total population of over seven million. Nunavik covers one third of Quebec's territory.

Mr Kouri noted that from 1972 to 2001 there were 145 deaths by suicide in Nunavik, more than half of which had occurred in the last six years. Every suicide in Nunavik has been by Inuit. The suicide rate started increasing more rapidly in the early 1980s, which coincides with the implementation of the James Bay and Northern Quebec Agreement (the land claims agreement which applies to Nunavik). Suicide is predominantly a male, youth phenomenon. While the 10 to 17 year-old age cohort accounts for about five per cent of deaths by suicide in Quebec as a whole, in Nunavik the proportion is 25 per cent. There were no suicides by 10 to 17 year-olds until 1983, then 14 in the fourteen years from 1983 to 1996 and 22 in the five years from 1997 to 2001. Most Nunavik suicides take place in communities on the Hudson coast and are mainly by hanging, both of these trends are also on the increase. Mr Kouri noted that suicides rarely take place on the land.

In his analysis of the suicide rates Mr Kouri noted that in terms of the seasonal variations, very few suicides occur during the summer -- particularly in July. He noted that an increasing number of suicides are occurring under the influence of alcohol. He pointed out that while from 1972 to 1995 suicides tended to occur at the beginning of the week, since 1996 they tend to cluster towards the end of the week -- on Thursday, Friday and Saturday. Mr Kouri explained that this fits with a profile of binge drinking, when individuals get paid or when the cargo arrives.

Mr Kouri explained that he travels with the group described by Mr Naktialuk. He indicated that he is the only qallunaat (non-Inuit) of the group, and sometimes is pleased to "feel useless" -- as the Inuit members of the group demonstrate more than appropriate resourcefulness. Other times he says he feels uncomfortable with the amount of anger directed towards non-Inuit. He also explained more about how the group operates.

A week or so before the group's visit to a community, he and a colleague will arrive, meet with the municipal authorities and representatives of regional organizations to inform them of the purpose of the committee's visit, and make presentations to interested groups. One weakness of the committee's work is that the local Wellness Coordinators, identified to ensure follow-up activities to this awareness field trip, have been undergoing major changes in their job descriptions and lack adequate training. The changes are now over, and training is now being planned for them.

Mr. Kouri reported that the Nunavik Regional Board of Health and Social Services is currently moving towards a greater focus on 'support services to suicide survivors' to accompany existing suicide prevention efforts. The new strategy will pay greater attention to the religious and cultural beliefs surrounding evil spirits and the evil character of suicide.

3.6.3 Louisa Brown

Louisa Brown began by praising the work of the group from the Nunavik Regional Board of Health and Social Services. Elders in particular have responded positively to the efforts. Ms Brown, who works for the Kativik School Board, explained that the board organized and developed suicide prevention counseling programs for those currently working in adult education, student services and special education. This first group of individuals initially received training through a program created by the Université Laval in Quebec City.

Ms Brown explained that the counselors were trained in how to use the guide and traveled to communities. The problem, however, is that if someone in the community committed suicide elders insisted the counselors had to wait three months so that the community would have time to grieve. The elder also wanted counselors to be careful in what they said to young people as they felt it could affect their growth.

> "It's wonderful to see elders being included again. It's like getting your backbone back in place. For a long time they were bent but now they're standing up. They're now told they can voice their expressions if they so wish. You can see it on their faces -- it feels like the pieces of the puzzle are coming back together."
>
> -- Louisa Brown,
> Kativik School Board

3.7 Nunavut Minister of Health and Social Services Ed Picco

Nunavut Minister of Health and Social Services Ed Picco visited the workshop during Friday afternoon. He arrived with Mr Jack Anawak, the Member of the Legislative Assembly for Rankin Inlet North. Mr Picco addressed the workshop and warned that aboriginal cultures throughout the world are coping with suicide and that regardless of what job you have or what community you live in suicide strikes every family. He acknowledged that the Members of the Legislative Assembly don't have the answers for the current suicide problem in Nunavut but said that an important first step was the debate recently held in the legislature.

Mr Picco explained that unlike in most southern Canadian communities, where suicides are normally prompted by terminal cancer or financial ruin, suicides in aboriginal

communities are often the result of pervasive disenfranchisement, helplessness and hopelessness.

Mr Picco announced that the Legislative Assembly had decided to establish a small team of Inuit staff members to travel to communities, interview survivors and families and try to better understand why suicide occurs. He felt this was a more appropriate step that relying solely on 'experts'.

Minister of Health Ed Picco

The Minister of Health stated that he felt young people don't have the necessary coping skills. He explained that sometimes individuals enter very intense and long-term relationships at a very young age. The end of the relationship, then, is like losing an appendage. He recalled one individual who indicated that suicide would be an appropriate revenge for a boyfriend, girlfriend or spouse leaving. He warned that this view is not uncommon.

Mr Picco indicated that he would like to learn more from the communities that have very low suicide rates. One community with very high rates of suicide formed small groups to visit residents who were feeling depressed, to visit families and to talk about how suicide isn't the answer. The suicide rate dropped as a result. Mr Picco added that strong families are an effective buffer against suicide.

Mr Picco acknowledged that there are conflicting views on the next step forward. At a recent suicide conference in Rankin Inlet youth representatives said they wanted less gambling, alcohol and drugs in the communities. Elders by contrast wanted more togetherness and wanted young people to have better land skills. He also noted that there are conflicting views on the role of elders in suicide prevention. Some Inuit feel that elders should have a central role in any program, while other Inuit feel that elders might inhibit young people from talking about their feelings.

Mr Picco identified religion as a second issue. He noted that some Members of the Legislative Assembly feel that there isn't enough religion in the culture at school and at home. He recalled that when he was young he was told that those who committed suicide would go to purgatory and couldn't be buried in sacramental ground. He pointed out that while some might dismiss the link between religion and suicide, there is a strong correlation between religious background and low suicide rates.

Mr Picco said he felt there wasn't just one answer to suicide. Hiring more nurses would be helpful, and so should be the upcoming project where two respected Inuit men will travel to communities to discuss privately, in a low key way, the causes of suicide, based on interviews with those survivors who come forward and are willing to share their thoughts. He acknowledges that there is frustration in the communities among those who

want a quick fix to the problem. He warned, however, that issues of dysfunctional families, violence, alcohol and disenfranchisement are difficult issues.

Discussion

Many respondents had questions or comments for the Minister of Health concerning the psychological autopsies. Dr Laurence Kirmayer warned that asking families about the details of suicides is a very delicate issue and can bring back feelings of grief and trauma. In addition, it could lead to anecdotal information without identifying the underlying causes of suicide. Dr Kirmayer warned that practitioners should distinguish between the need of individuals to talk, which the current group can meet, and finding a solution to suicide, which he feels the current group cannot meet.

Ms Davidee further addressed this issue and asked what support systems are in place for those who are contacted. She indicated that discussing suicide can trigger anger, guilt and grief, that suicide is a very sensitive issue and should be treated as such. Mr Picco responded that anecdotal evidence couldn't be discounted, and that no one was putting pressure on families to talk. He maintained that the interviews weren't traumatic and that they were helpful in identifying common markers in suicides. He noted that members of the group had experienced suicide in their own families and so would be sensitive to these issues.

Iqaluit counsellor Elisapi Davidee

Ellen Christoffersen, a member of the *Landsting*, sought to distinguish between experts who might not understand the relevant issues, and those in the room who shared knowledge and practical experience of suicide in the circumpolar Arctic. She explained to the Minister about suicide as a taboo. She indicated that for many years it was taboo to talk about the sexual abuse of children, and that politicians were equally reluctant to discuss the issues. When she finally did so, during her term as one of Greenland's representatives in the Danish parliament, the taboo had ended and the subject is now included in public discussions.

At this point the Co-Chairs recognized Caroline Anawak, whose many years of work on the issue of suicide in Nunavut include volunteering with the Kamatsiaqtut Crisis Line. Earlier in the day Ms Anawak had requested to address the workshop on the issue of terminology.

She pointed out that as suicide is a sensitive issue we should be very careful in the choice of words we use when discussing it. She drew the workshop's attention to two areas where suicide survivors have suggested the adoption of different terminology.

The first example deals with the use of 'medicalese' to describe a series of suicides. Rather than using 'contagion' or 'epidemic', which suggests a disease over which one has no control, it is preferable to use 'cluster'. Ms Anawak noted that suicide doesn't

fly off the sidewalk at you therefore we should use language that is more empowering.

The second example approaches how we describe suicide. Ms Anawak warned against using phrases such as ‘successful suicide’ or ‘completed suicide’ as it encourages us to place a value on suicide and view the act as a success. She suggested that ‘death by suicide’ is more neutral. She concluded by pointing out that if we standardize our language it would help us to deal with what is a very sensitive issue.

3.8 Greenland

Following the address by Nunavut’s Minister of Health the workshop returned to presentations from the various delegations in the circumpolar Arctic. The Greenlandic delegation began their presentation with a music video by the Greenlandic rock band Chilly Friday. The video addressed suicide and urges young people not to see suicide as a viable option.

3.8.1 Anne Cathrine Lefèvre

Anne Catherine Lefèvre began her presentation by chronicling the increase in suicides since the 1970s. She indicated that the rate has stabilized in the 1990s to approximately 50 per year. Those who commit suicide are usually young men. Greenland lacks a national strategy despite the recommendations of the World Health Organisation that every country should have such a strategy. She acknowledged that Greenland also lacks a method of evaluating the success of existing programs. Many efforts are local initiatives. In this context the *Landsting* is very concerned about the suicide rate.

Existing activities include the training of teachers to enhance the coping skills of students and enable them to deal with the suicidal thoughts of their peers. The health promotion unit has sent consultants to communities where people feel suicidal. These consultants then work with existing organizations and groups in the community. A new initiative is the use of telehealth facilities to allow trained counselors to supervise volunteer groups in two communities, thereby providing the support that non-professionals need when they take on the difficult task of counseling people in distress. Ms Lefèvre also noted that there is a national children’s phone line operating two hours each evening, and that the Inuit Circumpolar Youth Conference and the Inuit Youth Initiative are both active in Greenland.

Ms Lefèvre stated that practitioners require evidence-based knowledge about those who have attempted suicide, and about those who have taken their lives. She noted that practitioners often have assumptions about predictors of suicide, but very little evidence-based knowledge.

Ms Lefèvre explained that the treatment of those who have attempted suicide depends very much on the community where they live. In Nuuk young people would be

hospitalized until they receive psychological counseling, but this is not available in all places. Her personal opinion is that many young people who take their own lives have little sense of meaning and direction in their lives, and that the lack of religion and tradition has made it even harder to find this. She pointed out that Greenland has been pushed down a road against its will, and that social distress, neglect, child abuse and alcohol abuse is part of the result. She warned that we shouldn't expect children to develop a sense of meaning or cope with these changes on their own, that these are societal problems and should be seen as such.

3.8.2 Regitze Nyeland Castsensciold

Regitze Nyeland Castsensciold described the development of the Imminut Suicide Prevention Program, which consists of suicide prevention materials for schools. In 1994 the *Landsting* noted that there was no material to deal with suicide. Three years later a contract was signed with the publisher. The materials were developed in 2001 and as of 2002 there are courses for teachers, social workers and others working with children and adolescents. Ms Nyeland Castsensciold lamented that although they had been trying to hold five-day courses to train instructors to use the materials, they have only been able to hold three-day events. So far 88 instructors and 350 adolescents have completed the program.

Program materials include a booklet that contains a guide for instructors, sample assignments and miscellaneous statistics and poems that address themes of life, positive words and coping skills. This is accompanied by a pocket book for children and adolescents that summarizes warning signs, how to help those with suicidal thoughts, pro-life sayings, resources for help and internet links. Last there is a video with five short stories and debating topics including incest, rejection and loneliness, social problems, outcasts and 'unhappy love'.

Ms Nyeland Castsensciold acknowledged that some instructors are reluctant to participate because they don't feel that they can cope with the suicidal ideas, plans and emotions that children discuss. The instructors feel they need additional support. Ms Nyeland Castsensciold acknowledged that greater support for instructors and the evaluation of teaching materials would be important developments. At present there is no way of evaluating the effectiveness of the program.

3.8.3 Greenlandic youth

Nitta Lyberth explained that Greenlandic youth are coping with drastic change and a resulting disruption of identity. Urbanization has led to greater dependency on government and undermined the moral standards that used to govern life in a small community. She explained that the intimacy of a small community must be re-captured. Ms Lyberth concluded by noting that during the most recent election campaign youth erected posters proclaiming, "I choose life".

Petrine Hansen discussed the role of the cultural center in producing theatre, drama and body art that emphasizes themes such as love and the importance of family. She also mentioned that youth have held candle-lit ceremonies in graveyards where they sang hymns and discussed suicide.

Upaluk Poppel added that the Inuit Circumpolar Youth Council and Inuit Youth International are active in the field of suicide prevention. She stressed the importance of working together.

Discussion

Through an interpreter Doris Jacobsen, a 24 year-old member of the *Landsting*, reported that when she was young a lot of her friends in Ilulissat committed suicide and that the elders would tell them not to talk about it. She insists that young people have continued to talk about suicide despite this advice. She notes that most suicides occur during winter when daylight is limited. Ms Caroline Anawak of Nunavut Tunngavik Inc. congratulated Doris for standing up to elders and claiming the right to talk about suicide.

Ms Perry explained that in Nome, Alaska, all counselors go through 18 months of classes to work through their own personal issues, past traumas and grief. She asked what type of training exists for Inuit to work as licensed counselors.

Landsting member Asii Chemnitz Narup (left) and Pierre Kolit from the Nunavut Department of Health & Social Services

Asii Chemnitz Narup noted that there are two schools to produce social workers, one in Nuuk and one in Ilulissat. She added that it is important to rely on northern programs rather than activities that were developed in the south.

Ms Nyeland Castsensciold explained that the program she discussed was developed by Inuit in Greenland rather than by Danes in Denmark. She estimates that approximately 90% of the people she works with are Inuit.

Ms Christoffersen mentioned that she felt it was very difficult to get people to volunteer in Greenland, that they have become too interested in earning money and less interested in helping people. Ms Lefèvre

noted that she felt people volunteered more in Greenland than in Denmark where everyone is too busy rushing around. Mr Ellis suggested that conventional measurements of volunteer activities in the north might not accurately capture activity levels. People may not belong to the Rotary Club, he noted, but they are generous with the time that they spend helping members of their extended family or others at home.

Helene Berthelsen from Nuuk concluded the discussion by mentioned how important it was for people to work together. She noted that people with degrees and people with lived experiences were both necessary to solve this issue. She added that individuals must be properly trained and that youth must be led by example.

4 Summary of the Proceedings of Friday Evening

4.1 Friday, March 14, 2003, 1830-2100

Friday evening participants convened at the Discovery Lodge for dinner. Two keynote speeches by Nunavut Premier Paul Okalik and Inuit Circumpolar Conference Chair Sheila Watt-Cloutier followed the dinner. The speakers were introduced by Hugh Lloyd, the Government of Nunavut's Director of Aboriginal and Circumpolar Affairs.

