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K E E W A T I N

S U I C I D E P R E V E N T I O N

A N D

I N T E R V E N T I O N S T U D Y

Prepared for: The Keewatin Regional Council

Date: April, 1986

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The philosophy of Kivalliq Consulting, Management and Training Services, Ltd. is to ensure that there is maximum participation and a direct economic benefit to Northerners through the existence of our company and the services it offers. In keeping with this philosophy, we would like to acknowledge and thank the following people who worked on the study.

Fieldworkers
Terry Tungilik
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We would like to thank the Suicide Committee Members of KRC for making this study possible.
Chairperson Simeonie Sammurtok
Veronica Curley
Joani Kringayark
Jo MacQuarrie

Sue Shirley of the Resource Center, Department of Education deserves special mention for the printing of this study.

We would like to express our sincere thanks to the many community resource people who took the time to meet with us, as well as to the families of suicide victims who shared with us their thoughts and their pain. It is to the surviving family members that we would like to dedicate this study.

TABLE OF CONTENTS

The following Suicide Prevention and Intervention Study was prepared for the Keewatin Regional Council (KRC) by Kivalliq Consulting, Management and Training Services, Ltd.

The KRC was concerned and alarmed about the apparent rash of suicides in the Keewatin Region in the late 1970's and early 1980's. At the 1983 fall session of the KRC a motion was passed to conduct a study of the suicide problem.

To reaffirm this concern, Jack Anawak proposed a motion at the 1985 spring session of the KRC in Repulse Bay to form a committee on suicide prevention. This issue was raised again at the 1985 fall session in Eskimo Point. The Territorial Government responded with funding for this study. A contract was signed with Kivalliq on February 24, 1986, with the final report to be submitted by April 16, 1986.

TERMS OF REFERENCE

This portion of the study includes;

1. A review of the literature. Topics reviewed included various types of suicide intervention and prevention programs, articles discussing northern communities and/or native groups, suicide and the media, workshops on suicide and the history of suicide in the traditional Inuit community.
2. A review of the suicide problem in the Keewatin Region. To prepare this section, the statistics regarding suicide were reviewed and information was gathered from key

community resource people in several communities. In addition information was provided through interviews with families who had lost a son to suicide. It should be noted that no budget was provided for travel in this phase of the study, nor did the terms of reference require it.

3. The final phase of this study will take place after the submission of the final report. Kivalliq will be travelling to each community to conduct community meetings and/or workshops with interested people and agencies.

SECTION I

MAGNITUDE OF THE PROBLEM

In 1971 the NWT suicide rate was close to the Canadian average of 10 per 100,000. This figure rose to 35 per 100,000 by 1978.(1) In 1984 there were 16 suicides in the NWT.(2) The majority of the deceased were male (14 male, 2 female). The most common agegroup was 15-24, with eight suicides occurring in this category. The methods used included nine by firearms, four by hanging and three by overdose.

Suicides by Year

From 1977 to 1985 there were 16 known suicides in the Keewatin Region (See Table 1 and Figure 1.1).

Suicides by Community

Rankin Inlet has the highest number of suicides in the Keewatin Region from 1977 to 1985. Eskimo Point is the only community without a recorded suicide during this period. However, it was the opinion of one resource person in Eskimo Point that there has been at least one suicide in the community since 1980, but it was not officially classed as such. It was also reported to Kivalliq that there have been at least four recent attempts in Eskimo Point.

Rankin Inlet has the largest population in the Keewatin, followed by Eskimo Point, Baker Lake, Coral Harbour, Repulse Bay, Chesterfield Inlet and Whale Cove (See Table 2).

TABLE 1

Sucides in the Keewatin 1977 to 1985

Date	Age	Sex	Marital Status	Method	Community
July 1977	25	M	married	gunshot*	Rankin Inlet
Dec. 1977	22	M	single	gunshot	Repulse Bay
May 1978	15	M	single	hanging	Rankin Inlet
June 1978	23	M	single	gunshot	Rankin Inlet
Feb. 1978	23	M	single	hanging*	Rankin Inlet (in Frobisher)
July 1978	56	M	divorced	gunshot*	Baker Lake
Nov. 1978	58	M	married	gunshot	Rankin Inlet
July 1980	18	M	single	hanging	Baker Lake
May 1980	29	M	separated	gunshot	Coral Harbour
Nov. 1983	28	M	separated	hanging	Rankin Inlet (in Yellowknife)
Sept. 1983	30	M	married	hanging	Whale Cove
Aug. 1983	23	M	single	hanging*	Rankin Inlet
Nov. 1984	23	M	single	hanging	Rankin Inlet
Feb. 1984	19	M	single	hanging	Chesterfield Inlet (in Frob.)
Jan. 1985	25	M	married	hanging	Rankin Inlet
May 1985	19	M	single	hanging	Baker Lake

Note: These figures were compiled using statistics from G.N.W.T. Vital Statistics. However, several omissions were found and additional information was gathered from community resource people.

* - Denotes those suicides in which alcohol was known to have been involved.

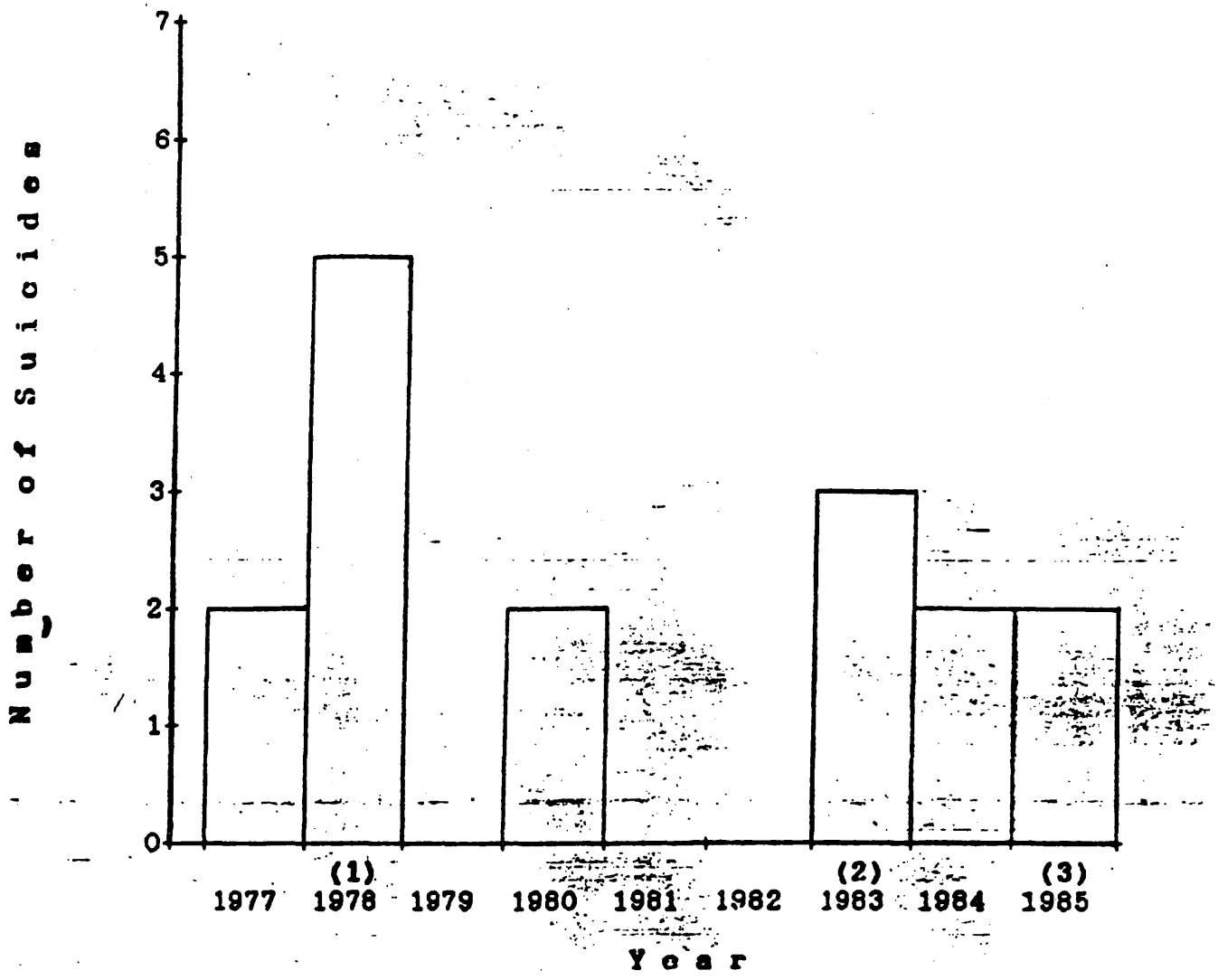


Figure 1.1 Suicide by Year - 1977 to 1985

(1),(3)Note: One person in each of these groups was from the Keewatin, but committed suicide while in Frobisher Bay.

(2)Note: One person from this group was from the Keewatin, but committed suicide while in Yellowknife.

