



Supporting Indigenous Children and Youth with Suicidal Ideation: Information for Primary Care



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Summary: Suicidal ideation is a significant problem among all children and youth, and in particular, Indigenous youth, who have rates of suicide 5 to 7 times the Canadian average (1-3). Historically, suicide was rare in Indigenous peoples, as children and youth enjoyed strong attachments with their families, culture and land that gave them a sense of purpose and belonging.

Since colonization, however, suicide rates have steadily increased. The policy of residential schools has led to intergenerational trauma. Children who were raised outside of a loving and caring family structure have themselves become adults at risk of repeating the cycles of abuse and neglect.

This complex issue is rooted in our shared history. The diversity among Indigenous peoples and communities is not fully considered here; however, common themes emerge. By being aware of the historical context, primary care providers can offer a more culturally safe approach to assessment and management of Indigenous youth who are feeling suicidal — one that focuses on strengthening resiliency and cultural connectedness.

Case: Lucy's Story

Identifying data

- Lucy is a 16-year-old First Nations youth from Sachigo Lake First Nation (a remote, fly-in community in northwestern Ontario), previously living at home with her parents and has five other siblings.

Chief complaint

- Lucy presents to your walk-in clinic in Ottawa stating she wants to end her life.

HPI

- Lucy is thinking of hanging herself in the bathroom of the house she has been staying at, however she has not obtained any rope.

- She is a survivor of childhood sexual abuse from an uncle (himself a survivor of childhood abuse and residential schooling), starting at age 11.
- A few months ago, she and her grandmother came to Ottawa. Lucy came acting as an escort for her grandmother to see a specialist at the Ottawa Hospital.
- She is quite close to her grandmother; they speak Ojibwe together and she learned how to cook traditional foods from her.
- Unfortunately, her grandmother was admitted to hospital, and Lucy began to explore the city on her own.
- She quickly connected with transient youth in the downtown core who “hooked her up” with “something better than oxy’s.” Her fentanyl addiction quickly spiralled out of control, and in order to pay for her drug use, she turned to prostitution.
- Lucy just saw on Facebook that her ex-boyfriend in Sachigo Lake died by hanging last week.

Past History including Substance use

- At age 12, she began experimenting with oxycodone.
- At age 15, she was using injection opioids.

Family history

- Both of Lucy’s parents attended residential school in Kenora, Ontario before being returned to their community.
- Lucy and her siblings have been apprehended multiple times by Tikinagan Family Services and placed in the care of family members in Sachigo Lake and neighbouring communities because of her parents’ substance abuse and frequent reports of violence.

How are you going to support Lucy?

Epidemiology

- Colonization has been devastating for the mental health of Indigenous peoples.
- Before European contact, suicide was rare among Indigenous people, but since then, rates of suicide have risen to several times the Canadian average. (1,4)
 - Inuit suicide rates:
 - 6-11 times the Canadian average (1,2)
 - 101.6 per 100,000 for males; 41.6 per 100,000 for females (5)
 - First Nations suicide rates:
 - 5 to 6 times the Canadian average (3)
 - 30.0 per 100,000 for males; 25.5 per 100,000 for females (5)
 - Métis:
 - Because of the way data is collected, rates of suicide in Métis children and youth are difficult to estimate. (2)
- Indigenous youth likely to die by suicide tend to: (4)
 - Be male, young and single
 - Have been drinking alcohol
 - Have used highly lethal means (guns and hanging)
 - Occur in clusters
- Half of the youth who die by suicide were seen by a primary care provider in the six months before their death, and up to 90% have well-documented untreated (or inadequately treated) mental health issues such as depression and substance abuse. (6)

Terms

Throughout this guide, the term Indigenous is used to encompass the three distinct groups recognized by the Canadian Constitution: First Nation, Inuit and Métis people. (2)

Background and History

“We must understand what suicide among Aboriginal people, in all its complexity, really is: not just a problem in itself, but the symptom of deeper problems.”

– Royal Commission on Aboriginal Peoples (8)

Inuit (2,9)

- Population of 45,000, divided into four main regions of the Canadian Arctic, each with its own association and land claim agreement: Nunatsiavut (Labrador); Nunavik (northern Quebec); Nunavut; and Inuvialuit (western Arctic).
- Language: Inuktitut (Inuvialuktun spoken in the western Arctic).
- Diet: “country foods” include sea and land mammals (whale, seal and polar bear) and berries.
- Perilous conditions in traditional nomadic camps demanded healthy social and psychological systems:
- Highly developed interpersonal communication skills included intentional listening; giving/receiving respectful advice; and strategic use of humour and silence.
- Customary adoption: children were fluidly accepted into the homes of adoptive parents.
- Men and women all actively shared responsibility for child-rearing, including the teaching of Inuit law, guiding development and providing discipline.
- Elders were treated with great respect. They held authority over community law and were responsible for sharing accumulated knowledge.
- Feasts, drum dancing, throat singing and games of dexterity and skill were the centre of community life.
- The circle represented “cyclical aspects of birth, life and death, as well as seasonal cycles marking changes in lifestyle, food, social activities and ceremonies.” (2)
- Medicines were derived from plants and animals.
- First contact with Europeans:
- Frobisher on his quest for the Northwest Passage in the 1500s first encountered the Inuit, and this was followed by European whalers in the mid-1700s.
- In the 1950s, discovery of rich mineral deposits and the demand for strategic NATO air bases marked the onset of forced relocation of the Inuit from ancestral homes and hunting territories to centralized, government-built settlements.