4.2 Nunavut Premier Paul Okalik

Nunavut Premier Paul Okalik began his speech by thanking all participants for taking the time to attend the workshop and by thanking the organizers of the event. He noted that all regions in the Inuit homelands share a similar suicide profile -- high rates of suicide by young men and high rates of attempted suicide by young -- and that this suggests that Inuit across the Arctic are facing similar stressors.

> "I very much look forward to the day when Nunavut has Inuit clinical psychologists, who can share and learn from their colleagues on similar issues affecting aboriginal people."
>
> -- Nunavut Premier Paul Okalik

The Premier pointed to the discussion in the Legislative Assembly as proof that suicide prevention is very much on the minds of Members of the Legislative Assembly. He noted that suicide prevention programs should be imbedded in a larger body of mental health programs. He added that we need to learn from one another how to evaluate whether suicide prevention programs have been successful or not. He urged the workshop to identify practical, solution-oriented initiatives that would help all Nunavummiut deal with suicide.

4.3 Inuit Circumpolar Conference Chair Sheila Watt-Cloutier

Sheila Watt-Cloutier began her speech by noting that she and Louisa Brown had studied counseling together and that in her previous incarnation as a counselor in Nunavik she had often worked on the issue of suicide. Like the Premier, she pointed out that suicide has affected everyone in the Inuit homelands.

Ms Watt-Cloutier pointed out that the Inuit have gone from leading a very independent way of life to now being highly dependent on substances, institutions and other people. We can't go back to the world we lived in, nor she argued would we want to, but we should examine what our organizations are doing and better learn how to deal with young people. Before, culture and learning was very holistic. They have since been separated, and this separation has created confusion among adolescents -- many of whom now seem unable to deal with the stressors of life.

The Chair of the Inuit Circumpolar Conference noted that when young men were taught how to hunt they were taught not just the technical skill but also about character, sound judgment, wise decisions, and how to be bold, creative and patient. Contemporary institutions have severed these links so that young people have not learned how to lead happy and independent lives. Children now find it hard to avoid self-destructive patterns of behaviour. They have been groomed to be dependent.

Ms Watt-Cloutier noted that while empowerment has become a ‘buzzword’ it is important for youth people to control and maintain their own personal power. They should be conscious of their ability to choose options for themselves. These choices are hard because of the rapidity of change. Individuals must be aware of the things that decay their personal power and freedom, and counteract dependence with freedom. Ms Watt Cloutier acknowledged that the exercise of freedom required the development of skills and that it doesn’t happen naturally. All institutions and practices must become dependency liberating not dependency inducing. She mentioned that her video, Capturing Spirit: the Inuit Journey attempts to address these issues.

Ms Watt Cloutier also warned that health practitioners should ensure that they’re not functioning from ‘wounded healer syndrome’ and that they’re not projecting their own issues onto adolescents.

She concluded by pointing out that many Inuit in Nunavut are dealing with issues of shame. Her generation, for example, had been made to feel shameful for speaking Inuktitut. When stressors are triggered it is the shame-based issues that surface first. A rejuvenated sense of culture would help individuals to overcome these issues and help them to deal better with stress when it arises. The solution, suggested Ms Watt-Cloutier, lies in the cooperation of those with clinical knowledge and those with traditional knowledge, of elders and youth.

Workshop participants discuss the day’s proceedings

5. Summary of the Proceedings of the Saturday Session

5.1 Saturday, March 15, 2003, 0830-1700

The Saturday session included three presentations from individuals working on suicide prevention. The presentations were followed by breakout sessions to discuss recommendations on suicide prevention strategies in Nunavut.

5.2 Dr Laurence Kirmayer, Division of Social and Transcultural Psychology, McGill University -- "Best Practices in Suicide Prevention in First Nations Communities"

Dr Laurence Kirmayer chairs the Division of Social and Transcultural Psychology at McGill University and also works at the Sir Mortimer B. Davis -- Jewish General Hospital in Montreal. From 1987 to 1993 he was a consultant for the hospital in Povungnituk and the seven communities on the Hudson coast of Nunavik.

He was recently part of a group created by the Minister of Health and the National Chief of the Assembly of First Nations to explore the issue of youth suicide in First Nations communities. The group attempted to develop practical, 'doable' recommendations to help stem the tide of youth suicides. Their recommendations are contained in the recently released report *Acting on What We Know: Preventing Youth Suicide in First Nations.* Dr Kirmayer recalled that when the group began its work they were disconcerted to receive a box full of past reports containing recommendations that had not been implemented.

Dr Kirmayer pointed out that suicide rates in First Nations communities in Canada are very high, and increasing in some communities. Overall, the suicide rate among First Nations is about three times that of the general population in Canada. The rate of suicide among First Nations elders is, however, lower than in the general Canadian population. He cited a 1990 study, described in Kirmayer, Malus and Boothroyd (1996), which indicated that one third of Inuit youth in a Nunavik community had attempted suicide, and that one in ten had made a serious attempt to commit suicide. He added that young males tend to be the most affected.

Rates of depression and acute stress are also high in First Nations communities, but the proportion of suicides attributable to specific types of psychological problems is unknown. As there is generally little reason to conclude that aboriginal peoples are genetically predisposed to disorders that might lead to suicide, the current high suicide rates should be attributed to social reasons.

Dr Kirmayer pointed out that each culture has its own way of understanding personal predicament and illness. The stigma attached to suicide in some religious and cultural groups has contributed to lower rates of suicide. The stigma of psychological distress,

however, may prevent people from seeking help and as a result can cause the suicide rate to increase. Communities must find a way to discuss emotional stress without portraying suicide as a normal response to stress and suffering.

Suicide is more common among economically disadvantaged and disempowered groups, and among marginalized individuals within groups. Dr Kirmayer noted that this was particularly relevant to First Nations communities in Canada. He noted that this also affected gender roles. In the rapid cultural change that occurred among First Nations in the twentieth century there was a greater discontinuity in the roles of males than in the roles of females. The tasks of women were more transferable to their current roles in social welfare, and human problem solving. The male role as provider, hunter and economic mainstay has been undercut by cultural change. The resulting confusion for young men about their role in society leads to considerable stress.

Dr Kirmayer said that we need to depoliticize the issue of suicide but politicize youth. Suicide should not be treated as a political issue because this may give the impression that it is an effective means of protest. However, because suicide may stem from feelings of powerlessness, working to engage youth in political processes and self-direction will aid suicide prevention.

Dr Laurence Kirmayer

Dr Kirmayer noted that suicide can also occur among people who seem to be highly functioning, who appear to 'have it all'. He pointed out that some people carry a lot of weight because they feel they are carrying the hopes of the community. Some young and talented aboriginal people who are doing well indicate that they can never escape this role, and may experience an extraordinary burden of expectations.

Dr Kirmayer also pointed out that suicide is sometimes an impulsive act. Among some First Nations and Inuit youth there is a pattern of very intense relationships. The intense relationship makes up for the perceived lack of love, and is a source of stability in their life. The end of those relationships can evoke feelings of abandonment and make any breakup much more traumatic.

Risk factors associated with First Nations suicide include being male, the victim or perpetrator of violence, having completed a previous suicide attempt, substance abuse including alcohol and inhalant abuse, and parental substance abuse. Dr Kirmayer noted that most studies focus on the individual. However, we should recognize that individuals exist within social networks of families and communities. Many young people are suffering on behalf of an entire family but that family many not be open to help.

Dr Kirmayer also highlighted some protective factors that he said could reduce the risk of suicide: a sense of social connectedness, a strong sense of value and self-esteem were important elements.

He explained that there are three primary individual factors which lead to suicide:

- depression, which could be characterized as an episode of illness;
- an interpersonal predicament, or acute crisis; and,
- the biography, or individual development history, which could include a personal history of abuse, family violence or lack of parental care.

The social predicament, Dr Kirmayer explained, is more likely to explain suicides that are the result of impulsive behaviour or are alcohol related. Dr Kirmayer warned that it is not clear how much these three factors may overlap but they are all embedded within a larger social world.

Dr Kirmayer noted that in addition to these individual factors we should look to social or cultural explanations of suicide. The rapid cultural change experienced by aboriginal communities in Canada is credited with creating a sense of dislocation. He cited a report by Michael Chandler and Christopher Lalonde that explained that First Nations communities in British Columbia that had higher levels of local control tended to have lower suicide rates. In particular, communities with a measure of self-government, who were at an advanced stage of land claim negotiations, who had control over their own education and health system, who operated their own police and emergency services and who had developed cultural programs had lower suicide rates. Whether the protection against suicide is because these communities have a stronger sense of culture, have more control over their destiny or simply because they are more organized is not clear.

The Advisory Group on Suicide Prevention that Dr Kirmayer worked with made a series of short-term and longer-term recommendations. These included health funding according to need, the training of local teams, a national crisis consultation service, a resource bank of professionals, integrated health services, training for youth to serve as peer counselors and role models, and programs for parenting and family wellness.

Discussion

Mr Kouri asked whether abuse had been a relevant factor in many suicides. Dr Kirmayer said that the actual level varies widely. Abuse can lead to ongoing mental health problems that in turn can lead to young people committing suicide. He pointed out, however, that the majority of people who have suffered limited episodes of abuse do not attempt suicide. Family support is an effective buffer. Abuse victims who are from strong families tend to have less suicidal behaviour than those who are from dysfunctional families.

Mr Ellis pointed out that interviews with survivors have led practitioners to believe that many families are suffering from second and third generation problems. Those who

suffered residential schools or abuse many not commit suicide but they are numbed as parents. The destruction of the family unit may in turn lead to suicide in later generations.

In response to a question about whether some people are "naturally sensitive", Dr Kirmayer noted that sensitivity to negative feelings leads some people to have a magnified sense of suffering. He added that life circumstances will dictate whether you feel miserable or not but whether you commit suicide is linked more to impulsivity. Anthropologist Hugh Brody noted that sensitivity is a striking characteristic of aboriginal communities. Living in small social units encouraged individuals to be attentive to discord, fear and apprehension. That characteristic may have less use in an urban setting and may in fact contribute to perceptions of suffering.

5.3 Dr Tracy Westerman, Managing Director, Indigenous Psychological Services, Western Australia -- "Best Practices in Suicide Prevention Among Aboriginal Australians"

Dr Tracy Westerman is the first Aboriginal Australian to receive a PhD in clinical psychology. She has worked as a clinical psychologist for ten years, and is now the Managing Director of her own company, Indigenous Psychological Services.

Dr Westerman began her presentation with a summary of suicide statistics in Australia. Australia has one of the of highest suicide rates in western world. Within this context the suicide rate for Aboriginal Australians is twice the rate for Australia as a whole. The suicide rate is particularly high for men aged 25 to 45. Both attempts and completions tend to be clustered. On community, for example, had a cluster of 18 suicides. Most suicides (68%) are by hanging and most young people commit suicide in a location where they could be found. Dr Westerman also spoke of the existence of 'respect' suicides. When a suicide occurs the entire community will come to pay its respects to the departed individual. This is seen by some as a way of receiving guaranteed attention if they commit suicide.

Dr Westerman noted that ten years ago the rising Australian suicide rate was met with increased government funding for youth intervention programs. The suicide rate plateaued but Dr Westerman warned that it is difficult to tell whether this was the result of intervention programs or other factors. Her work in this area has sought to determine whether the higher suicide rate among Aboriginal Australians was the result of mainstream risk factors that occurred at a higher rate within the Aboriginal population, or whether there were unique risk factors that heightened the risk for young Aboriginal people.

Dr Westerman stated that much of the prevention, intervention and postvention that occurs in Australia is not relevant to Aboriginal people. She pointed out that there are consistent problems with both the diagnosis and assessment of individuals. Non-Aboriginal practitioners have claimed that some Aboriginal individuals are depressed when, understood in an appropriate cultural context, they are not. Dr Westerman

provided examples of under-diagnosis, over-diagnosis and mis-diagnosis. She explained that while non-Aboriginal children may become withdrawn before they attempt to commit suicide, Aboriginal children tend to act out or become aggressive. By using non-Aboriginal methods of diagnosis, Aboriginal children who are 'at risk' are being misdiagnosed. She said the problem is further compounded by the lack of access that Aboriginal Australians have to existing programs and the fact that many of the existing programs are culturally inappropriate to Aboriginal Australians

Dr Tracy Westerman

Dr Westerman recounted that earlier it was difficult to talk about suicide among Aboriginal communities. Some believed that Aboriginal people weren't killing themselves but were in fact dying in custody. She recounted the policy of assimilation pursued by the Australian government until 1973 and explained that the effect of this policy has displaced people and generated a considerable amount of generalized grief.

Dr Westerman explained that the first step in solving the suicide crisis among Aboriginal Australians is to develop culturally appropriate methods of assessing the nature of Aboriginal suicide and identifying those individuals who are at risk. Existing methods have been unreliable in their application and are biased against Aboriginal people. To this end Dr Westerman organized focus groups to identify all the possible factors associated with the development and maintenance of a disorder. These focus groups, which involved youth, parents and youth workers, resulted in a coherent list of symptoms. Youth then verified that the descriptions of these symptoms used language that was relevant to them.

Dr Westerman explained that she used this list of symptoms to create a valid checklist of indicators, called the Westerman Aboriginal Symptom Checklist for Youth (WASC-Y), to evaluate who might be at risk. She then administered this checklist to youth. She found that 68% of individuals who completed the inventory were at risk. She noted that 28% had previously attempted suicide and the overwhelming majority of these individuals had had no contact with any health or psychological services. She also found that rates of depression and anxiety were very high. Measures of cultural resilience, which included questions about cultural activities and Aboriginal language use, were low among the children that she screened.

Dr Westerman pointed out that using a screening tool can help to identify people at the early stages of crisis. This activity is better than basing efforts on attempted or completed suicides because it is proactive rather than reactive. The screening tool is now being implemented in schools, who are screening children at six-month intervals.

From her discussions with youth Dr Westerman discovered that children who had both Aboriginal and non-Aboriginal friends appeared to cope best. Having a varied group of friends allowed children to believe that they could cope in Aboriginal and non-Aboriginal social worlds. She also found that children who had ideas of suicide didn't want to die, but rather wanted a way to stop the pain they felt. She noted that impulsivity, which is encouraged as a child-rearing factor among Aboriginal Australians, is the biggest factor in suicides.

Dr Westerman warned, however, that the use of a screening tool must be accompanied by an effective treatment program. Children who are identified 'at risk' must receive treatment quickly. She explained that she would usually wait in a community until the individual deemed to be 'at risk' was integrated into a treatment regime.

With regards to intervention and treatment, Dr Westerman urged that it was important to bring together people with clinical and cultural skills, and to involve both Aboriginal and non-Aboriginal practitioners. She advocated a community development approach that would supplement clinical treatment with service providers. She also mentioned that treatment should include the use of culturally appropriate psychotherapeutic techniques.

Nunavut's Director of Health & Social Services Programs Don Ellis and other workshop participants examine Tracy Westerman's Aboriginal Symptom Checklist for Youth (WASC-Y).

