Mental Health and Suicide in Indigenous Communities in Canada

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Problem History

Canada's Indigenous population, including First Nations, Inuit, and Métis people, comprises 4.3% of the general population. Despite representing a fraction of the population, the suicide rate among Indigenous youth aged 15-24 is 5 to 6 times the rate seen in the general Canadian population; this rate is especially high among Inuit youth, at 11 times the national average.(1,2) Suicide and self-inflicted injury is the leading cause of death among First Nation youth aged 15-24, whereas in the general youth population it is accidental death.(2) An example which speaks to the urgency of this issue is the number of suicide attempts in northern communities, such as in the Attawapiskat First Nation in Ontario. In April 2016, the Attawapiskat First Nation declared a state of emergency for the escalating problem of youth suicide in this region. Local and relief health care workers responding to the situation were overwhelmed by this public health crisis.(3) Suicide among Indigenous youth in Canada is a nationwide crisis that has been brought to public attention not only by recent media coverage, but also declarations from individual communities, and is apparent in national statistics dating back more than a decade.(1,2) Despite this, Indigenous communities have and continue to display resilience as shown through various community-led suicide prevention initiatives.

While suicide is not a distinct psychiatric disorder, 98% of people who die by suicide worldwide are believed to have a mental illness.(4) Risk factors in the general population (including Indigenous peoples), include a previous suicide attempt, a recent discharge from hospital, and a concurrent major depressive episode. Other risk factors include substance use, psychosis, lack of social supports and access to means.(5) With regard to Indigenous persons, the former National Aboriginal Health Organization (NAHO) put forward specific risk factors for suicidal behaviour: predisposing factors, contributing factors, and precipitating factors. Predisposing factors include engagement in self-harm, a personal history of a psychiatric disorder, and/or persons known to the individual – including a family member, friend, or community member – who have committed suicide. Contributing factors include poor coping skills, limited social supports, financial difficulties, familial and interpersonal conflict, separation of child from family, abuse and unresolved grief. Precipitating factors that were identified include a recent move, a sudden loss or failure, and humiliation.(6) While these elements also constitute risk factors among the general population they are often more prevalent in certain Indigenous communities due to factors such as small community size and deficits in infrastructure stemming from generations of neglect by the Federal Government and other parties, as described below.

It is worth noting that suicide is not universally pervasive within Indigenous communities. A strong sense of culture and ownership of community has been shown to be protective against suicide and self-harm behaviours in some communities.(7) A Regional Health Survey from 2002/2003 suggested that 70% of First Nations adults living on-reserve felt physically, emotionally, mentally, and spiritually balanced.(7) In addition to cultural aspects (which include language), other factors may protect against a heightened suicide risk in First Nations communities, such as job creation, employment, and opportunities for personal development (such as career training programs). (8) Despite the overall well-being of First Nations adults living on reserve, some Indigenous communities remain extremely vulnerable to mental illness and suicide. A cultural heritage of colonialism may play a role as evidenced by a substantial body of

qualitative research and a wealth of personal testimony, the now-defunct federal Indian Residential School System (created under direction of the Indian Act) left a legacy of physical and psychological trauma which has contributed to the disproportionately high suicide rate seen in some Indigenous communities.(9) Under the guise of formal education – which has now been acknowledged to have been part of an assimilationist policy – residential schools that were operated by various churches and the Federal Government of Canada subjected Indigenous children to many forms of abuse, including verbal abuse, physical abuse, sexual abuse, and neglect.(10) Factors including, but not limited to, poor sanitation, inadequate health care, physical abuse as punishment, and malnutrition resulted in physical and mental harm to students,which contributed to the high prevalence of psychiatric disorders among survivors.(11) To illustrate this point, The British Columbia Aboriginal Survivor's study found that of 127 residential school survivors, only two were free of mental illness.(12) The same study showed that 30.4% of residential school survivors experience a major depressive episode, while 26.1% experience chronic depression and 64.2% experience repercussions from post-traumatic stress disorder.(13) The aforementioned psychiatric disorders are risk factors for suicide in the general population.(5)