First Nations (2,9)

- Population of 734,000 registered First Nations people (does not include non-status First Nations people).
- 57% live on reserves; the remainder often live in larger cities.
- Prior to European contact, there were six major cultural regions: Woodland First Nations in the east, Iroquois First Nations of southeastern Ontario and Quebec, Plains First Nations of the Prairies, Plateau First Nations, Pacific Coast First Nations and First Nations of the Mackenzie and the Yukon River basins.
- Many regional differences in language and customs exist. A general cultural overview is provided below.
- Family structure was matrilineal; clans were comprised of extended families descended from a common female ancestor.
- Gender and gender roles were fluid concepts; however, in general, women were the owners of houses and agricultural land and were responsible for decision making. The men carried out these decisions as well and acted as providers and defenders of the family.
- Children learned proper behavior by modelling adults or experiencing the consequences of their misbehaviour and were not disciplined by European standards.
- First Nations peoples were highly skilled in agriculture and willingly shared their knowledge of crop cultivation, particularly with corn, tobacco, and potatoes.
- They prepared, preserved and compounded many medicines (quinine, ipecac, salicin, cathartic laxatives, black cohosh, petroleum jelly).
- The Medicine Wheel is a powerful symbol which “represents balance and completeness in the universe within a framework of ongoing cyclical change and transformation.” (2)

Métis (2,9)

- Population of 292,000 spread throughout Canada, with more than two-thirds living in western urban centres.
- Historically, the term “Métis” applied to the children of French traders and Cree women in the Prairies, and of British traders and Dene women in the North.
- Today, the term is broadly used to describe a group of people of mixed First Nations and European ancestry who can trace their lineage back to traditional Métis Nation territory and see themselves as distinct from other Indigenous people.
- After the fur trade was well established by the Hudson’s Bay Trading Company, a distinct Métis identity began to emerge:
 - Subsistence farming and the biannual buffalo hunt, as well as logging and mining, were a large part of Métis livelihood.
 - Women “produced clothing and footwear for trade, tanned hides, trapped and traded furs, dressed furs for shipment, grew vegetables, fished, built smoking lodges, smoked fish, as well as buffalo, for pemmican, and produced and sold large quantities of a dried fish gelatin.” (2)
 - Many retained strong ties to the Roman Catholic faith as well as aspects of their First Nations spiritual traditions.
- Ancestral knowledge of the healing qualities of things found in nature such as plants, roots and bark was passed down through the generations.
- Language: Michif is a mixture of French nouns tied to the Cree verb system.

Effects of Colonization on Indigenous Peoples

Residential Schools (2)

- The goal of the federal residential school policy was to aggressively assimilate Indigenous children into mainstream Canadian society through physical and cultural disconnection from their families and communities.
- The Indian Act legally removed the rights of Indigenous parents and gave the government authority to remove Indigenous children from their families and place them in residential schools, operated by the four major churches of Canada and designed to “civilize and Christianize” them. (8)
- Many Indigenous students endured what is described as “ritualized abuse” in these schools to further the goal of Indigenous ethnocide:
 - Cultural suppression meant children were taught to shame and reject everything about their heritage, ancestors, families and spiritual traditions.
 - Children grew up in institutions, forbidden to speak in their languages, taught that their parents were savages, and forced to adopt a new religion.
 - Many children experienced physical and sexual abuse by multiple perpetrators throughout their entire childhoods.
- Although all churches involved, as well as the Federal Government, have now apologized for their involvement in this tragedy, a great deal of further healing is needed to repair the damage that continues to ripple across generations.

Sixties Scoop

- Imagine being the happy parent of a young child. Then one day, some stranger along with a police officer come to your door and tell you that they are taking your child away. You haven't anything wrong, but that's the law.
- Following the closure of many residential schools, the Department of Indian Affairs ordered large numbers of First Nations children to be apprehended from their families and placed in non-Indigenous foster homes. (9)
- “By the end of the 1960s, 30%–40% of the children who were wards of the state were Aboriginal, compared to only 1% in 1959.” (8)

Historical Trauma

- Historical traumas are the “traumatic experiences that are cumulative over the lifespan of individuals, as well as across generations.” (2)
- Survivors of the residential school system grew up without traditional role models for what constitutes a healthy family and healthy relationships.