The training of service providers should address myths about suicide, barriers to seeking help and skill acquisition. Dr Westerman warned that elders in the community are sometimes the source of perceived 'myths' about suicide. The workshops were offered to youth and to community workers and are designed to help people identify those in high-risk emotional states. So far, Dr Westerman has trained 77 adults in community forums and 71 youth.

Dr Westerman noted that the combined use of screening tools, culturally appropriate treatment and training for youth and adults has affected the suicide rate in Western Australia. The region used to have one suicide per month. It has had only one death by suicide since July 2002.

Discussion

In response to a series of questions about culture and myths Dr Westerman elaborated that some elements of Aboriginal culture are helpful in preventing suicide. Other aspects of culture might be less relevant and still others might actually be harmful. She pointed out that knowledge of one's 'skin group' isn't a particularly good sign of cultural

resilience. Instead, eating traditional foods is a better predicator of a healthy cultural life. Healthy cultures are a protective factor against suicide as they are better able to produce individuals with a strong sense of self-esteem. Dr Westerman cautioned that elders don't necessarily have the answers, as they too are struggling with a culture that they haven't yet made sense of.

Mr Aquino asked about the implementation of the screening tool. Dr Westerman said that securing permission to administer the tool had been difficult, and that permission had taken approximately two years to secure. She added that the consent allows students to be re-screened at six-month intervals. The schools have now taken over the administration of screening.

Mr Naktialuk pressed Dr Westerman on the phrase 'culturally appropriate intervention'. He wondered whether that meant that elders were involved or whether it covered a wider range of activities. He noted that it was often watered down in its application. Dr Westerman responded that for her it meant engaging a range of cultural consultants and traditional healers. Aboriginal culture was involved in the creation of the screening tool and in the delivery of treatment. She added that it was important to give people the option of pursuing treatment in a traditional way, with, for example, spiritual healers or within the modern health system.

5.4 Chris Aquino, Associate Coordinator, Alaska Community-Based Suicide Prevention Program -- "The Evaluation of Alaska's Community-Based Suicide Prevention Program"

In his second presentation to the workshop Chris Aquino addressed the issue of program evaluation. He indicated that an early program evaluation, undertaken from 1990 to 1993, focused on whether they were accurately teaching individuals about the warning signs and whether the suicide rate had decreased. He acknowledged, however, that these indicators weren't much of a tool for communities to improve their suicide prevention projects. In 1998 an effort to bring together people from each region of Alaska sought to identify the data and methods required to accurately evaluate the success of suicide programs. As a result of this effort, since 1999 communities have provided data on suicide and self-destructive behaviour, the perceived strengths of the community, goals and specific activities. This allows for an evaluation of the processes, outcomes and impact of the suicide prevention program.

Evaluation of the programs relies on activity reports that are completed by communities. These reports indicate the number of times they have held activities, how many participants were involved and, on scale of one to five, whether the activity could be considered a success. According to these data there have been 10,000 activities in the past three years and over 150,000 people have participated. Noting that an average suicide attempt has hospital costs of over US $7,000, Mr Aquino pointed out that if the US $14,000 program prevents just two suicide attempts then it will have paid for itself.

Workshop participants listen to Chris Aquino's evaluation presentation

Evaluations of outcomes include the tracking of promotional indicators, such as the number of participating families and the number of cultural events, as well as prevention indicators, such as the number of reported drug/alcohol incidents and the number of interventions. Evaluations of impact, tracked by program staff, rely on the suicide rate and the alcohol-related injuries rate. Mr Aquino noted that communities with projects have seen a decline in their suicide rates. He added that communities without projects have seen a gradual increase in suicide rates.

He noted, however, that if suicide attempts are counted with alcohol-related events then the numbers of 'critical incidents' don't appear to have been affected by the community-based program. Mr Aquino suggested, however, that a distinction between communities with an active series of events and communities that are relatively inactive demonstrates encouraging results. Stability in the coordinator position, enthusiasm and community involvement, reasonable and clearly defined goals are all predictors of a successful program. Communities that plan five to nine activities per year to have better participation and management than communities that plan ten or more activities per year.

Discussion

Ms Nyeland Castsensciold asked how the program could ensure that communities completed the activity reports. Mr Aquino responded that, as the state doesn't require evaluation reports, it is sometime difficult to convince communities to complete their evaluation. He estimates that approximately half consistently submit reports.

Mr Kolit asked what happens to the activities if a suicide occurs. He reported that he used to go to the schools to talk to children in grades 5 to 12 but he wasn't sure when it was a good idea to return following a suicide. Ms Perry reported that following a suicide last September counselors, psychiatrists and clinicians arrived at the school, set up camp in the library and talked to students. She explained that some children spent the night there. She added that it depends on whether the community feels it is ready.

5.5 Break-out Groups

Following the presentations, workshop participants were divided into two groups to discuss recommendations for the creation and evaluation of a suicide prevention program in Nunavut. Because of pressures of time, the groups did not travel to different locations but rather occupied separate corners of the 'By The Sea' Bed and Breakfast. Participants were assigned to groups to ensure a balance of regions, professions and gender. Group membership was as follows:

Group A: Amalia Lynge Pedersen, Asii Chemnitz Narup, Caroline Anawak, Chris Aquino, Don Ellis, Ellen Christoffersen, Helen Berthelsen, Hugh Brody, Joan Brackenbury, Johnny Naktialuk, Louis Tapardjuk, Louisa Brown, Margaret Joyce, Nitta Lyberth, Olootie Koonoo, Sandy Little, Tamara Macpherson, and Tracey Westerman

Group B: Anne Cathrine Lefèvre, Doris Jacobsen, Elisapi Davidee, Joanna Quassa, John Vander Velde, Laurence Kirmayer, Lisa Stevenson, Manon Leblanc, Mary Akpalialuk, Monica Ittusarjuat, Petrine Hansen, Pierre Kolit, Regitze Nyeland Castsensciold, Richard Kouri, Sam Law, Sheila Levy, Teresa Perry, and Upaluk Poppel.

5.6 Reports from Break-out Groups

5.6.1 Group A

Dr Sam Law reported the list of recommendations from group A. The recommendations can be discussed in terms of five themes: holistic approaches, communication, awareness, skills and culture:

Holistic approach

- Return to a holistic approach.
- Equate mental health with promotion of wellness of being.
- Use more than one approach. For example, combine outreach, prevention and home visits.
- Evaluate strategies and conduct research.
- Have cooperation within circumpolar world.
- Develop pan-Arctic development of instrumentation to screen and evaluate outcomes.
- Hold regular workshops.

Communication/Integration

- Emphasize education about emotional life. Parents need to reclaim this issue and not relinquish it to the education system.
- Promote life.
- Build bridges within communities – between young and old, locals and those here for shorter time, white and Inuit.
- Promote communication through activities and common interests.
- Families should be taught to deal with suicide, how to talk about it.
- Teach to talk about emotion.

Awareness

- Make current knowledge understandable. At present it is too remote, and language isn't clear.

Skills

- Don't forget front-line people, they need training, support, recruitment.
- Develop core skills. Promote listening and being listened to as they will help people feel valued and respected.
- Give young people life skills. Some Inuit traditional skills are relevant, other necessary life skills are more modern.

Culture

- Ask elders to identify suicide-related issues.
- Recognize that some values from traditional lifestyle are useful and others are not. Some believe that youth shouldn't talk directly to elders, or only speak when spoken to. This encourages silence and inhibits their ability to ask for help.

- Youth should be made to feel that they are competent in both worlds, not made to feel inferior in one or the other (or both).
- Examine how having a spiritual life can be preventative and enriching.

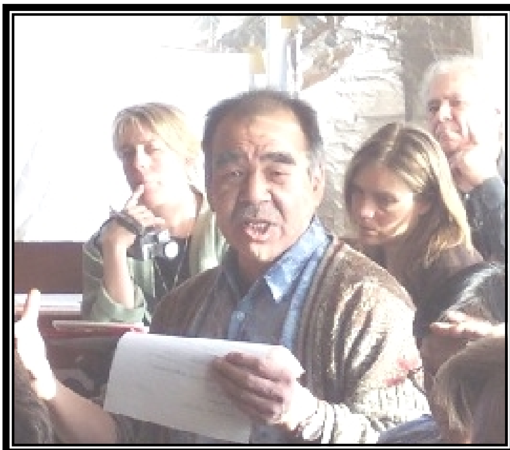
5.6.2 Group B

Joan Brackenbury from the Nunavut Department of Health and Social Services reported the recommendations of Group B. She offered a detailed description of the discussions that occurred within the group and also described developments in the suicide prevention activities mentioned by Mr Ellis on Friday. She then recommended the following:

- The time to act is now, we must mobilize.
- Restore Inuit pride.
- We should distinguish between crisis management and an intelligent plan for dealing with the causes of suicide.
- We should be careful about the words we use.
- We should go back to the conditions in which our grandparents survived to teach children the importance of language.
- We need screening tools, whether to use as is or adapt for Nunavut.
- We should support front-line workers.
- We should empower people.
- We should have culturally appropriate strategies.

5.7 Wrap-up Discussions

Following the recommendations presented by the breakout groups, workshop participants engaged in a final discussion about what needs to be done. The discussion centred on five themes: the promotion of emotional well-being, the inter-connected nature of potential problems and the role of family, the cultural content of prevention and intervention treatment, the practicalities of intervention, and future cooperation.



Nunavut Tunngavik Inc. staff member
Louis Taparjuk

Dr Laurence Kirmayer explained that emotional well-being relies on an ability and willingness to talk about emotions. He warned that making suicide a taboo might prevent young people from coming forward if they feel they are having a difficult time dealing with their emotions. For Dr Kirmayer, promoting life hinges on the ability to talk about emotions, whether good or bad.

Repeating a point made earlier in the workshop by Ms Towtongie, Alexina Kublu stated that “the time to tell us you love us is not when you’re burying us.” There was general agreement that

there must be greater discussion of emotions within families.

Mr Tapardjuk also addressed the promotion of life, pointing out that it is more than just trying to prevent suicide. He stated that we shouldn't just be promoting human life, but life in the world around us, in our environment and on the land. It's contradictory, he said, to talk about 'life' while we poison our environment. For these two speakers, the promotion of life relies on efforts to discuss emotions and efforts to protect our environment.

Ms Jacobsen pointed out that we must recognize the importance of family relationships when we discuss suicide. For her, an individual who feel suicidal may be reflecting a dysfunctional family relationship. She stressed that if a member of a family has a problem then the whole family has a problem. We must also recognize, she said, that if parents are having problems in their lives that this will result in problems from their children. We must look at the child as a product of his or her surroundings.

Ms Little agreed, and pointed out that this posed a problem for intervention. Sometimes young people have to be taken away from their families to receive treatment. This is hard for the child, it is hard for the family and it is also hard for the community, who may feel a sense of powerlessness over not being able to treat the child in the home community. This is difficult, also, because if the problems are not just with the individual but with the larger family unit, then treating only the child won't necessary help solve the problem.

Another theme addressed the role of culture in prevention, intervention and postvention. Dr Westerman repeated that much work needs to be done on the validity of measures and treatment. Measures are valid when they do what they're intended to do. To identify and treat northern residents, many of whom are Inuit, we need to develop culturally valid screening tools. Southern models, and indeed models designed for Aboriginal populations elsewhere in Canada or the world, might not be sufficiently valid. This work must be done within Nunavut. She added that the problem is not with the medical model, but that it hasn't yet been culturally adapted for a Nunavut context. Dr Westerman's approach advocates using the traditional counseling approaches of elders within a comprehensive treatment plan.

Following this discussion Mr Tapardjuk explained the work of the elders' society in Igloolik. At present, 70 elders provide counseling either one-on-one or in a group setting. A young person may approach the coordinator to ask elders to meet with herself and her parents in order to resolve internal conflict. Mr Tapardjuk explained the elders try to do counseling according to traditional values because they don't particularly trust the policies currently governing the social services system.

Mr Naktialuk suggested the establishment of a cultural watchdog that could track suicide prevention work. Mr Kouri suggested that a traditional healer could accompany the group currently traveling in Nunavik.

In a discussion of the day-to-day operation of intervention programs Ms Perry explained the role of mobilized intervention teams who would arrive in communities. Upon a suicide attempt these teams would descend on a community for three weeks, see the relevant child every day and then return a month later.

Speaking also of intervention, Mr Ellis highlighted that the treatment or intervention you receive depends on who you first approach. He explained that if you approach the Department of Justice you might be sent to meet with a family mediation team, but if you approach school counselors you might end up working with early childhood visitors or mental health workers. He suggested that it is not easy for individuals to locate the appropriate person or program.

Ms Anawak suggested that better marketing might help. “We need a sophisticated marketing strategy to pull people back from the edge,” she said.

The results of this discussion, in addition to the recommendations from Group A and Group B, are listed in the workshop recommendations in Appendix D.

Workshop participants discuss recommendations for Nunavut

Appendix A: List of Participants

Circumpolar Arctic

Nunavut, Canada (all participants from Iqaluit unless otherwise stated)

Gov't of Nunavut, Dep't of Culture, Language, Elders and Youth
Joanna Quassa, Director, Community Programs, Igloolik

Gov't of Nunavut, Dep't of Education
Margaret Joyce, Coordinator, Early Childhood and Student Support, Arviat
John Vander Velde, Children First Secretariat

Gov't of Nunavut, Dep't of Executive and Intergovernmental Affairs
Jack Hicks, Director, Evaluation and Statistics
Hugh Lloyd, Director, Aboriginal and Circumpolar Affairs

Gov't of Nunavut, Dep't of Health and Social Services
Mary Akpalialuk, Suicide Specialist
Joan Brackenbury, *Inuit Inuuq* Forum Coordinator
Don Ellis, Director, Health & Social Services Programs
Pierre Kolit, Finance Officer, Rankin Inlet
Manon Leblanc, Regional Psychologist

Gov't of Nunavut, Dep't of Justice
Olootie Koonoo, Clinician, Young Offenders

Nunavut Tunngavik Inc.
Monica Ittusarjuat, Community Wellness Coordinator
Louis Tapardjuk, Inuit Qaujimajatuqangit Director, Igloolik
Cathy Towtongie, President

Kamatsiaqtut Crisis Line
Caroline Anawak
Alexina Kublu
Sheila Levy

Other Participants
Elisapi Davidee, Counsellor
Lisa Stevenson, Researcher
Tamara Macpherson, Site Co-ordinator, 2003 Annual Meeting of the Canadian Association for Suicide Prevention

Northwest Territories, Canada

Sandy Little, Mental Health Consultant, Department of Health and Social Services

Nunavik, Quebec, Canada

Johnny Naktialuk, Chair, Nunavik Regional Board of Health and Social Services, Inukjuaq
Louisa Brown, Counsellor, Kativik School Board, Kuujjuarapik
Richard Kouri, Nunavik Regional Board of Health and Social Services, Kuujjuaq

Alaska, United States

Chris Aquino, Associate Coordinator, Alaska Community-Based Suicide Prevention Program, Anchorage
Teresa Perry, Counsellor, Shaktoolik

Greenland

Landsting **(Greenlandic legislature)**
Asii Chemnitz Narup
Doris Jacobsen
Ellen Christoffersen