Intergenerational trauma, which refers to a process by which trauma and stress are passed down from generation to generation, is strongly linked to the residential school experience in Canada.(6) A report prepared for the Aboriginal Healing Foundation summarizes aspects of the residential schooling system and how they contributed to a trauma cycle resulting in suicidal behaviours.(7) Furthermore, it is a well characterized phenomenon that adverse childhood experiences are associated with the development of mental health disorders and suicide.(14–16) Multiple sources provide evidence of a long-standing history of sexual abuse in the residential school system, and it has been shown that the survivors of this abuse were more likely to become perpetrators of sexual abuse in the future (often in their home communities).(13,17,18) The residential school system, and its associated physical and psychological abuses, cultural deprivation, and forced isolation of students from their homes and families, created a milieu for the traumatization of thousands of children directly or indirectly through intergenerational trauma.

Mounting public knowledge and evidence of the failure of the residential school system led the Federal Government to phase out the program. (17) The decline in overt assimilationist policy gave way, however, to the "Sixties Scoop", a multi-decade period in which thousands of Indigenous children were removed from their birth families and placed in the care of child welfare wards. (19) The highly disproportionate removal of Indigenous children by the child welfare system in the 1960s in comparison to non-Indigenous Canadian children initiated a trend which continues to this day. A 2016 report from the Office of the Child and Youth Advocate regarding Indigenous child welfare in Alberta acknowledges that Indigenous children and families are "overrepresented in every part of Alberta's child welfare system".(20) Previous reports from the Ministry of Children and Family Development in British Columbia, in addition to academic reviews have identified that Indigenous children are more often taken into care, remain in care longer, and are less likely to be reunited with their families.(21–23) The ongoing Indigenous child welfare crisis in Canada destabilizes the psychological well-being of parents and child; children in the welfare system are in turn at an increased risk of suicide.(21,24)

In 2015, the Truth and Reconciliation Commission (TRC) released a report summarizing the accounts of over 6,750 Residential School Survivors and provided recommendations on approaching its consequences. The report strongly affirms that Indigenous peoples and their cultures were subject to a systematic atrocity through the residential school system.(10) It includes Calls to Action (see Appendix) imploring the Federal Government, in consultation with Indigenous peoples, to assess and mount a collective effort to bridge the gap in health outcomes between Indigenous and non-Indigenous citizens.(10) Call to Action 21 asks that the Federal Government provide "sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority." This call speaks directly to the considerable disparities in infrastructure and health care services in remote communities when compared to urban centres. In July 2016, the Federal Government announced that $69 million dollars would be made available over three years to support mental health initiatives targeting First Nations, Métis, and Inuit communities.(25) This investment could significantly impact development of mental health services in rural, remote, and isolated areas.

Call to Action 22 asks agents in "the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients." Data supports the use of holistic approaches to mental health and well-being – especially in the context of Indigenous health.(26,27) Restoule *et al.* describe a successful approach to culturally safe multidisciplinary mental health programs in Indigenous communities, which incorporates a diversity of professionals in a community-driven framework.(8) Anecdotal experience and published literature support suicide and psychiatric intervention programming that focuses on rectifying structural rather than individual deficits.(8,28) Evidence suggests that a cohesive, unified intervention program with government, research agencies, health care authorities and Indigenous communities as stakeholders, which takes into account the culture, needs, and preferences of individual communities, is most likely to be effective at reducing rates of suicide and self-harm.(29) To this end, community-driven suicide prevention efforts are considered paramount to adequately address the disproportionately high suicide rate in Indigenous communities.(29)

