

INDIGENOUS SUICIDE PREVENTION RESEARCH & PROGRAMS IN CANADA AND THE UNITED STATES:

Setting A Collaborative Agenda

ALBUQUERQUE, NM
FEBRUARY 7-9, 2006



Conference Report and Recommendations



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Conference Supporters

Indian Health Service, Division of Behavioral Health

National Institutes of Health

(National Institute of Mental Health, Office of Rare Diseases, National Institute on Drug Abuse, National Institute on Alcohol Abuse and Alcoholism, National Library of Medicine)

Substance Abuse and Mental Health Services Administration

Canada organized a delegation to attend.



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Executive Summary



The Indian Health Service (IHS), the National Institutes of Health (National Institute of Mental Health, Office of Rare Diseases, National Institute of Drug Abuse, National Institute on Alcohol Abuse and Alcoholism, National Library of Medicine) joined with the Substance Abuse and Mental Health Services Administration, to host participants from the US, Canada and the US Territories to attend the first ever meeting for reducing suicide among Indigenous communities. Health Canada and the Canadian Institutes of Health Research sponsored a large delegation, representing nearly 25% of attendees, keynote speakers, and panelists.

This international conference brought together representatives from research, service organizations, youth, community programs, and governments (countries, tribes, and villages) to share the most current information on Indigenous suicide, to find ways to continue communication and collaboration, and to form and support workgroups to bring substantive research and prevention efforts forward in a multi-year effort. Towards this end, the needs for future collaboration and communication were identified as:

- **The need to build networks between Indigenous communities;**
- **Formal support for collaboration across systems and disciplines;**
- **Facilitated dialogue between communities and researchers; and**
- **Continued collaboration with government agencies and experts.**

Suicide in Indigenous communities has been the cause of great international concern, particularly as it has most significantly affected youth. Suicide is currently the second leading cause of death for American Indian and Alaska Native youth, ages 14 to 24, and is 2.5 times higher than the national average. Suicide rates for Aboriginal youth are 5 to 7 times that of non-aboriginal youth, with the suicide rates for Inuit youth being among the highest in the world, at 11 times the national average in Canada. Suicide rates have been steadily on the rise in Micronesia and Guam, with suicide being the leading cause of death among young men in Micronesia; and the rate of suicide for Native Hawaiians is currently 12.9% as compared to 9.6% for non-Native Hawaiian residents.

Rates of suicide vary among Indigenous communities, with some experiencing little to no suicide, while others have been reported to have some of the highest rates in the world. Looking across Indigenous cultures and communities to find understanding and solutions, this conference was an important adjunct to the IHS National Suicide Initiative established in 2003 and a step towards the collaborative development of resources, data systems, promising programs and the sharing of information across international boundaries and multiple systems.

Unique perspectives brought by participants from diverse regions contributed to important new and continuing dialogue with the planning agencies that supported this meeting. Data and cultural best practices were presented by Indigenous programs and researchers. Success stories, such as the dramatic reduction of suicide rates in Puerto Rico as an outcome of government laws and policies that support prevention networks and collaborative strategies, were shared.

By the end of the meeting, recommendations were made regarding logical next steps to facilitate research and program support, as well as establishing working groups to further research and service programming to reduce suicide. The recommendations for setting a collaborative prevention agenda in the areas of research, funding, policy, and prevention initiatives are as follows:

- **Research:** Prevention research needs to be reframed to look at the issue of suicide from an Indigenous perspective, looking for cultural strengths and commonalities. Training also needs to be provided to support cultural competency and the development of research best practices, including qualitative methods.
- **Funding:** Financial resources are needed to support long-term collaboration between researchers, policy makers and community representatives. Funding is also needed for formal networks and interdisciplinary working groups. Future capacity building grants need to support the development of community-based initiatives, professional recruitment and cultural best practices.
- **Health Policy:** Formal capacity building relationships need to be redefined to support networks, collaboration, and the lateral transfer of knowledge among Indigenous communities; creating change in current policies that limit the roles and financial reimbursement for traditional healers and cultural experts in the areas of research and program support.
- **Community Initiatives:** Cultural healing and community-led planning processes need to be supported to strengthen cultural knowledge and best practices regarding suicide prevention, with a focus on cultural continuity and family relationships. Training needs to be provided for community members to be active in planning, research and prevention.

The intention of the conference sponsors is that the following conference report and recommendations will be used to inform policy change and the development of funding opportunities for advancing suicide prevention and research programs for Indigenous people in Canada, the US, and the US Territories.



Cultural Performance
Ice Mountain Dancers
San Juan Pueblo
New Mexico



Conference Summary



“This conference was a Memorial event, in that it marked a place in time and memorialized the occurrence of suicide in Indigenous communities. From this place, we can begin to tell our stories and determine our health.”

-Madeleine Dion Stout, BC, Canada

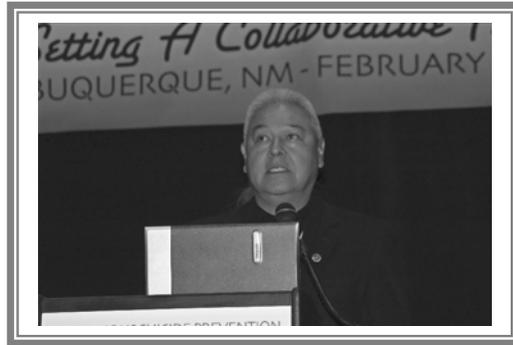
Sponsored by the Indian Health Service, Division of Behavioral Health and the National Institutes of Health (National Institute of Mental Health, Office of Rare Diseases, National Institute of Drug Abuse, National Institute on Alcohol Abuse and Alcoholism, National Library of Medicine), and the Substance Abuse and Mental Health Services Administration, the Indigenous Suicide Prevention Conference was the first ever international gathering of Indigenous researchers, service workers, community programs, and government representatives from across Canada, the US, and US Territories. This conference sought to illuminate the current state of knowledge of suicide across Indigenous people and to foster collaboration for addressing suicide prevention.

Goals of this international effort were stated as:

- Fostering knowledge exchange regarding what works to prevent suicide in Indigenous communities, including best practices and promising strategies;
- Increasing the number of Indigenous researchers and research projects that utilize community-based participatory research methods;
- Promoting collaborative action for suicide prevention initiatives across borders.

In preparation for this meeting, a planning committee comprised of representatives of the Indian Health Service (IHS), the National Institute of Mental Health (NIMH), the Canadian Institutes of Health Research (CIHR), and Health Canada’s First Nations and Inuit Health Branch (FNIHB), in collaboration with the Assembly of First Nations and Inuit Tapiriit Kanatomi, prepared the guiding principles, goals, and an overall agenda for this event. The theme of *Setting a Collaborative Agenda* was chosen and the planning committee structured the conference as a working group meeting to bring knowledge forward and to foster collaboration between policy makers, programs, and researchers working with Indigenous communities.

Participants, panelists, and presenters were invited at the recommendation of the planning committee, and a list of discussion questions was provided in advance to assist participants in preparing for the work of the 3-day meeting.



From Top: Hayes Lewis, Jon Perez, Jane Pearson, Kathy Langlois, and Jeff Reading

Facilitated by Hayes Lewis, a member of Zuni Pueblo and the IHS Suicide Prevention Advisory Committee, this conference brought together over 200 participants from a variety of backgrounds, disciplines and nations to take a closer look at the issues surrounding suicide prevention in Indigenous communities. Knowledge was shared and discussed through keynote presentations, panel discussions, and working group sessions that were facilitated by a team of Indigenous health leaders and prevention specialists.

Throughout the conference, participants were engaged in discussing the central needs and concerns regarding suicide of their respective communities. Significant recommendations were put forward and refined in the working group sessions during the final day. The overall content of discussion from the community perspective was guided by the following daily topics:

Day 1: Knowledge, Evidence, and Defining the Issues

Day 2: Identifying Current Approaches and Responses to Suicide

Day 3: Fostering Collaboration and Identifying Next Steps

The facilitated discussion of the *Knowledge, Evidence, and Defining the Issues* sessions identified the following needs:

- **Need for networking at the community level:** to share knowledge and best practices with ongoing collaboration between Indigenous programs and communities represented.
- **Need for collaboration across systems and disciplines:** to create programs that address the whole person, working to strengthen families, social needs, and community contexts.
- **Need for dialogue between communities and researchers:** to create relationships that are community led and driven, where cultural knowledge and practices are understood and respected, and traditional leaders and healers are seen as community experts.
- **Need for collaboration with government agencies and experts:** to strengthen the relationships between Indigenous communities to secure the resources for sustainable programs/prevention efforts, and participation in policy and decision making processes.

As these needs and concerns were carried forward in the working groups, information on *Current Approaches, Interventions and Responses* was also gathered. Throughout these discussions, crosscutting themes were identified by facilitators and carried back to the main plenary sessions. The following is a summary of the themes that participants discussed throughout the course of this three day event, including language, barriers, definitions, cultural knowledge, health determination, best practices, research, and capacity building.

Language, Barriers and Definitions

“One of the problems is that the definitions we are using here are too narrow. We need to remember the balance of the fire and the water, the male and female, the light and the dark, to be able to see this in a holistic way.”

Through the discussion of the language and definitions around suicide and prevention in Indigenous communities, the need for community-specific language and definitions was clearly expressed. Given the cultural and linguistic diversity of Indigenous peoples, the way that topics such as suicide are approached varies greatly from community to community.

- As Indigenous communities are individually governed and diverse, the need for community-specific language and approaches based on language, traditional knowledge and cultural practices exists.
- Researchers and practitioners need to be aware of and work within the language, approaches, and definitions of diverse communities.
- Shame, taboos, and readiness to discuss the issue of suicide are common barriers to prevention for many Indigenous communities.
- Prevention in Indigenous communities needs to be focused on life affirming messages and strategies, rather than suicide and death.

For many Indigenous cultures, sensitive subjects around death and disease are considered taboo and are traditionally not addressed directly. As these taboos come from cultural beliefs that discourage thinking or talking about dangers directly out of fear of causing these events to happen, participants shared ways that they found to approach their elders with the need to address suicide that are respectful of culture and tradition.

One successful approach for overcoming cultural taboos has been the use of life-affirming messages and interventions. Examples were provided in the presentations of youth-focused programs from Alaska and Canada that used messages and names like “Embrace Life” and “Youth for Life Council.” These prevention strategies have also been focused on supporting cultural knowledge

and activities for youth, such as the canoe making project and paddling journey that was presented in a video by the Saputiit Youth Association of Nunavik.

Clear agreement was reached that suicide, along with other health and social issues, needs to be spoken about in terms that are consistent with the Indigenous worldview. For many communities, the barrier has been that funding agencies and researchers have introduced and continue to use language and concepts that come from the dominant culture. Not only does this present a barrier for successful prevention, it has also been experienced as part of the suppression of cultural health knowledge and practices that has contributed to poor states of community health.

We find ourselves forced to speak about our health with language and concepts that are not our own. This is undignified, and is part of the continued acts of violence upon our sovereign language and identities.

Community members need to be able to tell their own stories, in their own words. When our stories are told, the healing can begin.

Once the topic of cultural-specific language and concepts was discussed, the doorway was opened for participants to share some of the unique perspectives regarding suicide from their individual communities. Participants from the Pacific Islands recognized that in many of their traditional languages, there was not even a word for suicide. One participant shared that the closest word in her language was *sacrifice*, and was able to show how the issue of suicide is dramatically reframed when it is talked about in this light. For some cultures, the act of taking one's own life is seen as a choice, and is not seen as shameful or an action for which others should have the right to intervene.



The definition of suicide also needs to be understood in a much broader sense, as many Indigenous cultures experience disproportionate rates of death caused by self-harm, such as chronic alcohol poisoning, alcohol and other drug-related deaths and accidents, unmanaged diabetes, and others.

Cultural Knowledge and Health Determination

“When we gather as Indigenous peoples, we can see that the same things are happening historically, environmentally that are bringing suicide into our communities, into our families lives.”

Following the discussion of Indigenous languages and definitions, the role of cultural knowledge and practices in suicide risk and prevention was addressed. Strong agreement was present among the Indigenous participants that cultural knowledge, beliefs, and practices need to be the basis of understanding and determining the health of communities; and that the challenges of keeping cultural practices, languages, beliefs, and identities are intimately related to the experience of resiliency and risk.

- Suicide needs to be understood within the cultural and historical context of colonization and globalization for Indigenous cultures.
- Traditional knowledge, along with the roles of Elders and spiritual leaders needs to be respected as a basis of community health.
- The issue of self-governance is central to the experience of health and is a major factor in determining Indigenous community health.
- The quality of relationship between government agencies, policy makers, and community members can also be an important factor in developing successful and sustainable prevention efforts.

Researchers and policy makers need to be more aware of the spiritual aspects of suicide in Indigenous communities, and be able to work with holders of cultural knowledge to better understand the larger context of the mental, physical, social and spiritual aspects of Indigenous health. The discussion of cultural knowledge was strongly tied to understanding the root causes of suicide, as well as other behavioral health issues in Indigenous communities.

Looking at suicide within the historical context, participants saw the presence of suicide in Indigenous communities as a manifestation of the psychic and spiritual pain experienced by their people as a result of colonization and globalization. With the loss of sovereignty, cultural practices, languages, traditional livelihoods, and the disintegration of our extended family kinship and clan systems, many Indigenous people are also experiencing a loss in the cultural continuity that has preserved their health and well being for thousands of years.

Sometimes our youth are caught in-between. We need to provide them with the means to build their cultural identity, and there needs to also be a positive reflection of this cultural identity within the mainstream culture, so they can feel that they belong.

We learned that the men in our community could not tolerate shame

A common belief was that the root cause of youth suicide is the disintegration of traditional extended family systems. Presentations focused on the challenges of preserving cultural practices and providing youth with the context they need to develop a strong sense of their cultural and individual identity. Understanding the effect of residential schools on traditional parenting practices, Indigenous communities are realizing that part of the work of youth suicide prevention is the strengthening of family relationships, cultural values, and practices; and restoring the context of community wellness overall. Indigenous youth need to be able to express themselves within their families, and to have access to both cultural knowledge and opportunities in the outside world.

The answer to suicide in many Indigenous communities is seen as a cultural healing process, and naturally traditional healers play a central role in this work. In many communities, the loss of language and family cohesion has also reduced the number of individuals who are qualified at a certain level of cultural knowledge. Traditional healers, spiritual leaders, Elders, and natural helpers need to be trained, respected, and validated for the important role that they play in community health. Throughout this conference, the Elders reminded all those present that the best intervention can be as simple as prayer.

We need to train prevention workers through mentorship with traditional healers to be the kind of person that our youth and families would want to talk to, having both the knowledge of systems and the qualities of caring that our Elders have.

We need to be in prayer, holy prayer, to support those people who are doing this work. As Elders, we also need to be very careful about what we say, understanding the importance of our words.

Self-governance is central to how Indigenous communities see their state of health and wellness. As a result, the quality of relationship that communities have to state and federal governing bodies and agencies also has a vital impact on the success of prevention efforts. Several participants expressed frustration that discussion of the political contexts that are impacting their communities' health was lacking, and the need to address the underlying structural issues that contribute to a collective experience of cultural oppression for Indigenous people was put forward as a necessary step in determining Indigenous health.

Research, Best Practices and Capacity Building

“One of things that frustrates me is that I see researchers presenting data about my region all the time, but I do not know any of these people and have never seen them in my community.”

A central theme of the conference was the understanding that Indigenous communities need to be involved at all levels of research, planning and service delivery to create prevention programs that are truly community led and driven. This recommendation addresses both the considerations of sovereignty, and the development of best practices for suicide prevention.

- Community members need to be involved at all levels of research, planning, and service delivery in order for prevention to succeed.
- Researchers need to be trained and aware of the unique cultural practices and protocols of a community prior to initiating work.
- Capacity building needs to happen at all levels in order to develop the competencies and relationships needed for collaboration.
- Cultural specific programs need to be developed that can integrate systems and services towards the goal of suicide prevention.
- Funding agencies need to support long-term initiatives for suicide research efforts to be more successful in Indigenous communities.

Education needs to happen for both communities and researchers in order to build better collaborative relationships. A common language also needs to be developed with which to understand the issue of suicide, entertaining research questions that are consistent with the Indigenous understanding of health.

The need to look at resiliency and risk factors from a holistic point of view, along with communities whose rates of suicide are low to see what these communities are doing right was thought to be a priority for prevention efforts. The roles of researchers and community members also need to be reframed, with researchers taking on the role of a *facilitator of knowledge* rather than an expert, working with community members on an equal basis.

Researchers also need to be trained in the cultural practices and protocols of the host community before entering to do any work. Community members also need to be informed of the goals, methodology, and potential outcomes of the research to be more comfortable participating and taking active roles in the process.

Throughout this conference I have been reminded to have patience. It takes a lot of time to educate researchers, we are better off than previous years, but we still have a long way to go . . . it takes a long time to change someone's worldview.

We also need to understand the culture of the researchers and funding sources, along with their customs, languages, professional restrictions, and needs.

A central part of the discussion around research was the issue of ownership, and who controls the data and outcomes. In the ideal situation, researchers would be present and have a longstanding relationship with a community for the feeling of partnership to be real for both. This enhances the quality of research, and supports the most respectful release and presentation of information. Clearly, communities need to retain the rights of ownership to their most sensitive information. One of the recommendations made was that Indigenous researchers use qualitative methods to record community stories, and work with community members on presentations and publications. Research outcomes need to be agreed upon, with community needs being considered in the research process.

With this understanding, general agreement that community stories do need to be told was reached; as these stories are an important part of building a cultural context for understanding suicide in Indigenous communities. From this place, Indigenous cultures can approach the issue of suicide with their own language, definitions, and solutions. One recommendation was for government agencies to sponsor regional gatherings of the spiritual and cultural leaders before attempting to conduct research or develop services. Another recommendation was that Indigenous people be trained to participate as co-researchers and become the gatherers of knowledge in their own communities.

We, the youth, need to take an active role in this, we need opportunities to be trained as researchers, presenters, and prevention workers for our peers.