Practitioners
Anne Cathrine Lefèvre, PAARISA
Amalia Lynge Pedersen, Psychiatrist, Queen Ingrid Hospital
Regitze Nyeland Castsensciold, Practitioner, Nuup Kommunea
Helene Berthelsen, Future of Nuuk Youth group

Youth
Petrine Hansen, Inuit Youth International
Nitta Lyberth, Inuit Youth International
Upaluk Poppel, Inuit Circumpolar Youth Council

Other Participants

Hugh Brody, anthropologist/author/documentary filmmaker, London
Dr Laurence Kirmayer, Division of Transcultural Psychiatry, McGill University
Dr Sam Law, private psychiatrist, until recently at the Baffin Regional Hospital
Dr Tracy Westerman, Indigenous Psychological Services, Western Australia

Appendix B: Original Agenda

Workshop on 'Best Practices in Suicide Prevention and the Evaluation of Suicide Prevention Programs in the Arctic'

Iqaluit, Nunavut -- March 13 and 14, 2003

Accommodations By the Sea (House 2536)

Hosted by the Government of Nunavut, Department of Executive and Intergovernmental Affairs, Evaluation and Statistics Division

Please note: Due to both the nature of the discussions and the limited space available, **participation in this workshop is by invitation only**. For further information, please contact Jack Hicks at 867.975.6061

DRAFT AGENDA

Wednesday, March 12

Most participants arrive during the day
Afternoon tour of Iqaluit by Polynya Adventure and Coordination Ltd
1930 Informal reception at Accommodations By The Sea (House 2536)

Thursday, March 13

0830 Welcome by Co-Chairs Jack Hicks and Alexina Kublu
Welcome by Nunavut Tunngavik Inc. President Cathy Towtongie
Introductions and review of agenda
0900 Presentation of suicide prevention programs in Alaska; discussion
0930 Presentation of suicide prevention programs in Northwest Territories; discussion
1000 Break
1015 Presentation on the suicide prevention programs in Nunavut; discussion
1045 Welcome by Nunavut Minister of Health Ed Picco
1115 Presentation on the suicide prevention programs in Nunavik; discussion
1145 Presentation on the suicide prevention programs in Greenland; discussion
1215 Soup & sandwich lunch (provided)
1300 Discussion: How broadly do we define 'suicide prevention programs'?
1400 Visit to the Legislative Assembly of Nunavut (in session)
1500 Break
1515 Presentation by Dr Laurence Kirmayer (Director, Division of Social & Transcultural Psychiatry, McGill University, and Editor-in-Chief, *Transcultural Psychiatry*): Best practices in suicide prevention in First Nations communities; discussion

1615 Presentation by Dr Tracey Westerman (Managing Director, Indigenous Psychological Services, Carlisle, Western Australia); Best practices in suicide prevention among Aboriginal Australians; discussion
1800 Dinner at the Frobisher Inn
-- evening session at the Frobisher Inn --
1900 Presentation by Christopher Aquino (Associate Coordinator, Alaska Community-Based Suicide Prevention Program): Evaluation of Alaska's Community-Based Suicide Prevention Program
1930 Discussion: Evaluating the effectiveness of suicide prevention programs

Friday, March 14
0830 Welcome by the Co-Chairs and review of the previous day
0900 Applying the lessons learned: Participants divide into two groups, each of which designs a suicide prevention plan (with evaluation component) for Nunavut
Group A: Accommodations By The Sea (House 2536)
Group B: Department or Executive and Intergovernmental Affairs boardroom (Building 1084)
1200 Soup & sandwich lunch (provided)
1300 Presentation of the work of the two groups; discussion
1500 Break
1530 Review of workshop and closing discussions
1830 Dinner hosted by the Government of Nunavut at the Discovery Inn; keynote speakers Nunavut Premier Paul Okalik and Inuit Circumpolar Conference Chair Sheila Watt-Cloutier

Saturday, March 15
Free day -- we would be happy to assist workshop participants in exploring Iqaluit and/or one of the nearby communities

Sunday, March 15
Most participants depart Iqaluit

Appendix C: Recommendations

General Principles

- Must act now to create culturally appropriate prevention, intervention and postvention programs.
- Must make information clear and accessible -- jargon-free, and available in as many languages as possible.
- Need holistic approach.
- Need method to evaluate strategies.
- Need to recognize the relationship between the formal (government, police) and informal (family, community) systems.
- Need to change emphasis -- equate mental health with promotion of wellness of being, promote life rather than avoidance of death.
- Must recognize that some aspects of Inuit culture are helpful in addressing suicide but others are less helpful.
- Must recognize that empowered individuals exist within empowered and healthy communities. We need to break down divisions between elders and youth, between Inuit and qallunaat, and between Inuktitut, English and French speakers.

Actionable Recommendations

Culturally Appropriate Prevention

- Develop and administer a screening tool that is culturally appropriate for Inuit.
- The development of a screening tool would require:
  - identifying behaviours that normally precede suicide attempts;
  - identifying other risk factors;
  - drawing up list of behaviours as a survey to administer as a screening tool;
  - administering screening tool (could be done in schools); and,
  - placing individuals deemed to be ‘at risk’ in counseling or psychiatric services.
- Need curriculum in schools that encourages discussion of emotions (formal system), wellness of being, skills for coping with stress.
- Need to encourage families to discuss emotions and wellness of being, skills for coping with stress -- not relinquish to the education system (informal system) -- could be possible through activities or workshops.
- Need activities within communities that build bridges within the population -- elders and youth, Inuit and qallunaat, long-term residents and newer-arrivals
- Need activities, particularly cultural activities, that restore Inuit pride.
- Need activities -- whether through formal or informal system -- that teach young people life skills -- some could be taught alongside (or through) Inuit traditional skills -- goal would be to teach them that they are valued, not inferior.
- Programs should be available in Inuktitut.

Culturally Appropriate Intervention

- Must ensure that there are Inuit front-line workers who receive adequate training in crisis intervention.
- These front-line workers must continue to receive support following their initial recruitment.
- Front-line workers should receive training in core skills such as active listening.
- Programs should be available in Inuktitut.

Culturally Appropriate Postvention

- Need to conduct culturally sensitive and culturally appropriate research into the causes of suicide.
- Need to examine how having a spiritual life can be preventative and enriching.
- Any attempt to conduct psychological autopsies/follow-back studies must take note of the following:
    - there is a difference between the need to talk and determining the causes of suicide;
    - there is the potential for unproductive finger-pointing; and,
    - there is the potential for re-traumatizing survivors and bringing up feelings of anger, guilt and helplessness.
- Programs should be available in Inuktitut.

Cooperation around the Arctic

- Annual meeting of practitioners working on suicide prevention around the Arctic.
- Creation of listserv of practitioners working on suicide prevention in the Arctic.
- Annual meetings and a listserv would allow practitioners to discuss developments in suicide prevention and the evaluation of suicide prevention programs on an ongoing basis.

Appendix D: Media Coverage

The workshop received coverage in the print and broadcast media. The following three items provide examples of the coverage received in the two local newspapers, Nunatsiaq News and News North, and the regional CBC radio. In addition, the Members of Nunavut's Legislative Assembly passed a motion directing the Government of Nunavut to establish a taskforce on suicide. Coverage of that motion is included at the end of this section.

1. In the days following the workshop the following interview was broadcast on the CBC Iqaluit regional news:

Arctic suicide prevention workers establish network

March 17, 2003 -- 7:30am, 2nd Story:

Suicide prevention workers from across the Arctic have set up a network where they'll be exchanging ideas on how to prevent suicide. They gathered in person for the first time in Iqaluit last week. They came from Alaska, the Northwest Territories, Nunavut and Greenland. The workers had a roundtable discussion about their programs.

Jack Hicks organized the workshop. He says the information from the workshop will be put together into a report and brought to a larger conference on suicide in Iqaluit this May.

"We now have a much better idea of the types of programs that are delivered in the different jurisdictions, a sense of how those programs have evolved, what some of the successes have been. We looked at the evaluation methodologies, particularly in Alaska. How do you know you're making a difference in suicide prevention?"

No concrete solutions came out of the workshop, but the delegates hope that by keeping in contact with each other they'll be able to continue to develop their own programs.

2. The following article appeared in *Nunatsiaq News*, March 21, 2003:

Iqaluit welcomes circumpolar suicide workshop
GN-funded workshop evaluates available programs

KIRSTEN MURPHY

Dr. Tracy Westerman, the first aboriginal Australian to earn a PhD in psychology, was one of a dozen visiting social scientists, authors and counsellors evaluating suicide prevention programs in Iqaluit last week.

(PHOTO BY KIRSTEN MURPHY)

Experts from around the circumpolar world gathered in Iqaluit March 13 to 14 for the Best Practices Suicide Prevention and Evaluation of Arctic Suicide Prevention Programs workshop.

Recommendations from the conference, sponsored by the Government of Nunavut, will be presented in Inuktitut and English at the Canadian Association for Suicide Prevention (CASP) conference in Iqaluit May 15 to 18.

“These are our beneficiaries who have been lost to suicide. It is their grieving families who are also our beneficiaries. I am aware that people cannot continue to live in such a highly reactive state, surrounded by such loss, without beginning to take on much of the anxiety and uncertainty that springs from it,” said Cathy Towtongie, the president of Nunavut Tunngavik Inc. in her opening address.

Visiting guests included Tracy Westerman, the first Australian aboriginal to earn a PhD in clinical psychology, Hugh Brody, whose books and films focus on the Arctic, and Chris Aquino, an Alaskan counsellor specializing in culturally specific suicide prevention programs.

Presenters said exchanging ideas would continue long after the conference.

“I’m going to continue to share information with people through e-mail,” Westerman said.

Westerman recently developed the first culturally sensitive suicide assessment administered by aboriginal youth for aboriginal youth. The written evaluation measures levels of anxiety and depression in youths 13 to 17 years old.

“What we found is a difference in symptoms between aboriginal and non-aboriginal youth which suggests [existing] mainstream tools aren’t assessing indigenous kids

properly," she said.

Westerman's research noted that acting out, such as picking fights, is a warning sign among Aboriginal youths contemplating suicide. Conversely, non-aboriginal youths were more inclined to become introverted before a suicide attempt.

Chris Aquino runs a series of land programs in villages in and around Anchorage, Alaska, for First Nations youth. There are about 125 deaths per year due to suicide in the region. While the number has not changed in 15 years, it's the villages without the state-funded projects that have more suicides, Aquino said.

"It's something for take a look at," he said.

Aware academics sometimes intellectualize suicide, Aquino said the workshop found balance between theory and reality.

But not everyone was so quick to applaud the conference. One participant wondered out loud why the workshop wasn't held two months later to coincide with CASP.

Co-chair Jack Hicks said not all presenters were available to attend the conference in May. He was also aware of other criticisms.

"It would be perfectly reasonable for someone to say every dollar spent on this workshop is a dollar that wasn't spent on front line [suicide prevention] programs. But that's not how government works," he said.

"There has to be a certain amount of stepping back and reflection. I think the question should be why has it taken this long, given the commonality of the suicide profile in the Arctic, to bring people together and say, 'What have you learned?'"

He said Westerman's work has huge potential in Nunavut.

"What Tracy showed us is a vision of the future when we have Inuit mental health professionals doing things in an Inuit way."

3. The following article appeared in *News/North*, March 24, 2003:

Countries combat suicide: *Iqaluit hosts multi-national workshop*

Chris Puglia, Northern News Services

Iqaluit (Mar 24/03) -- There are no easy answers.

It was the one thing suicide prevention groups from Greenland, Alaska, Nunavut and the Northwest Territories acknowledged when they met for a three-day workshop in Iqaluit last week.

This particular workshop was designed to share ideas to determine what is working and what is not in other regions.

Sheila Levy, president of the Nunavut Kamatsiaqtut help-line based in Iqaluit, was one of the people attending the workshop.

"It's good to bring everybody together to help put the pieces of the puzzle together," said Levy. "So often we work in isolation."

For Levy, this workshop was a prelude to the Canadian National Suicide Prevention Conference she will help organize in Iqaluit May 15.

International concern

Among the nations represented at the workshop, Alaska has the lowest suicide rate, but it is still twice the American average of 10.7 deaths per 100,000 people.

At the other end of the spectrum, Nunavut's rate (five times Canada's average of 12.3 deaths per 100,000 people) was the highest of those attending.

A vast majority of those deaths are among the Inuit and First Nations populations, but as the gathering indicated, this isn't just a North American problem.

Ellen Christoffersen is a member of the Greenlandic parliament and chair of the legislative committee on health and family.

"It's a problem in those countries that are under fast and rapid development and those that are former colonies," she said.

Over the three days the workshop was held, participants admitted there were no simple solution that would lead to a lower suicide rate.

Levy said each incident is unique and the factors are different.

One group at the table, however, has shown measurable results.

Chris Aquino from the suicide prevention program in Alaska said they have seen the suicide rate decrease as a result of their efforts.

"What we had to do is listen very closely to youth and elders to determine the needs we had to build upon," said Aquino.

Following the workshops, each group agreed to meet annually and keep in contact to share ideas and resources.

Support can be accessed through the Kamatsiaqtut help-line by dialing 1-800-265-3333 or in Iqaluit 979-3333.

4. One week after the workshop, the Legislative Assembly of Nunavut passed a motion directing the Government of Nunavut to establish a taskforce on suicide. The following coverage appeared on the CBC North website:

MLAs call for action on suicide
WebPosted Mar 25 2003 08:04 AM MST

IQALUIT, Nunavut -- The Nunavut government's regular MLAs say they may go to the United Nations to seek help with the problem of suicide in the territory.

The MLAs passed a motion at the legislature Monday to create a task force to study the problem and take concrete action.

'The issue of suicide is bigger than the territorial government'

-- Glenn McLean

The territory has the highest suicide rate in Canada.

"The issue of suicide is bigger than the territorial government and the agencies that are working at it," says Baker Lake MLA Glenn McLean.

He says the number of suicides in Nunavut is not decreasing and the regular MLAs want something done about it.

McLean says the government claims the number of suicides are going down, but he's not convinced.

"The numbers are not decreasing significantly," he says. "The minister says the numbers are decreasing but we are still averaging two or three times suicides a month in which in my opinion two or three too many."

McLean says he is not criticizing the Nunavut government's efforts, but says the territory needs outside help.

He says the task force might go so far as to ask for assistance from international organizations such as the United Nations.

"We're just starting to talk about it. Have we been talking about it enough? In my opinion we haven't," he says. "So hopefully we can make the rest of the country be aware of that we have an epidemic in this territory."

The task force is expected to be established by May 1, with a report due about six months later.

Appendix E: Selected Publications and Resources

Publications

Advisory Group on Suicide Prevention. (2003) *Acting on What We Know: Preventing Youth Suicide in First Nations.* www.hc-sc.gc.ca/fnihb-dgspni/fnihb/cp/publications/preventing_youth_suicide.htm

Alaska, Statewide Suicide Prevention Council. (2003) *Draft Alaska Suicide Prevention Plan.* www.hss.state.ak.us/suicideprevention/StatePlan/DraftAlaskaSuicidePreventionPlan.pdf

Barney, D.D. (2001) "Risk and protective factors for depression and health outcomes in American Indian and Alaska Native adolescents." *Wicazo Sa Review: A Journal of Native American Studies* 16(1): 135-50.