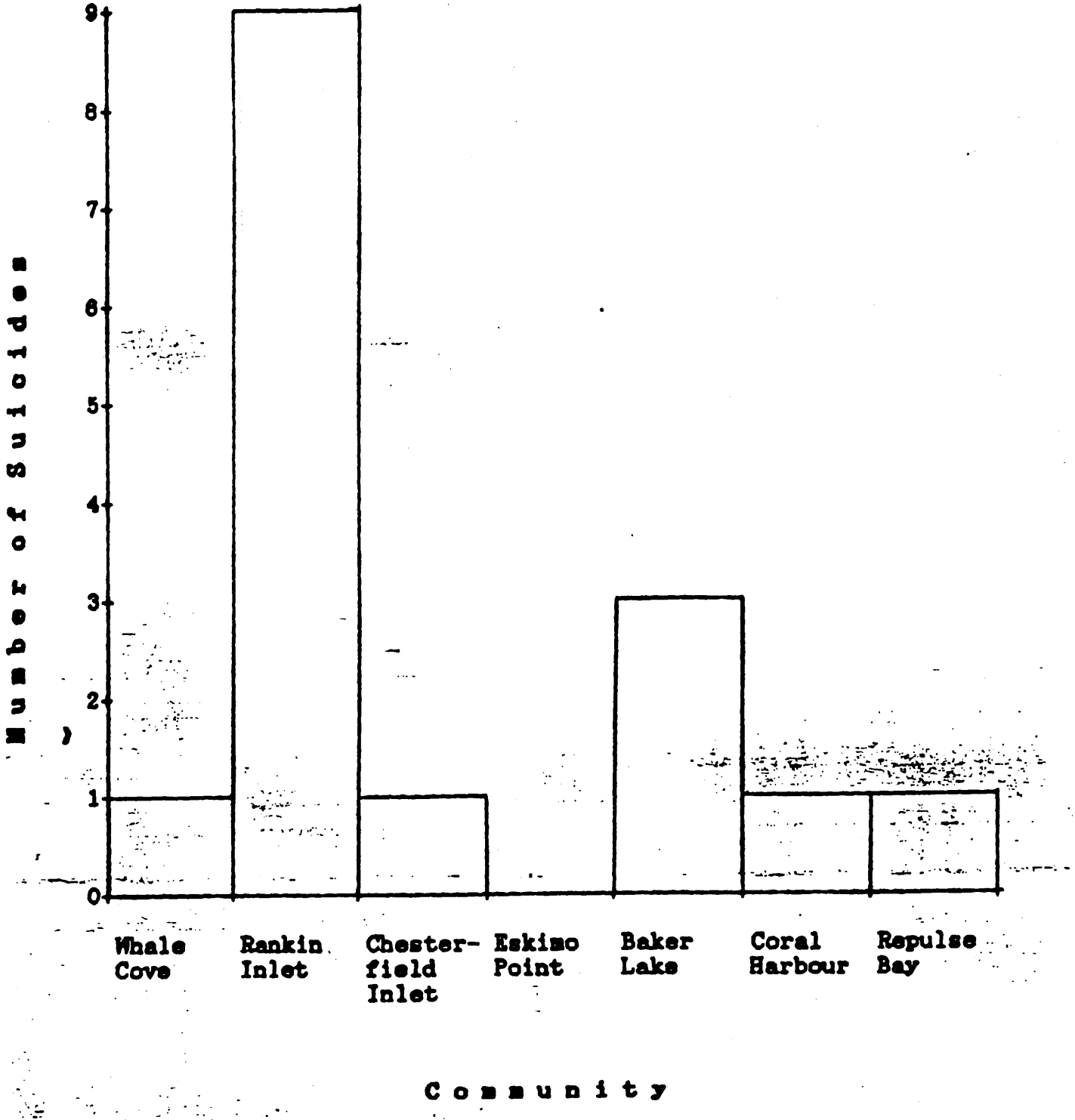


Figure 1.2 Suicides by Community - 1977 to 1985

Table 2

Populations of Keewatin Communities

Rankin Inlet	1,308
Baker Lake	1,071
Chesterfield Inlet	265
Coral Harbour	455
Eskimo Point	1,202
Repulse Bay	401
Whale Cove	218

Source: GNWT Vital Statistics population projections based on the 1981 census.

PROFILE OF THE VICTIMS

Ages

All of the suicide victims in the Keewatin from 1977 to 1985 were male, with 14 of the 16 between ages 15 and 30. Two of the men were in their mid-fifties. The Mean, or average age of the victims was 27.25 years. If the two older persons were deleted (since they could be considered to be atypical for this group), the average age becomes 23 years. The Mode, or most common age of the victims during this period was age 23.

Methods

Of the 16 suicides during this period, six were caused by gunshot wounds and ten were by hanging. Both of these could be considered very violent methods of ending one's life (as opposed to drug overdose). In a study of native people in Alaska, who have a suicide rate three times as high as the rest of the USA, Kost-Grant (1983) found that 75 per cent of the suicides between 1976 and 1980 were by self-inflicted gunshot wounds. In the Keewatin, from 1977 to 1980, six of the nine suicides were by gunshot.

Alcohol

In at least four of the suicides the victims were known to have consumed alcohol shortly before their death.

Marital Status

Nine of the suicide victims were single, 4 were married, 2 separated and 1 divorced at the time of their

death.

Reasons Stated

The most common reasons for the suicide which were stated (if known) were relationship problems and difficulties with the law.

Warning Signs

Many of the deceased had given an indiciation that something was seriously wrong, but people close to them did not notice clues, or did not know what to say or do. One victim left a party to kill himself after telling people at the party that he was very unhappy. Several of the victims had had previous suicide attempts and/or had expressed suicidal thoughts.

Other victims left friends and families bewildered. One father of a teenage boy who killed himself told the study "... after my son committed suicide, even myself or my wife who are the parents never knew that he was having problems as he never told us and it was quite obvious from his actions that things were not normal. Keeping his problem to himself gradually built up to the extent that he couldn't live with it anymore. I only learned of his problem from the note he left behind after his death."

Family History

At least 5 of the suicide victims were known to have been directly linked to a close friend or relative who had died violently.

SUBINTENTIONAL SUICIDES

The above statistics do not include what are termed subintentional suicides. These are deaths by which a person places themself in a life-threatening situation in which it is apparent that they are aware of the risks involved. Examples of this would include a person who takes his boat out on a very stormy day, or who walks out onto the land without adequate clothing. Many times the person has expressed suicidal thoughts or has given signs that he was seriously depressed prior to his death.

SUICIDE ATTEMPTS

The above statistics also do not include suicide attempts. It is very difficult to determine an accurate number of attempts, since all attempts would not be reported to the same source (for example, the nursing station). However, through contacts with community resource people in various communities, Kivalliq received many many reports of suicide attempts, even down to as young as a seven year old boy attempting suicide because of problems that occurred in the family that were not dealt with. This is contrary to the popular myth that young children do not attempt to take their own lives. Parents and teachers expressed their fears that today's young are beginning to see suicide as a viable option for dealing with problems. One parent remarked that when her young child threatened to kill himself she felt she had to deal with this very seriously, as it did not seem to

be merely an expression of speech.

Kivalliq also received widely differing estimates of the number of suicide attempts. For example, in a given community, the nursing station might see only two or three attempts, while a local church group or drop-in centre might have been in contact with four times as many persons who were expressing suicidal thoughts. Most attempts that the consultants were made aware of were of a less violent nature and many were by drug overdose.

In a meeting with Dr. Rogers, psychiatric consultant for Northern Medical Services it was discussed that approximately 10 to 12 per cent of suicide attempts can be considered genuinely suicidal. The remaining 90 per cent are termed parasuicides and are generally thought not to be serious attempts at taking one's life. These are most likely to be a cry for help, or an expression of anger. However, it is important to keep in mind that 10 to 12 per cent are actual attempts to die, so all attempts must be taken seriously.

SUMMARY SECTION I

All suicide victims in the Keewatin from 1977 to 1985 were male. In at least four of the suicides the victim was known to have consumed alcohol shortly before their death. The most common reasons for the suicide which were stated (if known) were relationship problems and difficulties with the law.

Many of the deceased had given an indication that something was seriously wrong but people close to them did not notice clues or did not know what to say or do.

At least five of the suicide victims were known to have been directly linked to a close friend or relative who had also died violently. Statistics from the Keewatin Region show that several of the victims had a family history of violence or suicide and were experiencing relationship problems at the time of their death. The relatives or people close to the victim have, in many cases, gone on to commit violent or self-destructive acts and this has created another population at risk for possible future suicides and other mental health problems. Counselling programs/crisis intervention programs that could be helpful to families of suicide victims do not exist at the present time.

There are many more attempts to commit suicide than there are actual successfully completed suicides. In many communities resource people had varying levels of awareness of the extent of this problem. Some resource people appeared to think the number of attempts was very low while others knew of four times as many people expressing suicidal thoughts. Ninety per cent of suicide attempts are most likely a cry for help or an expression of anger but all attempts must be taken seriously.

SECTION II

TRADITIONAL MEANING OF SUICIDE

Many people interviewed for this study told the consultants that suicide was very different in the traditional Inuit society. Rather than young, healthy men that tend to kill themselves today, it was mainly older, or sick members of the group that would take their own lives. The motive for suicide was a wish not to be a burden to the other members of the group.

Grove and Lynge (1979) describe a 1955 study by Leighton and Hughes (1955) in which they state that the two main reasons for suicide were suffering (psychological or physical) and feeling they were of no use to the community. "The authors emphasize the social role of suicide in the vulnerable societies without sufficient resources to support unproductive members... The institution of suicide was a barrier against destructive tendencies within the group against the single members."(3) According to Leighton and Hughes, suicide in traditional times was committed mostly by men and tended not to be an impulsive decision. Often a person's wish to die was sanctioned by the group.

Foulks (1980), in a study of suicide among Alaskan natives states that suicide might also be a reaction to the death of a close family member. The death of a kin often left the person feeling very vulnerable and no longer socially worthwhile (for example, a widow). Also, "it was

commonly believed that a suicide might save the life of another, such as a sick child, thus, suicide was considered altruistic and was positively sanctioned."(4)

Suicide methods also differed in traditional times. One community leader in the Keewatin stated "In the older days people usually just started walking and didn't come back to the camp. Most of these would take place in the winter. People would just walk out to the floe edge and walk or jump into the water."

PEOPLE AT RISK

According to the statistics available for the Keevatin Region, the group which is likely to be at highest risk is young males in their late teens to mid-twenties. The problem does not seem to be confined to unemployed youth. On the contrary, many of the suicides during the period 1977 to 1985 were people who were respected in the community, looked like "winners" and were well educated or employed.

O'Neil (1984), in a study of stress and the Inuit youth examines the experience of stress and coping responses in young adult men. One group he sees as high risk are "those who are now in their late twenties participated aggressively in wresting control over local affairs away from whites, but at the expense of losing their connectedness to the land, their families, and the wider community."(5) O'Neil also outlines a second high-risk group, that of young males in their late teens who have completed high school and are

often the favorite, first-born son. These suicides usually occur when relationship problems and drinking are present. O'Neil's study was conducted in 1977-78 and 1980-81, so presumably the groups he was referring to are now in their late twenties and thirties.