A strong belief among participants around development of best practices is that Indigenous people are able to find solutions for their own health issues. Given the limited resources in Indigenous communities, a common approach is to work with the strengths and resources that communities already have. In order to support community-based solutions, services need to be integrated to combine the skills and resources of traditional healers, mental health, substance abuse, judicial and social services, as well as other health serving agencies. Given the

distances and barriers faced by rural and isolated communities, the need to also work with Elders, family members, cultural leaders, and spiritual resources is understood to be a central part of a community prevention plan.

We need to create opportunities for Indigenous people to be trained as the researchers, service workers and decision makers in our health. Our young people need to see that we are really there, looking out for them in this way.

When we looked around, we saw that we had what we needed to take care of ourselves. We have our language, our traditions, our land, and our hunting and fishing skills. We called our approach “getting together to celebrate life.”



Understanding the root causes of suicide among Indigenous youth, prevention strategies are often based on the need to strengthen family relationships, cultural values, and the overall experience of wellness in their communities. In building cultural-specific prevention programs, communities can benefit from peer-to-peer relationships to learn from the strengths and solutions of communities that share similar risks and experiences. Given the challenges of suicide prevention, practitioners also need spiritual support and guidance from Elders, as well as peers in other

communities, in order to develop promising practices and sustain their own health while working in the field. The grieving process of Indigenous communities also needs to be supported for a complete healing to take place.

Although the concepts of *best practices* and *evidence-based interventions* are a strong focus of government funding and research, significant cultural barriers in approaching capacity building with Indigenous communities from this perspective may be present. While models of exemplary programs may be useful and considered necessary to review by some programs and communities, other participants felt a community-specific approach would better meet their program needs. The approach and language used often is the barrier for Indigenous communities accessing technical assistance resources. Strength-based approaches were thought to be more appropriate by most participants.

One approach suggested is that Indigenous community leaders be brought together to discuss and identify their needs and resources. From this place, they can begin to develop short and long-term plans for suicide prevention, and work with technical assistance providers to match the best resources to their individual community needs and expectations. This kind of preplanning can be helpful, as families and communities often become immobile when the tragedy of suicide

hits and are not able to rapidly respond to prevention needs. Capacity builders also need to understand the access to resources of communities, and work towards building solutions that would provide program sustainability over time.

Networking, Communication and Collaboration

“As Harrison Jim (traditional healer) reminded us when we were asked to lower ourselves before our Elder, we sat where it is most comfortable, in our chairs. This conference is much like that. If we are really going to prevent suicide we will have to go much deeper --place ourselves upon the ground as it were-- to really understand the work that is to be done.”

Although the conference was seen as a memorial event by many participants, this event was understood to be the beginning of the kinds of communication and collaboration that needs to follow. Throughout the working groups, suggestions were made for ways to continue the collaborations started at the conference, and expand to include other partners who also need to be part of the discussion around suicide prevention.

- Communication between Indigenous communities and programs needs to be supported by formal networks, for the sharing of data, best practices, funding information, and other resources.
- Collaboration needs to be built across services and disciplines in order to create better suicide response and prevention strategies.
- Relationships between programs, researchers, and policy makers need to be strengthened in order to build long-term research and prevention initiatives in Indigenous communities.
- Working groups need to be convened to work on special topics, such as youth, and regional specific needs and approaches.

Overall, participants felt that the conference had been helpful in exposing them to current research, data, program successes, cultural approaches, and strategies being used in other countries. One of the strongest opportunities presented was the ability to meet and network with other Indigenous participants from their disciplines and regions, and the need for networks to continue and be supported

by funding sources was expressed. Participants also wanted to hear more presentations from communities and programs, and were appreciative that the gathering brought in a broad representation from Indigenous communities in the US, Canada and US Territories.

I wanted to thank you for allowing my Pacific cousins to come and share their stories, often times Native Hawaiians are invited to the table and it is difficult to be asked to speak for our relatives in the whole region.

It is powerful to look at the data like this, across our communities, to see how suicide does happen in clusters and to track down what social events are happening just before, or during, the times we are having these losses.

Some of the working groups presented the need to enhance communication across systems and disciplines, describing the current conditions of government programs and health care systems working “in silos.” Integration of these systems needs to happen to provide for programs and services that consider the whole person and community. Participants spoke about the need to mobilize system-wide changes to include youth, Elders, and spiritual leaders as well as the professional providers in planning councils and committees at all levels. Participants also recognized that the kind of formal relationships they had with government systems determined resources and opportunities available to them, and were able to compare some of the differences across international borders.

It seems that things are a little farther along for us in Canada, because we have done some of this work already through government supported initiatives like the New Emerging Teams. We are closer to having cultural best practices, and do have some research training and capacity building measures in place.

The need for understanding youth culture and communication was also expressed, with the recommendation that youth be included at all levels of research and planning. In a special working session of the Indigenous youth present at the conference, strong leadership was shown by the group moving forward to create a formal network to unite their efforts called *The Indigenous Youth for Life Council*. Working groups representing special interests to the US, Canada, Pacific Islands, and US Territories also met and made individual plans to continue their networks and plans for collaboration.

One of the suggestions put forward was for establishing a central clearinghouse that would provide a free, easily accessible means to share data, best practices, program information, community success stories, and resources for funding and capacity building. Working groups, list-serves, and on-line chat groups were also discussed as ways of supporting further communication. Considering the

geographic distances and time constraints, the request was made that networks be formally supported by the government funding agencies present. Participants also felt that another general meeting or conference similar to this one would be important, with a stronger focus on community wellness and time for special working groups to carry their agendas forward.

Conference Outcomes

As a result of the conference working groups, a number of outcomes came about during the conference. These outcomes are just the beginning of significant collaboration and sharing across boundaries and health care systems that the conference organizers fully expect to see develop.

- Representatives from many Indigenous communities were able to gather and share information specifically about suicide and suicide prevention across international boundaries.
- An international list-serve was established to allow participants to maintain an open dialogue regarding resources and issues.
- Indigenous researchers, along with other researchers working in Indigenous communities, were able to meet and form networks to enhance the state of suicide prevention research internationally.
- A working group for youth was convened at the conference, with an outcome being the creation of the International Indigenous Youth for Life Council and leadership for planning future youth events.
- A special working group for the Caribbean, Pacific Islands, and US Territories was also convened to form working relationships.
- Peer to peer support was provided through the working group sessions and network opportunities at the conference.
- As a result of this conference, a number of participating programs are in the process of adjusting their program models and plans.
- Following the recommendations made by the working groups on the final day, plans were made to support continued collaboration by convening suicide prevention working groups and meetings at the next IHS/SAMHSA Mental Health Conference in June of 2006.

Recommendations



Gathering the key issues and recommendations from the preceding discussion, the final day of the conference was spent refining recommendations to foster collaboration and define a collaborative agenda for suicide prevention research and program development. The working groups presented the following recommendations for consideration:

- **Clearinghouse:** One clear and simple strategy for fostering collaboration is the creation of a free, easily accessible web-based clearinghouse to share data, best practices, programs, community stories, and resources for funding and capacity building.
- **Communication:** Establishing ongoing methods of communication for the Indigenous communities and programs represented at the conference, i.e., list-serves and talk groups is crucial for continuing collaboration. Language regarding suicide and prevention needs to come from the world-view of Indigenous peoples. Youth, Elders, family members and survivors also need to tell their stories in their own language.
- **Cultural Healing:** Cultural leaders need to have the opportunity to gather to determine community needs before any research or intervention is done in order to agree upon language, definitions, and responses. Funding also needs to be provided for programs that strengthen cultural knowledge and practices, with a focus on family relationships and communication.
- **Youth Driven Initiatives:** To support youth leadership in prevention, planning, service, and research, youth-driven initiatives are needed. Youth also need to be more involved in prevention planning at the federal, state, and local level, and be part of the planning of future conferences.
- **Working Groups:** Formal working groups are needed to bring together researchers, policy makers, and community members to look at specific issues and strategies in more depth, along with working groups to bring together providers across health and social disciplines. Expanding upon connections made at this conference, the recommendation was made that these networks be formally supported with technology and resources.
- **Research:** Research in Indigenous communities needs to be framed in historical and social contexts, looking for strengths, cultural determiners, and protective factors. Relationships need to be built to train researchers in culturally appropriate methods, and opportunities need to be created for Indigenous researchers to gather, present data, and share their expertise.

- **Ownership of Data:** Discussions need to happen with community leaders around the research, publication, and the use of data, establishing clear understanding and agreement around the release of the final data. Indigenous youth also need to be trained to conduct research in their own communities; building training programs and opportunities for youth.
- **Capacity Building:** Capacity-building needs to happen at all levels to inform researchers, funding sources, and government agencies of specific competencies needed for working with Indigenous communities; and to provide training and information for community members on the resources, skills, and strategies available for building program services.
- **Best Practices:** Support for community-driven program development to create prevention programs that are culturally relevant and successful and for evaluation for Indigenous communities to validate promising practices were recommended, along with the continued sharing of best practices and models between Indigenous communities.
- **Funding Initiatives:** The request was made that policy makers consider the length of time needed to support research, professional recruitment and program development in Indigenous communities, and revise current policies that limit reimbursement and funding for services that work; such as traditional healing services, sports interventions, and cultural activities.
- **Future Meetings:** The request was made that a general meeting or conference such as this one be held on an annual basis for several years, with bi-annual meetings after a period of time. These conferences need to include all the Indigenous partners present, rotate hosts and locations, and be structured into government funding plans and agreements.

Future Directions

From the discussion and recommendations of the conference participants, the following strategies have been drafted to advance the state of suicide prevention and research programs for Indigenous people in Canada, the US, and the US Territories.

- **Research:** Prevention research needs to be reframed to address and understand the issue of suicide from an Indigenous perspective, looking for cultural strengths and commonalities. Training also needs to be provided to support cultural competency and the development of research best practices, including qualitative methods.

- **Funding:** Financial resources are needed to support long-term collaboration between researchers, policy makers and community representatives. Funding is needed to support formal networks and interdisciplinary working groups. Future capacity building grants also need to support the development of community-based initiatives, professional recruitment and cultural best practices.
- **Health Policy:** Formal capacity building relationships need to be redefined to support networks, collaboration and the lateral transfer of knowledge among Indigenous communities; creating change in current policies that limit the roles and financial reimbursement for traditional healers and cultural experts in the areas of research and program support.
- **Community Initiatives:** Cultural healing and community-led planning processes need to be supported to strengthen cultural knowledge and best practices regarding suicide prevention, with a focus on cultural continuity and family relationships. Training needs to be provided for community members to be active in planning, research and prevention.



Appendices



Conference Agenda

Presentations

Poster Presentations

Speaker Biographies

Planning Committee

Participant List

Evaluations

Tuesday, February 7, 2006

Knowledge, Evidence, and Defining the Issues (continued)

10:00 am **Health Break**
Atrium

10:30 am **Panel #2: Knowledge, Evidence, and Defining the Issues**
Alvarado E Carmen Parrilla-Cruz, Suicide Prevention Commission, Puerto Rico
Margaret Gates, Suicide Prevention Coordinator, Standing Rock Sioux Tribe
Madeleine Dion Stout, Aboriginal Health Consultant, British Columbia, Canada

12:00 pm **Lunch (on your own)**

1:30 pm **Mixed Break-out Groups**
Alvarado F, G, H, Turquoise Room and Weavers Room
(Rooms to be assigned)

2:30 pm **Health Break**
Atrium

2:45 pm **Mixed Break-out Groups (continued)**
Alvarado F, G, H, Turquoise Room and Weavers Room
(Rooms to be assigned)

3:45 pm **Mixed Break-out Groups' Reports**
Alvarado E

4:30 pm **Closing of Day One**
Alvarado E Hayes Lewis, Zuni Pueblo
Rita Blumenstein, Yupik, Traditional Healer

6:00 – 8:00 pm **Poster Session and Exhibit Reception Hosted By Hotel Albuquerque**
South Atrium Jon Perez, Director, Division of Behavioral Health, Indian Health Service

Cultural Performance
Ice Mountain Dancers, San Juan Pueblo

Wednesday, February 8, 2006

Current Approaches, Interventions, and Responses

- 7:00 am** **Conference Registration, Exhibits, and Poster Session**
South Atrium
- 8:00 am** **Opening Prayer – East**
Alvarado E Ron Kingbird, Counselor, Red Lake High School
- Summary of Day One**
 Hayes Lewis, Zuni Pueblo
- 8:30 am** **Panel #3: Current Approaches, Interventions, and Responses**
Alvarado E Cornelia Wieman, Indigenous Health Research Development
 Program, University of Toronto
 Dale Walker, Director, One Sky Center
 Talalupelele Sunia, Department of Human and Social Services,
 American Samoa
- 10:00 am** **Health Break**
Atrium
- 10:30 am** **Panel #4: Current Approaches, Interventions, and Responses**
Alvarado E Laurence Kirmayer, McGill University, Quebec
 Jacqueline Mercer, CEO, Native American Rehabilitation
 Association, Portland, Oregon
 Osaia Santos, Federated States of Micronesia
- 12:00 pm** **Lunch (on your own)**
- 1:30 pm** **Mixed Break-out Groups**
 Alvarado F, G, H, Turquoise Room and Weavers Room
 (Rooms to be assigned)
- 2:30 pm** **Health Break**
Atrium
- 2:45 pm** **Mixed Break-out Groups (continued)**
 Alvarado F, G, H, Turquoise Room and Weavers Room
 (Rooms to be assigned)

Wednesday, February 8, 2006

Current Approaches, Interventions, and Responses (cont.)

3:45 pm
Alvarado E

Mixed Break-out Groups' Reports

4:30 pm
Alvarado E

Closing of Day Two
Hayes Lewis, Zuni Pueblo

5:00 – 7:00 pm
Franciscan

Health Canada Learning and Networking Session
Michael Chandler, Department of Psychology, University of British Columbia, Vancouver, British Columbia
Master of Ceremonies, Janice Rose, British Columbia

7:00 – 11:00 pm

Sobriety Pow-wow (Optional Cultural Event)
Rio Rancho Best Western

Thursday, February 9, 2006

Fostering Collaboration

7:00 am
South Atrium

Conference Registration, Exhibits, and Poster Session

8:00 am
Franciscan

Opening Prayer – West
Charlotte Herkshan, Confederated Tribes of Warm Springs

Summary of Day Two
Hayes Lewis, Zuni Pueblo

8:30 am
Franciscan

Identifying Opportunities for Collaboration and Follow-up
Break-out Group Facilitators

9:00 am

Networking Groups: Developing Plans for Collaboration and Follow-up in Identified Areas
Alvarado F, G, H, Turquoise Room and Weavers Room
(Rooms to be assigned)

10:15 am
Atrium

Health Break

Thursday, February 9, 2006
Fostering Collaboration (continued)

10:30 am
Franciscan

Networking Groups' Reports
Break-out Group Facilitators

11:30 am
Franciscan
Service

Closing Remarks
Jon Perez, Director, Division of Behavioral Health, Indian Health
Service

Jane Pearson, Chair, National Institute of Mental Health Suicide
Research Consortium

11:45 am
Franciscan

Closing Prayer
Elder Billy Two-Rivers, Mohawk Nation



Presentations



The following presentations were provided by the presenters for plenary sessions and panel discussions:

- **“Cultural Continuity” as a Hedge Against Suicide among Indigenous Youth**
by Dr. Michael Chandler
- **Suicide IS Preventable**
by Bernadette Dean
- **Native Hawaiian Suicide**
by Iwalani R. Nahuina Else, Ph.D.
- **Puerto Rico: Working Together Saving Lives**
by Carmen E. Parrilla Cruz, Ph.D.
- **Sounding the Depths of Indigenous Suicide Prevention**
by Madeleine Dion Stout
- **Addressing Suicide in Aboriginal Communities: Advancing the Research Agenda**
by Cornelia Wieman, M.D., FRCPC
- **Native Suicide Prevention: Approaches, Interventions, and Responses For An International Strategy**
by Dale Walker, MD, Denise Middlebrook, PhD, Patricia Silk Walker, PhD, Douglas Bigelow, PhD, Linda Frizzell, PhD, Michelle Singer
- **No More Fallen Feathers, a Native American Youth Suicide Prevention Program**
by Jackie Mercer
- **Suicide in Micronesia**
by Osaia Santos



“Cultural Continuity” as a Hedge Against Suicide among Indigenous Youth

Dr. Michael Chandler
University of British Columbia
Canada

INDIGENOUS SUICIDE PREVENTION RESEARCH
& PROGRAMS IN CANADA AND THE UNITED STATES:

Setting A Collaborative Agenda

ALBUQUERQUE, NM - FEBRUARY 7-9, 2006



Abstract

Youth Suicide is a cultural “columbus’s canary”—a grim signal reminding us that the dire prospects awaiting many of our young people are often judged by them to be lives no longer worth living. No where is this more apparent than among the young members of certain Indigenous communities—young persons who are obliged to construct a sense of self and culture out of the remnants of a way of life that has often been colonized and criminalized and assimilated almost out of existence. The research to be presented—work that examines the epidemic of youth suicide common to some but not other Indigenous communities in Western Canada—aims to make three points:

The first is that, however alarmingly high the overall rates of youth suicide may be, being suicidal is not some defining attribute of Indigenous peoples, but, rather, occurs in epidemic proportions in some communities and not at all in others. Given this widely seen-toothed pattern, what “inquiring minds” obviously want to know is: what especially characterizes communities that are effectively spared the problem of youth suicides, and what sets them apart from communities where such problems are rampant? The second line of evidence to be presented is intended to provide some provisional answers to this critical question. This research strongly associates low to absent youth suicide rates with various markers of “cultural continuity” indicators of efforts on the part of individual communities to rehabilitate their often badly savaged traditional culture, and to achieve important measures of community control over their own cultural future. Interestingly, some of what proved to be especially “protective” against suicide in the more than 200 communities studied was specifically undertaken in the name of suicide prevention. Finally, this program of research makes it clear that many communities are already in possession of Indigenous knowledge and cultural practices that evidently work to insulate their youth from suicide—knowledge and practices that could potentially be transferred laterally from one Indigenous community to another.



AN OVERVIEW: Questions & “Answers”

In the next 45 minutes I hope to take up 2 questions.



