COMMISSION ROYALE SUR LES PEUPLES AUTOCHTONES

ROYAL COMMISSION ON ABORIGINAL PEOPLES

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"for the record..."
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June 7, 1993 **Royal Commission on Aboriginal Peoples**

Ottawa, Ontario

--- Upon commencing at 9:15 a.m. on Monday, June 7, 1993.

MAGGIE HODGSON, CHAIRPERSON: My name is Maggie Hodgson and I will be your chair over the next day and a half.

I would like to introduce Ann Jock who is our elder and who will be saying the opening prayer.

Mrs. Jock, please.

Opening Prayer

MAGGIE HODGSON, CHAIRPERSON: I would like to thank you, Mrs. Jock, for reminding us that what suicide prevention is really about is the drawing on our natural gifts that the Creator gave us.

I would like to ask Mr. René Dusseault to make an opening welcome and also to introduce his fellow Commissioners that are sharing this time with us.

Mr. Dusseault, please.

CO-CHAIRMAN RENE DUSSEAULT: Thank you. Merci.

First, I would like to welcome each and every one of you to this special consultation. As you are aware the Commission has heard a lot of pain and problems in its hearings in the Aboriginal communities

during the past year. We have heard a lot as we have travelled across Canada about suicide from many presenters. It is a concern that has been brought up over and over again.

The Commission sees suicide as an extremely serious problem. We know it is a difficult one to tackle. We had a round table on health and social issues in Vancouver in mid-March where the issue of suicide was addressed, but only very briefly in one short session.

We decided jointly with the Assembly of First Nations, together with Inuit Tapirisat of Canada, the Métis National Council and the Native Council of Canada that we would have special consultations on the issue of suicide in order to try to focus on both the long-term solutions and also the short-term solutions and ways to try to be helpful as soon as possible. We know that there is an urgency. It is a burning issue.

As we speak and talk we are going to discuss and focus on this issue during the next day and a half. Communities across the country will have to live with difficult situations and this is an ongoing situation, so we hope to be able to come up with recommendations in an interim fashion as soon as possible after this second

part of our special consultation.

Sometime during the summer -- in order to help people in the communities, we will have recommendations that will probably address both governments and Aboriginal leaders. In fact, what we tried to do was put together the experience of people who have worked in this area and who have given thought to it.

There is hope and people are beginning to talk about the reasons for suicide and this is certainly the starting point. The problem of suicide, as you know, is complex and it would be wrong to oversimplify it. It's quite clear that unemployment among the youth is a crucial issue and that a solution is to improve self-esteem, both individually and collectively as part of the solution.

The Royal Commission's mandate is to examine the fundamental issues like self-government and economic development and longer term issues that should help to ease the situation as far as suicide is concerned. We undertook 110 case studies in the communities, many of them dealing with social and cultural aspects. We should be able to get some additional information from those studies as far as suicide is concerned.

While we hope our final report, that we hope to produce sometime in the fall of 1994, will help to bring some additional hope through long-term solutions to the situation in the communities, we are pretty much aware -- as I said at the outset -- that something has to be done now.

We need an open and frank discussion. We need to hear during this day and a half what has been tried, what has worked and what won't work. The special consultation that we had at the end April with the Assembly of First Nations has produced many recommendations, and a major awareness of the lack of a mental health policy. We understand from those recommendations that there are actions to be taken by governments and also by the communities.

One of the things that we were told is that unless the leadership recognizes the problems before the crisis happens, in a preventive fashion, the underlying factors that cause or are elements in suicide situations, it is difficult to act on. What we were told is that the solutions have to come from the communities. Governments should act as a back-up. External professional people or government people cannot come with solutions. The

solutions have to be community designed, and support must be given to those community-designed approaches by government.

These consultations illustrated the need for active participation by parents, educators and also the necessity for youth to talk to other youth, other young people. So, the community participation is essential. Mental health education must be provided. The health services within the communities and the social services have to come up with plans and these plans have to be supported.