Berry, J.W. (1990) "Acculturation and adaptation: Health consequences of culture contact among circumpolar peoples." *Arctic Medical Research* 49: 142-50.

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http://ww2.mcgill.ca/psychiatry/transcultural/cmhru.html

Suicide Information & Education Centre www.suicideinfo.ca

University of British Columbia, Mental Health Evaluation & Community Consultation Unit www.mheccu.ubc.ca

United States

Alaska Community-Based Suicide Prevention Council
http://health.hss.state.ak.us/dada/suicide.htm

Alaska Community-Based Suicide Prevention Program
http://health.hss.state.ak.us/suicideprevention

National Strategy for Suicide Prevention
www.mentalhealth.org/suicideprevention/strategy.asp

Appendix F: Statistics on Death by Suicide in the Arctic

This appendix, prepared by Nunavummit Kiglisiniartiit (Nunavut Bureau of Statistics), presents statistical data on the number, rates per 100,000, and characteristics of death by suicide in Nunavut, Greenland, Nunavik, the Northwest Territories and Alaska.

Nunavut

Graph A reports the number of deaths by suicide in Nunavut from 1984 to 2002. **Graph B** reports the age-standardized rate of death by suicide for Canada, the provinces and the territories (and Nunavik) for 1996. **Graph C** and **Graph D** report the same data for men and for women. **Graph E** reports the age-standardized rate of death by suicide for Nunavut Inuit for 1999, 2000 and 2001, *by sex.* **Graph F** reports the age-standardized average annual rate of death by suicide by Nunavut Inuit for the period 1999 to 2001, *by sex and age cohort.* These graphs show that the rate of death by suicide in Nunavut is high, and highest among young (15 to 24) Inuit males.

Greenland

Graph G reports the rate of death by suicide in Greenland from 1977 to 1997. The rate of death by suicide in Greenland rose considerably during the 1970s, but has remained fairly stable since the mid-1980s. The next five graphs are from Markus Leineweber's study *Modernization and Mental Health: Suicide among the Inuit in Greenland.* **Graph H** reports the rate of deaths by suicide in Greenland for the period 1990 to 1995, *by sex and age cohort.* It shows a similar pattern to that of Nunavut: suicide rates are highest among young males. **Graph I** reports the average annual rate of death by suicide in Greenland from 1975 to 1995, *by age cohort.* It shows that between the mid-1970s and the mid-1990s the rate of death by suicide rose significantly among 15 to 19 year olds. **Graph J** reports the average annual rate of death by suicide in Greenland from 1972 to 1995, *by type of community.* It shows that the rate of death by suicide in East Greenland rose during the early 1970s, fell somewhat during the early 1980s, and began to rise again beginning in the mid-1980s -- while the rate of death by suicide in Nuuk (the capital city) rose during the 1970s but has fallen steadily since the early 1980s. **Graph K** reports the average annual rate of death by suicide for males born in Greenland (the overwhelming majority of whom are Inuit) for the period 1987 to 1995, *by occupational groups.* It shows that the rate of death by suicide by males is highest among students and the unemployed, and lowest among white-collar workers and pensioners. **Graph L** reports comparable data for females. Leineweber obtained the data required for this analysis from death certificates and police reports. Another important study on suicide in Greenland is Peter Bjerregaard et al (2002), "Cultural change and mental health in Greenland: The association of childhood conditions, language, and urbanization with mental health and suicidal thoughts among the Inuit of Greenland."

Nunavik

Graph M reports the number of deaths by suicide in Nunavik from 1971 to 2000. It shows that suicides were very rare in the 1970s, but that the frequency of suicide increased significantly during the 1980s and 1990s. **Graph N** reports the average annual number of death by suicide by 10 to 17 year-olds in Nunavik from 1970 to 2001, *by sex.* It shows that there were no suicides by 10 to 17 year-olds during the 1970s, but that since 1983 the number has increased significantly -- more so among boys than among girls. **Graph O** reports the average annual number of deaths by suicide in Nunavik from 1972 to 2001, by coast. It shows that the number of deaths by suicide his risen much faster in the communities on the Hudson coast than in communities on the Ungava coast.

Northwest Territories

Graph P reports the number of deaths by suicide in the Northwest Territories from 1990 to 2002. Suicides which occurred in the area which now comprises Nunavut are not included.

Alaska

Graph Q reports the rate of death by suicide in Alaska from 1990 to 2000, *by race* -- 'race' being the term used in the United States for what Canadians usually refer to as 'ethnicity'. **Graph R** reports the rate of death by suicide in Alaska from 1990 to 2000, *by sex.* **Graph S** reports the average annual rate of death by suicide in Alaska from 1990 to 2000, *by age cohort.* Together these three graphs shows that Alaska has the same suicide profile as other jurisdictions in the Arctic -- high rates of suicide by young aboriginal males. **Graph T** reports the average annual rate of death by suicide in Alaska from 1990 to 2000, *by community type,* and **Graph U** reports the average annual rate[1] of critical incidents (suicides, attempted suicides, and alcohol-related injuries) in Alaska from 1997 to 1999, *by region.* Together these graphs show that while there is not a large difference in the rate of death by suicide between the large cities, the 'regional hub' communities and the villages, there is considerable variation in the average annual rate of critical incidents between different regions of Alaska. Finally, **Graph V** reports the average annual rate of death by suicide in Alaska from 1990 to 1997, by villages with suicide prevention projects vs. villages without suicide prevention projects. It suggests that implementation of Alaska's Community-Based Suicide Prevention Program has helped to lower the rate of death by suicide in the communities which have chosen to participate in it.

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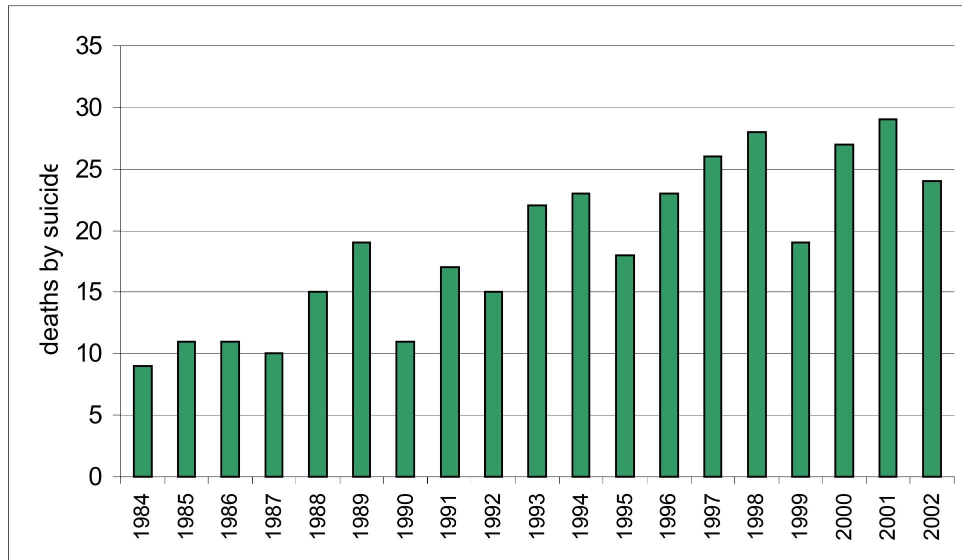
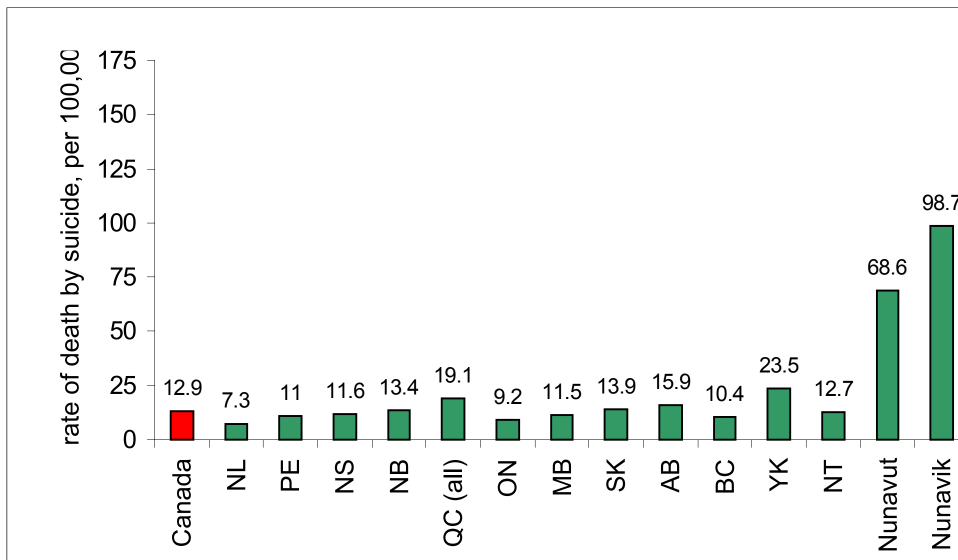
[1] The data obtained from the Alaska Department of Health and Social Services contained the following methodological note: "The rates for each region were determined by computing the rate for each village in the region and then averaging these together. This yields a different result than if you aggregated all incidents in the region and computed the rate against the aggregated population of the region. This methodology was chosen because we desired that all villages have equal value in this process. To use the other methodology, it would have given more weight to villages with larger populations. The results would have been slightly different, however, the trends would be similar."

Graph A: Number of deaths by suicide in Nunavut, 1984 to 2002



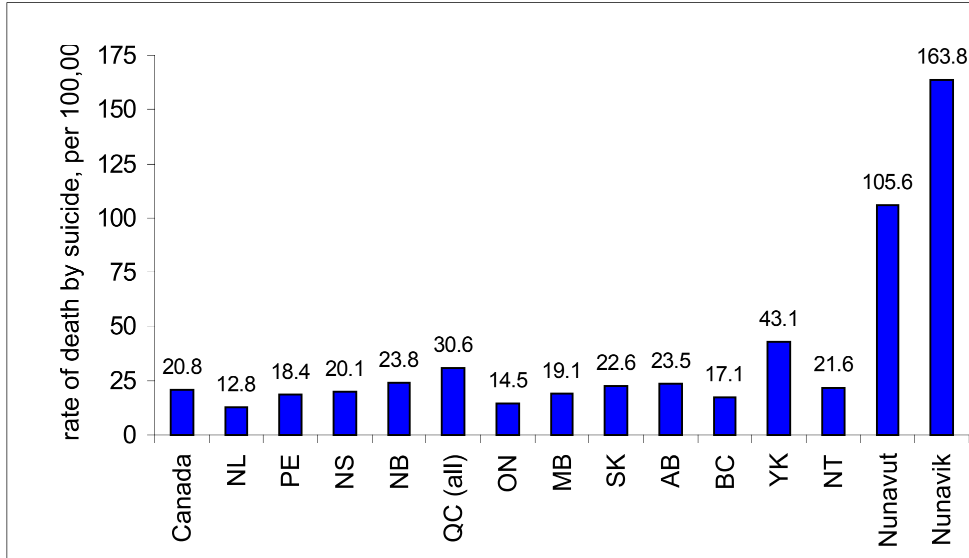
source: Offices of the Coroner, Northwest Territories and Nunavut

Graph B: Age-standardized rate of death by suicide for total population, Canada/provinces/territories and Nunavik, 1996



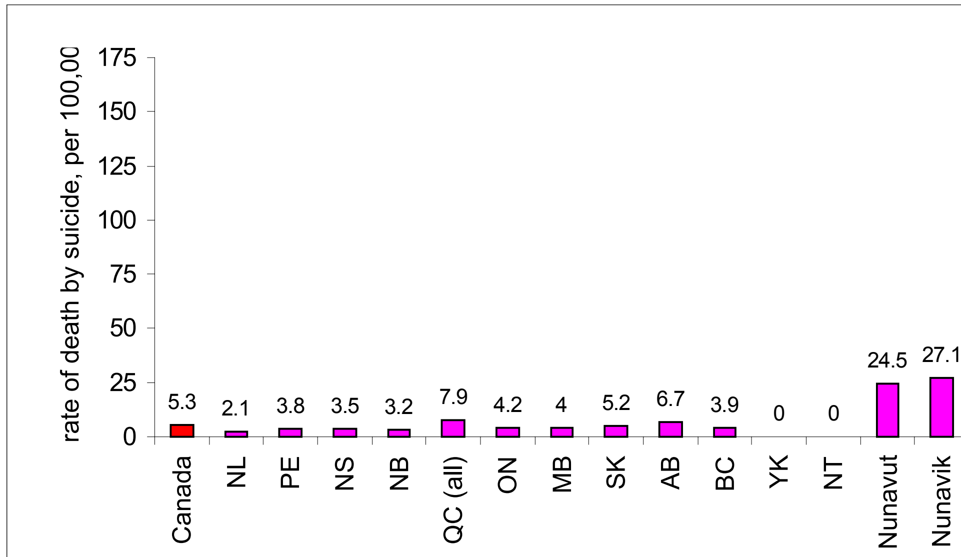
source: Statistics Canada

Graph C: Age-standardized rate of death by suicide for males, Canada/provinces/territories and Nunavik, 1996



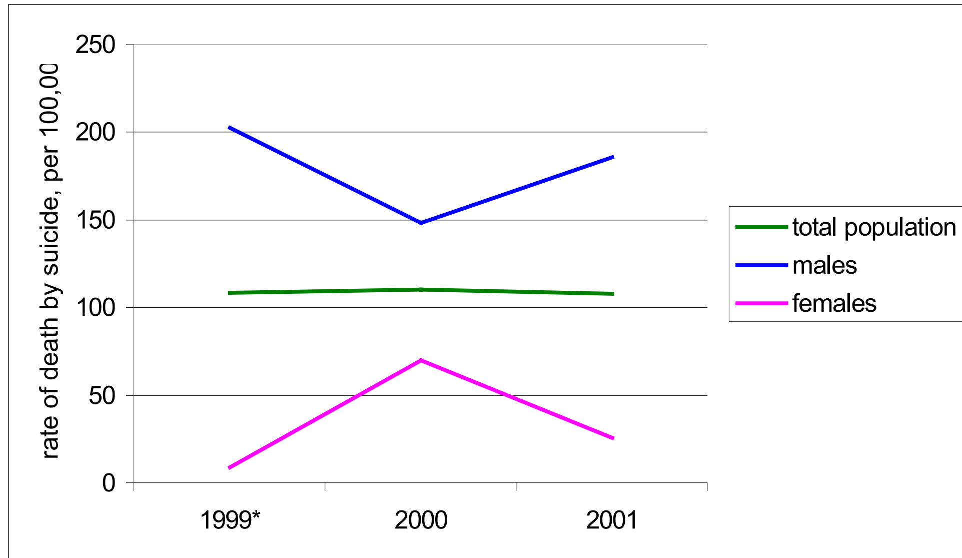
source: Statistics Canada

Graph D: Age-standardized rate of death by suicide for females, Canada/provinces/territories and Nunavik, 1996



