

**SUICIDE AMONG ABORIGINAL PEOPLE:  
ROYAL COMMISSION REPORT**

**Nancy Miller Chenier  
Political and Social Affairs Division**

**23 February 1995**



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## **SUICIDE AMONG ABORIGINAL PEOPLE: ROYAL COMMISSION REPORT**

In February 1995, the Royal Commission on Aboriginal Peoples released its special report on suicide. Over several years, in 172 days of public hearings in 92 communities across Canada, the Commissioners heard that suicide was one of the most urgent problems facing aboriginal communities. In addition, the Commission in 1993 had held two special consultations on suicide prevention in which national organizations represented aboriginal people. Included were the Assembly of First Nations, the Native Women's Association of Canada, the Native Council of Canada (now the Congress of Aboriginal Peoples), the Inuit Tapirisat of Canada, Pauktuutit (Inuit Women's Association), and the Metis National Council.

### **THE MAGNITUDE OF THE PROBLEM**

The report points out several problems in using existing data, especially since, for several reasons, they underestimate the total picture. Data collection has focused primarily on registered or status Indians and Inuit living in the Northwest Territories and has excluded non-status Indians, Metis and Inuit living elsewhere. Moreover, it may be difficult to determine whether suicide is the cause of death in certain cases; it has been estimated that up to 25% of accidental deaths among aboriginal people are really unreported suicides.

Although the true rate of suicide was considered to be higher than existing data suggested, the Commission estimated that suicide rates across all age groups of aboriginal people were on average about three times higher than in the non-aboriginal population. The suicide rate was placed at 3.3 times the national average for registered Indians and 3.9 times for Inuit.

Adolescents and young adults were at highest risk. Among aboriginal youth aged 10 to 19 years, the suicide rate was five to six times higher than among their non-aboriginal peers; however, it is in the years between 20 and 29 that both aboriginal and non-aboriginal people showed the highest rates of suicide.

## **THE CONTRIBUTING FACTORS**

The Commission report identified four groups of major risk factors generally associated with suicide; these were psycho-biological, situational, socio-economic, or caused by culture stress. Culture stress was deemed to be particularly significant for aboriginal people.

While mental disorders and illnesses associated with suicide (such as depression, anxiety disorders and schizophrenia) were documented less often among aboriginal people, community health providers suggested that unresolved grief may be a widespread psycho-biological problem.

Situational factors were considered to be more relevant. The disruptions of family life experienced as a result of enforced attendance at boarding schools, adoption, and fly-out hospitalizations, often for long-term illnesses like tuberculosis, were seen as contributing to suicide. To this was added the increasing use of alcohol and drugs to relieve unhappiness. Studies of aboriginal people who have committed suicide have found that as many as 90% of victims had alcohol in their blood. Brain damage or paranoid psychosis as a result of the chronic use of solvents is reported as a major factor in suicides by youth.

Socio-economic factors, such as high rates of poverty, low levels of education, limited employment opportunities, inadequate housing, and deficiencies in sanitation and water quality, affect a disproportionately high number of aboriginal people. In conditions such as these, people are more likely to develop feelings of helplessness and hopelessness that can lead to suicide.

Culture stress is a term used to refer to the loss of confidence in the ways of understanding life and living that have been taught within a particular culture. It comes about when the complex of relationships, knowledge, languages, social institutions, beliefs, values, and ethical rules that bind a people and give them a collective sense of who they are and where they belong is subjected to change. For aboriginal people, such things as loss of land and control over living conditions, suppression of belief systems and spirituality, weakening of social and political

institutions, and racial discrimination have seriously damaged their confidence and thus predisposed them to suicide, self-injury and other self-destructive behaviours.

### **SUICIDE PREVENTION: SOME COMMUNITY INITIATIVES**

In addition to the despair voiced about suicide, the Commission heard about suicide prevention initiatives that have emanated from individual, community and regional determination to make a difference. Each initiative was unique. Some aimed directly at preventing suicide and others aimed more broadly at affecting the causes and consequences of all violent and self-destructive behaviour. Six such initiatives are described in the report. They included efforts at the Wikwemikong Reserve on Manitoulin Island in Lake Huron, Ontario; at the Big Cove Reserve in New Brunswick; throughout the Northwest Territories; on the streets of North End Winnipeg, Manitoba; at Canim Lake in the central interior region of British Columbia; and within the communities making up the Meadow Lake Tribal Council in northwestern Saskatchewan.

The efforts at Wikwemikong started in the mid-1970s, when seven suicides took place in a small sector of the community. Following an inquest and research into the events, two local service agencies were funded. Rainbow Lodge, now called Ngwaagan Gamig Recovery Centre, was established as a non-medical alcohol and drug treatment and prevention (outreach) facility while the Wikwemikong Counselling Service, now called Nadmadwin Mental Health Clinic, was set up as an independent mental health support service. The presence of these facilities, along with increased public awareness, collective responsibility and community development, are credited with building the psychological stability currently enjoyed by the community.