The extended family and the community must develop and implement programs. In a blunt fashion it was said that life must be made more attractive than death. It's easier to say, the way to do it is more difficult. We know that suicide is not an Aboriginal problem, it's a problem that crosses all segments of society, but we know that the rate is higher among Aboriginal people in Canada. The Commission is committed to help to the measure that input will be made by everybody concerned.

Again, I would like to welcome everybody. We hope that a very frank and open discussion

will take place and that this special consultation dealing with the situation of Inuit people, the situation of the Métis Nation people, but also the Métis in Labrador, the Métis in Eastern Canada, the Maritimes and Quebec will be dealt with, and the situation of people living off-reserve in the cities will be examined.

The problem is there and the solutions are, of course, what everybody is looking at on a preventive path, as much as possible, but there is also elements to be dealt with as far how when there is a crisis and some kind of epidemic situation that develops and how these situations should be handled.

So again, on behalf of all the Commission, I would like to thank you for coming and sharing.

I would like to acknowledge the presence of some Commissioners here this morning. Mary Sillett, who is well known in this room. Mary is an Inuk from Labrador and very concerned with this situation. As you know she was the Vice-President of Inuit Tapirisat, President of Pauktuuit Women's Association for Inuit.

Also here is Bertha Wilson. Madam Wilson is the first woman appointed to the Supreme Court

of Canada. She made a tremendous contribution to human rights in this country. She is deeply committed to finding solutions, as are all the other Commissioners.

Paul Chartrand will join us later during the day.

The other Commissioners won't be able to attend as there were hearings and meetings that have been planned in the western part of Canada and near the border of the U.S. So, Georges Erasmus, in particular, has asked me to convey his best wishes for the success of this day. As you know, Georges and Viola Robinson are very much committed to finding solutions and, in particular, to this difficult issue that we're all involved in.

Without further adieu, I would like to turn the microphone over to our facilitator.

Thank you very much again for the contribution you are going to make during the next day and a half. Merci.

MAGGIE HODGSON, CHAIRPERSON: Thank you very much, Mr. Dusseault.

I would also like to thank you for being caught off-guard, but I wasn't sure whether all of our

other presenters were at the head table and I had to buy a few minutes to check out to see who was here at the head table. So, I thank you for that.

The welcoming address for the ITC will be made by Roda Grey.

RODA GREY, INUIT TAPIRISAT OF CANADA:

(NATIVE LANGUAGE)

I'm going to speak in two languages.

I'm Inuk from the North, but I work in Ottawa. I work for Pauktuuit Inuit -- as the health coordinator, but I am presented by ITC. I wanted to make sure you understand that. ITC is like a father organization and we work closely.

First of all, I would like to thank the Royal Commission who have given us this opportunity to have Inuit people come down south for this exciting event.

When there is an exciting event I worry about my grandfather. My grandfather is not in this room, but I am aware that if you say that you find this an exciting event that the purpose of this is not for the exciting event because suicide and youth is not exciting.

To me the exciting part is that the

people like yourselves on the Royal Commission, ITC and the other organizations in the world are starting to recognize that they have to do something about that. That kind of action is very exciting for me because we are looking for solutions. There is no single solution to stop suicides -- I'm telling you we have a long way to go and we are doing something about it. That is really the exciting part.

(NATIVE LANGUAGE)

The last message I would like to make is that I was a little bit troubled when I was told that we could invite eight Inuit people. We have 53 Inuit communities in the north. I want everybody to know that. I always tell that to other people, that we have 53 Inuit communities.

I would like to have had those Inuit people represented from 53 communities, but I also have to realize that the reality is that it's not possible to have 53 Inuit coming to this workshop to learn what to do about suicide. So, I am really grateful that I have more than 8 Inuit in this room. And, speaking for the Inuit people -- I'm sure that our First Nations felt that way too because you have many many communities and

especially small communities.

(NATIVE LANGUAGE).

MAGGIE HODGSON, CHAIRPERSON: Thank you very much, Roda.

Because we started a little late I would like to ask each presenter, if they could, to keep it as close to approximately two minutes, as possible. Now, that we have had the women speak Mr. Nelson Mayer will be speaking for the Native Council of Canada.