Question One

- **First** How did it come to pass that Indigenous peoples—in Canada, in the US, and, in general, across the Indigenous world—suffer rates of suicide (especially “youth” suicide) many times higher than their culturally mainstream counterparts?



Question Two

- **Second** Given finite resources, what can best be done to prevent such deaths? How can we work to insure that, for all of our young people, living is seen to be better than dying?



Provisional Answer One

Peoples bereft of a cultural past, and lacking a sense of stewardship or control over their own collective future, regularly find life meaningless, cheap, and often not worth living.



Provisional Answer Two

“Cultural Continuity” (defined here as a “rooted-ness” in one’s cultural past, and an ownership of those means necessary to insure cultural persistence) is the best available hedge against youth suicide.



MYTHS IN NEED OF DISPELLING

MYTH ONE

Suicide—especially youth suicide—is an endemic “feature” common to **all** contemporary Indigenous/Aboriginal/“Indian” communities—a **uniform** failing that admits to a **common** solution strategy.



INDIGENOUS SUICIDE AS AN ACTUARIAL FICTION:

Removing The “Race” Card

Against this view I hope to show that elevated suicide rates characterize some Indigenous communities, but fail to characterize others. As such, suicide is a problem, but not an Aboriginal or Indigenous problem. Because of this variability, suicide is not a problem that lends itself to “one-size-fits-all” solution strategies.



MYTH TWO

THE INDIGENOUS KNOWLEDGE “VACUUM”

Because Indigenous knowledge is widely assumed to be lacking, the “repair” for the problem of Indigenous youth suicide must be imported—perhaps from Ottawa, or Washington DC, or even New York City—and parachuted into Indigenous communities.



WHOSE KNOWLEDGE; WHOSE BEST PRACTICES?

Against such top-down, trickle-down views, I mean to argue that, as a matter of evident fact, many (perhaps most) Indigenous communities already possess the knowledge required to create for their youth lives judged to be worth living. This life-affirming Indigenous knowledge, and attendant cultural “best practices,” can, at least in principle, be transferred “laterally” from one cultural community to another.



MYTH THREE

FULL-FRONTAL APPROACHES TO SUICIDE PREVENTION

Suicide is a problem requiring a full-frontal assault—some head-on approach that aims directly at the suicidal thoughts and actions of “at risk” individuals.



SERENDIPITY

Against such exclusively individual and problem-focused strategies, evidence will be presented indicating that, among the community level initiatives strongly linked with low to absent youth suicide rates, few were undertaken for the express purpose of directly preventing suicide, but were initiated instead as a way of preserving a cultural past, and guaranteeing the future viability of Indigenous culture.



AN OVERVIEW

The evidence on which I will report in support of these strong claims is the result of work done in Western Canada—work meant to explore the process of identity development, and the challenges of achieving personal and cultural persistence in a rapidly changing world.



Four Easy Pieces -An Outline

- Part I: The “One Self to a Customer” Rule
- Part II: Self-continuity in Suicidal & Non-suicidal Youth
- Part III: The Epidemiology of Suicide in First Nations Communities
- Part IV: Potential Action & Policy Implications



Part I: The “One Self to a Customer” Rule

The antinomy of sameness and change



Part I: The “One Self to a Customer” Rule

If they are to remain recognizable as instances of what selves and cultures are standardly taken to be, both individuals & whole cultural communities must satisfy at least two constitutive conditions:

1. Both are forced by the temporally vectored nature of our public and private lives to constantly **change**.
2. Inevitable change notwithstanding, both individuals and cultures must be understood to somehow remain recognizably the **same**.

As such, **personal and cultural continuity** (which embed both *sameness & change*) are not elective “features” of persons or whole cultural groups, but “**constitutive conditions**” of their coming into being.



Bows & Sterns

“Life is like a skiff moving through time with a bow as well as a stern”
William James



- The claim that the earlier and later manifestations of a life or culture must somehow count as belonging timelessly to one and the same continuant is true for at least two persuasive reasons:
 - One of which is quintessentially historical and *backwards referring*;
 - The other *forward anticipating*, and so all about securing our own as yet unrealized futures.



Part II: Self-continuity in Suicidal and Non-suicidal Youth



Age Related Change in Self-continuity Warranting Practices



- Continuity in one’s own life, and the lives of familiar story characters

Self-Appointed Death at an Early Age

Self-continuity in suicidal and non-suicidal youth
Type of continuity warrant by suicidal status

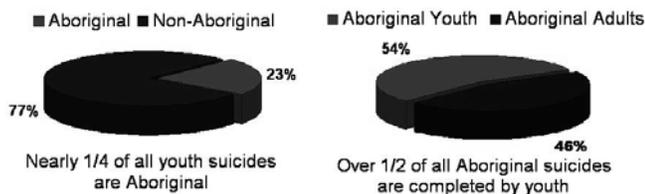
Suicide Risk	Continuity Warrant		
	None	Less Complex (Levels 1 & 2)	More Complex (Level 3+)
High	15 (83%)	1 (6%)	2 (11%)
Low	2 (9%)	18 (78%)	3 (13%)
Control	0 (0%)	15 (37%)	26 (63%)



Part III: The Epidemiology of Suicide in First Nations Communities

Cultural continuity as a protective factor against suicide in First Nations

Population Statistics: Youth

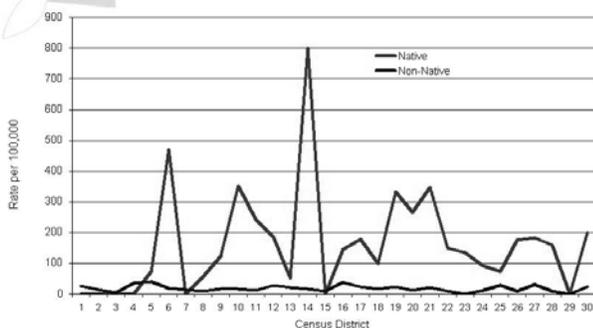


Aboriginal Suicide Rates as Actuarial Fiction

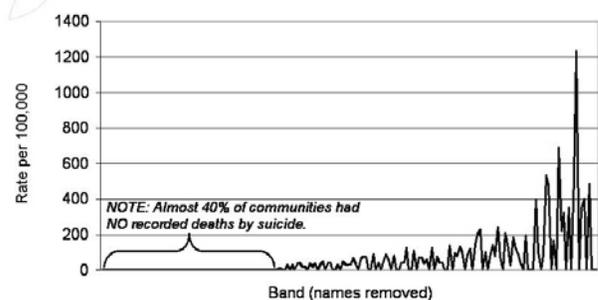
Variability as a function of:

- Census District
- Band/Tribal Council

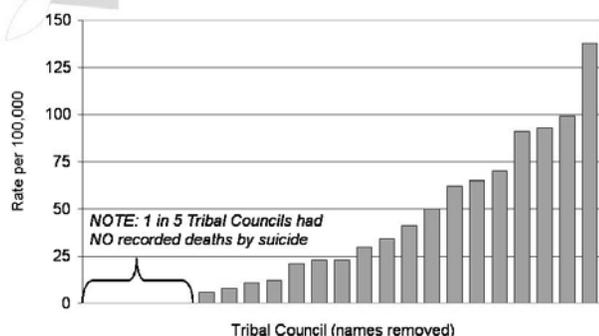
Suicide Rate by Census District



Youth Suicide Rate by Band (1987-2000)



Youth Suicide Rate by Tribal Council



THE OPEN QUESTION

What distinguishes Aboriginal communities with no youth suicides from those in which the rate is alarmingly high?

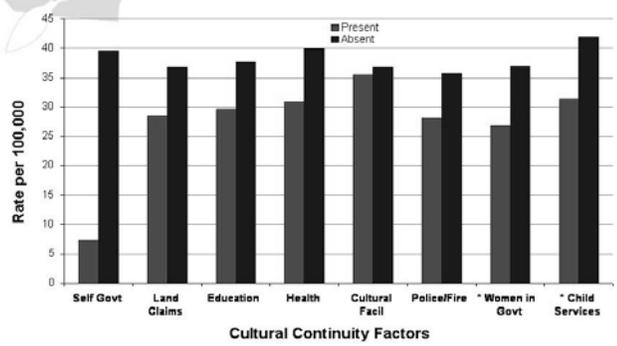
What Doesn't Work:

- Urban/Rural/Remote location
- Children and youth in care
- Population density
- Income adequacy
- Unemployment
- Labor force skill levels

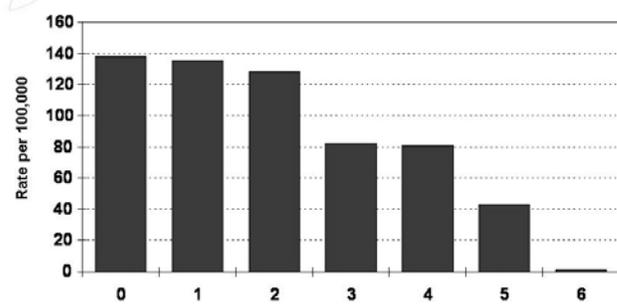
Cultural Reconstruction (What Works):

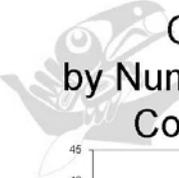
- Self-government
- Land claims
- Education
- Health services
- Police/Fire services
- Cultural facilities
- *Knowledge of Aboriginal languages
- *Women in government
- *Child protection services

Youth Suicide Rates by Cultural Continuity Factors (1987-2000)

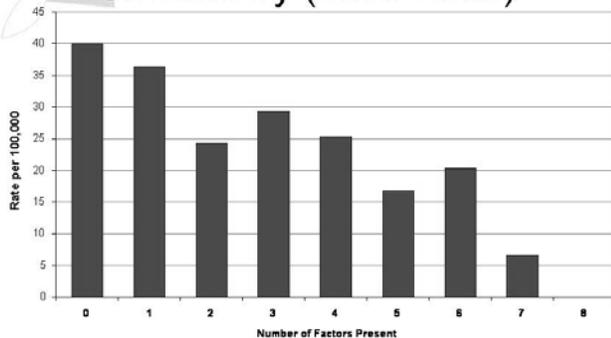


Youth Suicide Rate by Number of Factors Present in Community (1987-1992)





Overall Suicide Rate by Number of Factors Present in Community (1993-2000)




Part IV: Potential Action & Policy Implications

- The Myth of the Monolithic Indigene
- Indigenous Knowledge, Knowledge Transfer, & the Exchange of Best Practices
- Preventing Youth Suicide on the Margins



Three Potential Action & Policy Implications

- The first of these concerns the implications of exposing as false what I will call “the myth of the monolithic indigene.”
- The second turns on the low to absent rates of youth suicide noted in many Aboriginal bands—a fact that is seen to recommend a more “lateral” transfer of knowledge and best practices between Aboriginal communities.
- The third is that not everything that works to prevent youth suicide is done in the name of suicide prevention.



Action & Policy Implications: One

- If:
In light of the radical diversity in the rates of youth suicide evident across BC's Aboriginal communities, there really is no monolithic indigene, no “other,” and no such thing as the suicidal Aboriginal;
- Then:
A) All totalizing, blanket statements created by arithmetically averaging across all of the real cultural diversity that does exist—all attempts to tar everyone with the same broad brush—automatically amount to “actuarial fictions”—myths that, in addition to being seriously misleading and defamatory, tend to sponsor the misappropriation of scarce human and financial resources; and...



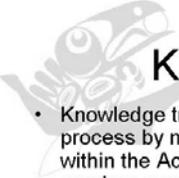
Action & Policy Implications: One...

- B) No “one size fits all” solution strategy to the problem of Aboriginal suicide could possibly be made to work. Rather, any serious attempt to address this or related health problems must necessarily begin with concerted efforts to determine how such problems are actually distributed across the Aboriginal population.



Action & Policy Implications: Two Indigenous Knowledge, Knowledge Transfer, & The Exchange of Best Practices

- The Second:
What our research also makes plain is the existence of a large, but poorly appreciated source of real *cultural knowledge* about how the problem of Aboriginal youth suicide might be addressed. That is, clearly contained in the finding that more than half of BC's Aboriginal communities have youth suicide rates lower than the general population is the evident fact that real *Indigenous knowledge* about how to address this problem must evidently already be well sedimented within these communities themselves. If proper attention and weight were given to this fact, then it would become necessary to radically re-think two of government's most cherished catch-phrases of the day: “knowledge transfer” and the “exchange of best practices.”



Knowledge Transfer

- Knowledge transfer, as commonly understood, is a “top-down” process by means of which scientific knowledge generated within the Academy is made to “trickle-down” until it eventually reaches community level workers. In addition to being suspect on other grounds, such “made in Washington or Ottawa” solutions are broadly seen as disrespectful by “served” communities, and openly confirmatory of the positional inferiority commonly accorded to Aboriginal culture.
- What the research that I have presented suggests as an alternative is that if Indigenous knowledge is recognized as real knowledge, then, in the place of more traditional top-down approaches, what needs to be seriously explored is the possibility of a community-to-community, “lateral” transfer of knowledges and best practices between groups that have enjoyed greater and lesser levels of success in meeting the needs of their own developing youth.



Action & Policy Implications: Three Suicide Prevention on the Margins

Although suicide prevention is most commonly viewed as a task best aimed directly at the suicidal thoughts and actions of “at risk” individuals, the evidence presented here suggests that the community level initiatives most strongly associated with reduced suicide rates were not undertaken for the express purpose of directly preventing suicide, but were initiated instead as a way of preserving a cultural past, and guaranteeing the future viability of Indigenous culture—as a way of insuring Cultural Continuity.



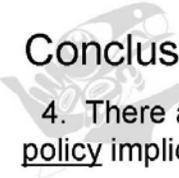
Conclusions: Four Easy Pieces

1. Recourse to some means of preserving a sense of personal and cultural persistence is a recurrent parameter of self-understanding, perhaps common to all human cultures.
2. Those individual adolescents fail to successfully sustain a sense of self-continuity suffer a loss of connectedness to their own future, and are thereby placed at special risk for suicide.



Conclusions: Four Easy Pieces...

3. Individual and cultural continuity are strongly linked, such that First Nations communities that succeed in taking steps to preserve their heritage culture and work to control their own destinies are dramatically more successful in insulating their youth against the risks of suicide.



Conclusions: Four Easy Pieces...

4. There are at least three obvious action or policy implications that flow from this research:

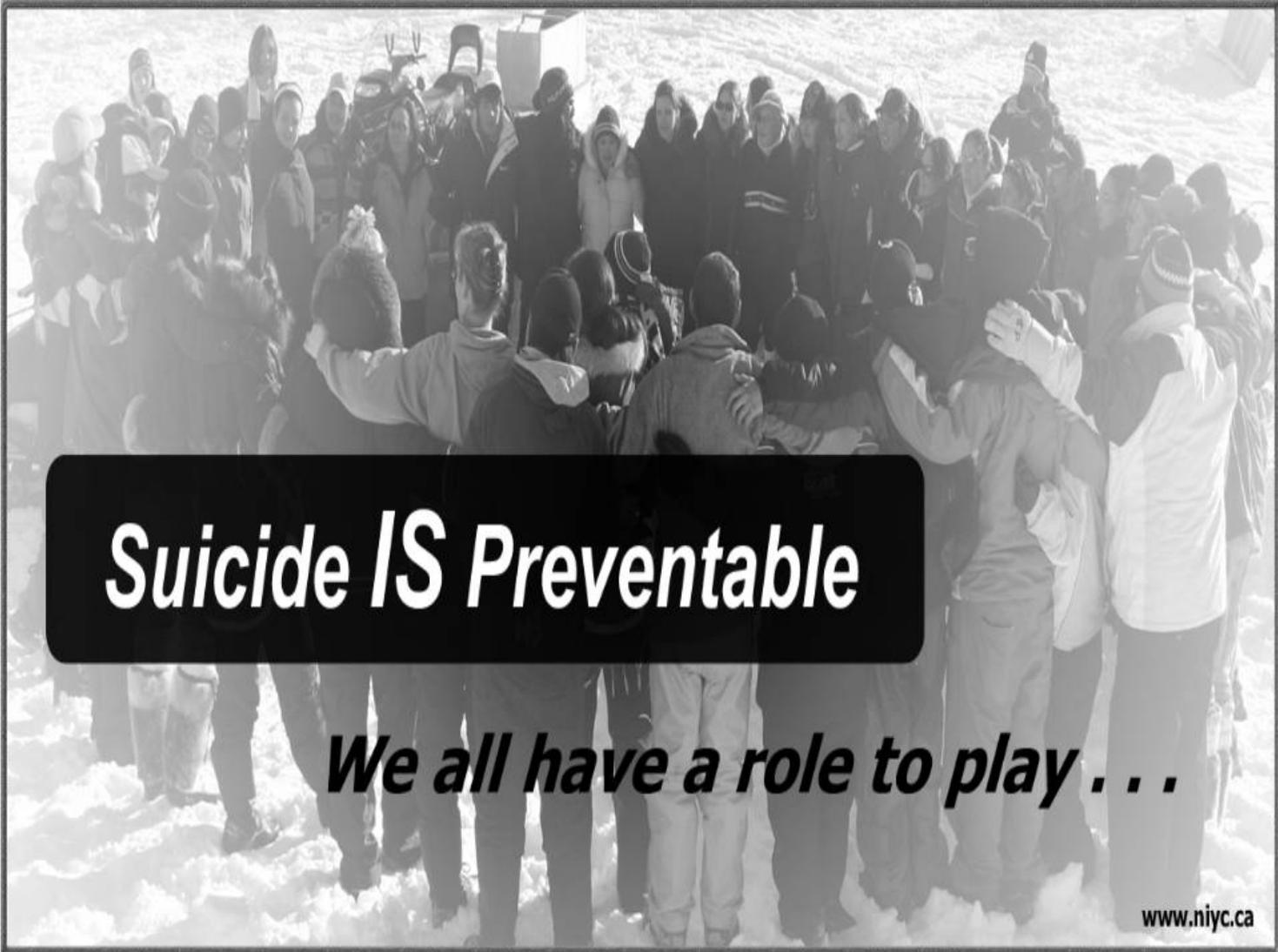
- The first of these turns on exposing as false the “actuarial fiction” that it is possible to capture the diversity of a whole province’s or country’s Aboriginal life in a single, totalizing (often statistical) gaze.
- The second is that, in light of the rich fund of Indigenous knowledges and practices shown to be scattered throughout the Aboriginal population, traditional “top-down” strategies of knowledge transfer should be retired in favor of a more “lateral” transfer of knowledge.
- The third is that not everything done to prevent suicide need be done in the name of suicide prevention.