Seven suicides and 75 attempted suicides occurred at Big Cove in 1992. An inquest recommended restriction of drugs and alcohol, job creation, provision of permanent on-reserve mental health services, and movement toward self-government. Community caregivers began collective consultation to determine what kind of community Big Cove could become if people took responsibility for improving it. This group supported greater reliance on traditional values, rituals and healing ceremonies for dealing with the underlying problems of family and community breakdown. A week-long community gathering for mourning and healing, combining Micmac spirituality, Christianity and western psychotherapy, was arranged. At a final community sharing circle, recommendations touched on issues ranging from responsibilities within the community to

racism outside it.

In the Northwest Territories in 1989, a debate in the legislative assembly on suicide among aboriginal people led to the appointment of a co-ordinator to develop a comprehensive strategy and the beginning of a suicide prevention program. A 1990 grassroots forum in Rankin Inlet sparked a series of seven regional forums bringing together more than 300 people. Recommendations were made for all territorial departments to contribute to strengthening families and communities and for resources to be aimed at community-based initiatives. The need for a territory-wide training initiative led to a partnership of the GNWT, the Canadian Mental Health Association and the Muttart Foundation of Edmonton. The resulting Suicide Prevention Curriculum trains people working at the grassroots level in their communities - alcohol and drug counsellors, community health representatives, women's shelter workers - to pass on their expertise to others.

On the streets of North End Winnipeg, the Bear Clan Patrol, a volunteer force, works to protect the vulnerable in this urban aboriginal community from violence and exploitation. The concerns about street safety were raised at the annual aboriginal youth assembly in 1991 and were taken up by the Ma Mawi Wi Chi Itata centre, an aboriginal child and family welfare agency. Made up of volunteers who receive about 20 hours of training in first aid, safety precautions and conflict resolution, the Patrol deals with the harassment of women and children on the streets, intoxication and overdoses, family violence and threats of suicide.

At Canim Lake in the mid-1970s, attempts were made to address serious problems by turning the community from rampant alcoholism to almost total sobriety. When the problems persisted, further probing by community leaders revealed abuse within the community. The perpetrators had themselves been victims of physical and sexual abuse at St. Joseph's Residential School, which they had been forced to attend between the ages of 6 and 16 years of age. The fight to overcome addiction and abuse ranged from therapy and traditional ceremonies to treatment programs based on Shuswap models of justice.

The Meadow Lake Tribal Council saw in the mid-1980s that the children in the communities were lacking both a nurturing environment for development and a cultural sense of language and traditions. At the same time, no child care was available when adults were attending school or substance abuse treatment. After months of discussion, a plan for community-based child care was developed; it was guided by First Nations culture, traditions and values and adhered to the highest education and care standards. A partnership with the University of Victoria's School of Child and Youth Care provided a curriculum adapted to the needs and priorities of the community. Training and child care facilities are housed in a building known as the Wakayos Child Care

Education Centre where a shift to concern for children and families is promoted.

## **BARRIERS AND SOLUTIONS**

The Commission acknowledges that some of the barriers to change are in the aboriginal communities themselves. It points out that community leaders are often more interested in economic development and self-government than social problems; that the events and risk factors associated with suicide create shame and secrecy; that adults fail to act as role models for the young; and that conflicts and rivalries in communities prevent action. However, it also notes that non-aboriginal control over programs and resources has resulted in little response to calls for long-term prevention; uncoordinated emergency measures; no comprehensive, nation-wide mental health policy; unequal access to programs and resources; confusion due to multiple funding sources; and inadequate information and training resources.

The Framework for Action proposed by the Commission recommends a Canada-wide three-part response to suicide that is community-based. It encompasses the establishment of direct suicide crisis services, the provision of resources for broad preventive action through community development, and the building of support for self-determination, self-sufficiency, healing and reconciliation. This approach is to be based on seven elements: cultural and spiritual revitalization; strengthened family and community bonds; focus on children and youth; holism; whole-community involvement; partnership; and community control.

In addition, the Royal Commission has specified some particular goals. A ten-year timetable is to be established for meeting the primary aims of the Canada-wide campaign to prevent aboriginal suicide and self-injury. By 1997, every aboriginal community must have at least one resource person trained in suicide prevention, intervention and grief support techniques. By 1998, each community must have a resource person trained in community development planning and methods. A National Forum on the Prevention of Suicide among Aboriginal people is to be held in the first year and every three years thereafter until the tenth year of the campaign.

## **CONCLUSION**

On its release, the Royal Commission report was both criticized for promoting

traditional solutions that would stall modernization in aboriginal communities and praised for attempting to address a complex problem and to move aboriginal communities toward health and wellness on all levels. One Commissioner declined to endorse the overall policy view while emphasizing the need for appropriate measures in communities where suicide is a concern. Overall, the report provides a comprehensive approach to a problem that is of increasing concern for aboriginal communities in general and for their children and youths in particular.