NELSON MAYER, NATIVE COUNCIL OF CANADA: Thank you, Maggie.

It's always difficult to put a microphone in front of a politician and say, "You only have two minutes to speak." I will try.

Our National President of the Native Council of Canada, Ron George, is presently leading a caravan that has left Vancouver on July 4th and is travelling to Ottawa, so he is unable to be here this morning to provide a welcoming address.

I have spoken to the National Vice-President, Mr. Phil Fraser, who was slated to be here this morning and make the opening address and welcome to all of the workshop participants. Unfortunately, he too

is on the highway, but he is stuck in a traffic jam with some truck that has rolled over.

I spoke to him on his cellular and he has asked me to convey the wishes of the Native Council of Canada for a successful workshop to the participants and a special welcome to all of the delegates and other people from the Native Council of Canada's list, as well as the other lists. It is you from the community level who have been selected, based upon your expertise, to come up with your thoughts and ideas through the proceedings here on what the solutions are for our people, whether it is within an Inuit community, a Métis community on reserve level, or for us who reside in the urban area.

A significant amount of work, we recognize, has already been done and still needs to be done in addressing the solutions to the high rate of suicides amongst our Aboriginal population, and most particularly the youth.

So, on behalf of our national leadership and the Native Council of Canada, we thank the Royal Commission for the opportunity to express the urban viewpoint regarding suicides, prevention, intervention, crisis intervention as well post-trauma aftercare.

I would like to thank Maggie Hodgson and I would like to thank the elder, Ann Jock, for providing our opening prayer. Thank you very much. We look forward to a very good workshop and you will hear our presentations on our participation.

Thank you.

MAGGIE HODGSON, CHAIRPERSON:

For those people who are little cold, there's some good news and some bad news. The bad news is that it's still cold in here, but the good news is that if you go to the bathroom the bathrooms are all really heated. So, if you start suffering from hypothermia just go to the bathroom and warm up.

The next speaker is Joey Hamelin from the MNCW.

Joey, please.

JOEY HAMELIN, METIS NATIONAL COUNCIL:

Good morning, conference delegates, and thank you Elder Jock for your heart-warming prayer.

On behalf of the Métis National Council I would like to thank the Royal Commission on Aboriginal Peoples for including and inviting the Métis Nation as equal partners throughout this entire process.

Suicide is a serious problem for the Aboriginal peoples of Canada. I think today I agree that we have to look beyond the symptoms of suicide, we must look at the causes. When we look at the causes through that process we must develop our short-term and long-term strategies and come up with some firm recommendations that we can take back to our communities. We must look at some unique models that we can experiment with or that we can present to our communities and hopefully reduce the number of people that complete suicide.

I would just like to briefly mention Richard Cardinal, many of you may be familiar with his suicide. He was a young Métis boy from Fort Chipoyain (PH) in northern Alberta. On June 24, 1984 he completed suicide. He lived in 22 foster homes, was assigned 26 social workers. Richard was reaching out and we never -- the community, the child welfare authorities and the various systems didn't listen or didn't hear Richard in his attempt to reach out for someone to care about him, love him and give him some hope.

It has been nine years since this tragic incident, but out of this tragic incident was the Thomason (PH) Report which came up with a number of recommendations.

There is another case in Manitoba, Lester Desjeurlais, that also -- from these particular cases that received this national and provincial recognition -- we must now look at what has happened since that time.

We must now, through our respective organizations, take action. It is our responsibility from the community level, and also as technicians, and also our political leadership must now take the issue of suicide prevention seriously. It is as equally important as the Constitution. Without taking care of our children and our youth then it makes it harder to be united and strong as a Nation.

I thank you on behalf of the Métis National Council. It is a pleasure for me to participate throughout this process. I don't know how long that took, but thank you.

MAGGIE HODGSON, CHAIRPERSON: Thank you very much, Joey.

For the Native Women's Association of Canada, Jane Gottfriedson.

Jane, please.