- Experiences of their own damaged childhoods left residential school survivors few strategies for living other than unacceptable ones, such as violence, abuse, addictions and self-destructive behaviour. (8)
- Residential school survivors often sought refuge in marriage and partnerships. But their own lack of secure childhood attachments meant that they struggled with the complex demands of intimate relationships and parenting, often leaving their children feeling abandoned. (2,8)
- There is an additional loss of Indigenous tradition because of the fractured relationship between children and Elders. (10)
- Disempowerment and loss of self-efficacy were the results of forced sedentarization and social disorganization. (9,10)
- The legacy of the residential school system is “lateral violence” (or intergenerational trauma), a cycle in which the physically or sexually abused become perpetrators themselves. (9,10)
 - 25% of Indigenous women and 13% of men report experiencing violence from a current or previous partner over the past five years; 57% of the women who experienced abuse reported their children had witnessed it. (2)
 - The ratio of Indigenous to non-Indigenous children in the care of a Children’s Aid Society is 7 to 1. (2)
 - Up to 30-40% of children and youth placed in foster care are Indigenous. In fact, there are more living in out-of home care than there were in residential schools at the height of the residential school movement. Additionally, there is a growing trend toward placing Indigenous children in group or institutional care (11)

Clinical Environment

The physical environment of the clinic and your waiting areas can send a powerful message to everyone (including cis-people (i.e. non-LGBTQIA people) as well as to non-Indigenous people) that your clinic is an accepting environment:

- Consider using scents (e.g. cedar), Indigenous artwork and warm earth tone colours. (7,12)
- Ensure that staff are welcoming and inclusive. Consider cultural competency training for your employees, as part of their professional development.
- Use discreet monitoring/safety alerts and barrier-free spaces (11)
- To make your clinic a culturally safe place, having these in the waiting area and the clinic, after first asking a local LGBTQIA organization and/or Indigenous health group for what they would recommend:
 - Rainbow flags or materials to help LGBTQIA patients feel at ease.
 - Culturally appropriate resource material to help Indigenous patients (2,12)
 - Advertisements for local cultural events.
 - Place condoms and shelter information in washrooms and other discrete locations.

General Principles

- Create cultural safety, by understanding how power imbalances, discrimination and colonial relationships have affected Indigenous peoples (12), which ultimately leads to better health outcomes (7).

Cultural safety is an endpoint in a continuum of care, whose steps include:

- Awareness: This continuum starts with awareness, an acknowledgment of difference between the cultures of provider and patient.
 - Sensitivity: The next level up is sensitivity, which respects the cultural difference.
 - Cultural competence refers to the provider having skills and attitudes for cultural safety. Cultural safety includes the previous phases, but it also includes self-reflection leading to empathy, advocacy and understanding. Cultural safety promotes better health outcomes.
- Avoid re-victimization. “Re-victimization” happens when circumstances replicate the original abuse experienced by survivors. They can feel disempowerment, disconnection or pain. (2)

- Build trust and connection: (2,7)
 - Accept that the patient may not trust you. The power imbalances between Indigenous youth and non-Indigenous care providers are increased by the historical treatment of Indigenous peoples. In addition, you are an adult, and this youth may not have experienced adults as sufficiently caring and protective.
 - Provide unconditional compassion.
 - Be present and pay close attention.
 - Listen. Seek first to understand.
 - Foster an atmosphere of safety and hope.

- Use a patient-centred approach:
 - Try to be flexible if the patient is late for appointments.
 - Patients may have beliefs about causes and cures that do not fit with established medical views. Take time to understand those beliefs and how they may impact treatment. (12)
 - Engage youth in shared decision-making about their treatment, and be careful not to impose directives. (2)
 - Coordinate services so that multiple disclosures are not necessary, and screen or educate referral services about practices that may re-victimize patients. (2)
 - Allow time for traditional healing ceremonies. (12)

- Use non-verbal communication:
 - Make youth feel visible and welcome with brief eye contact and a warm smile. (7)
 - Pay attention to body language and non-verbal cues. Inuit, in particular, may only nod or blink to acknowledge understanding, raise eyebrows to indicate yes and wrinkle nose for no.
 - Be silent when appropriate (2). Being silent is a way of accepting others, is a highly respected skill and is considered a form of healing itself. When a person shares in a healing circle, there is no interruption. Non-interference is highly valued.
 - Inuit have the longest pause time of any culture. Speaking too much or too quickly may undermine trust. (2)

- Verbal communication:
 - Greet patients in their Indigenous language (7), for example:
 - Inuktitut: Good morning = Ublaahatkut
 - Ojibwe (an Algonquian language): Hello = Bozhoo
 - Avoid immediate direct and personal questions at onset of relationship.
 - Consider the spirit and intent of all questions and be able to explain the purpose of the information requested. (7)
 - Provide explanations in appropriate, respectful plain language without medical jargon (12)
 - Use a cultural interpreter where appropriate; cultural interpreters not only translate language, but are able to take into account the cultural background of the patient. (10,12)

History and Risk Assessment

When seeing the “undifferentiated” patient in primary care (i.e. patient with suicidal ideation who has not yet been assessed or diagnosed by a mental health specialist), the focus is on risk assessment, not a comprehensive diagnostic assessment, differential diagnoses or ‘understanding the full story’. The goal is to assess whether or not the patient is acutely suicidal, and then be able to refer the child or youth if necessary.