The Suicide and Attempted Suicide Study outlined the typical profile of a male suicide as a "... young adult with access to a gun, drinks heavily, often from a stable background but hasn't been able to establish a stable family unit of his own."(6) As stated in the previous section, four of the 16 suicide victims were known to have drank alcohol shortly before committing suicide.

Kost-Grant (1983) outlines the typical profile of the suicide victim in a study of Alaska natives. "He is unlikely to have a formal psychiatric history or be experiencing a major depression. The incident often followed a conflict with a family member or girlfriend. It is likely that a family member or friend had died by violence, often self-inflicted."(7) Not all of the above examples are exactly the same as the profile in the Keewatin Region, but certain similarities can be seen.

Similar to the Alaskan group, a review of the statistics from the Keewatin Region reveals that several of the victims had a family history of violence or suicide and were experiencing relationship problems at the time of their death. In many instances families the relatives and/or people close to the victim have gone on to commit violent or

self-destructive acts. This creates another population at risk for possible suicides and other mental health problems, the families of suicide victims. Throughout this study, Kivalliq heard numerous tales of the problems that have occurred in families following a tragedy such as a suicide. One example of a family in crisis, which was by no means unique was described to the consultants. A tragic accident occurred during which several of the children died. Due to an alcohol problem, the parents were unable to cope with the situation, and the parents separated and the children were sent to stay with relatives. The parents tried to reconcile, but after a brief, unsuccessful period one parent and favorite child disappeared under highly questionable circumstances, never to be seen again. The other parent went on to establish a new relationship in which there were problems with incest, beatings and alcohol abuse. As a result of the ongoing, unresolved problems, the remaining children in this family have exhibited serious problems such as failure to thrive, school problems and a suicide attempt by an elementary school age child. Little support or counselling for any of these specific crises has been available for the family. As a result, the stress continues to build and become unmanageable, creating further crises.

FAMILIES OF SUICIDE VICTIMS

Rudestam, who has done several studies of the families of suicide victims draws four main conclusions from his work

in this area.

1. He found that survivor-victims (Rudestam's term for surviving family members) tend to suffer a large number of medical problems and psychosomatic disorders. This points to the need for medical personnel to be aware of this relationship so they can treat the medical problems as symptoms of the grief process.

2. The process of trying to make sense of what happened continues for a very long time.

3. The survivor-victims have a need to talk about the suicide incident. Rudestam's study found that those people who had never discussed the event with anyone felt the least relieved.

4. A suicide incident changes the family structure. While some families become more disorganized after a suicide, others seem to pull together and become closer.

In recognition of the fact that the families of suicide victims may be at high risk for suicide and other mental health problems, and in response to the many comments Kivalliq received regarding the lack of counselling programs/crisis intervention available for the families following a suicide, a number of families in Rankin Inlet and Chesterfield Inlet who had experienced a suicide were interviewed.

The results obtained from these interviews are remarkably similar to the findings by Rudestam and others.

Physical and Mental Health

All of the family members interviewed experienced various physical symptoms such as fatigue, sleepnessness and loss of appetite. Most spoke about deteriorating health. One parent said they became constantly sick after the death of their son and feels they have never fully recovered. Another parent described becoming physically and mentally exhausted, to the point of having to be hospitalized.

All of the parents described being unable to get thoughts of the deceased off their mind. One father spoke of racing thoughts, while another parent said she tried to go on with caring for her other children, but all she could think of was her son. "As for me, my life changed the day I lost my son and I've never been able to get back to the way I used to be."

A few parents described how they have made increased efforts to talk with their remaining children and appear to have built a more close knit family structure. For other families, this does not appear to be the case. One mother spoke of how she used to love to cook and prepare the family meals, but since the death of her son she has stopped preparing meals, and the rest of the family is left to fend for themselves.

Suicidal Thoughts

Several of the parents recalled feeling suicidal themselves after the death of their child. One father stated "At that time I felt that if my son can do this

without fear, then I too can do it.", while another mother said "I just didn't care anymore as to what happened to me...I was even determining myself that if my son could hang himself and die, so can I."

Effects on the Siblings

All of the parents stated that the only thing that kept them from taking their own lives, or from completely giving up, was knowing they had other children to think of and take care of. "Our children needed us very much at the time, because they are so young that they need us to understand what happened to their brother."

The parents who were interviewed all spoke of the feelings of terror, of being constantly worried that one of their other children would take their own life. One parent told the consultants "After it has occurred, you can never stop worrying that one of your other children might do it too as you watch your children grow."

Several of the community resource people interviewed observed that the siblings of a suicide victim can tend to use their parents' fears to manipulate them into always giving them their own way.

What is Needed

It can be seen that the effects on the survivors of a suicide are longlasting and serious. The parents were asked what helped them at the time and what they feel could have helped. The parents interviewed outlined things such as prayer, visits from friends and relatives, going out on the

land to fish and hunt, and just getting away, as helping to ease the pain felt at the time of the suicide.

All of the families interviewed felt the need for help outside of the family. They often felt that if there was counselling available for suicidal persons, their son's suicide might have been avoided. One mother said "... even though I'm a parent, I felt our son needed outside help that we as parents couldn't offer him." In speaking about the need for professional help, another parent described how she is still grieving for her son "...who still could have been alive today only if things had gone in a different way." From the families' descriptions of the events leading up to the suicides, it was clear that some of the deceased were exhibiting very serious emotional symptoms which definitely should have been brought to the attention of professionals.

Parents also asked for help for themselves and for their remaining children. One parent said "As I have never really relaxed since my son hung himself, I need to know there can be a place where I can go and get the proper help I've been needing. I simply can't stop worrying about my existing children."

All of the families interviewed felt they could have benefitted from a survivor's support group and would be interested in joining such a group today (which for some is years after the loss of their child to suicide).

SUMMARY SECTION II

According to statistics for the Keewatin Region the group which is likely to be at highest risk are young males in their late teens to mid-twenties. One group also seen as high risk are those people who are now in their late twenties to early thirties. These men have spent years and a great deal of effort toward seizing control away from non-Inuit, but this has been accomplished at the expense of losing (through lack of time) their connectedness to the land, their families and the wider community. Many of the present day leadership function under these very stressful conditions.

Rudestam, who has done several studies of families of suicide victims found the surviving family members suffer many medical problems after the incidents. They spend a long time afterwards trying to make sense of what happened and have a need to talk about it.

Kivalliq interviewed family members of several suicide victims in Rankin Inlet and Chesterfield Inlet. They had experienced problems with exhaustion, sleeping and loss of appetite. Many found that their health had been poor since the loss of their family member to suicide.

Several of those interviewed said they also had suicidal thoughts after they had lost a son and that they constantly worried about their other children taking their own life.

All family members interviewed felt the need for help

outside the family and many felt that if this help had been available the suicides could have been avoided.

Parents also asked for help for themselves and for their family. They said they felt they would join a Survivors' Support Group if such a group were to exist today even though for some it is years after the loss of their child to suicide.

SECTION III

CONTRIBUTING FACTORS

Suicide in the 1980's is a complex, serious problem. Because of this complexity there are no simple answers to why a person takes his/her own life. The following are several of the major factors which are thought to contribute to the stresses which result in today's suicide problem. This section was compiled from information from the literature review and from Kivalliq's meetings with community resource people.

The major contributing factors could be broadly categorized as: 1. Changes in the Inuit Culture and the Family System, 2. The Education System and the Employment Situation, and 3. The Misuse of Alcohol.

1. CHANGES IN THE INUIT CULTURE & THE FAMILY SYSTEM

In the words of one community resource person, "in remote and isolated communities, suicide now has become one of the killers. This is mainly amongst the younger generation, who seems to be caught between their own and the caucasian culture and society. This is sad because the young people are in the middle and trying to make adjustment to both. They are like having two different personalities because at home they are within their own culture, but at school or at work they must act and do like the other culture. They are trying too much to please others they

forget their own inner feelings."

Rapid Change

In the past 25 to 30 years, the Inuit culture has undergone a dramatic change. Families have moved from living on the land into the settlements and have been introduced to the southern education and social welfare and justice systems. Kost-Grant (1983) states that "Rapid, externally generated change has at times contributed to social disorganization, cultural conflict and family disorder. These consequences in turn can precipitate low self-esteem, depression, and hopelessness which might trigger self-destruction."(8) Some of those interviewed felt that because of the reliance on government agencies, families were less likely to try to solve their own problems. One community leader spoke of the lack of participation in decision making and of the feeling that the Inuit people were getting left behind. He described his people as developing an "Inuit inferiority complex". O'Neil (1984), in describing the relationship between social change and mental health states "improvements in self-government and self-determination are fundamentally linked to reductions in social and mental health problems in northern communities."(9)

Another by-product of the rapid change is the introduction of the southern justice system. There are many problems in trying to deliver a justice system designed for the south in northern communities. The southern-type

justice system and staffing, travel and funding restrictions cause long delays between when a person is charged and the date when their case will be heard. This situation and a lack of understanding of the legal system combine to place an additional strain on young people who already may not be feeling at their best. Some of the suicides in the Keewatin occurred while people were waiting for a court date or had been threatened with legal action. An insufficient budget for Courtworker training, program delivery and travel in the Keewatin further complicates this problem.

Leadership

In the past, leaders were traditionally revered. In more recent times, society has begun to express disappointment and disgust in the behaviour of their leaders. In the October 28, 1985 Report on the Territorial Youth Forum to the Legislative Assembly of the Northwest Territories, one of the youth recommendations on social issues was the following; "...Alcohol and drug abuse, and assaults among youth are presently serious problems. However, the blame should not be entirely directed toward us, as we are seeing and hearing about our local territorial and federal leaders being charged with similar crimes. Therefore we recommend that our leaders should be more aware and respectful of their actions as we look up to them as our role models."(10) More recently, there has been a trend in the media towards holding leaders accountable for their actions. (Refer to Figures 3.1 and 3.2). The Editorial in

Figure 3.1

Cartoon Courtesy of News/North 1986..