JANE GOTTFRIEDSON, NATIVE WOMEN'S

ASSOCIATION OF CANADA: Good morning, everyone. Ladies, gentlemen, elders and especially Ann Jock who opened the day with a special prayer.

Thank you.

I think it's really important that -- I guess, on behalf of the Women's Association and the women across the country, this is a very important issue. It's something that we are trying to grapple and work with. It's important that a dialogue begin, we need to talk about this issue.

It not only affects the family directly of someone who commits suicide, but the whole community is impacted. It's really devastating and it takes, it seems forever, to come to grips with a situation like that.

We are always looking for solutions, innovative ideas, different ways of helping and trying to watch for the signs. That needs to be brought to the communities because sometimes these young people -- and in my community we have had elders commit suicide and the signs have always been there, but if you don't know what to look for you lose these people.

I wish all of you success in the workshops and I'm looking forward to seeing the

recommendations, ideas and thoughts that come forward. We are, at the present time, working on a major suicide project so a lot of this workshop is timely and it will help us in our communities when we go to our perspective homes.

Thank you.

MAGGIE HODGSON, CHAIRPERSON: Thank you very much, Jane.

I was asked to do a keynote, however I'm going to try to just make a few short remarks because we want to allocate a little bit more time after coffee break for discussion and for an opportunity for each one of the groups to present a particular project that seems to be working in their community.

My first involvement in the area of suicide prevention on a national basis was in 1984. Health and Welfare Canada sponsored a national training set on suicide prevention. I was one of the trainers for that training set. There were 40 people from across Canada brought together.

At that time there were certain assumptions made about suicide prevention. Since that time there are a number of things that I've been able to

look back and look at differently.

The three elements in the area of suicide prevention that it is important that we look at is the process of incorporating respect, relevance and reciprocity. Respect, that Mr. Dusseault talked about, and each one of the speakers talked about with regard to respect for regional differences, cultural differences and size of community. The relevance of the strategies that are adopted by each community suited to their particular needs and finally, the process of reciprocity.

I think that the opportunity and what's already happening is where there is already a process of giving and receiving, so that we both benefit and so that we both learn in the process.

I come from the field of training, as some of you know, so I'm going to talk about what I know best as it relates to training in the area of human services.

One of the difficulties that has existed for the NADAP Program, for the friendship centres across Canada, for the CHR Program and the different health services across Canada has been a challenge of how to access adequate resources to deliver training in the human

services field, and in this case, suicide prevention.

Suicide prevention, as you know, and you are going to be talking about, is part of family violence, it's part of parenting, and it's part of the health intervention field generally. When people are being trained what seems to happen is that they identify a program, whatever that program is, with some face of suicide prevention. Then they go about trying to identify resources to deliver the training. Each group experiences difficulty in doing that.

However, I think that there is an opportunity, an opportunity that we could look at. The opportunity is looking at resources outside of the health field itself, resources within Canada Employment and Immigration through CEIC.

If there was a national labour market analysis done in the health field for the Métis people, Native women, Inuit people and the Assembly of First Nations and the different groups, and out of that national labour market analysis, if that was conducted by Canada Employment and Immigration, then it would provide us data and it would provide the federal government data in which they, in turn, could re-prioritize some of the existing

resources within Canada Employment and Immigration.

For example, right now because of the economics of the situation we don't need a lot of cat skinners, you know. There are a number of people who are involved in the trades now and there is funding allocated for the trades. If they could look at re-prioritizing and moving some of the monies out of the areas that have been cut back because of the economics of Canada, and then in turn each respective organization and the community organizations could apply for those funds to deliver training in the human services and the health field, specifically in this case, suicide prevention regionally -- of course, that would require some coordination and some cooperation between those two departments.

However, one of the things that we do know -- there is data that we do know and that is that people in the human services field are retained, but they may not be retained in the specific field that they were hired into. An example, community health representatives stay in their jobs say an average of five years. The NADAP workers stay in their job an average of two and a half years. Where do those workers go? They move into more senior management positions and leadership positions.