There are several examples of Indigenous community initiatives addressing mental health and suicide prevention. One example is, the 'National Inuit Suicide Prevention Strategy' prepared by the Inuit Tapiriit Kanatami (ITK), the national organization representing Canada's Inuit. This community-driven document speaks to current challenges to mental health care as identified by Inuit communities and outlines six priority areas of focus for reducing of suicide, including: social equity, cultural continuity, Inuit children, access to a continuum of mental wellness services including healing unresolved trauma and grief, and lastly, mobilizing Inuit knowledge for resilience and suicide prevention.(30) Priorities in mental wellness services include creating helplines and electronic resources available in Inuktitut, as well as suicide intervention and mental health first aid training opportunities. Their strategy emphasizes the importance of hiring professionals who are knowledgeable of Inuit culture and trained in family counselling as well as community development. To ensure this strategy reflects Inuit priorities and circumstances, multiple Indigenous advisory committees and organizations were consulted to inform the

approach used by ITK in developing new mental wellness services. Globally, the ITK stresses the importance of Inuit self-determination in suicide prevention, and call for an Inuit-led approach to the suicide crisis. This is just one example of grassroots efforts being employed in Indigenous communities; it is worth noting the importance of recognizing and supporting community-led efforts among First Nations, Métis, and Inuit groups.

National policy, originating over a century ago, has had intergenerational repercussions and has negatively impacted the wellbeing of many Indigenous peoples in Canada, leaving a persisting legacy of colonial trauma. Despite this, the overwhelming embodiment of resiliency and strength by Indigenous persons across Canada – manifested in motivations to support community-driven programs, policy changes, and collaboration of health care agents at all levels (among other things) – shows incredible promise of overcoming the damaging effects of colonial policies past and present.

Problem Definition

Government policies and programs, including the Indian Act and the residential school system, have contributed to increased prevalence of mental illness, intergenerational trauma, suicide attempts and Indigenous overrepresentation in the child welfare and penitentiary system. Despite the last residential school having closed in 1996, continued trauma is experienced within Indigenous communities and is reflected by the high suicide rates which are more than double those seen in the general Canadian population. Currently, the efforts of the Canadian healthcare system are inadequate in addressing the short-term increase in suicides in Indigenous communities and the associated long-term issues, such as tackling social determinants of health and ensuring the availability of adequate mental health services. Additional effort by medical students, faculties of medicine, and the CFMS to petition the Federal Government and Provincial Health Authorities for change, in addition to a commitment to consultation with Band Councils and other groups of Indigenous leaders (i.e. Metis Nations or the Inuit Tapiriit Kanatami) must be made a priority; if not, it is unlikely that those at risk of suicide will receive the help they need.

Position Statement

There is a disproportionate burden of mental illness and suicide among Indigenous peoples in Canada. This high rate of suicide is inextricably linked to past governmental policies and action that served to marginalize and disenfranchise Indigenous persons in Canada, as well as reverberations from systemic racism and inequity that presently affect Indigenous persons in Canada. These include (but are not limited to) the Indian Act, the Residential School System, the Sixties Scoop, and the ongoing child welfare crisis. As future medical practitioners, the CFMS believes that it is healthcare workers' duty to acknowledge this public health crisis and to devote resources to working with and supporting affected communities. Moreover, it is imperative that medical trainees and faculties develop an understanding of the unique needs of Indigenous communities in Canada, and commit themselves to collaborative, non-judgmental, and community-driven suicide prevention efforts. The CFMS has prepared a list of recommendations

in the spirit of reconciliation supporting Indigenous community-driven efforts to promote individual and community mental health and well-being.

Recommendations

1. **The CFMS supports the Truth and Reconciliation Calls to Action that are specific to health and justice in healthcare provision for Indigenous populations** (see Appendix A).
   a. As a national document, it speaks for the collective need for all Canadians to work together towards reconciliation to improve mental health outcomes in Indigenous communities across Canada.

2. **The CFMS supports Indigenous communities in identifying goals with respect to suicide prevention strategies and supports Indigenous community-driven programs to meet these goals.**
   a. As medical students, our support for grassroots initiatives is influential. Since community-driven initiatives have proven to be the most effective, aligning our influence with these programs may generate the momentum required to ensure continued growth for these programs.