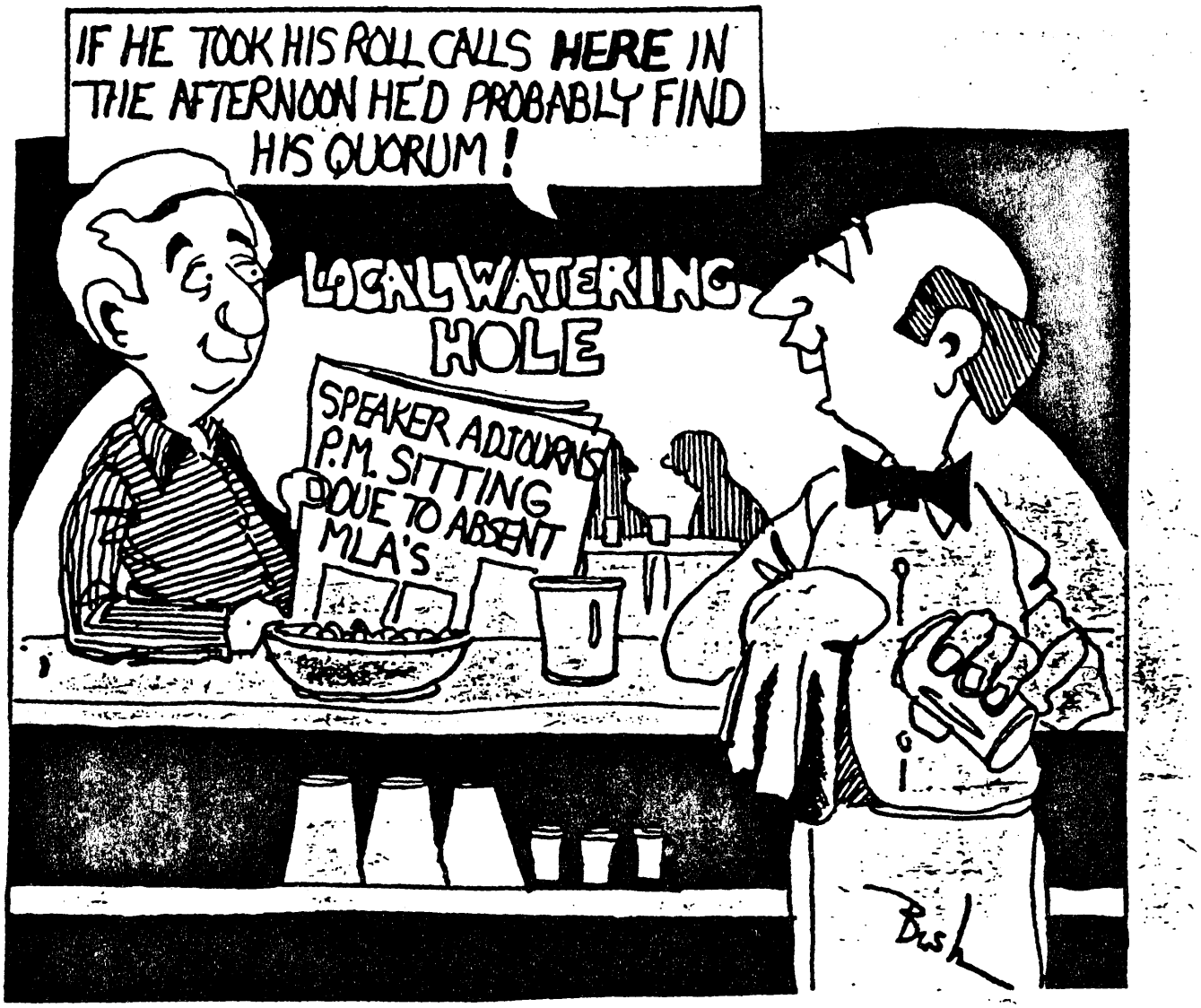


Figure 3.2 Cartoon Courtesy of News/North 1986.

the March 7 issue of News/North discusses the fact that while many of our leaders are the first to lobby for solutions to social problems such as alchoholism, "...few have been willing to take the single most effective action to combat the problem - clean up their own backyards. Everybody cares but few care enough to restrict their own consumption."(11) Perhaps before the north can begin to improve the mental health of the people by O'Neil's suggestion of improvements in self-government and self-determination, they must first regain this trust in their political leaders.

Inability to Express Feelings

In the traditional Inuit culture, according to some of those interviewed, it was not considered acceptable to openly express feelings of anger and people tended not to talk about their feelings, especially negative emotions. Because the Inuit lived in small family groups, sometimes under very harsh conditions, it was essential for the survival of the group that everyone get along. "It was inevitable though, living in the close quarters of the igloo, that tensions would arise both within the family as well as occasionally with outsiders. Release of resentments was frequently provided through the ritual catharsis of songs and dances..."(12) Several community resource people mentioned the lack of cultural activities available in the Keewatin Region.

Many people interviewed for this study expressed the

opinion that young people, young men in particular, had not learned to deal with feelings of anger and frustration. Similar to the Inuit people, Ward, Fox and Evans (1977), in a study of Canadian Indians found that "The Indian traditionally internalizes pain until the stress becomes so intolerable that a minor failure will trigger an extreme over reaction."(13)

Changing Role Expectations

It would appear that young men do not have a lot of outlets for discussing problems or for working off their frustrations. Perhaps part of the reason that young men seem to be more likely to commit suicide is related to the changing role expectations. Over the past 30 years, most men have lost their traditional role of hunter/fisherman due to having jobs in town and having less time. In contrast, women's roles of mother and sewer have changed very little, even when they are also employed outside the home. In the older days, the people living in a family unit knew exactly what was expected of them.

Related to the changing roles of men and women many people the consultants dealt with felt that the traditional roles of old and young have changed. One person thought that "Some of the problem may stem from the fact that we now live in larger communities and some of the old ways are slowly disappearing such as calling relatives by title rather than by name basis as nowadays." Some people felt that this indicated a lack of respect for elders. One woman

spoke of seeing older people carrying heavy things from the stores, while young people walk by, or drive by on their hondas, and don't seem to see them. Other people did not view the problem as a lack of respect, but as a communication gap between the old and young based on experience, with neither group understanding the other. They felt that today's young people have a feeling of not belonging anywhere - with the older people or with the whites.

In the past, when families were still operating on the land, there was not the same type of peer-group pressure on young people that there is today. In those times, young people married much earlier, and had more responsibilities such as supporting a family. There was less freedom and fewer choices, therefore there was less need for outside structures. Some of those interviewed stated that in the older days, children were taught skills by their parents, which equipped them for survival in their environment. These people felt that today's youth are not being taught the skills necessary to cope with the present environment. In reviewing the 1983 Keewatin Youth Survey it was clear from the responses of the youths, that they felt they were not given instructions on how to surivive. The youths interviewed talked of having no clear goals or direction. They also said that they felt they were given no firm direction, and that when they decided to drop out no one was concerned, and they were not provided with any skills or

options with which to replace school.

Parenting Styles

The changes in the Inuit lifestyle have placed new demands on parents and have perhaps made the older style of parenting ineffective. Traditionally, parents did not have to place very many restrictions on their children. Also, it was felt that children should enjoy their childhood, because when they grew up life would be hard. In the older days, within the limited confines of living on the land, parents had to teach their children about the dangers such as seasonal ice changes, weather out on the land and migratory patterns of animals. In today's times, there is a much more complicated network of things for parents to teach their children. For many of these lessons, the consequences are not obvious, or are delayed. In the past, if a young man did not learn the skills for hunting, he knew he would not survive, whereas today, the value of education is often not realized by people until they are past school age. Many people interviewed blamed parents for not teaching their children the culture and for wanting to find quick solutions instead of looking at the suicide problem.

Ward, Fox and Evans (1977) discuss the effects on children when they are raised with very little required of them and few responsibilities. These children grow up with a low tolerance for frustration, so that when they do not reach their goals, they feel a "...sense of helplessness and hopelessness that could lead to an impulsive suicidal

act."(14)

As can be seen from the above discussion, the impact of rapid change on the Inuit culture and family system has resulted in a breakdown of family units and cultural traditions without replacements.

2. THE EDUCATION SYSTEM AND THE EMPLOYMENT SITUATION

As was discussed previously, the education system has been introduced to this region in the past 25 to 30 years. There have been, and continue to be many problems in the delivery of this system.

Elementary and High School

The vast majority of Inuit children do not continue in school past the elementary grades. There is a very high rate of absenteeism, non-attendance and drop-out.

At this time, school attendance is compulsory, but there is no mechanism for enforcement. Some of those interviewed mentioned that children were allowed to drop out and to make their own decisions. This may relate to the traditional mode of parenting in which parents placed fewer restrictions on their children. Many of those interviewed blamed parents for not sending their children to school.

Perhaps one reason why some parents do not insist their children attend and why many drop out is that the present education system, which is based on southern values and culture may not be seen as relevant to children or parents.

One resource person described the lack of Inuit

teachers and the culture clash in the school system. They described the problem of the high rate of staff turnover in the schools, which does not create a sense of continuity for the students.

For the students who do continue in the school system, there is the problem of coping with both cultures, for example making the transition from school to home.

Two of the suicide victims killed themselves while away at school, and several had recently returned home after completing school.

Adult Education & Training

Although there is a trend towards adult education and training, adult educators pointed out that many young adults lack the basic education levels necessary to access these programs. For example, in the 1983 Keewatin Youth Survey, each community had over 75% of the labour force (excluding students) with less than a grade ten education. The Adult Education Upgrading Program is designed to upgrade education levels from grade six to grade ten. Adult educators however, spoke of a large number of clients who have below a grade six level, and many who are virtually illiterate. Therefore, there is a group of persons who are presently without job skills who do not even qualify for the basic education and training programs.

One adult educator spoke of how difficult it is to access most of the available training programs. They questioned how many groups would have the capability of even

applying for such programs.