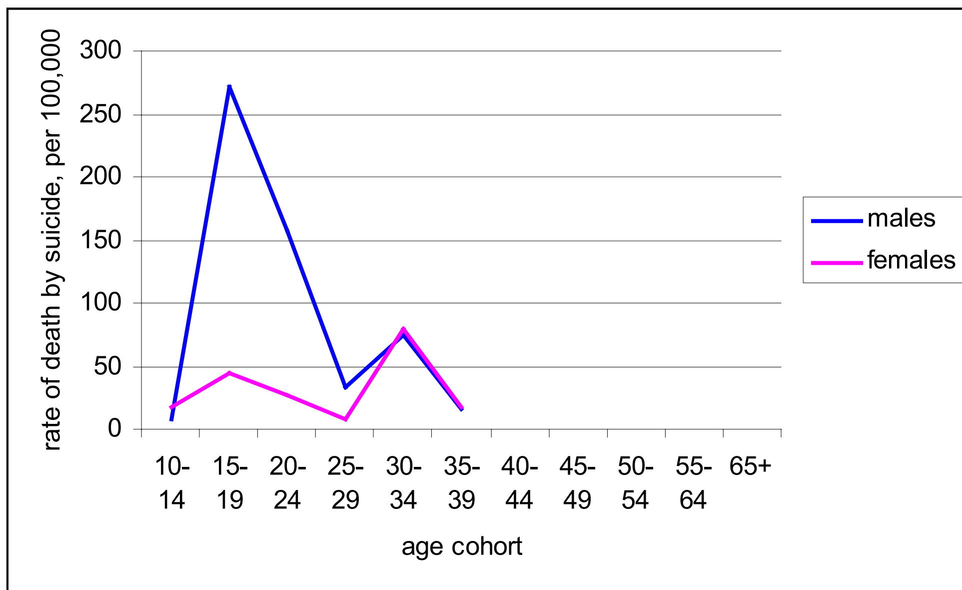
source: Statistics Canada

Graph E: Age-standardized rate of death by suicide, Nunavut Inuit, 1999 to 2001, by sex



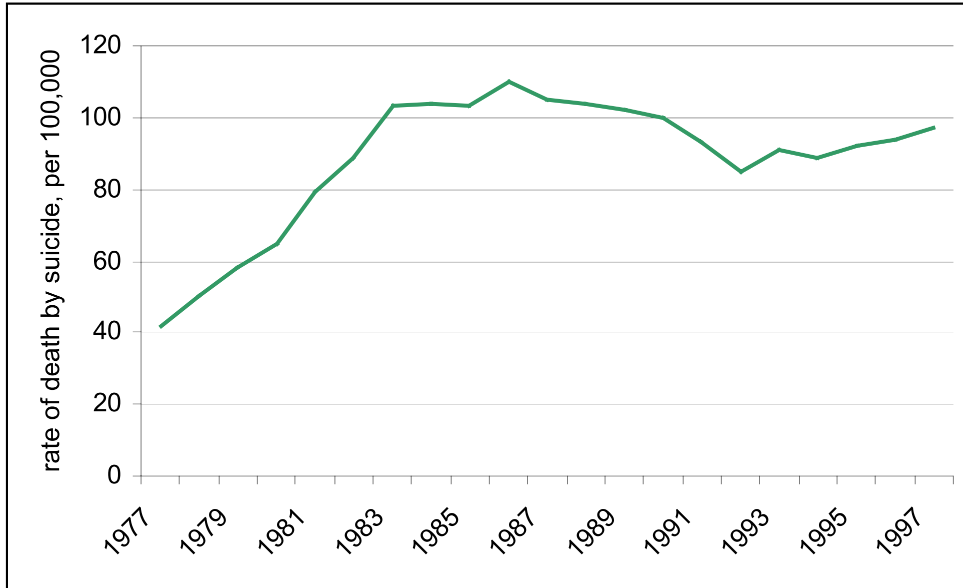
source: Nunavummit Kiglisiniartiit (Nunavut Bureau of Statistics). note: 1999 rates are for the 9 months April 1 to December 31, adjusted to reflect a 12-month period

Graph F: Age-standardized average annual rate of death by suicide, Nunavut Inuit, 1999 to 2001, by sex and age cohort



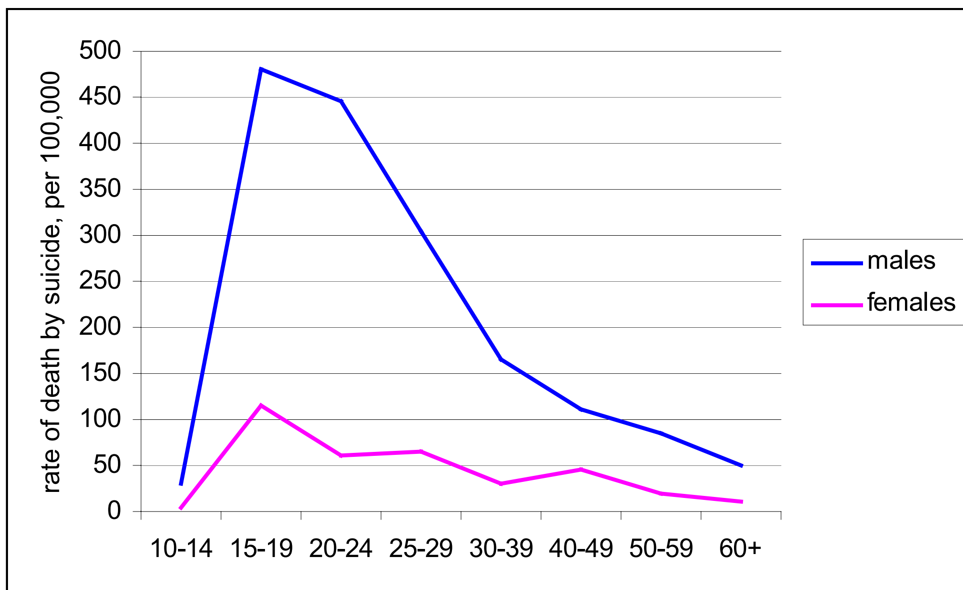
source: Nunavummit Kiglisiniartiit (Nunavut Bureau of Statistics)
note: data for the period April 1, 1999 to December 31, 2001

Graph G: Rate of death by suicide, Greenland, 1977 to 1997, 3-year rolling averages



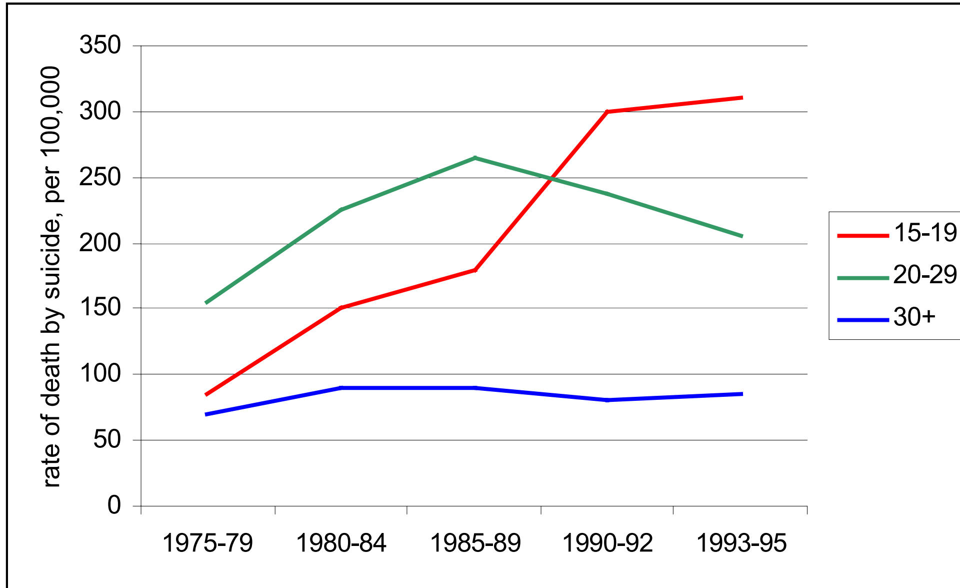
source: Statistics Greenland

Graph H: Rate of death by suicide, Greenland, 1990 to 1995, by sex and age cohort



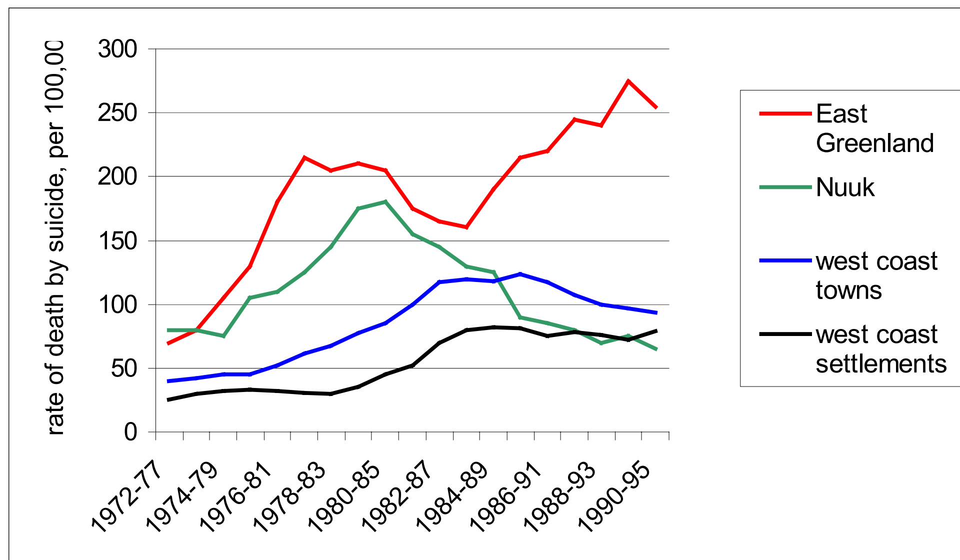
source: Leineweber (2000)

Graph I: Average annual rate of death by suicide, Greenland, 1975 to 1995, by age cohort



source: Leineweber (2000)

Graph J: Average annual rate of death by suicide, Greenland, 1972 to 1995, by type of community



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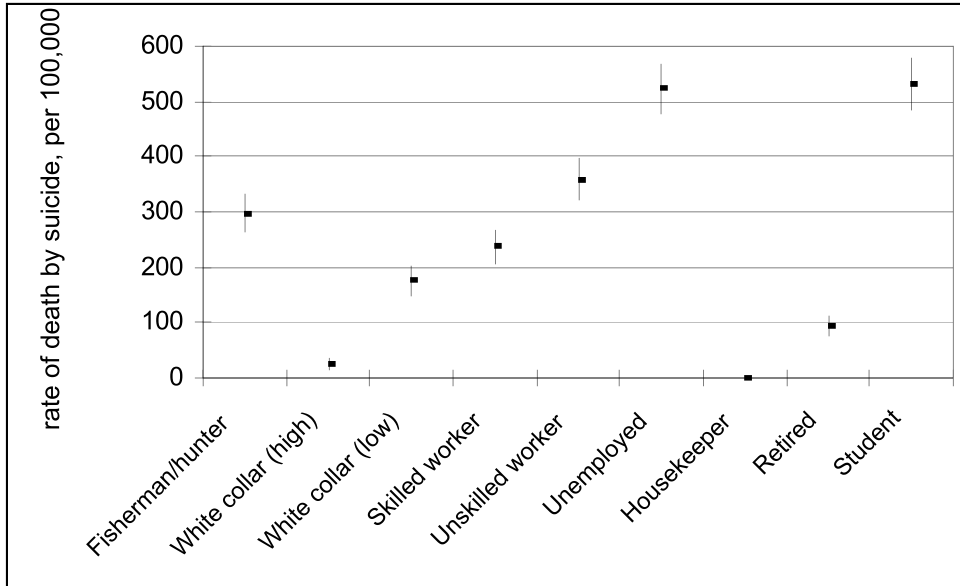
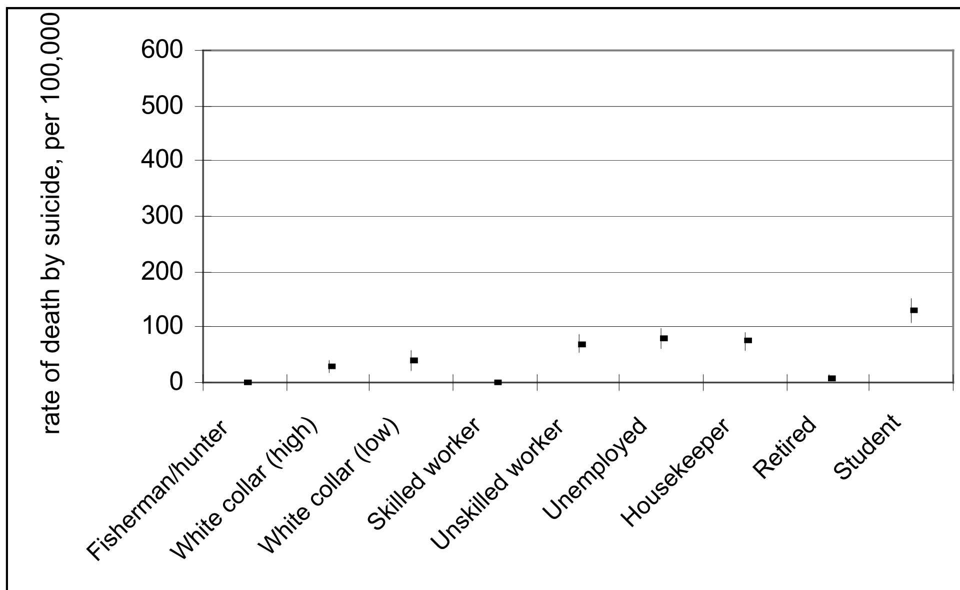
Graph K: Average annual rate of death by suicide (95% confidence intervals) for males born in Greenland, 1987 to 1995, by occupational groups



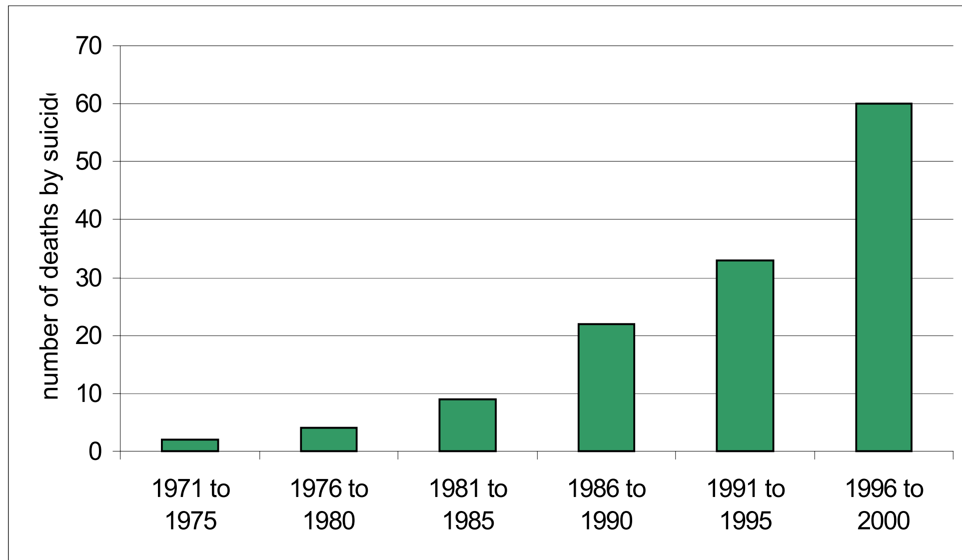
source: Leineweber (2000)