With thanks to...

- Marlene Atleo, Jessica Flores, Pam Frank, Erica Gehrke, Darcy Hallett, Catherine Horvath, Cathy Hull, Marla Jack, Chris Lalonde, Aislin Martin, Lisa Moberly, David Paul, Holly Pommier, Bryan Sokol, Ulrich Teucher, Florence Williams
- Canadian Institute of Health Research; Michael Smith Foundation for Health Research; Social Sciences and Humanities Research Council of Canada; Hampton Fund; Human Early Learning Partnership; Network for Aboriginal Mental Health Research

E-mail: chandler@interchange.ubc.ca





Working with Inuit Tapiriit Kanatami, the National Inuit Youth Council will work to benefit all Inuit youth through the strength of our voice and action. The National Inuit Youth Council will work with our elders and other partners in the preservation and strengthening of the Inuit language(s) and culture; and to provide opportunities for young Inuit to attain their dreams and visions.

The National Inuit Youth Council was established in 1994 in Kuujuaq, Nunavik. The board is made up of representatives from each of the Inuit regions. The council works with several national, regional and community groups and governments and ensures partners are informed and in a position to make informed decisions on behalf of

Inuit youth

www.niyc.ca Original Photograph provided by: TOSHIO YATSUBISHI, 1998

The National Inuit Youth Council's 3 priorities for action include:

Language and Culture
Education
Suicide Prevention/Inuusiqaṣiarniq

WJ8N6yi6 WQxMs6ymJ6 W0JtQ9IA m4fgw5 w1uic5b3iqi4, wkw9l wodyq8i4 wo8ixDmiq8i4

Pijunnaqsiniq Culture Camp for youth was developed to address the high rate of youth suicide and to address the priorities that Inuit youth identified of the need to learn traditional Inuit skills of survival in our environment

s4WE/s9li h3l wk4 wcl1u4 giA[s4 s2lw8N3u4 iEt4Xw5 ryxio wk4 wo8ix6t4d[s4 wc9ox3i3u4 N1ui6 WJ8N3i3u4 gi/w5 wky14bz4i4.

"If you give a man a fish, you feed him for a day, but if you teach him how to fish you feed him for a life time!"

Living Life

The Saputiit Youth Association has developed a suicide prevention project, Living Life. Living Life is a multiyear project that begins with youth kayaking from Kuujuaq to Akulivik this summer. There are 6 youth kayakers with guide following them by canoes, these guides are adults of which are experts about kayak and the weather conditions along the coast of Hudson Bay. Each time they will arrive to the community other adults will follow them who know the area to another destination.



"The purpose of the project is not only about suicide prevention, it's also a means of motivation and encouragement for youth to Live Life".

In addition to paddling up the Hudson Bay coast the team will make presentations to each community along its route engaging in celebrations of life with local youth.

Kuujuaq (819) 964-2925 or within Nunavik at 1-877-Makvik (625-4845) any other inquiries please contact Miss. Shelly Watkins, Living Life Project Coordinator at the Makvik Office in Kuujuaq.

To present, the team had went to Umiujaq, Inukjuak and is presently in Puvimtuq each time they arrive in the community there are activities taking place to celebrate life. They are very courage's youth to inform all youth that life is precious and we all should help each other to have better life in



Inuit Circumpolar Youth Council

1st Inuit Circumpolar Youth Symposium on the Inuit Language

Summary Report
Isulut, Nunavut
August 15 - 19, 2005

© 2005 Inuit Circumpolar Youth Council

Knowing, learning and using Inuit language

"I want to hear about other groups facing same issues and how they're dealing with it."
- Keisi Ivanoff, Unalakleet, Alaska

"Youth should be called the 'Inuit Language Protectors' "
- Elder Lizzie Mary Angnakak

"I'm so inspired by watching people speaking Inuktitut doing business. It's very powerful to speak it and to translate it. Wow, they're doing that effort!"
- John Chase, Bethel, Alaska

"We need to make the link between international, national, regional and community efforts. What we do at higher levels must reflect needs of lower levels. Nunavut Inuit Youth Council (for example) takes all advice from local groups and flows to higher up."
- Jason Tologanak, Cambridge Bay, Nunavut

"I came here believing I was part of a community of 50,000 Inuit, now I know I am part of 155,000"
- Janus Chemnitz Kleist, Nuuk, Greenland

"I'm excited about this sharing of knowledge and bringing it home so that we can start revitalizing our language and bringing up smart beautiful Inupiaq speaking babies."
- Elizabeth Saaguliik Hensley, Anchorage, Alaska

"Say to yourselves, 'If it's going to be, it's up to me' "
- Bernadette Dean, Rankin Inlet, Nunavut

To support and encourage Nunavummiut to VALUE LIFE

Isaksimagit Inuusirmi
Iqitlitaqimalugu Inuuhiq
Embrace Life
Saisis la vie

theyouthsuicide preventionwalk.com

Life Book Inuuhiq

National Inuit Youth Council Website
Share your good news and opportunities and read about some. Read or contribute to one of the discussions in the forum. Keep in contact with friends and what's going on. Check out the links and visit other websites. Access and share useful resources.

w'kyc5yx3i6
Visit www.niyc.ca for more information
(don't forget to register)



Native Hawaiian Suicide

by

'Iwalani R. Nāhuina Else, Ph.D.

Indigenous suicide conference – February 7, 2006

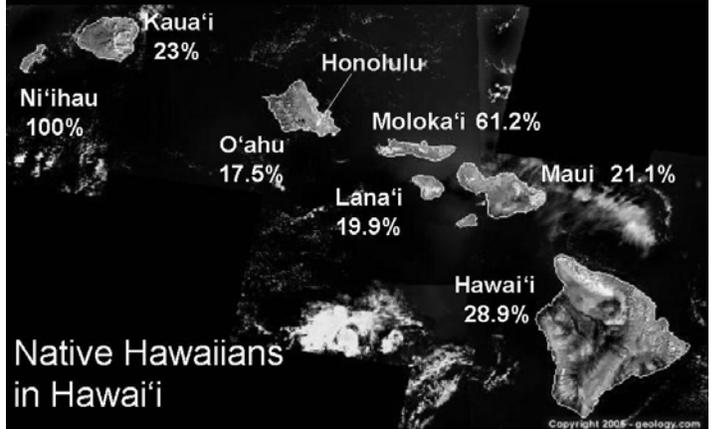
National Center on Indigenous Hawaiian Behavioral Health
Department of Psychiatry
John A. Burns School of Medicine
University of Hawai'i at Mānoa



The North Pacific



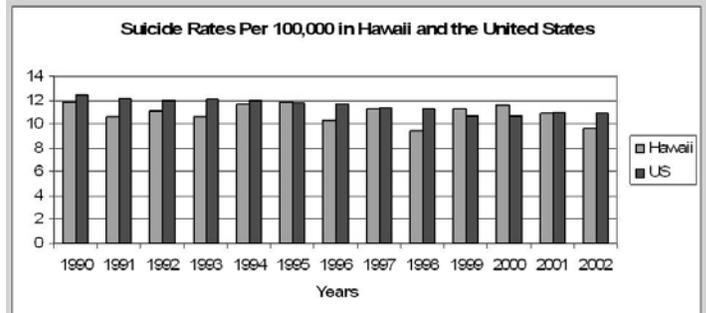
The Hawaiian Islands



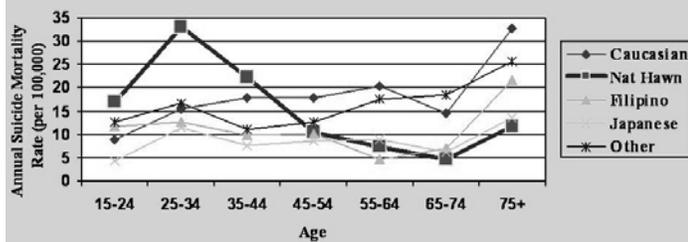
Peoples of Hawai'i

- Native Hawaiians (Kanaka Maoli) are the indigenous peoples of Hawai'i
 - +60% live in the state of Hawai'i
 - +Make up 20% of the state's population
 - +Ethnically diverse
 - Two-thirds (~67%) of Native Hawaiians claimed more than one race/ethnic group
 - ◆ Compared with 38% of Whites and 32% of Japanese

Suicide rate for Hawai'i & US

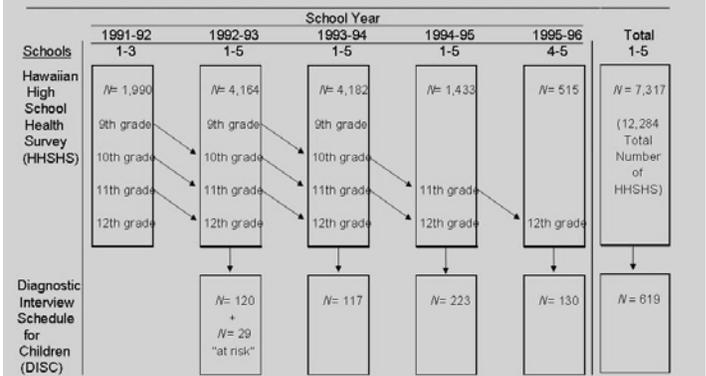


Hawai'i suicide rate by gender & age



Annual Suicide Mortality Rates of Major Ethnic Groups by Age Range in Hawai'i, from 1990-2000

Flowchart of cohorts - HHSHS



Note: An approximately 60% participation rate was obtained from the total enrollment of the schools. Nearly 28% of Native Hawaiian adolescents in the state were surveyed.

Attempted suicide, 1992-1996

- | | |
|---|---|
| ■ Native Hawaiians
+ 12.9% | ■ Non-Hawaiians
+ 9.6% |
| ■ Risks/Predictors
+ Depression
+ Substance use
+ Hawaiian cultural affiliation
+ Education of main wage earner | ■ Risks/Predictors
+ Depression
+ Substance use
+ Aggression |

Yuen, et al. 2000. Cultural identification and attempted suicide in Native Hawaiians. *Journal of American Academy of Child and Adolescent Psychiatry*, 39: 360-366.

Pacific People's project (NIMH)

- 7 intermediate/high school complexes on 4 islands
 - 8th and 12th graders
- Data collected from 2001 to 2004
- In total, about 1,500 students were surveyed
- Investigation into the prevalence of mental health concerns in adolescents, with a particular focus on Native Hawaiian youth

Attempted suicide - 2001-2004

- | | |
|--|---|
| • Native Hawaiians (n=700) <ul style="list-style-type: none">• 9.21% | • Non-Hawaiians (n=472) <ul style="list-style-type: none">• 6.38% |
| • Females – 11.86%, depression, aggression, substance use <ul style="list-style-type: none">• 28% smoked cigarettes• 24% smoked pot• 21% drank alcohol | • Females – 8.55%, depression, aggression, substance use <ul style="list-style-type: none">• 31% smoked pot• 26.7% smoked cigarettes• 16.4% drank alcohol |
| • Males – 5.32%, depression, <i>anxiety</i> , aggression, cigarettes <ul style="list-style-type: none">• 20% smoked cigarettes | • Males – 3.49%, substance use <ul style="list-style-type: none">• 12.5% smoked pot |

Family environment and functioning

- Resilience and protective factors
 - Family cohesion, ability to express one's self in the family hierarchy, and parental support
- Risk factors
 - Family conflict, lack of family/parent support, witness/heard family violence, family member dying, and having a family member commit suicide
 - Family conflict: **21 times more likely** to have made a suicide attempt in the past year
 - Sexual activity: **22 times more likely** to have made a suicide attempt during the past year,

Hawaiian Culture

- For the total sample (n=1172), Hawaiian culture overall and several subscales were all risk factors for lifetime suicide attempt.
- Higher scores on the overall culture scale were associate with three times the risk of lifetime attempted suicide.

PUERTO RICO: WORKING TOGETHER SAVING LIVES

Carmen E. Parrilla Cruz, Ph.D.
February 2006



Estado Libre Asociado de Puerto Rico
Departamento de Salud



VER DESPUES NO VALE, LO QUE VALE ES VER ANTES Y ESTAR PREPARADOS

José Martí

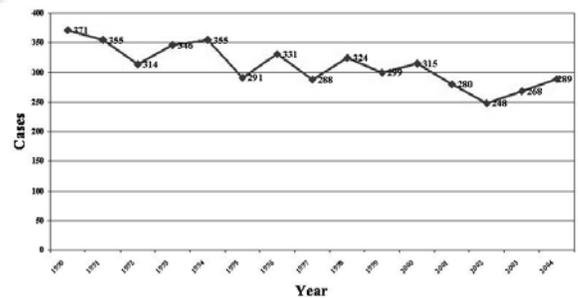
SUICIDAL BEHAVIOR CULTURAL PERCEPTION

PUERTO RICO:

■ 1990 – 2004	4,674 completed suicide
Average	312 per year
	222 children and adolescents
Average	15 per year
11%	10-14 (24)
89%	15-19 (198)
5% of all suicides	10-19
	1990 – 2004

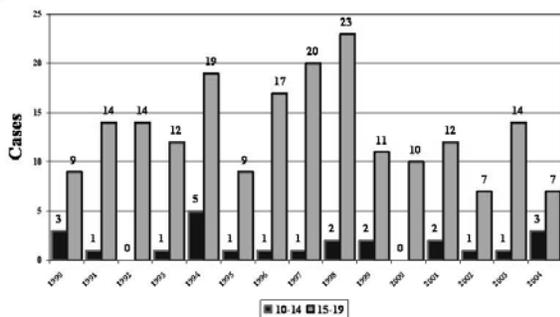
Departamento de Salud. Comisión Prevención Suicidio 2005

DEATH BY SUICIDE PUERTO RICO, 1990 - 2004



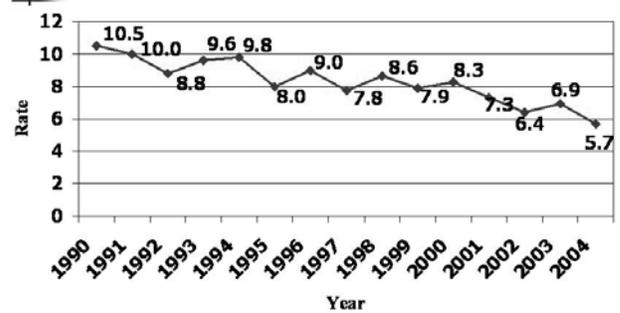
Vital Statistics
Department of Health, Puerto Rico 2005

DEATH BY SUICIDE CHILDREN AND ADOLESCENTS PUERTO RICO, 1990 - 2004



Estadísticas Vitales de Salud
Departamento de Salud 2005

Trends of Mortality Rate by Suicide Puerto Rico 1990-2004



Rates by 100,000 Inhabitants
Source: DEPARTAMENTO DE SALUD, SECRETARIA AUXILIAR DE PLANIFICACION Y DESARROLLO, DIVISION DE ANALISIS ESTADISTICO, SAN JUAN, PUERTO RICO



Efforts to Save Lives

- Law 227 – August 12, 1999
 - **National Suicide Prevention Commission**
 - 11 central government agencies
 - 2 non-profit org.
 - Survivor
 - Academia UPR-RCM
 - **Duties:**
 - Public policy
 - Promote networking
 - Recommendations to the Governor



Puerto Rico: Preventive Activities

- Public policy
- Data analysis
- Surveillance / adolescents suicidal attempts registry
 - Pilot Project – University Children Hospital
- Support groups



Puerto Rico: Preventive Activities

- 3rd National Conference on Suicide Prevention, 2003
- 10th National Suicide Prevention Week, August 2006
- National Suicide Prevention Day, August 12th
- World Suicide Prevention Day, September 10th
- Christmas Seasons Suicide Prevention Alert December 5th



Puerto Rico: Preventive Activities

- PANAS – Youth Helping Youth
- Education to community gatekeepers
- Media campaign
- Kit PARA SALVAR VIDAS



Collaborative Initiatives

- Central government agencies
- Municipal administrations
- Hospitals
- State and private universities
- Non-profit community – based orgs.



Collaborative Actions

- Religious leaders
- The media
- Workers unions
- Members of the Senate and the House of Representatives

Sounding the Depths of Indigenous Suicide Prevention

By Madeleine Dion Stout

Indigenous Suicide Prevention Research and Programs in Canada and the United States:
Setting a Collaborative Agenda

Albuquerque, NM
February 7, 2006

Key Issue

- Indigenous suicide prevention has to shift to the rightful persons, place and prize.

Key Messages

- Indigenous suicide prevention
- is a long overdue initiation and ritual
 - has to channel unconventional knowledge, evidence and definitions
 - must focus on social constructs and cultural truths
 - belongs to many sides of the border and all sides of the argument

Key Concepts

■ Social Constructs

– Ingrained in scientific/rational meanings, explanations and interpretations

■ Cultural Truths

– Embedded in age-old values, beliefs, traditions, perspectives and practices

Key Social Constructs and Cultural Truths

Social Constructs

1. Knowledge
2. Evidence
3. Suicide
4. Suicide prevention
5. Colonization/globalization
6. Sickness, disease, ill health

Cultural Truths

- kiskaytamawin* (achieved wisdom)
- aymoosihu* (ascribed wisdom)
- aymsonatsihu* (uncleansing oneself; self harm)
- kiyah aywak kamsonatsihuwak* (do no further self harm)
- kitimakisoonah* (poverties)
- kayas oma kanutsikweyah* (historic trauma)

Key Social Constructs and Cultural Truths (cont'd)

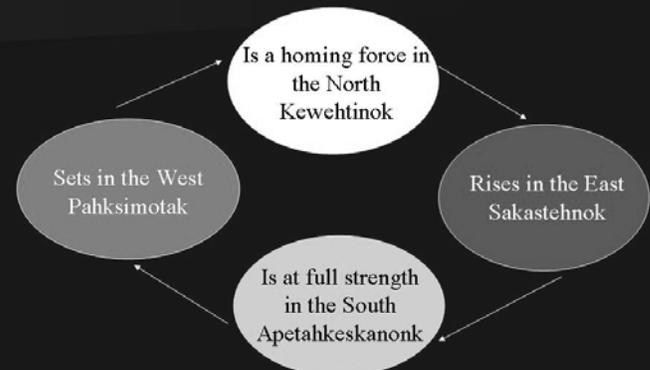
Social Constructs

7. Power
8. Research
9. Witchcraft
10. Health status indicators
11. "The powers that be"
12. "The low life"

Cultural Truths

- aymamatakoositsik* (awesome beings)
- waytinah emamtoonaytah* (re-search)
- aypastahu* (transgression of taboos)
- aytamatsihu* (sensory analysis)
- Kitsimanitou* (Great Spirit)
- manitsoosak* (big/little spirits)

Indigenous Suicide Prevention



HAI HAI!