For those persons who have begun the process of upgrading and training, there is the added complication that the programs are often moved around from year to year. Therefore, if a person began upgrading with the hopes of entering a training program in their own community the next year, the program may be moved to another location or discontinued by the time they are ready to enter.

Although the Government of the NWT has allotted various trainee and apprenticeship programs, there is often no guarantee of a job once the training is complete. Some of those interviewed spoke of the difficulty of looking for work outside of your own community because of the high cost of travel. Another difficulty that others mentioned is that when people are hired in trainee or apprenticeship positions, they are hired with good intentions, but there are not enough built-in support systems to ensure success.

Employment

There is a high rate of unemployment in the NWT and the Keewatin Region. According to the 1984 NWT Labour Force Survey the NWT unemployment rate was 17 per cent, and 26 per cent for the Keewatin. When the statistics are compared by age group, the younger people (age 15 to 24) have a much higher unemployment rate.

Many people interviewed talked of how few Inuit there are in management positions. It appears that most of the Inuit people are in entry-level positions (clerical,

janitorial). This is related to the earlier comments about the lack of role models available for younger people to look up to.

Resource people talked about the tremendous pressure on some people who are trying to be successful in both cultures (Inuit and non-Inuit). They felt there were many pressures put on these persons to help out, at the expense of having less time for themselves or their families. Many of the political leaders are in this very stressful situation, where there are so many issues making demands on their time.

While most of those interviewed saw the employment situation as a major contributing factor to the problem of suicide, it should be noted that many of the deceased were employed and/or had fairly high levels of education as compared to other Inuit. It would seem that part of the answer lies in the area of meaningful employment and better opportunities for advancement. It was also mentioned that there should be better coordination between education and employment, as students often graduate with employment expectations that do not match with the present job market. However, what is also clear, is that while on the surface people may seem to have 'made it', this is not necessarily a sign of a person who feels good about themselves.

3. THE MISUSE OF ALCOHOL

Alcohol is recognized as being a major mental health problem in the north. Some steps have been taken to begin

to deal with the problem, such as restricting the availability of alcohol in the settlements. The method of determining the availability of alcohol in the Keewatin has tended to be through plebiscites.

At least four of the suicide victims in this study were known to have consumed alcohol shortly before their death. The methods used in all of the deaths were violent and most could be described as impulsive. Almost all of the resource people interviewed felt that alcohol was a big factor in the suicide problem.

Many people described the relationship between drinking alcohol and depression. The relationship between drinking alcohol and suicide might be described as "The more you drink the deeper into apathy you slide, the harder it is to get out. Nothing seems to matter much anymore. It is cold out there. Hunting is hard and you probably won't get much anyway. The government won't let you starve. It will take care of your kids. Let the government do it. It's better than me. This is a vicious course, once begun hard to reverse with self-hate and suicide waiting at the end."(15)

In a 1985 survey by the First Nations Confederacy, Brotherhood of Indian Nations and the Manitoba Keewatinowi Okimakanak, of the mental health concerns of the status Indians of Manitoba, a strong correlation was found between communities with a high rate of alcohol abuse and suicide rates. Although the relationship was strong, it was not found in every case, which suggests there are other factors

at work also. Kost-Grant (1983) found that alcohol allowed the victims to separate themselves from their actions. "The patient became detached from the self-destructive act, as if it had occurred in another time and place and bore little relationship to the current reality."(16) Therefore, in some cases it may be that although alcohol did not cause the problem that led to the suicide, it helped to take away that last portion of inhibition. In other cases, alcohol may have helped to perpetuate the apathy that led to the act of suicide.

SUMMARY SECTION III

The rapid changes that occur in any culture are usually followed by family problems and community breakdown. People who feel lost in such rapid change usually feel they are being left behind and are powerless to have a say in the decisions that affect their lives. They can experience feelings of isolation and anger which may lead to depression with little sense of hope for the future. One author (O'Neil 1984) states that improvements in the mental health of a community are closely linked to improvements in self-government and self-determination.

The southern-type justice system's Court Circuit is presently inadequate due to low levels of funding for travel, staffing and legal aid. This causes long delays and insufficient contact with defense lawyers. As a result, people have few opportunities to learn about the legal

process, or about the law itself. Some suicides in the Keewatin occurred while young males were waiting to go to Court or had been threatened with legal action.

While leaders were traditionally very respected youth have more recently expressed their disappointment with the behaviour of many of the current leaders who are either facing charges for or who misuse alchohol and drugs.

In the past, cultural activities such as the songs and dances allowed people to work off their frustrations in a positive way. Today, there are not many places for young people to get rid of these feelings.

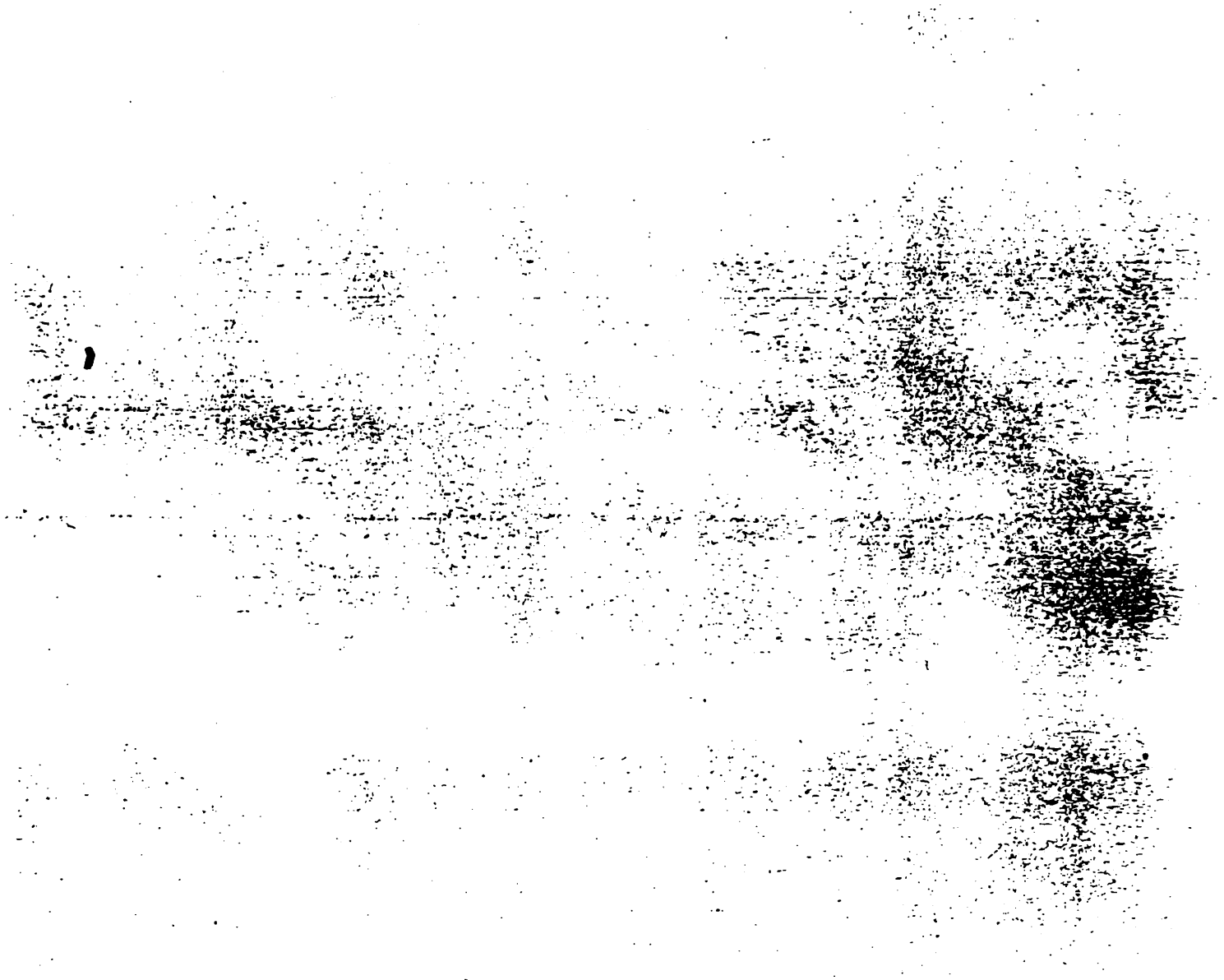
Young males traditionally would have been supporting families of their own and would have had a clear idea of what was expected of them. However, today they may find that for a period of five to ten years after age 15 they remain dependent on their parents with few demands placed on them by the family or the community. This further contributes to their sense of failure and isolation.

In a previous study youth in the Keewatin expressed the opinion that they were not being given instruction on how to survive in the world of today. Nor did they feel much energy was being spent to hold them accountable or to equip them for the future.

The above study also indicated that 75 per cent of the Labour Force in this region have less than a grade ten education. Adult Education offers upgrading programs for grades six to ten. However, there are large numbers of

youth who fall far below the grade six level required to qualify for these basic programs.

The use of alcohol was involved in at least four of the suicides. These victims had all chosen violent, impulsive ways to end their lives. Many felt alcohol could break down the final barriers or survival instincts, allowing a person to take their own life.



SECTION IV

RECOMMENDATIONS

Material for this section is based partly on the comments from the community resource people and the families of the suicide victims who were interviewed for this study. The consultants received many, many recommended solutions.

A review of the literature revealed an overwhelming amount of work being done throughout North America in the area of suicide. Where possible, Kivalliq has included for review programs which are northern based, serving smaller communities, and/or dealing with Inuit or other Native groups.

Similar to the previous discussion of Contributing Factors, suggested recommendations have been grouped under the general headings of 1. Counselling/Treatment, 2. Public Education, 3. Youth Programs, 4. Education & Training and 5. The Justice System. As can be seen by the above discussion, suicide is a complicated problem, therefore, there are no simple solutions. It is important to recognize that no single recommendation will solve the problem of suicide. This will be discussed in greater detail later in this paper.