Graph L: Average annual rate of death by suicide (95% confidence intervals) for females born in Greenland, 1987 to 1995, by occupational groups



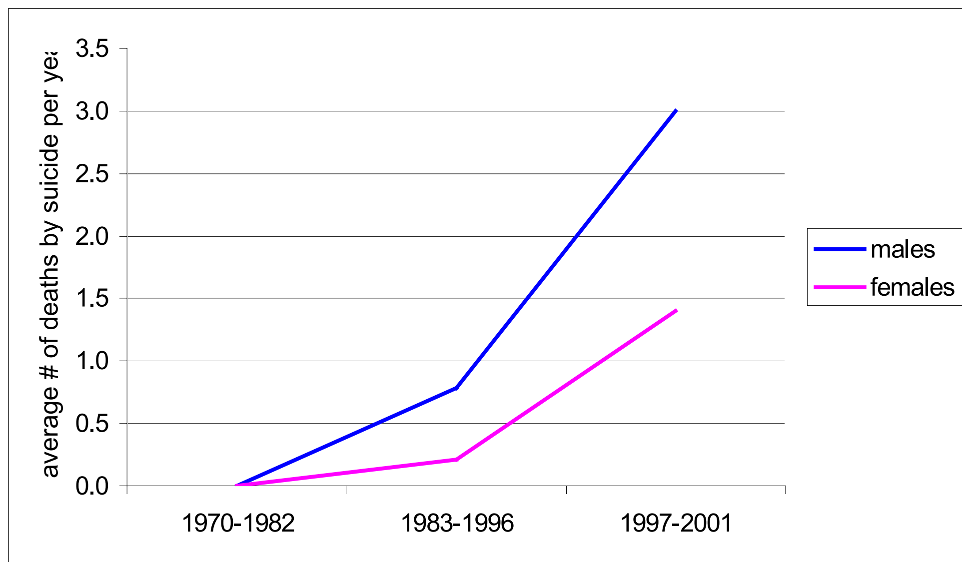
source: Leineweber (2000)

Graph M: Number of deaths by suicide, Nunavik, 1971 to 2000



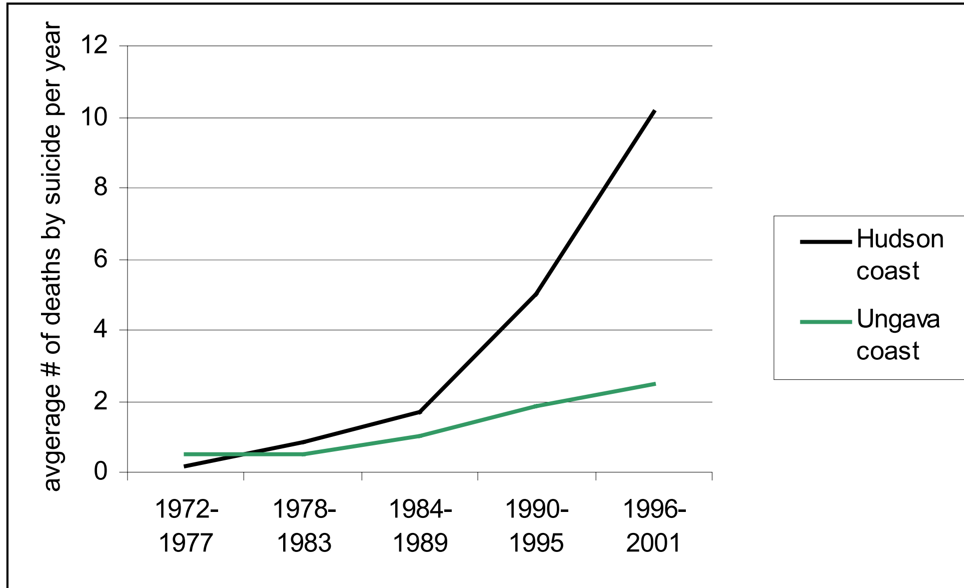
source: Nunavik Regional Board of Health and Social Services

Graph N: Average annual number of death by suicide by 10 to 17 year-olds, Nunavik, 1970 to 2001, by sex



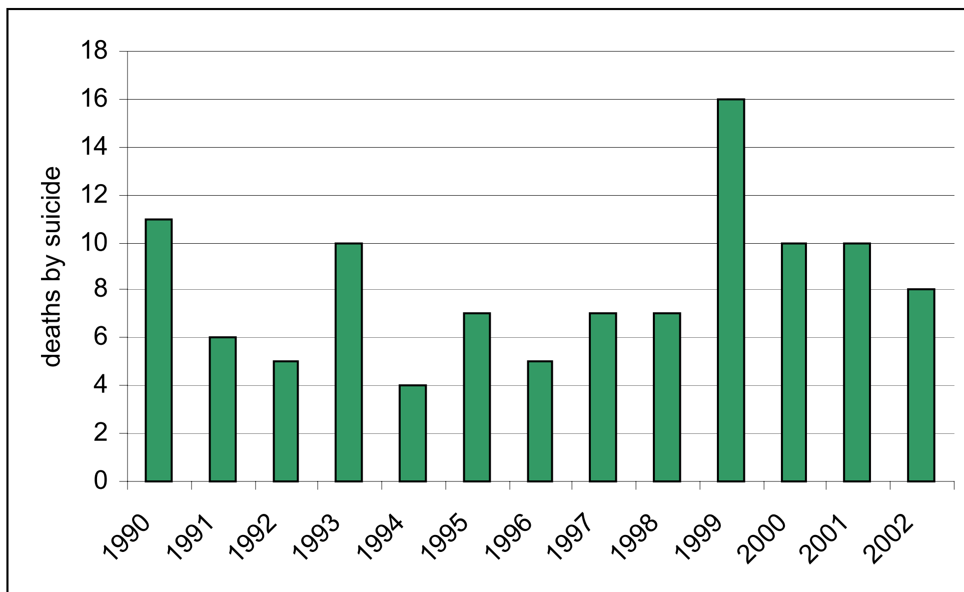
source: Nunavik Regional Board of Health and Social Services

Graph O: Average annual number of deaths by suicide, Nunavik, 1972 to 2001, by coast



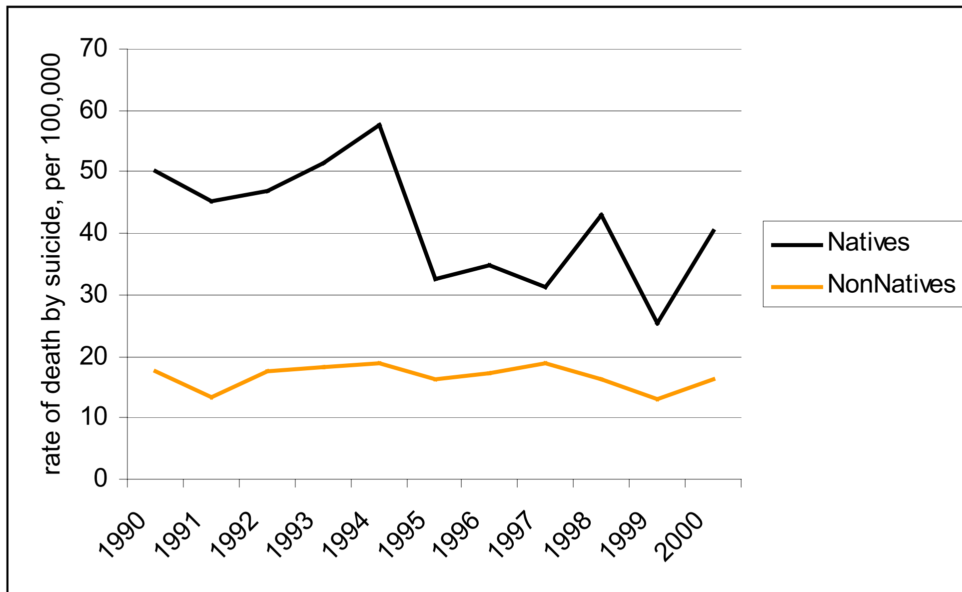
source: Nunavik Regional Board of Health and Social Services

Graph P: Number of deaths by suicide, Northwest Territories, 1990 to 2002



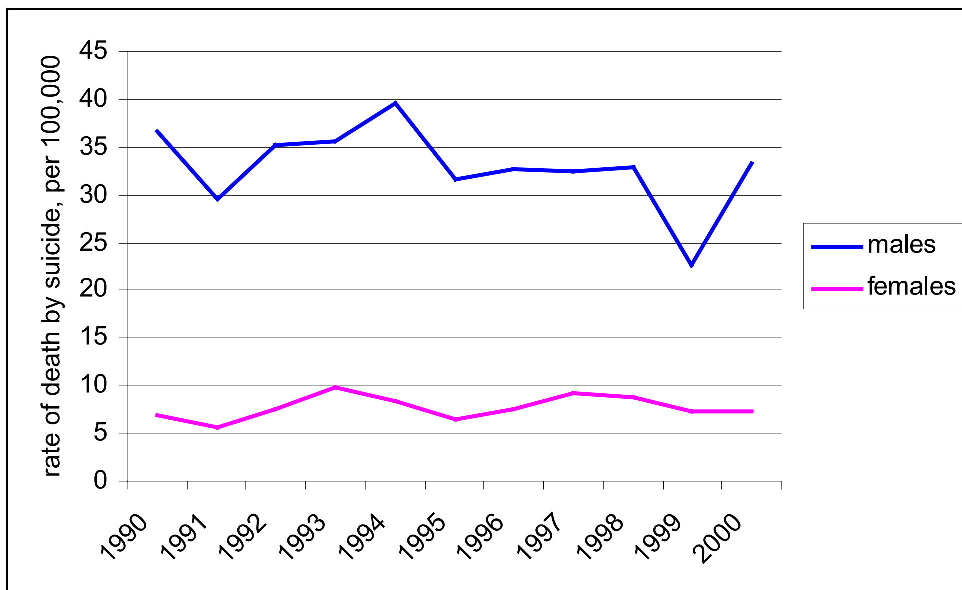
source: Government of the Northwest Territories

Graph Q: Rate of death by suicide, Alaska, 1990 to 2000, by race



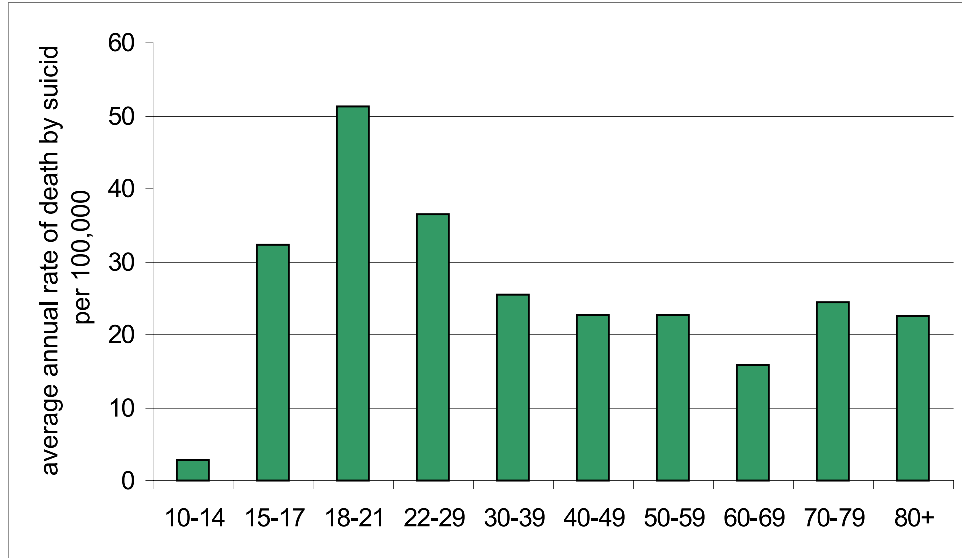
source: Alaska Department of Health and Social Services

Graph R: Rate of death by suicide, Alaska, 1990 to 2000, by sex



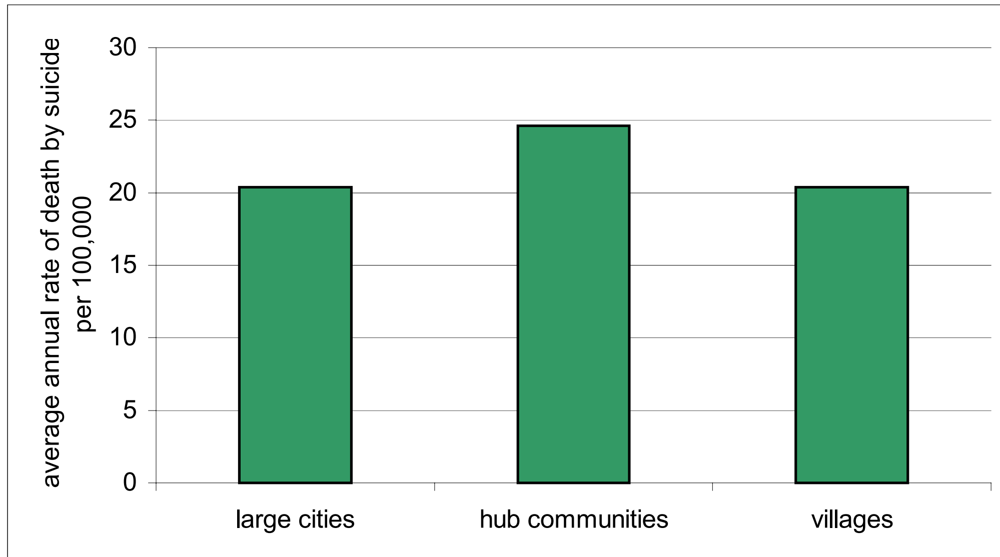
source: Alaska Department of Health and Social Services

Graph S: Average annual rate of death by suicide, Alaska, 1990 to 2000, by age cohort