Thank you!

Merci!



Addressing Suicide in Aboriginal Communities: Advancing the Research Agenda



Joint Canada-US Research Meeting

February 8, 2006
Albuquerque, New Mexico



Cornelia Wieman, M.D., FRCPC

Indigenous Health Research
Development Program,
University of Toronto

Determinants of Health:

including historical trauma & the ongoing effects of colonization



Photo: The Oriskany Project - Ruth A. (Cox) Inger's Photo Albums



- physical
- economic
- cultural
- social
- psychological

suicide

post-traumatic
stress

conflict

self-esteem



depression

grief & loss

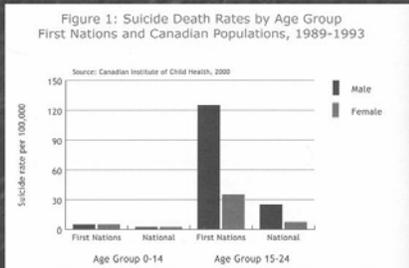
identity

stress

"woman in mourning"

First Nations youth suicide rates are high

- Aboriginal suicide rate is 2-3X higher than the non-Aboriginal rate
- Aboriginal youth suicide rate is 5-6X higher than non-Aboriginal youth



Suicide rates differ by tribal council and by language group

Figure 7: Native Youth Suicide Rate by Tribal Council (B.C.)

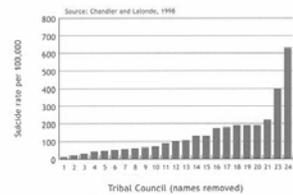
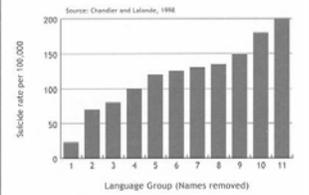


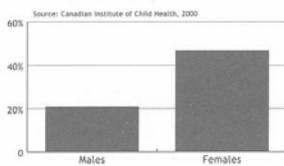
Figure 6: Native Youth Suicide Rate by Language Group (B.C.)



this suggests the importance of identity risk and protective factors that may account for some of the differences across communities

Rates of depression and acute stress are high in First Nations

Figure 11: Percentage of Mi'kmaq Youth Reporting Sadness or Depression 12-18 Years of Age 1997 (n=87)

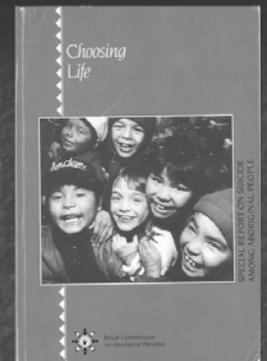


- many First Nations youth report depression, feelings of sadness & loneliness
- almost half of Mi'kmaq females (12-18 years) experience depressive feelings

Royal Commission on Aboriginal Peoples, 1996

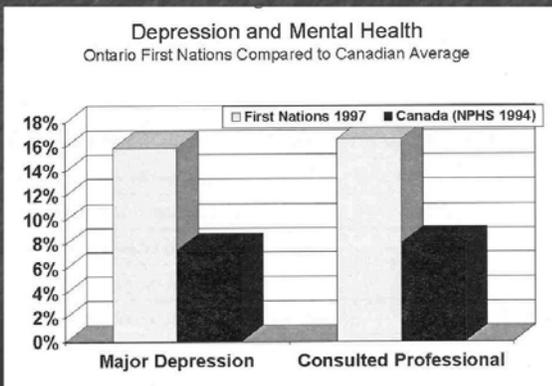
Choosing Life, 1995

"Aboriginal youth described both exclusion from the dominant society and alienation from the now idealized but once-real 'life on the land' that is stereotypically associated with aboriginality. The terrible emptiness of feeling strung between two cultures and psychologically at home in neither has been described..."

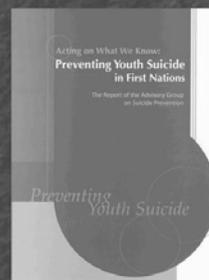


issues of identity

Depression First Nations & Inuit Regional Health Surveys



Acting on What We Know: Preventing Youth Suicide in First Nations



The Report of the Advisory Group on Suicide Prevention March 2003

- 30 Recommendations
- 4 themes:
 - research/knowledge
 - mental health services
 - community-driven approaches
 - youth identity, resiliency & culture

www.hc-sc.gc.ca/fnih-spni/pubs/suicide/prev_youth-jeunes/index_e.html

Developing effective & integrated holistic health care at national, regional, territorial & local levels



- support the creation of a comprehensive national First Nations mental health strategy including a mandate, policies & programs

Advancing the Aboriginal mental health research agenda & building capacity



CIHR-funded National Network for Aboriginal Mental Health Research (NAMHR)



www.mcgill.ca/namhr

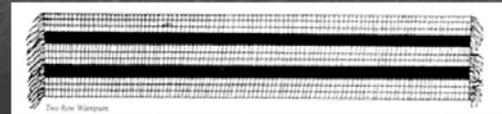
Emerging Research Initiatives



National Network of Aboriginal Mental Health Research

Health research with Aboriginal communities

- extensive community preparation/buy-in
- community advisory groups including Elders
- research ethics review
- Respect for indigenous knowledge & protocols
- capacity-building
- Knowledge translation
- OCAP & intellectual property rights



Six Nations Mental Health Services

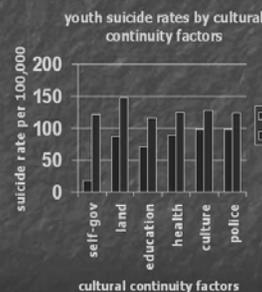


- 8 years of community-based clinical service (1997-)
- extensive database of information
- future plans for research & service evaluation



Cultural continuity as a hedge against suicide in Canada's First Nations

(Chandler & Lalonde, 1998)



- markers of cultural continuity: self-government, land claims, education, health, cultural facilities, police & fire services
- presence of each factor was associated with a lower rate of suicide

Nunavut follow-back study

- Carry out a follow-back study investigating suicides from Nunavut (2004-2008)
 - DSM-IV axis I and II disorders
 - life stressors
 - developmental history
 - personality dimensions
 - access to services and social support/networking

Resilience Study #1

CIHR-Suicide NET
McCormick & Wieman (2006)

- cross-national study of suicide attempters
- qualitative narratives of suicide attempt(s) & decision to now live
- 5 sites x 25 narratives/site
- BC - Musqueam (west), Saskatoon or Winnipeg (urban), Six Nations (central), Iqaluit (north), Eskasoni (atlantic)



Roots of Resilience: Transformations of Identity & Community in Indigenous Mental Health

CIHR International Collaborative Indigenous Health Research Partnership



Canada – New Zealand collaboration

- individual & community roots of resilience: stories of transformation & healing [McCormick, Wieman & Kirmayer]
- community level factors in youth resilience [Chandler & Lalonde]
- determinants of school performance and outcome [Bureck]
- alternative models for psychiatric assessment: relational models & resilience [Bennett, McKendrick, Kirmayer & Wieman]

Resilience Study #2

CIHR – International Collaborative Indigenous Health Research Partnership Grant
Wieman & Kirmayer (2006)



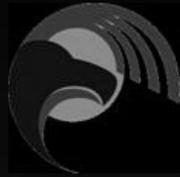
- qualitative narratives of past recipients of the National Aboriginal Achievement Award
- First Nations, Metis & Inuit – recognized by the Aboriginal community
- 14 recipients/year: 12 career, 1 youth, 1 lifetime
- awarded 1994 – present (potential pool of 182 recipients)
- barriers & enablers to success

THE TRUTH ABOUT STORIES
A Native Narrative
THOMAS KING



"this is why I tell these stories over and over again. And there are others. I tell them to myself, to friends, sometimes to strangers. Because they make me laugh. Because they are a particular kind of story. Saving stories, if you will. Stories that help keep me alive. But help yourself to one if you like. It's yours. Do with it what you will. Cry over it. Get angry. Forget it. But don't say in the years to come that you would have lived your life differently if only you had heard this story. You've heard it now."





One Sky Center

The American Indian/Alaska Native National Resource Center
for Substance Abuse and Mental Health Services

Native Suicide Prevention: Approaches, Interventions, and Responses For An International Strategy

Indigenous Suicide Prevention in Canada and the United States
Albuquerque, New Mexico
February 8, 2006

Dale Walker, MD Denise Middlebrook, PhD Patricia Silk Walker, PhD Douglas Bigelow, PhD
Linda Frizzell, PhD, Michelle Singer



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

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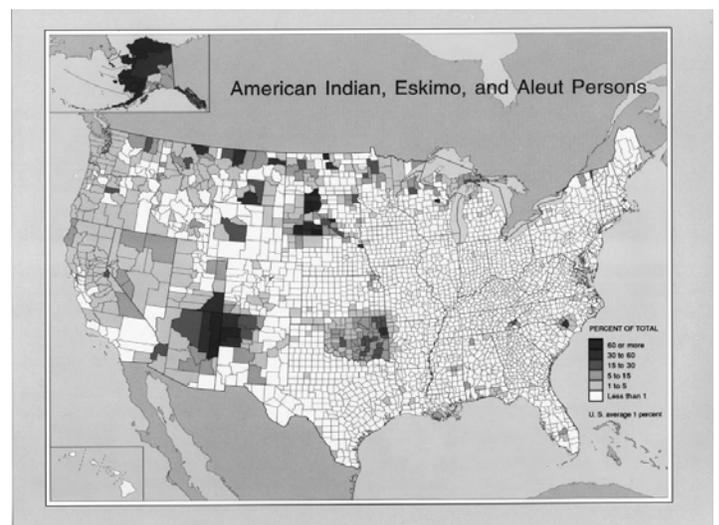


Overview

- An Environmental Scan
- Behavioral Health Care System Issues
- Fragmentation and Integration
- Discuss Suicide, Disaster
- Indigenous Knowledge + Evidence Based Knowledge = Best Practice
- Integrated care approaches are best for suicide prevention

Six Missions Impossible?

- How do we define problems?
- How do we define disaster?
- How do we ask for help?
- How do we get Federal and State agencies to work together and with us?
- How do we build our communities?
- How do we restore what is lost?



Health Problems

1. Alcoholism 6X
2. Tuberculosis 6X
3. Diabetes 3.5X
4. Accidents 3X
5. Suicide 1.7 to 4x
6. Physicians 72/100,000 (US 242)
7. 60% Over 65 live in poverty (US 27%)

American Indians

- Have same disorders as general population
- Greater prevalence
- Greater severity
- Much less access to Tx
- Cultural relevance more challenging
- Social context disintegrated

Agencies Involved in B.H. Delivery

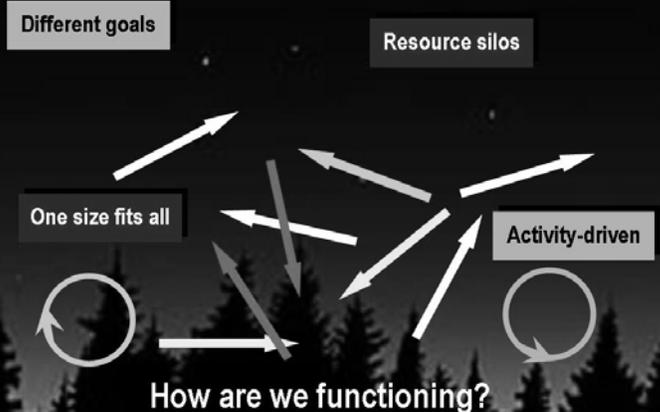
1. *Indian Health Service (IHS)*
 - A. Mental Health
 - B. Primary Health
 - C. Alcoholism / Substance Abuse
2. *Bureau of Indian Affairs (BIA)*
 - A. Education
 - B. Vocational
 - C. Social Services
 - D. Police
3. Tribal Health
4. Urban Indian Health
5. State and Local Agencies
6. Federal Agencies: SAMHSA, VAMC

Disconnect Between Addictions/Mental Health

- Professionals are undertrained in one of two domains
- Patients are underdiagnosed
- Patients are undertreated
- Neither integrates well with medical, emergency, educational, legal, and social services

Difficulties of Program Integration

- Separate funding streams and coverage gaps
- Agency turf issues
- Different treatment philosophies
- Different training philosophies
- Lack of resources
- Poor cross training
- Consumer and family barriers





Suicide: A National Crisis

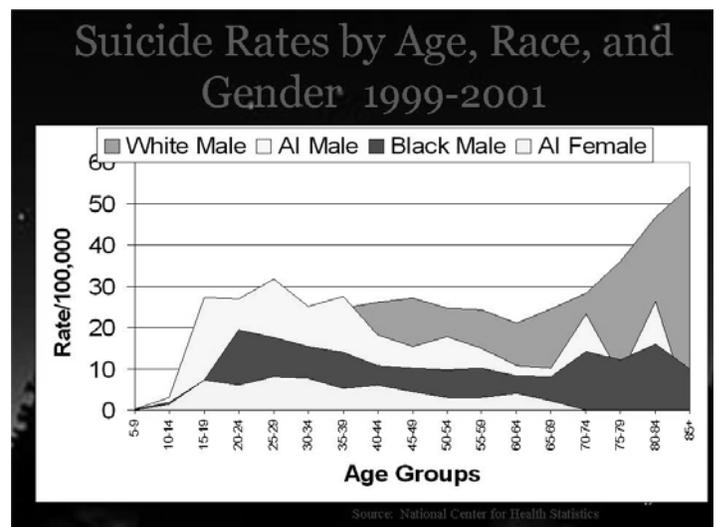
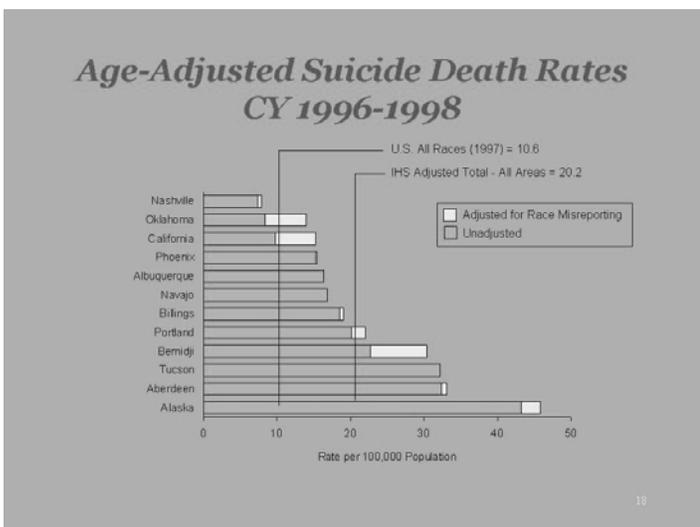
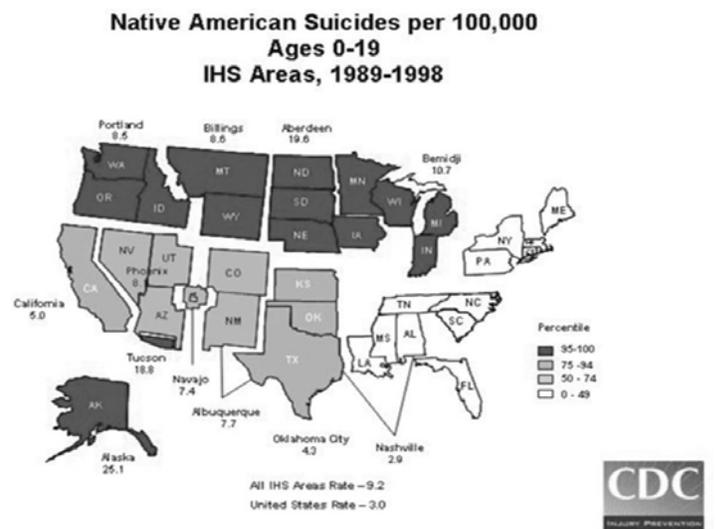
- In the United States, more than 30,000 people die by suicide a year.¹
- Ninety percent of people who die by suicide have a diagnosable mental illness and/or substance abuse disorder.²
- The annual cost of untreated mental illness is \$100 billion.³

¹The President's New Freedom Commission on Mental Health, 2003.
²National Center for Health Statistics, 2004.
³Bazeloni Center for Mental Health Law, 1999.

Our Community Issue

- For every suicide, at least six people are affected.⁴
- There are higher rates of suicide among survivors (e.g., family members and friends of a loved one who died by suicide).⁵
- Communities are linked to each other via a national network.
- Healthy communities are stronger communities.