1. COUNSELLING/TREATMENT

The community resource people and the families of victims were unanimous in their requests for

counselling/treatment programs. One mother, who had lost a son to suicide said "Before my son died it was really difficult to find the kind of help he needed." She went on to say, "We just could not find any other type of help that could be offered to our son even during the time we knew he needed help and ...it became obvious he was going through a very difficult time in his life." Suggested counselling programs included crisis counselling, counselling of high-risk individuals (including those who have attempted suicide) and support for the families of the deceased.

There are several alternatives for staffing counselling/treatment programs, including the use of existing community resources, mental health professionals, and paraprofessionals (community people who are trained to deal with mental health concerns).

Using Existing Community Resources

The Alberta Suicide Prevention Provincial Advisory Committee (Boldt 1985) has designed a program for coordinating existing community agencies to deliver suicide services. This program is based on the premise that "...a specialised service aimed at a specific problem such as suicide must not be isolated from other community helping services."(17) Boldt emphasizes that the responsibility for the delivery of services should be at the community level.

The Alberta program consists of an Interagency Council, Host Agency and Program Coordinator. The Interagency Council is made up of representatives from each agency and

is responsible for coordinating the core services, overseeing program development and program implementation and operation. In the Keewatin, such a council might be made up of representatives from the RCMP, Nursing Station, Departments of Social Services and Education and Alcohol Committee.

The Host Agency covers the developmental work, such as budget preparation, funding administration, periodic evaluation and reporting on program activities.

The Program Coordinator answers to the Host Agency for administrative and financial matters and to the Interagency Council for program-related matters. The Coordinator acts as the "executive arm" of the Interagency Council, as well as a resource person. They are responsible for gathering information regarding suicide service needs, providing education and training for the public and community resource people and for making the public aware of the interagency referral network.

While the Alberta model is designed for "secondary urban" Albertan communities with populations ranging from 35,000 to 55,000, the underlying philosophy of tying suicide programs in with existing community resources may have some merit in the Keewatin Region.

One of the drawbacks of such a model is that many of the existing agencies have very heavy workloads/caseloads at present. Most agencies however, expressed frustration with the lack of interagency coordination. They also indicated

that they felt a need for more training and information regarding the problem of suicide.

Mental Health Professionals

Many people interviewed expressed the need for professional counselling and/or professional backup. At the fall 1985 session of the KRC in Eskimo Point a motion was passed requesting that the Mental Health and Health Educator positions which are at this time slated for Churchill and Yellowknife, be based in the Keewatin accompanied by realistic travel budgets. Similar resolutions were passed at the March 8, 1986 International Women's Day Conference in Rankin Inlet and were sent to politicians at all levels.

There are some disadvantages to using professionally or formally trained individuals as counsellors. Most professionals to date are non-Inuit which can create difficulties in the delivery of services. Hodson (1985) discusses the cultural differences between Native clients and non-Native therapists.

Paraprofessionals

There has been considerable research on the effectiveness of the use of 'lay counsellors', who are people from the community who are trained to deal with mental health problems. These people in general have no professional training. However, what they do have is an insider's knowledge of the client's culture, values and belief systems. Several writers (Bergman, 1974, Timpson,

1983, Torry, 1969 and Truax and Carchuff, 1965) have argued that paraprofessionals, when given proper training and backup can provide therapy that is at least as effective as professionals.

Another benefit of the use of paraprofessionals relates to O'Neil's comments which were mentioned earlier, regarding improving the mental health of the people through self-government and self-determination.

Crisis Counselling

Many of those interviewed spoke of the need for a 24 hour crisis or hot-line service. This service could be community based or could be operated on a regional level. A crisis line is very important because problems/crises usually do not occur during regular business hours. For such a service to be effective, confidentiality would have to be ensured. The service could be staffed by trained members of the community with access to professional backup.

High-Risk Counselling and Followup

There is a need for counselling services for people who have attempted suicide, as several of the deceased had previously attempted suicide. Even for those persons who are not seriously suicidal, the attempt is still an indication that the person is having problems coping with life. There is also a need for counselling for those people who are thought to be at risk. Several community resource people indicated that it is this group who often 'falls between the gaps'. At present in the Keewatin, unless a

person has attempted suicide and can be classed as a medical emergency, or is exhibiting such serious problems as to require medivac, there are few, if any services available.

Help for Families of Suicide Victims

As stated previously, at least five of the suicide victims were known to have been directly linked to a close friend or relative who had died violently. Harnisch and Letofsky(1982) of the Toronto Survivor Support Programme state that "survivors of the suicidal death of a family member are an identifiable high risk group".(18)

All of the family members of suicide victims who were interviewed indicated they felt a survivor's support group would be of great value and all indicated they would join a support group, even though for some it had been several years since the death of their sons by suicide. One mother said "Such a support group would be one of the most essential things to exist in our community."

An example of one type of service to support the survivors of a suicide is the Toronto Survivor Support Programme. This service is designed for adult survivors only, as children are thought to have different needs following the death of a parent or sibling to suicide. The families are responsible for referring themselves to the program, although it may be suggested to them by their physicians, counsellors, friends or relatives.

Interested family members meet with two volunteers for a period of eight two hour sessions. The topics for these

sessions are "Getting acquainted and remembering; Understanding ourselves: accepting and expressing feelings; Understanding reactions to suicide; Feelings of loss: stress and coping; Facts of loss: role changes; Reliving and family renewal; Support systems: recognising and using them; Summing up and going on."(19) Following the eight sessions for the family members, participants are invited to attend four bi-weekly group sessions designed to facilitate further discussion of feelings and concerns.

The volunteers for this program are not all survivors of suicide. This is because there is some research to indicate that a balance between survivors and regular volunteers can be more therapeutic. The volunteers undergo an eight session training period and then meet with the Director (who is a trained professional) every two weeks for supervision and consultation. The program is time limited because the focus is on helping survivors to begin working through their feelings about the incident so that they may be able to continue with the rest of their lives.

Other types of programs which can be offered to survivors include early outreach programs (where the families of suicide victims are contacted immediately following the death of their loved one) and various counselling programs. Some programs are offered by professionals, while others advocate a self-help model.

Multi-Intervention Strategies

Most studies maintain that in order to be effective, a

counselling/treatment program should include the three types of services (crisis, high-risk and post-suicide counselling for the families of victims), as well as public education. The following are two examples of multi-intervention programs, in which the goal is to provide a comprehensive treatment program.

Hodson (1985) describes the Native Mental Health Program in the Rainy Lake/Kenora regions of Northwestern Ontario. This program uses both a non-Native formally trained therapist and two Native paraprofessional counsellors in the treatment of mental health concerns. The professional is responsible for giving seminars, workshops, program planning and evaluation, research, and providing supervision and back-up to the lay therapists. The paraprofessionals diagnose and treat mental health concerns, make referrals to other agencies and work along with child care workers, alcohol workers and community health representatives. These lay therapists receive training in the areas of "alcohol and drug abuse, marriage and family counselling, grief and mourning, suicide prevention and followup, depression, spouse abuse and self-exploration."(20)

Fitchette (not dated) outlines a model for the development of crisis intervention services in Northern Ontario communities. The author emphasizes the importance of local planning and control in the development of mental health services. Fitchette also suggests that before

establishing a program "the attitudes of the community must be explored, its cultural patterns studied, available facilities taken into account and the nature and severity of the problems documented."(21) This model utilizes trained community volunteers and recommends a community-developed crisis line with professional backup and training. It also advocates the training of community people as crisis workers. These workers should have direct access to professional supervision and to community resources.

While the above programs may be appropriate for some of the larger communities in the Keewatin, the smaller communities may not have the resources for programs of this size. The Native Counselling Service of Alberta (reported in Boldt 1985) has prepared a suicide training manual which deals with attitudes surrounding suicide, methods of crisis intervention, counselling for the survivors and increasing awareness of the need for suicide prevention. The next step is to select and prepare Native trainers to conduct suicide prevention workshops in their own communities and to act as resource persons. While this program is still at the pilot stage, it is an example of a program that could be used in small communities by people from the community.

Richardson and Manitowabi (1976) describe a population-based model of intervention which was developed in response to a suicide epidemic on the Wikwemikong Indian Reserve near Sudbury, Ontario. In 1975, there were nine suicides in a small community on the Reserve, which had 40

families and was geographically isolated (as are most of the Keewatin communities). A suicide committee examined the circumstances surrounding each of the nine deaths and developed a victim profile. The profile revealed that all of the suicides occurred at home and were by gunshot or hanging and were most likely to be males (7 males, 2 females) between 17 and 24 years. All were unemployed high school drop-outs. The excessive use of alcohol and family problems were also present. Using this information, they developed a questionnaire to determine high-risk situations.

All of the families in the area were visited and given the questionnaires. When there was a high-risk person identified, regular, supportive counselling was offered. Fourteen individuals were identified as high-risk, and the authors concluded that all of the individuals became less withdrawn and depressed, and most went on to participate in work or training programs. Counselling/treatment programs will vary according to the needs of the individual community. It is recommended however, that any suicide program be conducted in conjunction with alcohol awareness and/or support programs, such as AA, Ala-Teen, and so on.

COUNSELLING/TREATMENT RECOMMENDATIONS

1. Counselling/Treatment programs should be of a multi-interventionist nature. That is, they should include crisis, high-risk and follow-up counselling, as well as programs for the families of suicide victims.
2. To help develop a coordinated system of treatment, the

establishment of a mental health network, such as the Interagency council suggested by the Alberta Suicide Prevention Provincial Advisory Committee is recommended.

3. The use of paraprofessionals with ongoing training and readily accessible, professional backup is highly recommended. This professional backup should be based in the Keewatin Region.

2. PUBLIC EDUCATION

Information gathered during this study indicates there is a widespread need for public education in the areas of suicide prevention and general mental health concerns. To a certain extent, public education can be carried out as a function of the above mentioned counselling/treatment programs. However, public education can also be accomplished through the churches, schools and other community organizations. The following are several examples of public education programs which were suggested by the people interviewed for the study.

It was suggested that the school and adult education could offer courses in Stress Management/Life Skills. The development of a suicide resource centre in the school for the use of the teachers and interested community groups was requested by several community resource people.