Identifying data	<p>“How would you like me to address you?”</p> <ul style="list-style-type: none"> • This sends a message of acceptance from the start to LGBTQIA youth. <p>Gender</p> <ul style="list-style-type: none"> • Male gender: Majority of deaths by suicide are among young men. (3,10) • Female gender: More likely to have been abused but also more likely to seek mental health help. (10) <p>If you are wondering about gender identity: “What gender do you identify with?”</p> <ul style="list-style-type: none"> • Western social norms introduced with colonization placed two-spirited, lesbian, gay, bisexual, transgender, queer, questioning, intersex and asexual (LGBTQIA) people at 2 to 14 times increased risk of suicide. (13) • Many two-spirited and transgendered Indigenous youth leave their communities because of intolerance and move to larger urban centres where they are even more vulnerable to victimization. (4) <p>“Who do you live with?”</p> <ul style="list-style-type: none"> • Those who have had changes in childhood caregivers, non-parental caretakers, foster home placements or other instability at home are at increased risk of suicide. (4,8,10,13) <p>“Where are you living?”</p> <ul style="list-style-type: none"> • Homelessness (4,13) is a risk factor, as well as drug/sex trade. (10) • “Do you attend school?” • Poor engagement with school (e.g. poor attendance or low grades) is a risk factor. (3,5,10,13) <p>For older youth and adults: “Do you work?”</p> <ul style="list-style-type: none"> • Unemployment and poverty are risk factors. (3-5,8,14,15) • “Is there any particular cultural background that you identify with?” • Asking specifically can be helpful, as some Indigenous patients may not self-identify.
Current resources and supports	<p>“Any professionals that you see? Any Elders? Any counsellors/therapists?”</p> <p>Do you have a close friend or group of friends?”</p> <ul style="list-style-type: none"> • Interpersonal isolation is a risk factor. (3-5,10)

Suicide Risk Assessment

*Adapted from (13)

Ideation	<p>“Have you had any thoughts of ending your life?”</p> <p>“Since when?”</p> <p>“Tell me more about those thoughts...”</p> <p>“How strong are those thoughts?”</p>
Planning	<p>“Do you have any plans of how to end your life?”</p> <p>“How would you end your life?”</p> <p>“How far have you gotten with those plans?”</p> <ul style="list-style-type: none"> • Explore access to methods with high lethality such as firearms. Suicide risk is 5 times higher in homes with firearms than in those without them. (4,8,10) • Choice of methods, time and place may be strongly influenced by exposure to previous suicides. (10) <p>“When do you plan to carry out your plans?”</p> <p>“Where do you plan to carry out your plans?”</p> <p>“In the past, have you ever attempted to end your life? What did you do?”</p> <p>“Were there other people around?”</p> <ul style="list-style-type: none"> • Previous suicide attempt is the strongest predictor of future attempts. (3-6,10) • Attempts can range from mild “gestures” with minimal lethal intent to serious attempts in which death is averted only by chance. (10)

Stressors and Triggers

Listen for signs of cultural identity loss, such as: (5,8)

- Having a parent who attended residential school. (15)
- Living in urban centres away from contact with Elders and spiritual ceremonies; being caught between two cultures and identifying with neither. (1,3,10)

“Everyone has stress. Typical ones are family, school and relationships. What are your biggest stresses?”

- Identifying stresses is helpful because then there can be specific problem-solving to support the youth/family.

Common stresses:

- Death by suicide of a friend or family member (4,8,10,13), or multiple suicides (i.e. suicide clusters): (3,5)
 - Suicide contagion: After a suicide, surviving youth may feel more suicidal and hopeless, reflecting their strong connection with peers rather than with healthy, non-suicidal adults. (8,16)
- Loss of relationship: (5,8,10)
 - Romantic relationship problems are the trigger for most youth suicides. (16)
 - Disrupted families, communities and traditions may “lead youth to cling to each other in adolescent love relationships. The intensity of this dependence increases the risk of interpersonal conflict, various forms of abuse, and catastrophic emotional reactions when relationships founder.” (10)
- Boredom: (10) Boredom reflects the lack of meaningful activities or opportunities in their community. Youth who talk about “boredom” may be minimizing or denying their distress or expressing emptiness.

“Sometimes people use alcohol or drugs to cope with their feelings or simply to escape. Is this something you sometimes do?”

- Acute alcohol or substance intoxication: 60% to 90% of all Indigenous people who attempt and die by suicide are intoxicated at the time, compared to 24% to 66% of non-Indigenous people who die by suicide. (4,10,13)

Protective Factors

“Despite these thoughts of ending your life, you are still alive. What keeps you going?”

Evidence of resilience includes:

- Strong cultural identity and connectedness (4,5,13)
 - The Creator gave meaning to all life on Earth. Most Indigenous cultures have explicit proscriptions against suicide on the grounds that it contravenes natural laws or the design of the Creator. (8)
 - Healthy attachments such as family members, extended family, other adults and peers (3-5,10,12); open communication and respect among family members. (13)
 - Attendance at spiritual events (17)
 - Access to culturally relevant health services (5)
 - Participation in traditional activities (17)
- Appropriate housing (5)
- Healthy lifestyle (food, exercise, sleep) (5,13)
- Self-acceptance (4,5,10,13)
- School engagement (3-5,10,13,17)
- Skills in stress management, communication and problem solving (4,5,10)
- Future orientation (5,10)

Additional History to Explore

When time permits, these are additional areas to explore at future visits.