3. **The CFMS supports the utilization of tool kits, documents and/or guidelines developed by Indigenous groups for Indigenous communities where there is a need for such resources to address the issues of mental health and suicide** (see Appendix B for examples).
   a. As documents prepared by and for Indigenous communities, the research and conclusions made relate to this demographic specifically and more applicable when compared to other resources dealing with suicide.

4. **The CFMS supports fair and equitable funding for Indigenous mental health programming and resources available to Indigenous peoples in rural, remote, and urban settings.**
   a. Funding and allocation of resources for community initiatives should reflect the needs of the given community as well as the urgency of arising crises.

5. **The CFMS supports coordinated efforts between Indigenous community leaders, the Federal Government, and Provincial Governments in providing mental health care to Indigenous peoples, to best serve communities.**
   a. We acknowledge the current complexities and shortcomings of the current funding system for mental health services for Indigenous communities.

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APPENDIX A: Relevant Truth and Reconciliation Commission of Canada: Calls to Action

We acknowledge that the Truth and Reconciliation Commission (2008-2015) and the recommendations yielded in this report are the product of work done by the appointed commissioners, the appointed members of the Indian Residential School Survivor Committee (IRSSC), members of the Inuit Sub-Commission, and all those who shared their stories and knowledge regarding the residential school system in Canada. Stories were shared at National events held in major cities from 2010-2014 (with an estimated 155,000 in attendance, including over 9,000 residential school survivors), Regional events in Victoria, Whitehorse, and surrounding communities, and town halls held in conjunction with National and Regional events, where members of the general public were invited to share ideas surrounding their ways of supporting reconciliation, and thoughts on how to provide further support. Individual statements were gathered from over 6,750 residential school survivors, their family members, and others wishing to share their knowledge of the residential school system. Statements were obtained at Sharing Panels and Sharing Circles at National, Regional, and Community events, as well as through visits to correctional institutions across Canada. Finally, interviews were conducted with former staff of residential schools, as well as their children (2015. "Commission Activities", Summary of the Final Report of the Truth and Reconciliation Commission of Canada.)

("Health")

18. We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.

19. We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, *suicide*, *mental health*, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

20. In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address *the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.*

21. We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, *mental, emotional, and spiritual harms* caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.

22. We call upon those *who can affect change within the Canadian health-care system* to recognize the value of *Aboriginal healing practices* and use them in the *treatment of Aboriginal patients* in collaboration with Aboriginal healers and Elders *where requested by Aboriginal patients*.

23. We call upon all levels of government to:
i. Increase the number of Aboriginal professionals working in the health-care field.
ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
iii. Provide cultural competency training for all healthcare professionals.

24. We call upon *medical* and nursing *schools in Canada* to require all students to take a course dealing with *Aboriginal health issues*, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require *skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism*.

<u>(”Justice”)</u>
40. We call on all levels of government, in collaboration with Aboriginal people, to create adequately funded and accessible Aboriginal-specific victim programs and services with appropriate evaluation mechanisms.

41. We call upon the federal government, in consultation with Aboriginal organizations, to appoint a public inquiry into the causes of, and remedies for, the disproportionate victimization of Aboriginal women and girls. The inquiry’s mandate would include:
i. Investigation into missing and murdered Aboriginal women and girls.
ii. Links to the intergenerational legacy of residential schools.

APPENDIX B: Published Indigenous Mental Health and Suicide Prevention Toolkits

Hope, Help, and Healing A Planning Toolkit for First Nations and Aboriginal Communities to Prevent and Respond to Suicide (1)
Assessment and planning toolkit for Suicide Prevention in First Nations Communities (2)
Acting On What We Know: Preventing Youth Suicide in First Nations (3)
National Inuit Suicide Prevention Strategy (4)

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