It was suggested that government employees, especially those in a program area should be made more aware of suicide and other mental health problems and should receive training

in cross-cultural awareness (on both sides). One suggestion involved community sponsored orientation sessions for incoming Health Professional and key resource people to sensitize them to the problems and expectations of the community.

From the literature, one of the keys to making a public education program a success, is to have a well-planned and well-coordinated campaign. Also, it is important that before such a campaign is carried out, that adequate means are in place to handle the concerns of the public. It is likely that a campaign encouraging people to seek help, etc. will result in some people asking for help and it could be tragic if they then discovered there was no help available.

PUBLIC EDUCATION RECOMMENDATIONS

1. It is recommended that coordinated efforts through the schools, churches and community organizations be undertaken aimed at suicide prevention and at raising community awareness about the stresses that can lead to suicide and other mental health problems.

2. This study recommends the instigation of regional and community campaigns aimed at the youth through the media, posters and brochures, underscoring the potential of today's youth and how they are to be depended upon in the future as leaders, planners, doers and so on.

3. YOUTH PROGRAMS

During the period studied, 14 of the 16 deceased were

between the ages of 15 and 30 years with the most common age being 23 years. All of the victims were male and attempts were mostly by females. It was well recognized by the community resource people, and especially the parents of victims, that the youth of the community constitute a high risk group. Therefore, everyone made suggestions that were specifically aimed at helping alleviate some of the stresses faced by today's young people.

Some of these suggestions dealt with creating more recreational activities for young people, both traditional and non-traditional, such as the IKPIK Camp near Igloolik at Ikpik Bay, taking youth out on hunts, and setting aside more gym/ice/arena time for the youth who are not necessarily the top competitors. These youth may not be capable or organized enough to demand and obtain scheduled time and the use of facilities on their own.

Other suggestions dealt with creating new groups, such as a big brother/sister organization, junior hunters and trappers and cadets.

It was also recommended that young people be helped to build leadership skills through the establishment of youth committees (to deal with land claims, mental health issues, and so on) and perhaps running for public office or positions on boards. One community resource person indicated however, that when young people have run for office, older people generally have not supported them, and if younger and older people are together on boards, the

younger people are often told how irresponsible, disrespectful and so on their generation is.

YOUTH RECOMMENDATIONS

1. This study recommends that efforts be made to establish more Youth Groups or Youth Programs such as those suggested above.

2. Young people should be encouraged and assisted in the establishment of Youth Committees to deal with the issues of importance today, such as land claims, suicide, education and employment.

3. Leadership Training Programs should be offered to young people that are well financed, well advertised and with built-in incentives.

It is important that the above youth recommendations be well financed, carrying with them actual authority and the ability to create change.

4. EDUCATION AND TRAINING

Many people interviewed thought that there should be changes in the education system and the opportunities for training. As was discussed earlier, some aspects of the present education system are seen as contributing to the stressful conditions of life in the North.

EDUCATION AND TRAINING RECOMMENDATIONS

1. It has been suggested that the current NWT Elementary Health Curriculum be revamped to provide greater emphasis on

stress identification and management.

2. A greater range of support materials should be developed for the Elementary Civics Curriculum and training provided for new teachers to assist them in being able to make the subject content relevant to the Inuit students.

3. Funding for third world type literacy programs might help to bridge the gap between education levels and training programs. The suggested programs are designed to deal with people at all levels of literacy. The present system tends to build in a sense of failure for those participants who fall below the minimum requirements.

4. A Senior Practical Program may soon be offerred in the High School to deal with those students on the verge of leaving school due to an inability to handle the academic courseload. It is important that this program be established as soon as possible, and that efforts be made to develop a range of courses in the non-academic area.

5. The Department of Education should hire truant officers/attendance counsellors to encourage parents to send their children to school and to follow up with students who do have attendance problems or who have left school. Due to the current perceived split in some communitites between the school and the community, attendance counsellors should be Inuit, or at least have a knowledge of the Inuit culture and values.

6. Better support systems and followup to those in training, adult education programs and apprenticeship

positions might increase the success rate of such programs.

5. JUSTICE SYSTEM

One of the most common reasons for the suicides which was stated was difficulties with the law. One of the victims hung himself while in a police cell, and three others were known to have had criminal charges pending or previous conflicts with the law.

JUSTICE SYSTEM RECOMMENDATIONS

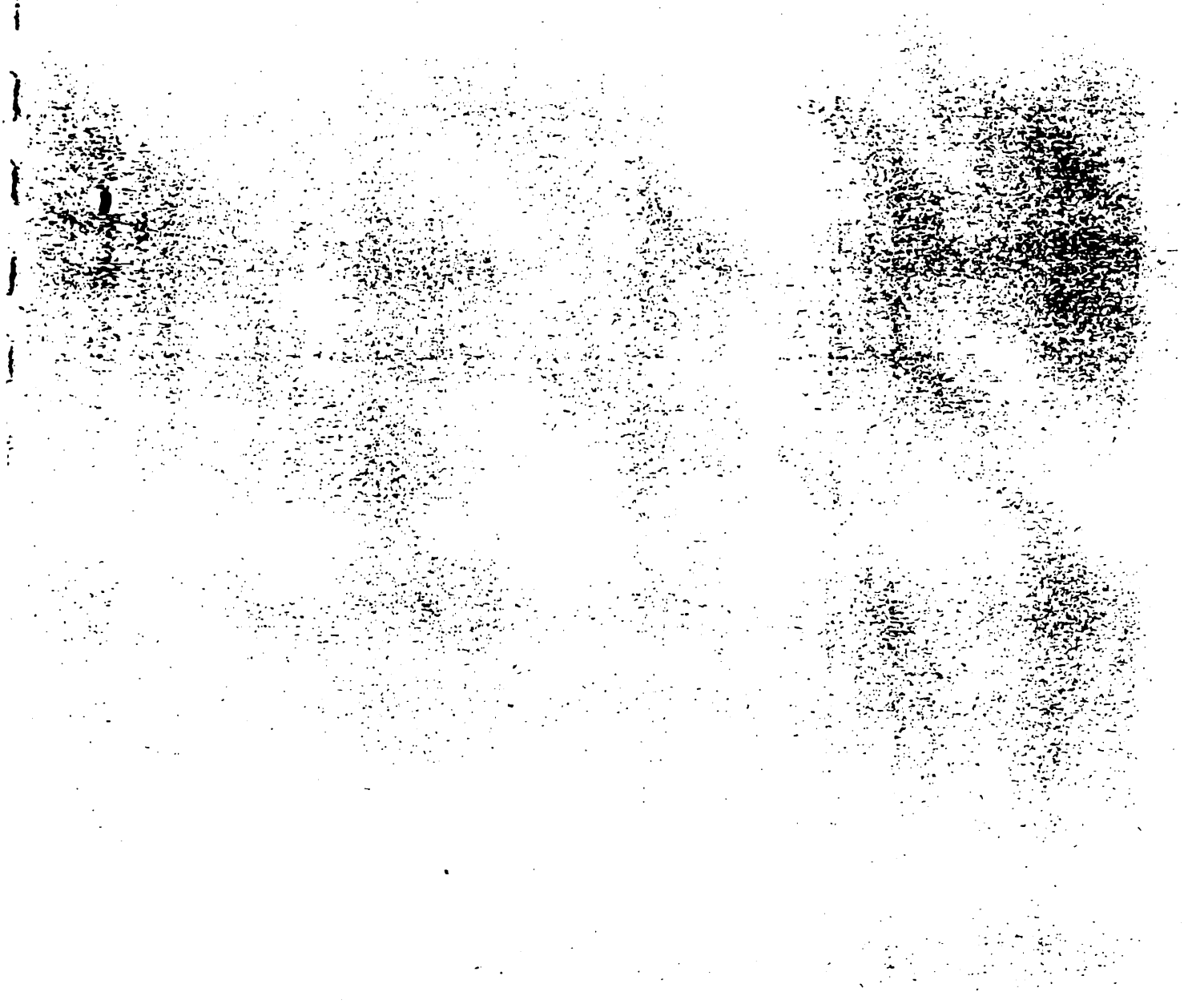
1. At this time there is a Keewatin Courtworker Program in operation. However, the training, staffing and travel budgets of the program must be increased, and the courtworker provided with more professional support.

2. There is a need for additional Territorial/Supreme Court Circuit visits to shorten the length of time between charges and court dates. It is strongly recommended that defense attorneys on the Court Circuit arrive ahead of the court party. In keeping with this, legal aid lawyers should be assigned well in advance of their arrival so they could begin their preparation work ahead of time.

3. There should be immediate visits to incarcerated and/or charged youth and followup contacts to ensure they have a realistic picture of what to expect from the court process, the range of penalties, and so on.

4. There is a need for an increase in the publication, distribution and translation of materials to educate the public regarding their legal rights and the workings of the

court system.



CONCLUSIONS

Suicide is one of a series of mental health problems that are threatening the future of the Inuit people. It is vital that these issues be addressed immediately. While it is important that the emergency needs be dealt with, it is also necessary that efforts be made to deal with the factors that are contributing to the stresses which cause mental health problems such as suicide. Some of the contributing factors which were discussed in this study are; Changes in the Inuit Culture and the Family System, the Education System, Employment Situation and the Misuse of Alcohol.

One community leader expressed the fear that in today's changing times, the Inuit are being left behind. While the leaders are focusing on the future of the North, more attention must be paid to present day problems, to ensure the Inuit people are prepared to meet the challenges of the future.

Many recommendations have been proposed in this study. In recognition that funds are limited, the consultants have attempted to provide the KRC with a prioritized list of recommendations.

PRIORITY RECOMMENDATIONS

1. No one program or one series of programs in isolation can be expected to be effective in addressing the long term implications of the suicide problem. Therefore, this study recommends that a multi-disciplinary approach be taken to

help combat this problem.