Psychiatric Review of Symptoms	<p>Psychiatric illness is a risk factor for suicide. (3-5,8,10,14,15,17)</p> <p>Mood</p> <ul style="list-style-type: none"> • Any troubles with depression? Anxiety? Severe mood swings? • Any troubles with self-criticism? Lack of self-acceptance or self-compassion? <p>PTSD</p> <ul style="list-style-type: none"> • Do you think you've been traumatized before? Any flashbacks? Any problems with nightmares? <p>Schizophrenia / psychosis</p> <ul style="list-style-type: none"> • Any troubles with your thoughts? Hearing voices? Seeing things that others can't see? Have you felt paranoid that others are out to harm you? <p>Personality traits and cognitive styles (4,8,10) such as:</p> <ul style="list-style-type: none"> • Emotional dysregulation, attachment issues such as fears of abandonment • Negative thinking, including negative self-concept/self-criticism • Rigidity, perfectionism
Past Mental Health History	<p>Any past problems with depression, anxiety or other mental health issues?</p> <p>Have you ever received counselling/therapy? Was it helpful or not?</p> <p>Would you be interested in getting help now?</p>
Alcohol / Substance Use	<p>How much do you drink?</p> <ul style="list-style-type: none"> • Indigenous youth begin drinking earlier and more heavily and are also more likely to consume alcohol on their own. (4,10) <p>Do you use any substances? How about sniffing? (3-5,8,13,17)</p> <ul style="list-style-type: none"> • Chronic solvent abuse/"sniffing" may cause paranoid psychosis, permanent epileptic foci and cognitive impairment. (18) • Ask about use of non-conventional substances (keyboard cleaner, gasoline, propane, hand sanitizer).
Abuse / Neglect	<p>Do you think you've ever been abused?</p> <ul style="list-style-type: none"> • Any type of abuse/neglect is a risk factor. (4,5,8,10,13,15,17) • Witnessing violence at home is a risk factor. (3,4,10,15,17)
Pregnancy History	<p>Fetal Alcohol Spectrum Disorder (13)</p> <ul style="list-style-type: none"> • Is there a history of alcohol use in the mother? • For parent: "During your pregnancy, were you on any medications at the time? Recreational drugs? Alcohol?"
Family History	<p>Do you have other family members or friends who have made a suicide attempt or died by suicide?</p> <p>Do you have other people you can turn to?</p>
Legal History	<p>Have you had any problems with the law? Ever been in jail? (4,5,8,10)</p> <ul style="list-style-type: none"> • Although they make up only 3% of the Canadian population, Indigenous people make up 22% of those sentenced to custody in the correctional systems. (1) <p>Have you ever had to sell drugs for money? Ever have to have sex with others for money?</p> <ul style="list-style-type: none"> • High-risk Indigenous youth often become street-involved at a young age and are overrepresented in the drug/sex trade. (10) • A Save the Children Canada report estimates 90% of all child prostitutes in Canada are of Indigenous descent. (2)

Differential Diagnoses and Comorbid Conditions Seen with Suicidal Ideation

Patients who present with suicidal ideation generally have comorbid conditions, which if identified, can be targeted for intervention.

Common differential diagnoses and comorbid conditions include:

- Depressive disorders, including major depressive disorder, adjustment disorder, persistent dysphoric disorder and bipolar disorders
- Anxiety disorders

- Psychotic disorders, e.g. schizophrenia, substance-induced psychotic disorder
- Post-traumatic stress disorder (PTSD)
- Alcohol / substance use disorders
- Oppositional defiant disorder / conduct disorder
- Cluster B personality traits (borderline personality traits, antisocial personality traits)

Physical Exam (Px)

If there has been a suicide attempt, perform a primary survey and activate emergency services as needed.

General	Any signs of intoxication or withdrawal?
Vital signs	Always remember your ABCs and assess stability
Neurologic	Level of consciousness
Head and Neck	Bruising or abrasions on neck (i.e. suggesting attempted strangulation or hanging)
Abdomen	RUQ tenderness in chronic alcohol use or toxic ingestion Distention related to constipation in opioid abuse
Skin/MSK	Any evidence of self-harming behavior Injection sites, signs of infection

Investigations

- Strongly consider a pregnancy test in young women.