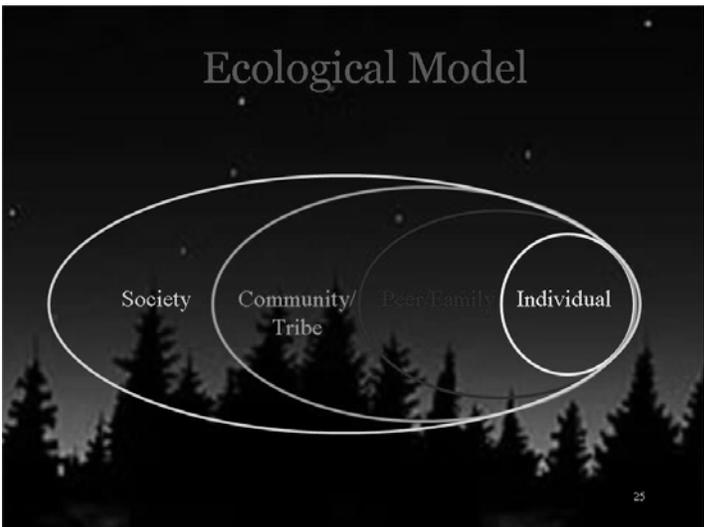
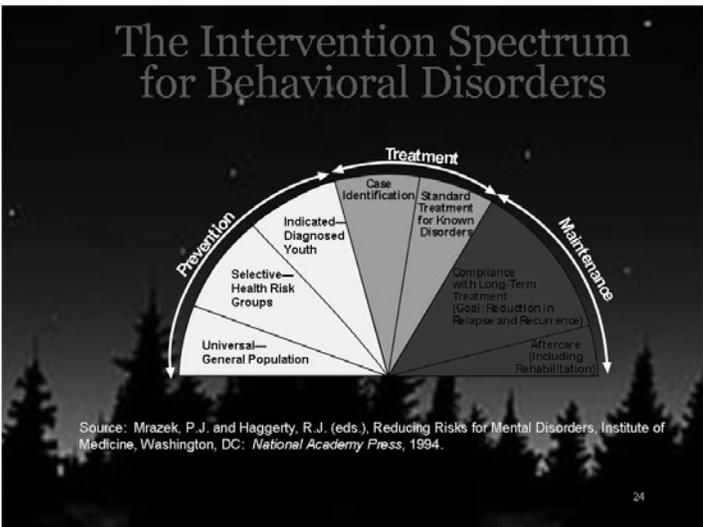
⁴National Center for Health Statistics, 1999.
⁵National Institute of Mental Health, 2003.

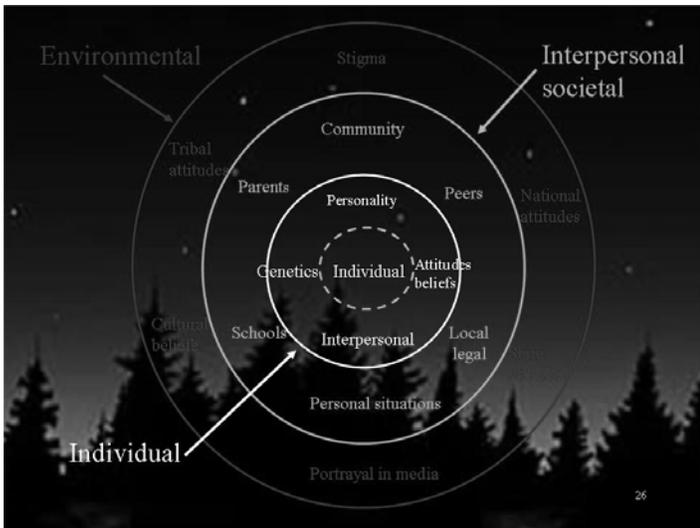




- ### Current Cluster Suicide Crisis in a Tribal Community
- 300+ attempts in last 12 months
 - 70 attempts since November
 - 13 completions in 12 months
 - 8 completions in 3 months
 - 4 to 5 attempts per week
 - Some attempts are adult
 - Age range of completions: 14-24 years of age
 - Most completed suicides are female
 - 80% Alcohol related
 - All hanging

- ### Disaster Defined
- **FEMA:** A natural or man-made event that negatively affects life, property, livelihood or industry often resulting in permanent changes to human societies, ecosystems and environment.
 - **NHTSA:** Any occurrence that causes damage, ecological destruction, loss of human lives, or deterioration of health and health services on a scale sufficient to warrant an extraordinary response from outside the affected community area.
 - **NOAA:** A crisis event that surpasses the ability of an individual, community, or society to control or recover from its consequences.





- ### Suicide: Individual Factors
- | <u>Risk</u> | <u>Protective</u> |
|--|--|
| <ul style="list-style-type: none"> • Mental illness • Age/Sex • Substance abuse • Loss • Previous suicide attempt • Personality traits • Incarceration • Failure/academic problems | <ul style="list-style-type: none"> • Cultural/religious beliefs • Coping/problem solving skills • Ongoing health and mental health care • Resiliency, self esteem, direction, mission, determination, perseverance, optimism, empathy • Intellectual competence, reasons for living |

- ### Suicide: Peer/Family Factors
- | <u>Risk</u> | <u>Protective</u> |
|--|---|
| <ul style="list-style-type: none"> • History of interpersonal violence/abuse/ • Bullying • Exposure to suicide • No-longer married • Barriers to health care/mental health care | <ul style="list-style-type: none"> • Family cohesion (youth) • Sense of social support • Interconnectedness • Married/parent • Access to comprehensive health care |

- ### Suicide: Community Factors
- | <u>Risk</u> | <u>Protective</u> |
|--|--|
| <ul style="list-style-type: none"> • Isolation/social withdrawal • Barriers to health care and mental health care • Stigma • Exposure to suicide • Unemployment | <ul style="list-style-type: none"> • Access to healthcare and mental health care • Social support, close relationships, caring adults, participation and bond with school • Respect for help-seeking behavior • Skills to recognize and respond to signs of risk |

- ### Suicide: Societal Factors
- | <u>Risk</u> | <u>Protective</u> |
|--|---|
| <ul style="list-style-type: none"> • Western • Rural/Remote • Cultural values and attitudes • Stigma • Media influence • Alcohol misuse and abuse • Social disintegration • Economic instability | <ul style="list-style-type: none"> • Urban/Suburban • Access to health care & mental health care • Cultural values affirming life • Media influence |





WHAT ARE SOME PROMISING PREVENTION STRATEGIES?

34

- ### Community-Based Suicide Prevention Program, Alaska
- Based on what communities want; Application non-competitive
 - State provides funds, information, and training
 - Communities implement projects
 - Link communities so they can learn from each other
 - Most communities implemented projects that include traditional cultural activities and activities designed to bring families together.
 - All project coordinators are trained to recognize and respond to risk
- 35

- ### American Indian Life Skills Curriculum
- Build self-esteem
 - Identify emotions and stress
 - Increase communication, problem-solving skills
 - Recognize and eliminate self-destructive behaviors, e.g. pessimistic thoughts or anger reactivity
 - Receive suicide information
 - Receive suicide intervention training
 - Set personal and community goals
 - Curriculum three times a week for 30 weeks in a required language arts class
- 36

- ### Community Based Prevention Interventions
- **Public awareness and media campaigns**
 - **Youth Development Services**
 - Social Interaction Skills Training Approaches
 - **Mentoring Programs**
 - **Tutoring Programs**
 - **Rites of Passage Programs**
- 37

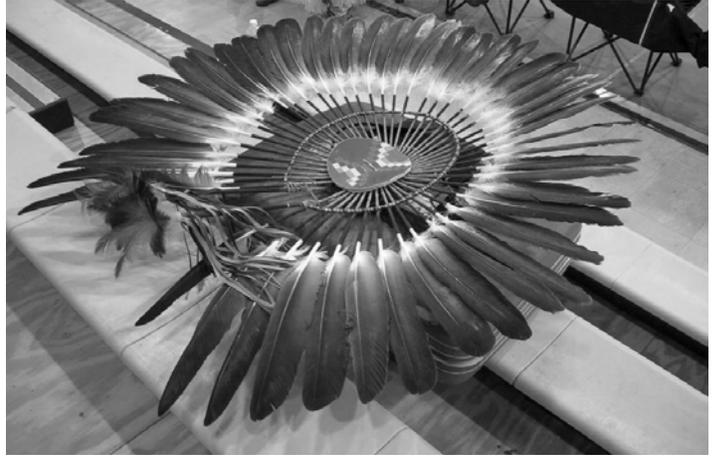
Effective Family Intervention Strategies: Critical Role of Families

- Parent training
- Family skills training
- Family in-home support
- Family therapy

Different types of family interventions are used to modify different risk and protective factors.

38

Native Aspirations!



One Sky Center Outreach



40

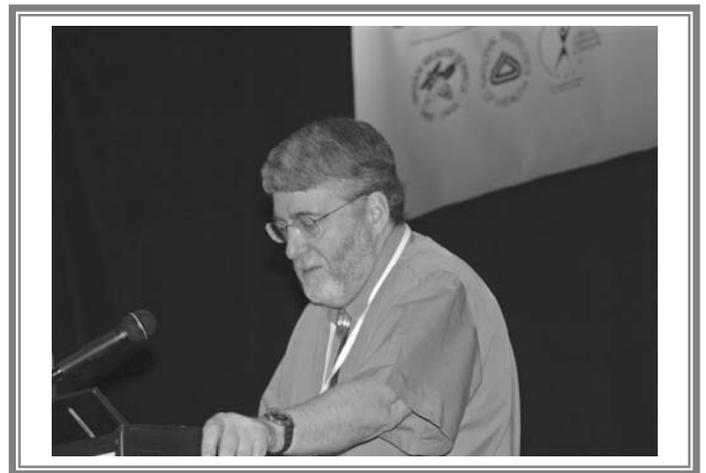
Suicide Prevention Resources

- Suicide Prevention Resource Center <http://www.sprc.org/>
- Indian Health Service Director's Initiatives <http://www.ihs.gov/>
- Office of Juvenile Justice Model Programs http://www.dsgonline.com/mpg2.5/mpg_index.htm
- One Sky Center <http://www.oneskycenter.org/>
- Screening for mental health <http://www.mentalhealthscreening.org/>
- Jason Foundation <http://www.jasonfoundation.com/home.html>
- T LaFromboise, The Zuni Life Skills Development Curriculum: Description and Evaluation of a Suicide Prevention Program. *Journal of Counseling Psychology* 42(4): 479-86

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Contact us at
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Or visit our website:
www.oneskycenter.org





Painting by Sam English,
Turtle Mountain Chippewa

No More Fallen Feathers: Native American Youth Suicide Prevention

2006-2008

Native American Rehabilitation
Association of the Northwest

Portland, OR

Funded through a grant from U.S.
Department of Health and Human Services,
Substance Abuse and Mental Health Services
Administration



No More Fallen Feathers

Native American Youth Suicide Prevention Program
A Three Year Project: 2006-2008

Our warriors are our people, and we lose them today not to warfare, but to the disintegration of our traditional ways. Our people must come together with a common vision for our youth...a belief that the time will come when there will be "No More Fallen Feathers".



What is the Problem?

- Suicide rates for Native Americans 1979-1992: 1.5 times higher than national average
- 64% of suicides were among Native American males 15-24 years old
- Native Americans age 15-34 – highest suicide rate
- Native American youth in Oregon age 10-24: Suicide rate is 3 times higher than white youth

(Oregon State Suicide Prevention Plan, 2001)



The Target Population

- Native American Youth ages 10-24 in
 - Nine Tribes of Oregon
 - Greater Portland Metropolitan Area
- **927 youth are directly impacted by the grant** (20% of 4835 Native American youth in Oregon)
- **Families and Communities of these youth**



Goals: No More Fallen Feathers

- **Goal #1: Statewide Network**
 - Create a sustainable tribal suicide prevention network
 - Throughout the State of Oregon
 - Linked to state youth suicide prevention efforts
 - Increase community awareness about suicide prevention approaches
 - A common culturally appropriate vision for prevention and intervention
 - Access to culturally appropriate and evidence based programs



Goals: No More Fallen Feathers

- **Goal #2: Mobilize and Build Capacity**
 - Design and implement cultural responses— collaborative effort
 - Establish council of Elders
 - Conduct needs assessment
 - Create Community Action Teams
 - Identify and assess risk factors for youth
 - Provide training for youth, adults, Elders
 - Create local linkages among emergency response and social services and community support
 - Include Portland State University's United Indian Students in Higher Education



Goals: No More Fallen Feathers

- **Goal #3: Media Campaign**
 - Promote awareness
 - Highlight risk factors
 - Link Local initiatives to state-wide campaigns
 - Communicate suicide prevention efforts within communities
 - Create website



Goals: No More Fallen Feathers

- **Goal #4: Evaluation**
 - Monitor effectiveness of culturally based programs
 - Collect and analyze data
 - Separate Self-Evaluation – funded by Centers for Disease Control
 - Government Program Reporting Act (GPRA) surveys
 - SAMHSA cross-site evaluation



Tribal and Community Network

- Warm Springs
- Umatilla
- Burns Paiute
- Klamath Falls
- Cow Creek
- Coos
- Coquille
- Siletz
- Grand Ronde
- Portland Metro Native American Community



Year 1: Organize Statewide Network

- Tribal Prevention Committee
- Representatives from each tribe
- Council of Elders
- State Youth Suicide Prevention Committee



Year 1: Engage the Communities

- Sacred Hoop Journey
 - Raise Awareness
 - Mobilize communities
 - Recruit Community Action Team (CAT) members
 - Engage youth & families
- Journey to 9 tribes and Portland Metro Area
 - 1 day in each location
 - Community Gathering
 - Sacred Hoop Ceremony



White Bison, Inc. of Colorado Springs, CO is the keeper of the Sacred Hoop



Year 1: Engage the Communities

- Suicide Prevention Quilt
 - Mobilize the community
 - Engage community members
 - Create community network
 - Engage Survivors & Families
 - Memorial for Youth Suicide victims
 - Displayed at all events



Year 1: Raise Awareness

- A Day of Listening
 - High School Youth
 - Each community
 - Youth Needs Assessment
- Results used for
 - Designing strategies
 - Developing curriculum
 - Recruiting youth peers
- Community Needs Assessment



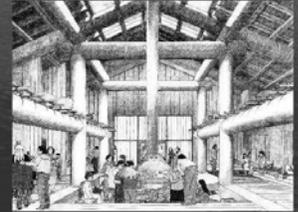
Year 2: Build Capacity-- Training

- Suicide Prevention Certification Training
- Community Action Team Member training
- Warrior Down: Youth Suicide Prevention Training
- Healing Hurt Children Training
- Community Visioning



Year 2 and 3: Implement and Evaluate

- Community Response
- Culturally Appropriate Prevention & Intervention Approaches
- Media Campaigns
- Community Action Teams
- Warrior Down
- Healing Hurt Children
- Statewide Network
- Process & Outcome Evaluation
- Follow up with A Day of Listening
- Return of the Sacred Hoop Journey



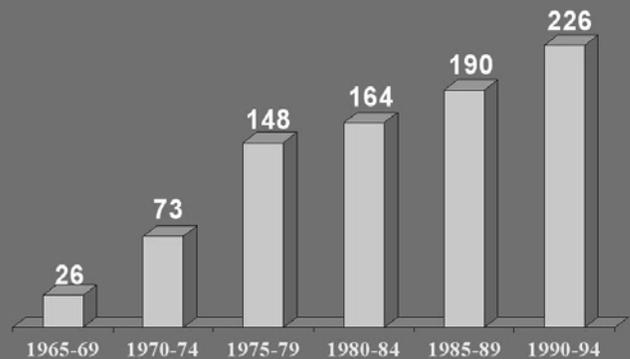
Suicide in Micronesia

Methodology

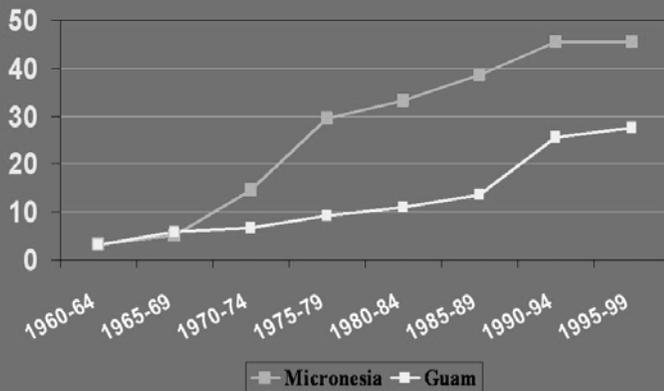
- Number of cases: 1,064 (all known suicides in FSM, Marshalls and Palau, 1960-1999)
- Database with biodata, family relations, circumstances surrounding death
- Sources of information: death certificates, police files, personal interviews
- Conferences in island groups on suicide
- Published articles

Suicide over the Years

[No. in FSM, Palau, Marshalls by 5-Year Periods]

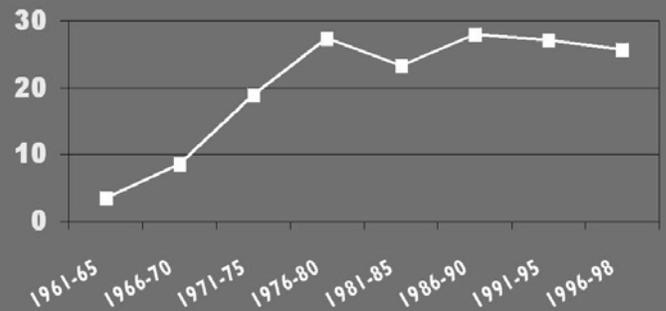


Average Yearly Suicides Micronesia and Guam 1960-1999

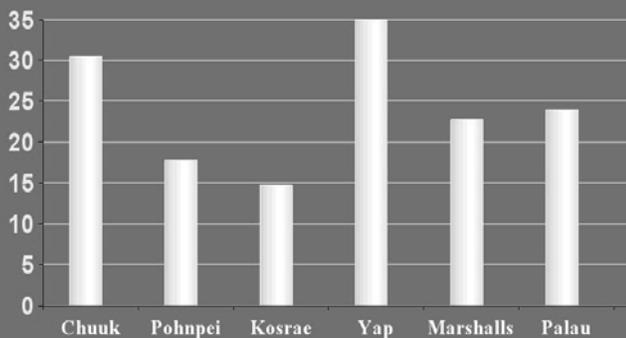


Micronesian Suicide Rate

(per 100,000 yearly)



Suicide Rates by Islands 1970-1998 (per 100,000 yearly)

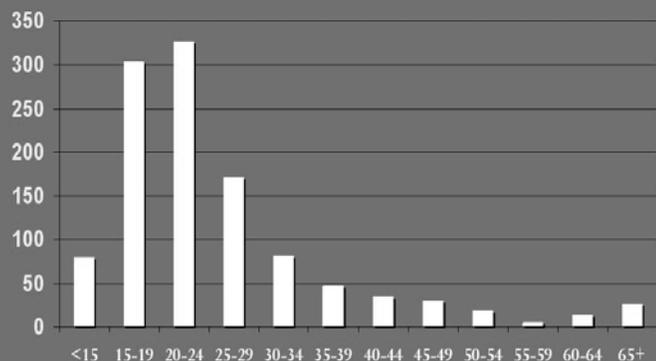


Suicide: Past and Present

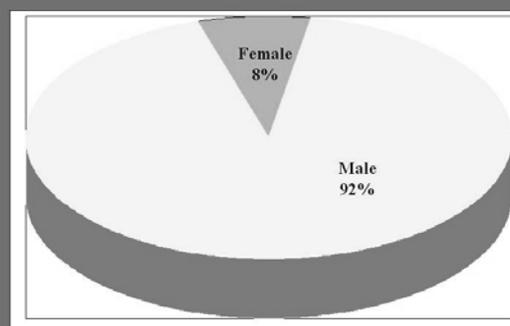
- Suicide was endemic to island societies
- Rates in mid-19th century Guam and during Japanese period: 6-8 per 100,000
- Enormous increase since late 1960s
- Increase perhaps a function of social change

Age Distribution

(Number of suicides by age cohort)



Distribution by Sex



Suicide among young males

- One of every 40 boys kills himself
- One of every 10 boys attempts suicide
- One of every 2 or 3 considers suicide

Characteristics of Suicides

Sex: 12 out of 13 suicides are males

Age: Most victims are young

57% - age 15-24

14% - age 25-29

Thus, nearly 3 out of 4 victims are between 15 and 30 years old.