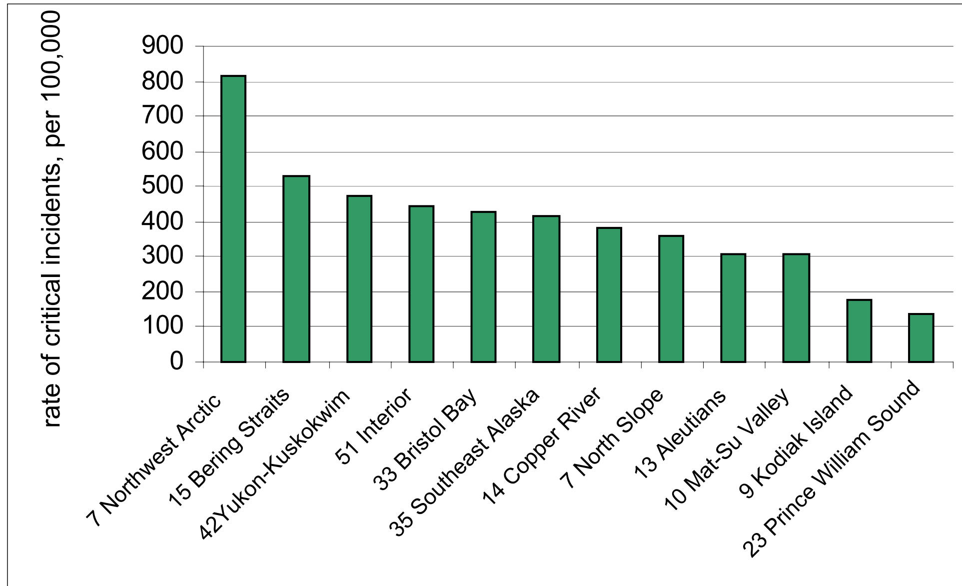
source: Alaska Department of Health and Social Services

Graph T: Average annual rate of death by suicide, Alaska, 1990 to 2000, by community type



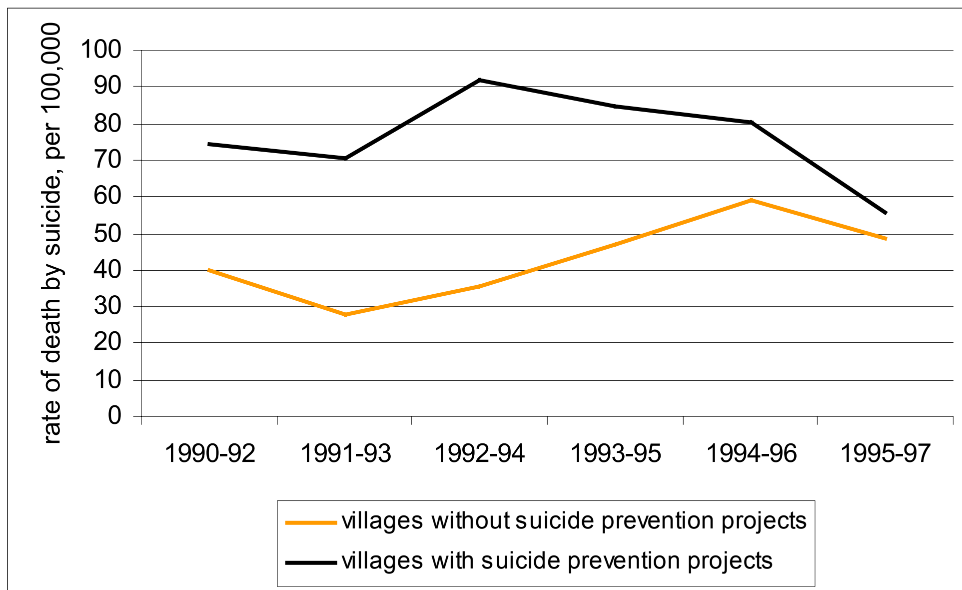
source: Alaska Department of Health and Social Services

Graph U: Average annual rate of critical incidents (suicides, attempted suicides, and alcohol-related injuries), Alaska, 1997 to 1999, by region



source: Alaska Department of Health and Social Services

Graph V: Average annual rate of death by suicide, Alaska, 1990 to 1997, by villages with suicide prevention projects vs. villages without suicide prevention projects



source: Alaska Department of Health and Social Services

Appendix G: Alaska's Suicide Prevention Follow-back Study

At several points in the workshop, participants expressed frustration with the limited amount of data available on suicides in their jurisdictions. We know that the Inuit suicide profile is quite different than the suicide profile in other cultures and jurisdictions, but much of what we believe we know about Inuit suicide is anecdotal in nature rather than evidence-based.

'Follow-back studies' (or 'psychological autopsies') are the established methodology for obtaining important data on deaths by suicide -- such as risk factors which could assist communities in identifying persons at risk.

Shortly after the workshop, the State of Alaska issued a Request for Proposals for such a study. The following is an excerpt from the State of Alaska Department of Health and Social Services' Request For Proposals # 2003-0600-3754: Suicide Prevention Follow-back Study, issued April 4, 2003:

SECTION FOUR: BACKGROUND INFORMATION

4.01 Background Information

The suicide rate in Alaska is twice the national average, with high-risk groups having suicide rates four to five times the national average. This consistently high rate, within the top 10 states in the nation, has not changed substantially in the past decade. Statistical analyses and follow-back studies contribute to our understanding of the factors leading to suicide and therefore to our ability to address the range of issues contributing to suicide throughout Alaska.

A follow-back study, also called a psychological autopsy or a retrospective profile, is a thorough, retrospective exploration of the life history of a person who died. It is used as a means to understand the complex nature of suicide as an act with psychological, physical, emotional, spiritual, social, cultural, economic, and legal factors all possibly playing a role in the death. History, emotional health, relationships, grief, incidents of stress, work and/or educational issues, family dynamics, substance abuse, sexual abuse, domestic violence and recent personal or financial losses are areas into which a psychological autopsy probes.

A follow-back study is usually not just one examination but a series of intensive interviews and investigations designed to reconstruct the social and physiological circumstances prior to suicide. By performing these interviews it is hoped that psychological intent can be uncovered by reconstructing the decedent's behavior and communication during his final days, supplemented by history, personal habits, personality traits, and character. A psychological profile is developed through documents

such as diaries and journals, letters, criminal records, physical and mental health files and other "speaking" documents, and by interviewing surviving family members, friends and associates, co-workers, physicians, and others who are able to provide relevant information about the personality and lifestyle of the deceased. Because it increases understanding both of the internal dynamics of suicide and of the external dynamics, or the relationship between the suicide victim and the community, it can be a valuable a tool in the design of more precisely focused and targeted suicide prevention, intervention and treatment programs.

Follow-back studies produce detailed descriptive profiles of suicide victims and can achieve several different goals:

1. Better understanding of the dynamics of lives and deaths of suicide victims;
2. More accurate identification of individuals and groups at high risk;
3. Identification of those who recognized the deceased had problems prior to his or her death; and
4. Identification of barriers that kept the deceased from getting professional help.
5. Identification of involvement with formal treatment system.
6. Point of contact and involvement in justice, primary care, and other settings.

An additional benefit of follow-back studies is that they offer family, friends and others close to the deceased the opportunity to talk about the deceased and their knowledge and feelings about the person's life and death. There is good evidence that this increases understanding and acceptance and promotes healthy grief and healing.

Models and Timeframes for Conducting Studies

While the tasks and approaches remain similar, the recommendations regarding the time frame of the family/friend interview part of the study vary considerably. Offerors are expected to select and justify their selection of models. Below are a brief summary of established models:

Model 1 suggests the following steps and timeframe:

1. a review of information from government agencies such as education, justice, family services and the medical examiner
2. a review of medical and psychiatric records (requires family consent)
3. a community investigation which includes in depth structured interviews with family, friends, employers, teachers, health, mental health and social service providers etc. Family consent is required.

This model, which emphasizes the research aspects of the work, suggests contacting family members and commencing the second and third phases about two months after the death.

Model 2 while also collecting information, places equal emphasis on the healing properties of the study. It suggests contacting the family and conducting the interviews within two days of the death. This model, because of the high probability that the interviews will be highly emotionally charged, requires particularly skilled interviewers and notes the stress on the interviewers and the need to debrief and support them.

Model 3 says based on the recommendations of at least one ethics committee, suggests interviews with survivors should not take place until four weeks after the suicide.

Model 4 is based on several studies that suggest that some survivors continue to suffer psychological distress, even crisis symptoms, for months after the death and that interviews have proven beneficial in this longer time frame. Data in one study suggest 9 weeks after the suicide as an acceptable therapeutically useful time for the interview when the suicide is a young person. This study also suggests initial contact be by telephone.

SECTION FIVE: SCOPE OF WORK

5.01 Scope of Work

The project requires collecting, writing and analyzing three levels of data on suicides in Alaska. Level 1 and Level 2 statistical analyses for all completed suicides identified by law enforcement and the medical examiner during the agreed upon time frame. Level 3 requires in-depth retrospective interviews. Contractors will be required to perform Level 1 on all completed suicides. Contractor will be required to perform Level 2 (if they have families written consent) and Level 3 (if the case is to be included in final sampling population).

Level 1:
For all completed suicides (identified by law enforcement and the medical examiner) during the agreed upon time period: Review of governmental agency information about the deceased such as age, sex, race, level of education, residence, location of death, cause of death, criminal history, health history, etc.
Product: Statistical analysis (see *Deliverables,* Section 5.02)

Level 2:
For all completed suicides (identified by law enforcement and the medical examiner) during the agreed upon time period *for which families provide written consen*t: Review of medical and psychiatric records.
Product: Statistical Analysis (see *Deliverables,* Section 5.02)

Level 3:
For either a stratified sample or the entire population of completed suicides (during the agreed upon time frame): On-site, in-depth interviews (follow-back study) with key informants, willing family, friends, and others in the deceased's community who knew him/her well.

Identification of Level 3 Cases
Offerors are expected to develop a system for working with the medical examiner to identify suicides for the timeframe of the study.

Product: Statistical Analysis (see *Deliverables, Section 5.0*2)

Preliminary Level 3 Activities

To the maximum extent possible, as a preliminary step to conducting the psychological autopsy, the offeror should review the following data:

(1) Inpatient and outpatient medical records.
(2) Physical autopsy report including toxicity results.
(3) Military police and Criminal Investigation Division investigation results.
(4) Line of duty investigation report.
(5) Any records existing in the Community Mental Health programs, hospital, drug and alcohol treatment facilities, Alcohol and Drug Abuse Prevention and Control Program, and so on.
(6) Availability of specific suicide prevention and crisis intervention services available to the community.

Level 3 Interviews

Level 3 analysis includes in-depth interviews with key informants, willing family, friends, and others in the community of the deceased who were well-acquainted with that individual. Level 3 cases will be determined as part of the Planning document (see deliverables Section 5.02 (1). Researchers will be required to obtain family consent for each interview. All interviews are to be conducted within the communities of the deceased.

Interviews should include key questions in the following areas: (1) circumstances of the suicide (specifics of the act, evidence of planning, etc.); (2) emotional state in the period before death (include mental health and substance abuse); (3) past history of mental illness and substance abuse (include suicidal ideation and behavior earlier in life: diagnosis and treatment history); (4) physical health status (including health contacts, utilization, treatments) current and in the past; (5) developmental history (personality, coping; include exposures to suicide; (6) family history (psychiatric illness, suicidal behavior); (7) social network and supports (include a description of the person's living situation -- family, community); (8) stressful life events; (9) perceived availability of suicide prevention/crisis intervention services; and (10) any other pertinent information.[i]

Cultural Issues

Conducting follow-back studies in Alaska, especially in rural Alaska, adds the need to do the work in a manner that is culturally sensitive and sensitive to the protocols of a given small community. This suggests the need when conducting follow-back studies in villages especially to have small teams or at least pairs of interviewers culturally sensitive to the village culture. Appropriate timing of the interviews may also vary from group to group.

The contractor should utilize teams of at least two interviewers utilizing teams of at least two interviewers who are culturally sensitive to the particular culture represented in the community being visited. Contractors are expected to train co-interviewers. Every follow-back study at Level C must be conducted by culturally sensitive interviewers with local knowledge.

Completion of the work of Level C will involve travel to large and small communities for the purpose of conducting key informant interviews. Because these are interviews with people in various stages of grief, they are likely to be emotional and if handled well have the potential to be therapeutic in terms of healing.

Interviews should be structured but interviews also need to be trained, sensitive and able to adjust to the mood and needs of the interviewees. Offerors should document the interviewees' response to interviews by a simple self-report measure.

5.02 Deliverables

The contractor will be required to provide the following deliverables:

(1) Initial Planning Report, due June 30, 2003:

a. Comprehensive literature review of psychological autopsies/follow-back studies.
b. Systematic, structured interview protocol to be utilized for follow-back study .
c. Training protocol for indigenous co-interviewers.
d. Proposed statistical sampling procedure for Level 3 reports, based on analyses of Alaska suicide data based on prior year data. Should include the estimated number of Level C studies to be completed for the project.

(2) Quarterly narrative reports, due July 15, 2003, October 15, 2003, January 15, 2004, April 15, 2004 to include summary of completed tasks and preliminary results. In addition to the narrative report, the primary investigator or designee will present to the Suicide Prevention Council at their quarterly meetings.

a. Detailed analyses of Level 1 and 2 reports, summarizing the trends noted and addressing all factors extracted from Medical Examiner files.

Level 3 reports: A detailed report following a structured format should be written for each follow-back case study, including, but not limited to:

a. Stressors present at time of suicide; may include family perception.
b. Determination of agency or system identification of a problem before the suicide took place. If so, include an analysis as to the care provided (e.g., reasonable medical/psychological care, inadequate medical/psychological care, or system failure.
c. Comments, lessons learned, and usefulness and relevance of suicide prevention training (if any) in each case.
d. Report on aggregate data, to include any conclusions/recommendations regarding system changes and other factors that may reduce future suicides.

(3) Final Narrative Report, to include:

a. The statistical analyses noted in Levels 1 and 2.
b. The individual follow-back studies.
c. A comparison and analysis of the information from all follow-back studies completed and from the statistical analyses; discussion of the implications of the findings for suicide prevention and a statewide suicide prevention plan.
d. Observations and recommendations regarding the therapeutic nature of the key informant interviews with suicide survivors.

For all levels of research, please note that care must be taken to respect confidentiality in all published materials. Suicide follow-back studies provide detailed information about individuals and all aspects of their lives. Confidentiality and anonymity of all materials are essential. All reports should eliminate personal identifiers, providing only demographic information. Published reports should aggregate data wherever possible to further protect confidentiality and anonymity.

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[i] See, for example:

Beskow J, Runeson B, Asgard U: "Psychological autopsies: Methods and ethics." *Suicide and Life-Threatening Behavior* 1990; 20:307-323.

Clark DC, Horton-Deutsch SL: "Assessment in absentia: The value of the psychological autopsy method for studying antecedents of suicide and predicting future suicides." in: *Assessment and Prediction of Suicide.* Edited by Maris RW, Berman AL. New York, NY, Guilford, 1992.

Ebert BW: "Guide to conducting a psychological autopsy." *Professional Psychology: Research and Practice* 1987; 18:52-56.

Hawton K, Appleby L, Platt S, Foster T, Cooper J, Malmberg A, Simkin S: "The psychological autopsy approach to studying suicide: A review of methodological issues." *Journal of Affective Disorders* 1998; 50:269-276.