Prevention of Suicidal Ideation in Primary Care

"[T]he first step in reducing the incidence of suicide among Aboriginal people lies in accepting and building on the fact that there is no one answer — there are many answers....The essential thing is to try....Don't worry about the size of the problem, and how complicated it is. Start somewhere." (8)

A continuum of culturally safe resources and supports is needed to promote resiliency, mental health and wellness in Indigenous youth, including: (10,13,19, 20)

Health promotion and prevention

- Be optimistic and hopeful, which encourages hope in your patient
- Use a holistic, integrative approach that "seeks to balance the mind, body, and spirit with community and environment" and is strongly related to the social determinants of health. (21)
- Help youth find meaning in their lives and discover a sense of belonging with their peers, families, communities and culture through:
 - Engagement in sports
 - Helping others
 - Traditional activities. (20)

Strategies to minimize risk and promote protective factors:

- Consider referral to healthy parenting programs. (3)
- Consider therapeutic programs and activities that may be able to help with life skills, self-acceptance, healthy relationships, coping strategies for depression anger, as well as health-promoting skills and a sense

of well-being, self-esteem and competency. (4)

- Recreation programs (8) can be a way out of the monotonous life of non-work and non-school that faces so many Indigenous youth and help them develop physical, social and emotional skills and self-confidence.

Management of Suicidal Ideation in Primary Care

There are few peer-reviewed studies on the effectiveness of Indigenous suicide interventions. (3,10,14,19)

Is the patient at imminent risk of suicide, necessitating immediate, emergency care?

- Consider referral to more specialized mental health services such as a crisis centre, particularly if the centre is run by Indigenous persons. (10)
- Strict supervision is essential for anyone considered to be at high risk of an immediate suicide attempt, until the crisis has passed. (8)
- This may necessitate hospitalization and transfer to a tertiary care centre, if working in a remote or rural area.

If there is passive suicidal ideation (i.e. suicidal ideation, but the patient is not at immediate risk):

- Limit the patient's access to lethal methods used for suicide. Ensure that family members safely store all medications and poisonous substances and remove all firearms and closet rods from home. (8,10,16)
- Advise the patient to abstain alcohol and other substances.
- Refer for detoxification or substance use treatment as necessary.
- Create a Safety Plan with the youth and family, including key strategies that can be used in times of crisis or stress. A safety plan is written down and can be carried with the youth at all times (13). It typically includes:
 - What 3 things can I do that are meaningful for me?
 - If I am starting to get stressed, what are 3 things that are calming and soothing for me?
 - Which adults can I call when I am starting to feel sad or worried?
 - What are my reasons for living?
 - Who are my trusted resources I can call if I don't feel better? Include their phone numbers.
 - What are my local emergency services and how do I contact them?
 - What local professional can I call or go see?
 - [Sample crisis plan on eMentalHealth.ca](#)
- Refer to mental health supports/treatment. Effectiveness and cultural appropriateness of psychotherapy has not been conclusively demonstrated for Indigenous peoples, however, consider referral to: (8)
 - "Just" therapy (2): Considers the historical, social and political context of Indigenous people, reduces their feelings of self-blame and guilt, and fosters empowerment.
 - Mindfulness therapy (22): Is consistent with traditional Indigenous ways of being and may help youth to connect to their inner wisdom. Decreases stress, impulsivity and distress intolerance by increasing self-regulation and emotional regulation skills.
 - Counselling with Elders: Counsel provided directly to youth, but primary care providers can also advise caregivers on how to use culturally appropriate psychotherapeutic techniques. (10)
- Refer to cultural supports, which are essential in effective healing work with Indigenous people (2).
- Coordinate care and care planning: Many Indigenous centres have care coordinators who can help youth access and navigate the available services. Ensure close follow-up with at least one consistent professional.

Is the immediate crisis resolved? If so, consider the following:

- Support and aftercare: (8)

- Ensure appropriate follow-up. The “simple effort to contact someone after the acute crisis or hospitalization is over may send a powerful message of caring and concern.” (10)
- “Interventions that increase contact between youth and trained professionals show promise in preventing youth suicide attempts and suicidal ideation.” (6)
- Cultural enhancement: (4)
 - Refer to cultural supports (2). “Culture is treatment, and all healing is spiritual.” (1)
 - Help promote meaningful relationships between youth and Elders (3). An Elder is “someone who is considered exceptionally wise in the ways of their culture and the teachings of the Great Spirit. They are recognized for their wisdom, their stability, their humour and their ability to know what is appropriate in a particular situation. The community looks to them for guidance and sound judgement.” (2)
 - Strengthen the cultural identity of youth in “order to provide them with a feeling of security, a sense of belonging, and hope for the future” (4). Reinforce with youth the importance of Indigenous culture and traditions.
- Traditional healing practices: (2,4,22)
 - Promote traditional healing practices so that the young person can:
 - Recognize and stop using unhealthy coping strategies.
 - Start using positive healing strategies.
 - Examples of traditional healing practices that may be used by Elders:
 - Healing circles: connect with others through mutual disclosure
 - Smudging: cleanse negative energy by burning sage, sweetgrass or tobacco
 - Prayer: communicate with the creative spirit of the universe
 - Sacred objects: eagle feather or talking stick guide the circle
 - Dream imagery: gain insight on a person’s life journey
 - Sweat lodge: cleansing and purification ceremony
 - Lighting of the qulliq: honour the spirit and wisdom of the ancestors
 - Dance: honour connections with community.
 - Drum dancing (Inuit), Reveillons jigs (Métis), Pow Wows and Sunrise Ceremonies (First Nations)
 - Vision quest: developmental ritual at adolescence of self-reflection and self-understanding
 - Fasting: seek new direction in life by shedding old or negative energy and replenishing positive energy
 - Seven sacred gifts (Respect, Humility, Compassion, Honesty, Truth, Wisdom and Love): everyone was given gifts from the Creator at birth to use as medicine for the mind, body, heart and spirit
 - Art and music (new trend for Indigenous youth to engage in learning rap music)
 - Humour and play (traditional Inuit throat singing and games with goal of making opponent laugh)

Has a contributing stress been a completed suicide in the community?