Characteristics (cont'd)

Method: 90% by hanging
4% by gunshot
2% by poison
1% by drowning

Alcohol: 45% in FSM, 65% in RMI drunk at the time of death

Sample Cases

- 16-year old boy whose request for a new shirt was denied by his parents
- 20-year old boy whose mother would not give him money for drinking with friends
- 20-year old boy reprimanded by older brothers for not contributing to family event
- 18-year old girl, pregnant, scolded by her older sister

Reasons for Suicide

Main Pattern [72%]

- Prompted by a problem with blood family;
- Common in Pacific;
- Emotions of anger or shame

Minor Pattern [20%]

- Prompted by quarrel with wife or lover
- Found in Marshalls [Lajudokwa] and Palau
- Emotions of jealousy or anger

Cultural Pattern of Suicides

- Tight pattern to suicides in Micronesia
- Suicide NOT due to angst, failure in school or work, or public shame
- Rooted in interpersonal problems, especially in family
- Perceived rupture between victim and family
- Self-worth grounded in family ties

Psychodynamics of Suicide

- Rebuff from the family seen as lack of love
- Often confirms a sense of drifting from the family's affection
- Evokes emotional response of anger (mixed with disappointment and melancholy)
- Provokes cultural strategy of withdrawal or distancing (eg, suicide)
- Leaves with hope that his death will heal rupture

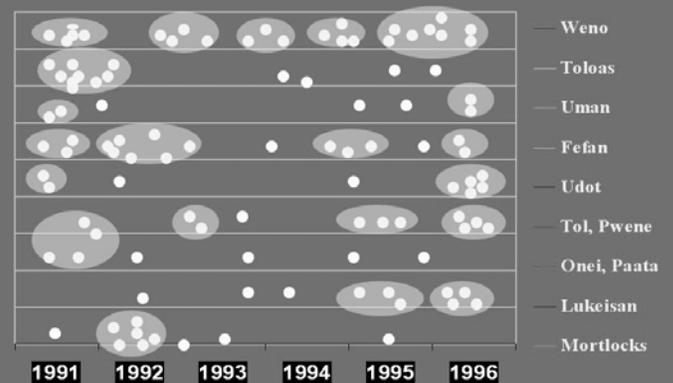
Cultural Context of Emotions

- Anger or shame usually at play
- Cultural rules for display of anger, according to age rank
- Anger that can not be expressed often introverted against self
- Shame: feeling that victim has let his family down

Contagion Effect of Suicide

- Clustering of suicides apparent in data
- Impact of suicide on other young people
- Belief in a haunting spirit of suicide
- Creation of "culture of suicide", as seen in songs, stories, etc.
- Suicidal climate today

Suicide Clustering in Chuuk



Why the Epidemic Today?

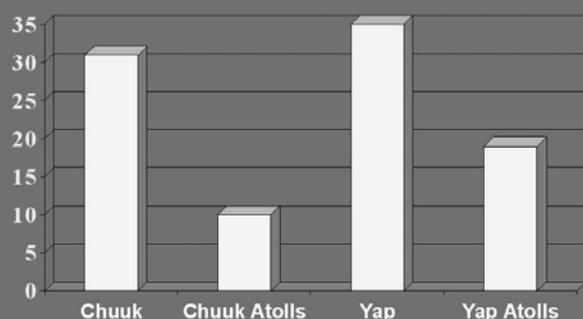
- Is there more tension between the young and their parents today?
- Are the resources young people once had for coping with family problems gone?

A Social Explanation

- Data on rising rates show suicide is epidemic as well as endemic
- Low rates in outer atolls suggest problem arises from modernization
- Suicide rates began increasing in late 1960s as social change intensified
- Suicide springs from family; perhaps family is key to understanding the problem

Comparative Rates in Remote Atolls (1970-1998)

Chuuk vs. Western Islands and Namonwitos
Yap vs Atolls of Woleai and Beyond



Changes in Micronesian Family

- Suicide generally due to family tensions
- Shrinking of family in Micronesia today due to cash economy and shift in resources
- Two-parent family replaces multi-parent family
- Father-son relationship more tense; fewer relatives to serve as intermediaries

Intervention

- Level of intervention:
structural or individual
- Problem with individual: secretive about family problems, often no clear signs
- Impulsivity leaves no time to intervene

Prevention Strategies

#1: Parenting education for a new age

- Emphasis on easier communication between parents and children
- Developing stronger links between children and their extended family
- New guidelines for parenting where these are needed.

Prevention Strategies

#2: De-romanticize suicide

- Message that suicide is selfish and harms the community
- Must be proclaimed in practice (eg, make funeral of victim less appealing)
- Must be a total community effort, involving churches, government and other institutions

Prevention Strategies

#3: Provide social buffers for youth

- Purpose: to cushion frustrations within family and lessen self-absorption
- Peer support from youth organizations and other interests outside family
- Activities could include: sports, singing, education, skills training

Prevention Strategies

#4: Keep good data on suicide

- Data can be used to continue study of the problem and develop better tools for research
- Sends a message to the community that there is something wrong with suicide

Prevention Strategies

**But in the end,
the best defense against suicide**

Is Strong and Healthy Families

Bear in mind

- Suicide is the #1 cause of death among young males
- It claims more young lives than auto accidents, drowning and homicide combined

**ISN'T IT TIME TO MOUNT A
SERIOUS CAMPAIGN AGAINST
SUICIDE?**



Poster Presentations



Title: IHS Community Suicide Prevention Website and National Suicide Prevention Network

Author(s): Tamara Clay, MSW, Public Health Advisor

Summary: In 2004-2005, the Indian Health Service and the Center for Mental Health Services, of the Substance Abuse and Mental Health Services Administration, collaborated via an Inter-Agency Agreement to target two areas. The first area was the development of a Community Suicide Prevention Website or “tool kit”. The Community Suicide Prevention Website includes existing information on suicide prevention/intervention, and other relevant material, which is culturally appropriate and addresses the needs of American Indians and Alaska Natives. The exhibit will provide an opportunity to showcase the website and solicit feedback from participants. The second area focuses on training a network of approximately 20 people, representing at least one person for each of the 12 IHS Areas. The trainings provide participants with skills to deliver assistance to communities which are experiencing suicide clusters, or are in need of suicide prevention assistance. This project is referred to as the National suicide Prevention Network (NSPN).

Title: Suicide Prevention Resource Center

Author(s): Ramya Sundararaman

Summary: An exhibit about the Suicide Prevention Resource Center will be displayed along with resources relevant to this event.

Title: The Process is Everything: Community-Based Action, Research, and Knowledge Transfer for Suicide Prevention in Nunavut

Author(s): Lori Idlout, Embrace Life Council; Michael Kral, McGill University and University of Toronto

Summary: The Nunavumiut, Inuit of Canada's new Arctic territory, have experienced struggles beyond their control. They have been made to radically change their lifestyle, language, and ways to ensure their livelihood. The transition has been so immediate that today's youth are showing symptoms of poor coping skills, poor relationship skills, and an inability to deal with pressures they still don't fully understand. Suicide has reached an all-time high with a rate of 122.5 per 100,000 for the years 1999-2003, ten times the national rate. This has given rise to Inuit-directed, community-based knowledge gathering and

action. Initial findings indicate that community responsibility and action, particularly by youth, the high-risk population, leads to not only a reduction or cessation of suicide during such action, but to other positive community outcomes for youth. In this presentation we describe four representative research projects and a new organization in Nunavut dedicated to suicide prevention and community wellness, the Embrace Life Council. Lateral knowledge transfer between communities has begun and will be described.

Title: One Sky Center

Author(s): One Sky Center (OHSU); First Nations and Inuit Health Board (Canada); Indian Health Service

Summary: Program profiles on suicide prevention programs for Aboriginal/ American Indian/Alaska Native populations, and websites upon which this information will be posted, will be shown to and discussed with visitors to our table. Display copies of supporting documents will be available for inspection, together with directions for accessing the materials.

Title: For a Stronger Circle on the Front Line

Author(s): Normand D' Aragon, Director

Summary: To describe objectives and activities of the First Nations and Inuit Suicide Prevention Association of Quebec. Focused on giving a voice to the frontline workers to strengthen their actions, through training conferences, advocacy, and networking.

Title: Assembly of Manitoba Chiefs Youth Suicide Prevention Initiative

Author(s): Assembly of Manitoba Chiefs Youth Secretariat

Summary: The Assembly of Manitoba Chiefs Youth Secretariat has demonstrated the capacity to take ownership of a serious health issue critically affecting First Nations. Suicide is a community health problem, and one of the biggest challenges in mental health promotion is the sustainability of initiatives that emerge at a community level. The work conducted by the Youth Secretariat has engaged communities and leadership to confront the issue of youth suicide and to develop community based strategies that reflect the diverse situations, existing resources and varying levels of community readiness. In response to the issue, the Youth Suicide Prevention Initiative is comprised of four related areas as follows: a) Training and Awareness of First Nation Youth/Community b) Research and Consultation c) Resource Development d) Envisioning Committee and Networking.

Title: Community Engagement Toolkit

Author(s): Gayle Broad and Jude Ortiz, Algoma University College; Graphic Designs: Calna McGoldrick

Summary: This poster session illustrates tools and techniques, as well as basic principles for engaging Indigenous communities in decision-making processes. The poster uses the Medicine Wheel model to explore the definition, create the space, and identify activities that have worked well in a diversity of First Nation communities in Canada.

Title: Principles for Participatory Research with American Indian and Alaska Native Communities: Lessons from the Circles of Care Initiative

Author(s): Brenda Freeman, Pamela Jumper Thurman, Ethleen Iron Cloud-Two Dogs, James Allen, Pamela L. LeMaster, Pamela B. Deters, & Douglas K. Novins

Summary: This poster will describe the principles for participatory planning, evaluation, and research with American Indian and Alaska Native communities based on the experiences of the first cycle of Circles of Care grantees.

Title: A Community-Based Participatory Research Project in Rural Alaska

Author(s): Pamela B. Deters, Ph.D., University of Alaska Fairbanks

Summary: To date there has been little research conducted to investigate how Alaska Native children, families, and communities understand and respond to abuse, trauma and deprivation in their villages, and none found among Alaska Athabascan children. The present study is investigating the nature and extent of trauma experienced by Alaska Native children in rural Athabascan communities, and explores what types of culturally appropriate interventions make the most sense for Alaska Native children, family members and communities, as well as for varying forms of trauma. The project was conducted in two Alaska Athabascan villages, using a community-based participatory approach to project design, implementation, and interpretation. Initial trips to each of the villages were conducted to establish relationships with village elders, tribal governance, and community members, seeking their cooperation and participation in this research. In subsequent trips, the researcher conducted audio-taped focus groups and individual semi-structured interviews with elders and community members. Initial analysis of qualitative data from the focus groups and individual interviews has revealed findings of primary traumas, including suicide, sexual abuse, and substance abuse related traumas, and neglect secondary to caregiver substance abuse. Conclusions with respect to treatment intervention appear to indicate a need for a culturally-based intervention that integrates traditional practices with western approaches to mental health issues.

Title: National Library of Medicine, Office of Outreach and Special Populations

Author(s): National Library of Medicine, Office of Outreach and Special Populations

Summary: The National Library of Medicine provides free Internet access to medical/environmental databases for health care providers/educators/consumers concerned with health disparities.

Title: Qaujivallianiq Inuusirijauvalauqtunik: Suicide Follow-back Study

Author(s): Gustavo Turecki and Jack Hicks

Summary: Poster describing the Qaujivallianiq inuusirijauvalauqtunik suicide follow-back study.

Title: New Emerging Team on Aboriginal Mental Health Research

Author(s): Gustavo Turecki and Jack Hicks

Summary: Poster describing a New Emerging Team on aboriginal mental health research funded by the Canadian Institutes of Health Research.

Title: The Transition from the 'Historical' to the 'Modern' Inuit Suicide Profile

Author(s): Jack Hicks

Summary: Poster presenting the transition from the 'historical' to the 'modern' Inuit suicide profile.

Title: Navajo Nation Dept of Behavioral Health Services

Author(s): Alberta Curley and Elvira Curley

Summary: We will be displaying prevention posters and information on the proposed 72 bed treatment center to be built in Shiprock, NM.

Title: Conceptualizing Suicide in Native American communities: Situating Risk and Protective Factors

Author(s): Carmela Alcantara & Joseph P. Gone; University of Michigan--Ann Arbor

Summary: This poster presents a framework for understanding suicidality as well as suicide prevention in the American Indian and Alaska Native population. Drawing upon the most current empirical reports, this poster offers a brief review of the epidemiological

profile of suicide in Indian Country, while situating biopsychosocial risk factors along developmental pathways. The result is a reconceptualization of suicide intervention within a transactional-ecological framework. Given the alarming prevalence of suicidal behaviors among American Indians and Alaska Natives, combined with the impossibility of accurate predictions of suicide, situating suicidality along developmental pathways that lead to heightened risk is important for determining opportunities for intervention.

Title: National Suicide Prevention Lifeline

Author(s): The National Suicide Prevention Lifeline, funded by SAMHSA and administered by Link-2-Health Solutions, a subsidiary of the Mental Health Association of New York City

Summary: This exhibit includes information about the federally funded National Suicide Prevention Lifeline, a network of over 114 crisis centers across the country responding to callers in suicidal and emotional crisis. The Lifeline exhibit includes educational materials regarding the National Suicide Prevention Initiative and it's goals, a listing of participating crisis centers as well as promotional materials to assist individuals and crisis centers in promoting the Lifeline's 24/7 free, confidential hotline number 1-800-273-TALK.



Speaker Biographies



Rosebud Bighorn-Madinger (*Cheyenne/Sioux*) is a student at Rocky Mountain College (RMC) in Billings, MT where she is majoring in biology. As a student at RMC, she tutors fellow American Indian students and is an active member of the American Indian Cultural Association, currently serving as the secretary. Ms. Bighorn-Madinger also works as an oral surgical assistant. She has been a participant and has also assisted in the coordination of Native American Teen Suicide Prevention Conferences in Montana.

Dr. Rita Pitka Blumenstein, TH (*Yup'ik*) is an artist, teacher, speaker, and storyteller. She is also the first certified traditional doctor in Alaska. In her presentations that have been delivered around the world, Dr. Rita has focused on the health and social development of people. She is an able emissary for promoting international goodwill as well as the status of women. She is a learned voice for passing on knowledge of the environment and the ways of the land. Dr. Rita has made outstanding contributions in health, social development, education, environment, human rights, and international goodwill. She teaches by just "being" and is an outstanding role model for other women as well as for all those who encounter her.

Michael Chandler, Ph.D. is a Researcher in the Department of Psychology, University of British Columbia (UBC) in Vancouver, BC. He is a Distinguished CIHR & MSFHR Investigator and is a developmental psychologist engaged in research at UBC. The focus of his ongoing program of research is to illustrate how an understanding of the normative course of young people's social-cognitive development, coupled with an appreciation of the role that culture plays in constructing the course of identity development, strongly shapes a youth's emerging sense of responsibility for their personal past and commitment to their future well being. Most recently, his program of research dealing with identity development and suicide in Aboriginal and non-Aboriginal youth has been singled out for publication in the Society for Research in Child Development's monograph series.

'Iwalani R. Nāhuina Else, Ph.D. is an Assistant Professor with the Department of Psychiatry at the University of Hawaii. She also serves as the Associate Director for the National Center for Indigenous Hawaiian Behavioral Health. She is the Principal Investigator of a pilot grant from the National Cancer Institute to study the use of tobacco in Native Hawaiian adolescents and Co-Principal Investigator of a National Institute of Alcohol Abuse and Alcoholism grant for a community study on patterns of alcohol consumption and alcohol related problems among Filipino, Japanese, Native Hawaiian, and Caucasian adults in Hawaii. Dr. Else, who is of Native Hawaiian ancestry, is a NIH Health Disparities Scholar through the loan repayment program in Health Disparities Research and is a former fellow of the American Sociological Association's Minority Fellowship Program in Mental Health. Her research interests include the health disparities of Native Hawaiians, the link between mental health and

medical conditions, and providing culturally and socially responsive, community-based behavioral health services.

Charlotte Herkshan (*Confederated Tribes of Warm Springs*) is a traditional practitioner and a Mental Health/Cultural Outreach Specialist at the Community Counseling Center in Warm Springs, Oregon.

Margaret Gates (Standing Rock Sioux Tribe) has had 13 years experience working for the Indian Health Service, and is currently the suicide prevention coordinator for the Standing Rock Sioux Tribe.