2. To help facilitate the multi-disciplinary approach, the Keewatin Region should form a Mental Health Network similar to the program suggested by the Suicide Prevention Provincial Advisory Committee in Alberta. As described earlier in this paper, the Alberta program is made up of an Interagency Council, Host Agency and Program Coordinator. The Interagency Council is made up of representatives from each agency and is responsible for coordinating the core services, overseeing program development and program implementation and operation. In the Keewatin, such a council might be made up of representatives from the RCMP, Nursing Stations, Departments of Social Services, Education and Health, and Drug and Alcohol and Health Committees.

The Host Agency covers the developmental work, such as budget preparation, funding administration, periodic evaluation and reporting on program activities.

The Program Coordinator answers to the Host Agency for administrative and financial matters and to the Interagency Council for program-related matters. The Coordinator acts as the "executive arm" of the Interagency Council, as well as a resource person. They are responsible for gathering information regarding suicide service needs, providing education and training for the public and community resource people and for making the public aware of the interagency referral network.

3. Counselling/Treatment programs should include the range

of services including Crisis, High-Risk and Followup Counselling and Support for the Surviving Familiy Members.

4. Funding sources should be lobbyed for at all levels. Care should be taken to ensure ongoing, adequately financed support.

The authors would like to emphasize that "Any creative attempt to provide new, more appropriate programmes must be directed at two levels; 1. to responding to the most urgent, emergency needs in the community in the North and 2. to a longer term goal of promoting social cohesiveness, psychological renewal and cultural rebirth within communities."(22)

You've Lost Me Now

You've lost me now, and you wonder how

You've filled my life with hurt and sorrow
Today I have trouble facing tomorrow

You've lost me now, do you really care?
If so then why weren't you there?
All my troubles and hurts without you to share

You've lost me now, can you hear?
You left me standing in my tears
Not worrying about my losses and fears

I just can't understand why you
were never near

I think you've lost me
forever, to all the years

You've lost me now

This poem was written by a young teenager who has attempted suicide many times. Permission was given for the consultants to print it on the condition that the identity of the author remain confidential.

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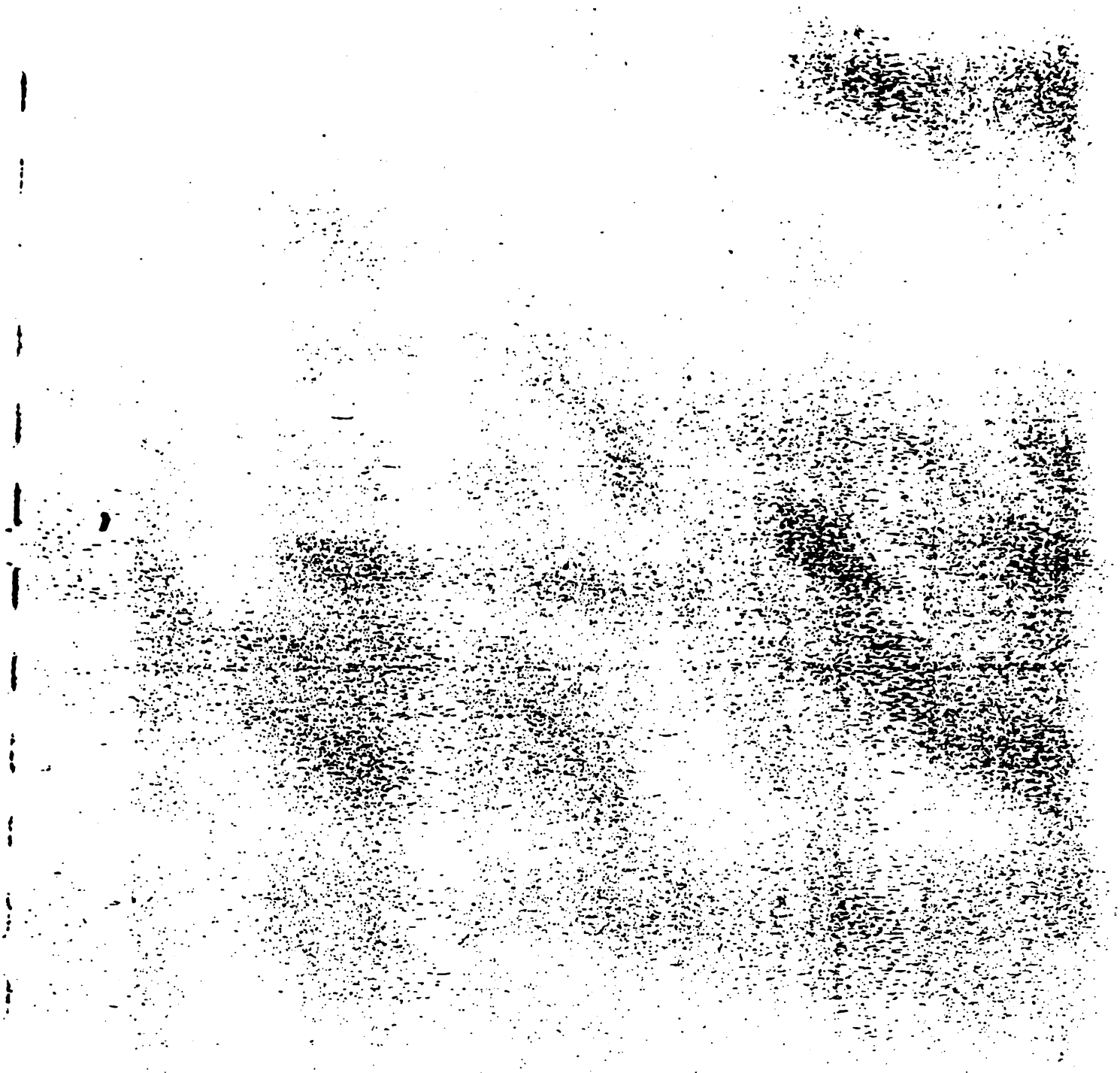
APPENDIX A



PRACTITIONER'S QUESTIONNAIRE ON SUICIDE

THE FOLLOWING IS A LIST OF QUESTIONS TO BE USED AS A GUIDELINE WHEN INTERVIEWING COMMUNITY RESOURCE PERSONS.

1. HAVE YOU HAD ANY DIRECT/INDIRECT EXPERIENCE WITH SUICIDE IN YOUR CAPACITY AS _____ (JOB TITLE)?

2. WHAT DO YOU SEE AS THE FACTORS CONTRIBUTING TO THESE PARTICULAR SUICIDES?

3. WHAT ARE/WERE THE REACTIONS TO THE(SE) SUICIDE(S) ON THE PART OF THE COMMUNITY, FAMILY ETC.?

4. DO YOU SEE A PATTERN IN THE SUICIDES IN THIS COMMUNITY?

5. DO YOU FEEL SUICIDE IS A MAJOR HEALTH PROBLEM IN THIS COMMUNITY?

6. WHAT WOULD YOU SEE AS THE BEST WAYS TO COMBAT THE PROBLEM OF SUICIDE?

7. OTHER COMMENTS:

APPENDIX B

INFORMATION REQUIRED (IF POSSIBLE) FROM FAMILIES WILLING TO PARTICIPATE IN DISCUSSION ON THE TOPIC OF SUICIDE.

CLARIFY NAME, DATE OF BIRTH AND AGE AT THE TIME OF DEATH AS LISTED IN STATISTICS. IF NOT CORRECT OR IF INFORMATION IS ABSENT, WRITE DOWN CORRECT INFORMATION.

1. PARTICIPANTS FEELING THEN/NOW AS IT RELATES TO THE INCIDENT.
2. CIRCUMSTANCES (IF ANY) THAT MAY HAVE REQUIRED ATTENTION PRIOR TO THE SUICIDE IF HELP HAD BEEN AVAILABLE.
3. GENERAL HEALTH OF FAMILY MEMBERS THEN/NOW.
4. AFTER DEATH OF LOVED ONE HOW LONG WAS IT BEFORE FAMILY ACTIVITIES COMMUNICATION AND OUTSIDE INTERESTS RETURNED TO NORMAL.
5. WAS THERE ANY PROBLEMS WITH REGARD TO HEALTH, SLEEPING PATTERN, EATING HABITS AFTER THE DEATH OCCURRED EXPERIENCED BY PARTICIPANT.
6. WHAT HAS HELPED THE PARTICIPANT MOST IN BEING ABLE TO COPE WITH THE LOSS.
7. WHAT SERVICES DOES THE PARTICIPANT THINK ARE NEEDED THAT COULD ASSIST FAMILIES WHO HAVE SUFFERED SUCH A LOSS.
8. WHAT AFFECT HAS THIS LOSS HAD ON THE SPOUSE/CHILDREN/PARENTS AND HOW THEY DEALT WITH OTHER TROUBLED BEHAVIOUR (IF ANY) SINCE THAT LOSS.
9. HAS THE LOSS AFFECTED HOW THEY DEAL WITH OTHER PEOPLE IN THE FAMILY/ OUTSIDE THE FAMILY/GOVERNMENT AGENCIES.
10. IF THEY COULD ADVISE ANOTHER PERSON WHO WAS FACING THE SAME LOSS-A LOVED ONE THROUGH SUICIDE, WHAT ADVICE COULD THEY GIVE IN ORDER TO HELP THEM DEAL WITH IT.
11. IF A SUPPORT GROUP MADE UP OF OTHER PEOPLE WHO HAD SUFFERED A SIMILAR LOSS WAS EVER DEVELOPED WOULD THEY ATTEND SUCH MEETINGS.
12. WOULD IT BE HELPFUL IF INFORMATION ON THIS TOPIC WAS MADE AVAILABLE BY GOVERNMENT/SCHOOLS/NURSING STATIONS/ALCOHOL AND DRUG ABUSE PROGRAM/SOCIAL WORKER/OTHER COUNSELLING PROGRAM.
13. OTHER COMMENTS/QUOTES MADE BY THE PARTICIPANT RELATED TO THIS TOPIC.
14. RECORD ANY QUESTIONS ASKED OR REQUESTS MADE.
15. FEEL FREE TO CONTINUE THE DISCUSSION, TAKING NOTE OF OTHER INFORMATION WHICH MAY BE OF VALUE TO THE STUDY IF THE PARTICIPANT IS WILLING.