- Support the survivors with follow-up services and education prevention to reduce the risk of contagion and suicide clusters. (3)

Case: Lucy’s Story, Part 2

- Your risk assessment shows that Lucy is not in immediate danger of ending her life.
- You notice that she is not yet connected to any Indigenous supports and services. You contact Minwaashin Lodge, which provides culturally appropriate, Indigenous mental health support as well as a drop-in, and you are able to set up an appointment for her to meet with an intake worker. The worker will help her find safe housing following a short stay in a detoxification centre.
- You give Lucy the phone number for the agency (and name of worker), as well as the local crisis line number.
- As her grandmother is admitted to hospital, you also leave a message with her grandmother’s doctor to see if there is a social worker at the hospital who can help support Lucy.

- You also encourage Lucy to seek wisdom and counsel from her grandmother or an Elder at one of the Elder's Lodges.
- You make a follow-up appointment for Lucy to see you in a week or so, in order to continue getting to know her.
- You will attempt to: 1) ensure she is connected to healthy adults, and 2) encourage her to connect to people and activities that give her a sense of meaning and belonging.

Patient and Family Education

For Youth / Parents

- eMentalHealth.ca has a variety of handouts written specifically for parents and written specifically for youth. Although the information is not tailored for Indigenous people, the approach to depression, anxiety and other conditions is based on attachment and strengthening the child/youth's connection to healthy people. This is similar to the First Nations concept of mental wellness. Relevant topics for children/youth feeling suicidal include: 1) suicide; 2) depression; 3) self-cutting; 4) safety plans; and 5) self-compassion.
<http://www.eMentalHealth.ca>
- Child & Teen Suicide Prevention - Government of British Columbia
<http://www2.gov.bc.ca/gov/content/health/managing-your-health/mental-health-substance-use/child-teen-mental-health/child-teen-suicide-prevention>
- Suicide - Teen Mental Health - Information from Dr. Stan Kutcher's team
<http://teenmentalhealth.org/learn/suicide/>

For Youth

- "Darkness Calls" is a graphic novel on suicide for youth, visual learners and hard to reach populations by Steve Sanderson and The Healthy Aboriginal Network.
http://ccamhr.ca/resources/Darkness_Calls.pdf
<http://www.turtleisland.org/healing/abcomic1.pdf>

Medication Treatment

- If non-medication strategies have not been helpful, then consider medications for treatable conditions such as anxiety and depression.
- Antidepressants may increase short-term suicide risk in some adolescents. However, this increase is balanced by overall reductions in suicide-related behaviours associated with drug treatment of adolescent depression. (6)
- If there are issues with addictions, consult with addiction medicine specialists, as there may be options such as anti-craving medications or opioid antagonists in older youth/young adults.

When to Refer

- Refer to Psychiatry for the diagnosis and treatment of any psychiatric illness you are uncomfortable managing in primary care.
- ALWAYS include referral to Indigenous programs that enhance cultural connection.

Where to Refer in Ottawa, Ontario

Health and Social Services

Wabano Centre for Aboriginal Health

Education support, legal support, cultural programming, recreation, child welfare support, youth in transition support, counselling, cultural and self-esteem building programs, addiction management.

<http://www.wabano.com/>

Akausivik Inuit Family Health Team
Primary Care, Psychiatry
<http://aifht.ca>

Minwaashin Lodge
Counselling services, art therapy, cultural programming, domestic violence support, education and employment assistance, women's shelter, parenting support, cultural youth programming, sex trade outreach, housing support.
<http://www.minlodge.com/>

Odawa Native Friendship Centre
Cultural youth programming, education, legal assistance, parenting support, family violence, homeless outreach, recreation.
<http://www.odawa.on.ca/>

Ottawa Inuit Children's Centre
Care coordination, addiction services, life-skills and self-esteem building programs, recreation, educational support.
<http://www.ottawainuitchildrens.com/>

Tungasuvvingat Inuit
Counselling, crisis intervention, legal assistance, parenting and family support, housing support, food and clothing bank, employment and education assistance, cultural programming, youth in transition support.
<http://www.tungasuvvingatinuit.ca/>

Addictions

National Native Alcohol and Drug Abuse Program (NNADAP) and the National Youth Solvent Abuse Program (NYSAP)
<https://www.canada.ca/en/health-canada/services/substance-abuse/get-help/addictions-treatment-first-nations-inuit.html#a5>