Harrison Jim (*Dine'*) is a Traditional Healer certified by the Navajo Nation. He is an advocate for the importance of integrating Western methods, alongside the cultural and traditional healing ways of our people of indigenous cultures. Mr. Jim is a co-founder of the "Hiin' ah Bits' os Society," a traditional residential treatment program of Gallup NCI, NM. Currently, Mr. Jim is a member of the 2006 Indian Health Service/Substance Abuse and Mental Health Services Administration and National Behavioral Health Conference Planning Committee.

Ron Kingbird is a Traditional Healer and a counselor at Red Lake CHS in Bemidji, MN.

Laurence Kirmayer, MD, FRCPC, is Professor and Director, Division of Social and Transcultural Psychiatry, Department of Psychiatry, McGill University. He is Editor-in-Chief of *Transcultural Psychiatry*, a quarterly scientific journal published by Sage (UK). He directs the Culture and Mental Health Research Unit at the Department of Psychiatry, Sir Mortimer B. Davis Jewish General Hospital in Montreal, and the CIHR-McGill Strategic Training Program in Culture and Mental Health Services Research. From 1987-1993, he was a psychiatric consultant for the Inuit communities of Nunavik on the east coast of Hudson Bay. He founded and co-directs the National Network for Aboriginal Mental Health Research, and is a member of the Advisory Board of the Institute for Aboriginal Peoples Health. Currently, he is the principal investigator on a cross-national study of resilience among Indigenous peoples in Canada and New Zealand and co-director of a CIHR New Emerging Team on Aboriginal Suicide prevention. His past research includes funded studies on cultural concepts of mental health and illness in Inuit communities, risk and protective factors for suicide among Inuit youth in Nunavik (Northern Québec), and on the development and evaluation of a cultural consultation service in mental health. He has two co-edited books in preparation, *Healing Traditions: The Mental Health of Canadian Aboriginal Peoples* (University of British Columbia Press) and *Understanding Trauma: Integrating Biological, Clinical and Cultural Perspectives* (Cambridge University Press) as well as a book on the anthropology of psychiatry, *Healing and the Invention of Metaphor*.

Kathy Langlois, MPA is Director General of Community Programs in the First Nations and Inuit Health Branch at Health Canada. She is responsible for health promotion and prevention programs, specifically mental health and addictions, children and youth programming, and chronic disease and ongoing prevention. Kathy is dedicated to realizing the shared vision of vibrant First Nations and Inuit communities supporting the

physical, mental, emotional, cultural, and spiritual health of individuals and families.

Hayes Lewis, Ed.M. (*Zuni Pueblo*) is the Director of the Center for Lifelong Education, Institute of American Indian Arts, Santa Fe, NM. He is a member of the Indian Health Service Suicide Prevention Advisory Committee. Mr. Lewis has facilitated, developed, and implemented a culturally-specific suicide prevention program that reversed a 20-year trend in school aged youth suicide.

Jacqueline Mercer, MA is the Executive Director of the Native American Rehabilitation Association (NARA) in Portland, OR. Jacqueline has dedicated her career to developing and administering various mental health and chemical dependency services within multicultural communities.

Carmen Parrilla-Cruz, Ph.D. is the Executive Director of the Suicide Prevention Commission in San Juan, Puerto Rico. She is the founding member of Asociación Suicidiología de Latinoamérica y el Caribe (ASULAC), Fundación Puertorriqueña Investigación y Prevención del Suicidio (FPIPS), and International Association Thanatology and Suicide (IATS). She is also a member of the following organizations: International Association Suicide Prevention (IASP), American Association Suicidology (AAS), American Foundation Suicide Research and Prevention (AFS), Red Mundial de Suicidiólogos (RMS), and Suicidology section, World Psychiatric Association (WPA).

Jane Pearson, Ph.D. chairs the National Institute of Mental Health's (NIMH) Suicide Research Consortium. She is the Acting Deputy Director for the Division of Services and Intervention Research (DSIR) at NIMH and is also the Associate Director for Preventive Interventions in DSIR. Dr. Pearson serves as the National Institutes of Health representative to the DHHS Federal Steering Group on Suicide Prevention and she assisted in the development of the Surgeon General's Call to Action to Prevent Suicide and the National Strategy for Suicide Prevention. Dr. Pearson is an adjunct associate professor at Johns Hopkins University, a Fellow of the American Psychological Association, and recipient of a U.S. Health and Human Services Secretary's Award for her work in suicide prevention. She has had a private practice in clinical psychology and has authored papers on the ethical and methodological challenges of suicide research.

Jon Perez, Ph.D. is the Director of Behavioral Health at Indian Health Services (IHS) Headquarters in Rockville, MD. He began his career with IHS in 1992. His first assignment was as a Public Health Service (PHS) Commissioned Corps Officer assigned, under an Intergovernmental Agreement, to the White Mountain Apache Tribe in central eastern Arizona. He directed the Tribe's Behavioral Health Services from 1992 through 1999, where he was instrumental in developing community mobilization models for suicide prevention that continue to be used throughout Indian Country. He then accepted a position in December of 1999 with the Indian Health Service at Phoenix Indian Medical Center, where he became the Chief of their Behavioral Health Services in early 2000. In October 2002, he was transferred to the IHS Headquarters in Rockville, MD, where he provides leadership for and management of behavioral health services for IHS including budget, policy, and program management. Dr. Perez continues to

provide national leadership, as he has for over 20 years in the areas of American Indian and Alaska Native mental health issues; psychological trauma; trauma response networks; and international health diplomacy efforts. A practitioner by training and professional experience, he has also written numerous articles and papers that have been published in mental health and related publications.

Dr. Jeff Reading, PhD. is the Scientific Director of the Canadian Institutes of Health Research -- Institute of Aboriginal Peoples' Health, which is based at the University of Victoria. Understanding and improving the state of health of aboriginal people in Canada is a lifelong pursuit of Dr. Reading. For more than two decades, Dr. Reading has dedicated his energy to the emerging importance of aboriginal health issues in mainstream Canada. As an epidemiologist, his research has brought attention to such critical issues as disease prevention, smoking, healthy living, accessibility to health care and diabetes among aboriginal people in Canada. The long-term outcome of research activity aims to improve the health of aboriginal people of Canada and abroad.

Janice Rose (Cote) is the owner of J.M. Rose & Associates, a management consulting firm. She has over 20 years management experience and assists organizations with management and governance capacity building, program and organization-wide evaluations, community and strategic planning, and addressing debilitating conflict and morale issues. She has delivered hundreds of workshops covering topics such as governance, management, conflict resolution/negotiation skills, community and strategic planning, community economic development, and human resource management. Her facilitation skills have also been called upon to moderate and/or chair several national and provincial committees that range from engaging Aboriginal people in academic research on suicide prevention in Canada to involving Aboriginal people in economic revitalization in major urban areas.

Osaia M. Santos is the FSM National Youth Coordinator for the Department of Health, Education and Social Affairs (HESA). He has over 25 years of experience in working with youth. Mr. Santos founded Micronesia Bound School, a youth survival outward bound school in 1976. He has also served as Deputy Assistant Secretary for the Department of Foreign Affairs. Additionally, Mr. Santos is the President of the FSM Karate Federation and a member of both the FSM Youth Council Incorporated and the FSM Suicide Prevention Coalition Taskforce.

Madeleine Dion Stout, MIA is a registered nurse and she serves on several Aboriginal and non-Aboriginal boards and committees including the British Columbia Women's Health Research Institute and the Aboriginal Women's Health and Healing Research Group (AWHHRG). She has been President of the Aboriginal Nurses Association of Canada and a member of the National Forum on Health. Madeleine was a Professor in Canadian Studies and founding Director of the Centre for Aboriginal Education, Research and Culture at Carleton University in Ottawa. Now self-employed, she continues to work as a researcher, writer, and lecturer on Aboriginal health and health care, paying particular attention to children and women. Madeleine has worked closely with organizations dedicated to mental wellness and has co-authored papers on suicide prevention and resilience.

Talalupelele Sunia is the Assistant Director of the Social Services Division Department of Human and Social Services in Pago, American Samoa.

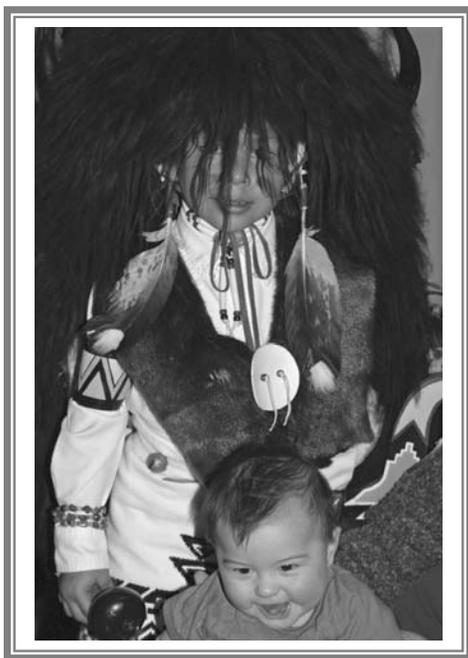
James Toya, MPH (*Laguna Pueblo*) was selected as the Indian Health Service (IHS) Albuquerque Area Director in August 1998. As the Director of the IHS Albuquerque Area, Mr. Toya manages a varied health care and environmental health services program. His geographic area of responsibility covers the states of New Mexico and Colorado, with additional services provided in Texas and Utah. This four-state area provides medical care to more than 85,000 American Indians comprising 20 Pueblos, 3 Navajo Tribes, 2 Apache Tribes, and 2 Ute Tribes. As part of a national Indian health system of federal, tribal, and urban Indian health programs, the Albuquerque Area also contributes to the support of one urban Indian health program in Albuquerque and one in Denver.

Billy Two-Rivers (*Mohawk*), Elder with the Assembly of First Nations in Ottawa, ON. He was involved in Mohawk Community of Kahnawake politics for 20 years. While on Council, Billy played a role in political movements nationally and internationally. Shortly after stepping down from his political position, Billy served as advisor to First Nations Leader Phil Fontaine during Mr. Fontaine's first term as National Chief of the Assembly of First Nations in 1997, and then as Chief Commissioner of the Indian Land Claims Commission in 2000, and now during his second term as National Chief. Billy also serves along side Elder Elmer Courchene as the Elder Advisors to the National Chief of the Assembly of First Nations. Billy is a Historian, and a Cultural and Spiritual Advisor to his Nation.

Dale Walker, MD (*Cherokee Nation*) is professor of Psychiatry and Public Health and Preventive Medicine and Director of the Center for American Indian Health, Education and Research at Oregon Health and Science University in Portland, OR. Currently, he is chair of the Governor's Council on Alcohol and Drug Abuse Programs for the State of Oregon. He and his staff recently received a grant from the Substance Abuse and Mental Health Services Administration for a National Resource Center for American Indian/Alaska Native Substance Abuse Services, named One Sky Center. One Sky Center is the first national resource center dedicated to improving prevention and treatment of substance abuse among Native people. Dr. Walker recently chaired a task force for the state's Department of Health and Human Services that focused on co-occurring addictions and mental illness. He is working on three major research projects, drawing attention to best practices for the treatment of addictions disorders.

Cornelia Wieman, MSc, MD, FRCPC (*Anishnawbe*) is Canada's first female Aboriginal psychiatrist. In July 2004, she joined the University of Toronto as Co-Director of the Indigenous Health Research Development Program (IHRDP) and as Assistant Professor in the Department of Public Health Sciences, Faculty of Medicine. She holds an academic appointment as an Assistant Clinical Professor in the Department of Psychiatry and Behavioral Neurosciences, Faculty of Health Sciences at McMaster University. She is a co-investigator on several research initiatives funded through the Institute of Aboriginal Peoples' Health (IAPH), Canadian Institutes of Health Research

(CIHR) including the National Network for Aboriginal Mental Health Research (NNAMHR) and a New Emerging Team (Suicide NET) investigating aspects of suicide in Aboriginal populations. Dr. Wieman has been the Director of the Native Students Health Sciences Program for the Faculty of Health Sciences at McMaster and served as the Acting Director of Emergency Psychiatry Services for the Hamilton-Wentworth Region. She continues to provide independent consulting services to various F/P/T agencies (government & NGOs) involved in the delivery of health services to Aboriginal communities. Dr. Wieman travels widely, speaking about Aboriginal health and mental health issues in order to advocate for the improved health status of the Indigenous Peoples of this country. She takes a special interest in Aboriginal youth and tries to encourage them to achieve their dreams. She has worked with Creative Wellness Solutions since 2002 as part of their ACT NOW Role Model Program for First Nations.



Planning Committee



Barbara Beckett, Ph.D., Assistant Director, Canadian Institutes of Health Research - Institute of Neurosciences, Mental Health and Addiction

Michele Bourque, Manager, Mental Health Team, Community Programs Directorate, First Nations and Inuit Health Branch, Health Canada

Beth Bowers, M.Div., MSW, Assistant Director for Community Engagement, DSIR, National Institute of Mental Health, National Institutes of Health

Frank Canizales, MSW, Management Analyst, Division of Behavioral Health, Indian Health Service, Headquarters

Tamara Clay, MSW, LISW, Public Health Advisor, Division of Behavioral Health, Indian Health Service, Headquarters

Laura Commanda, MSW, Assistant Director, Canadian Institutes of Health Research - Institute of Aboriginal Peoples' Health

Jane Pearson, Ph.D., Chair, National Institute of Mental Health Suicide Prevention Consortium, National Institute of Mental Health

Jon Perez, Ph.D., Director of Behavioral Health, Indian Health Service, Headquarters

Gary M. Quinn, MSW, Emerging Leader, Division of Behavioral Health, Indian Health Service, Headquarters

Kari Nisbet, Program Officer, Mental Health Team, Community Programs Directorate, First Nations and Inuit Health Branch, Health Canada

Nathalie O'Neil, Senior Policy Advisor, Policy Development Division, Strategic Policy, Planning and Analysis Directorate, First Nations and Inuit Health Branch, Health Canada

Patricia Wiebe, MD, MPH, FRCPC, Medical Specialist in Mental Health, Community Programs Directorate, First Nations and Inuit Health Branch, Health Canada

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Evaluations



In order to evaluate the overall usefulness and effectiveness of the conference organization and design, the following information was gathered at the end of this event. Participants were asked to respond to most questions in narrative form to allow a broad range of responses. This information will be considered by the planning committee in the coordination of future meetings.

How do you define your perspective as a participant?

Elder	7%	Community Researcher.....	3%
Youth	4%	Academic Researcher.....	8%
Community/Family Member...	5%	Government Staff.....	14%
Practitioner/ Clinician.....	5%	Other.....	8%
Community Agency Staff.....	9%	Multiple Perspectives.....	37%

Summary of Most Frequent Responses

Day 1 Morning Panels #1 and #2: Knowledge, Evidence, and Defining the Issues

What new knowledge, evidence, and definition of the issues did you gain about how suicide is understood?

- A broader understanding of Indigenous cultures/cultural health determinants.
- The need to redefine the issues from cultural and strength-based perspectives.
- Importance of using community based language that promotes life and culture.
- Better understanding of community-driven approaches and the need to provide links between the approaches of researchers, community leaders and providers.
- Increased understanding of current data, research methods, and outcomes.

What other knowledge, evidence, and definition of the issues were not covered that need to be considered to set an effective research agenda?

- More in-depth discussion of the root causes of suicide, including the spiritual, social and political factors/trauma that impact health and health determinants.
- Understanding the risk and protective factors for youth across communities.
- Youth, survivors and family members need to be invited to tell their stories.
- Ways to mobilize community leadership and use media to raise awareness.
- Funding issues related to sustainability and disparities in grant writing skills.

Day 1 Mixed Break-out Groups:

Was the process used to run your break-out group useful/effective?

Yes.....77% No.....14% N/A.....9%

Was the content of the morning panels addressed in a way that will allow you to use the results in your work in community, practice, or research?

Yes.....78% No.....13% N/A.....9%

**Day 2 Morning Panels #3 and #4:
Current Approaches, Interventions, and Responses**

What new approaches and /or interventions to suicide prevention were presented that may be useful in your community, your practice, or a component of future research?

- Presentations were very good, useful for work in respective disciplines.
- The concept of best practices was understood to be a combination of evidence-based practices and cultural-based knowledge and practices.
- It was valuable to hear grassroots programs from a broad scope of regions and communities, along with the technical/professional resources shared.
- Leadership development is needed to support Elders working with youth, and important for integrating traditional healers at the program level.
- Requests were made for handouts/electronic versions of presentations.

What other approaches and/or interventions to suicide prevention were not covered that need to be considered to set an effective research agenda?

- Youth and Elders need to be more centrally involved, with the inclusion of more presentations and panel discussions by youth presenters.
- The focus of this event is too much on research; traditional healing and faith-based approaches also need to be presented and discussed in more depth.
- Discussions were still very general; need to have much more detailed presentations on the root causes and steps for program development.
- More information on how to mobilize communities to begin prevention.
- Community-based research to investigate social issues and contexts.

Day 2 Mixed Break-out Groups:

Was the process used to run your break out-group useful/effective?

Yes.....82% No.....10% N/A.....8%

Was the content of the morning panels addressed in a way that will allow you to use the results in your work in community, practice or research?

Yes.....71% No.....5% N/A.....24%

Day 3 Networking Groups and Overall Meeting:

What kinds of opportunities for research collaboration did you identify during the meeting?

- Program participants learned a lot from meeting with researchers.
- Networking was valuable, with information being taken back home.
- More time was needed to form serious research collaborations.
- Sharing of traditional knowledge was valuable, but needed more time.
- Opportunities were identified to follow up with sponsors and participants.

What other information would you like to have heard/learned from meeting the other participants?

- Youth need to be more represented in prevention, participants wanted to hear directly from youth about their needs, languages and sub-cultures.
- More collaboration with government officials and communities is needed to be responsive and responsible to the culture and needs of youth.
- More information needs to be provided on how to gain financial support to start programs, and how to build collaboration for sustainable funding.
- More sharing about the development of programs and lessons learned in the process of developing promising practices would also be helpful.
- A network needs to be maintained for Indigenous researchers.

Were the networking groups' reports informative and useful to your work?

Yes.....77% No.....10% N/A.....13%



KAUFFMAN & ASSOCIATES, INC.

Report prepared by
Kauffman & Associates, Inc.