Housing/Employment

Gignul Non-Profit Housing Corporation
<http://www.gignulhousing.org/>

Tewegan Housing for Aboriginal Youth
Housing, educational and employment assistance, life-skills and cultural programming.
<http://www.teweganhousing.ca/>

Kagita Mikam Aboriginal Training and Services
<http://www.kagitamikam.org/>

Student/Educational Support

Infinite Reach Métis Student Solidarity Network –
Métis peer support, educational assistance.
<http://www.metisnation.org/programs/education--training/infinite-reach>

Aboriginal Resource Centre – University of Ottawa
<https://sass.uottawa.ca/en/aboriginal>

Centre for Aboriginal Culture and Education – Carleton University
<https://carleton.ca/aboriginal/>

Mamidosewin Centre – Algonquin College
<http://www.algonquincollege.com/mamidosewin/>

Parenting Support

Makonsag Aboriginal Head Start
<http://www.makonsag.ca/>

Elders Lodges

Kumik Elder's Lodge
<http://www.aadncaandc.gc.ca/eng/1100100013751/1100100013752>

Clinical Guidelines

Wilson D et al.: Health Professionals Working with First Nations, Inuit, and Métis Consensus Guideline, J. Obstet Gynaecol Can 2013; 35(6):550-553.
[http://www.jogc.com/article/S1701-2163\(15\)30915-4/pdf](http://www.jogc.com/article/S1701-2163(15)30915-4/pdf)

Further Reading

Every healthcare provider for Canada's Indigenous peoples (and indeed every Canadian) is urged to read the findings of the Truth and Reconciliation Commission of Canada.
<http://www.trc.ca/websites/trcinstitution/index.php?p=890>

First Nations Mental Wellness Continuum Framework
<http://nnapf.com/first-nations-mental-wellness-continuum-framework/>

Suicide with Indigenous Populations
<https://www.suicideinfo.ca/workshop-category/Indigenous/>

National Inuit Suicide Prevention Strategy by Inuit Tapiriit Kanatami
<https://www.itk.ca/wp-content/home/ementalhealth/ementalhealth.ca/frontend/uploads/2016/07/ITK-National-Inuit-Suicide-Prevention-Strategy-2016.pdf>

Indigenous Peoples, Indigenous Voices – United Nations Permanent Forum on Indigenous Issues Fact Sheet
http://www.un.org/esa/socdev/unpfii/documents/5session_factsheet1.pdf

Health and Health Care Implications of Systemic Racism on Indigenous Peoples in Canada – The College of Family Physicians of Canada Fact Sheet
http://www.cfpc.ca/uploadedFiles/Resources/_PDFs/SystemicRacism_ENG.pdf

National Collaborating Centre for Aboriginal Health
<http://www.nccah-ccnsa.ca/en/>

First National Health Authority – Cultural Safety and Cultural Healing Webinars
<http://www.fnha.ca/wellness/cultural-humility/webinars>

Aboriginal Ways Tried and True (WTT) section of the Public Health Agency of Canada's Canadian Best Practices Portal <http://cbpp-pcpe.phac-aspc.gc.ca/category/intervention-type/aboriginal-wtt/>

Quiz Questions

1. The Canadian Constitution recognizes the following groups of Indigenous peoples:

- a) First Nations
- b) Inuit
- c) Métis
- d) All of the above

2. Which of the following is NOT an outcome of colonization on Indigenous peoples:

- a) Loss of traditional nomadic lifestyle and sedentarization
- b) Attempted ethnocide through residential schooling and the Sixties Scoop

- c) Strengthened relationships between family members and in intimate relationships
- d) Lateral violence and intergenerational trauma

3. The following are all ways to promote cultural safety except:

- a) Minimize physical barriers between patients and staff
- b) Speak quickly and interrupt to redirect when necessary
- c) Allow time and space for ceremonies such as smudging
- d) Provide detailed referrals to other care providers to avoid need for multiple disclosures

4. Indigenous youth most likely to die by suicide are:

- a) Female
- b) Often acutely intoxicated
- c) Using means of low lethality such as overdose
- d) Well connected to their families and communities

5. Primary care providers can help Indigenous youth who are feeling suicidal by:

- a) Performing a thorough assessment of risk and protective factors
- b) Fostering cultural connectivity through referral to local Indigenous resources
- c) Building trust and providing adequate follow up
- d) All of the above

Summary

Indigenous peoples are resilient; they have survived grueling natural conditions, plagues of introduced diseases, attempted systemic ethnocide and the resultant intergenerational trauma. There is great diversity in the Indigenous peoples and not all individuals and families struggle with the problems detailed in this module. Care must be taken to recognize those that are vulnerable and provide the culturally safe care that is required. Non-Indigenous care providers are urged to learn about the strength and resilience of our Indigenous brothers and sisters by visiting local community centres and partaking in traditional healing ceremonies. This type of healing is sacred work; Indigenous children and youth deserve care from physician “who honour their own healing paths and can model self-care and respect of the body, mind, heart and spirit” (2).

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