All of the old CHR's are leaders right across Canada. So, we are retaining them in the labour market. It is not a one-shot deal. We must train our workers in the area of suicide prevention right now. It must be a minimum of a 10 year investment of a cooperative effort between CEC and Health and Welfare Canada.

Then, I believe, we could look at the expansion and the development of the process of reciprocity, where our communities could receive back the benefits. I will just give you an example of one small region in Canada. There are 196 health workers in this one small region. Twenty of those workers are trained. There was a report that was commissioned by the federal government that said that they needed another 150 workers in that area. Do they need another 150 workers, or do they need the 176 that they have that are untrained provided training?

Is training the only solution? No, but I believe that training in the health field has generally been a community development strategy and that has manifested itself and been proven. For example, in our organization 47 per cent of our graduates have moved into management and leadership positions within five years.

Then those people start setting social policy.

The challenge I think that we have, and I know that we have as an agency, is how can we influence government policy so that they in turn can be more creative to address the recommendations that are going to be put forward by the Royal Commission and by our communities in this time of restraint?

Thank you very much.

The next speaker that I would like to invite to speak is Rheena Diabo. Rheena was one of our suicide prevention trainees in 1984. In 1984 she was a bit of a trouble maker on that training set. She is from Kahnawake, you know, and trouble maker not in a negative sense, but in an energetic sense, in a stimulating sense and in a challenging sense. She has taken all of those attributes and continued to develop and has been involved in the post-trauma work that was done with Kahnawake after the Oka crisis.

RHEENA DIABO, SHAKOTIIA'TAKEHANES COMMUNITY SERVICES: First of all I would like to thank the organizers for inviting me, the Commission, and our elder, Nistah (PH) Yamagohah (PH). In our traditions we don't have words for aunt or grandmother. The word in

our language is mother and all our female relations have that title. So, I feel really supported this morning having one of them here with me.

When I was contacted to come and speak to the assembly I sort of negotiated because what they wanted me to come in and talk about was post-trauma work. I said I would do it, but I have to tie in worker wellness because I think the two are very connected. So that was agreed to and I'm hoping to pull those two things together for everybody this morning.

As Maggie indicated, my work in the area of suicide started in 1984 with that conference. At that time how we were invited to participate in the conference is that we were contacted by regional offices and they said there was a national workshop going on in Toronto and could we please attend.

Of course I had just had a couple of weeks training in the area and had done maybe two interventions at that point, so I was really interested in getting that type of support that I felt could happen at a national workshop. So, we attended. Much to my dismay, the very first morning of the workshop they introduced us to the participants as the specialists in the field.

So, for the first three days of the workshop we functioned under a lot of pressure and by Wednesday morning I was feeling quite oppressed, having to live up to this title of being a specialist in the field of suicide. I decided to disclose at that point and I said, "I feel really uncomfortable about being here, being titled a specialist. I have basically six weeks training and I've actually only done two interventions. I don't know if that qualifies me as a specialist." It had a ripple effect because what happened was the 40 other participants sort of shared the same thing.

I don't know if there are specialists in the field. I think sometimes our titles get in our way, like I'm a Therapeutic Intervention Facilitator. Now, if I told my grandmother that she would say, "That's nice, but how are your kids?" They put you back into perspective.

I think sometimes, working in the field, that titles tend to also oppress us. We have to be careful of that. So, when we're looking at worker wellness what we actually have to do is look at our responsibilities.

I was told by an elder that we don't have

rights, we have responsibilities. The Creator gives them to us, we are born with them and then we have our lifetimes to carry them out.

As workers in the field working with other human beings, I guess our responsibility is to connect with these people and at some point in time try to help them facilitate their healing.

The hard part about that is that responsibility carries with it a high degree of power, actually. I mean if I asked you to all stand up and close your eyes for five minutes because you thought it was part of what I had to do you would actually do it. So, I have a lot of power in working with people. A lot of times our workers I don't think honour that in a good way and as a result their own wellness becomes impacted.

I'm coming to believe more and more that in the field of intervention, whether it be suicide or family violence, what workers need to do is start looking at their own wellness and how you function, where you're coming from and as you work with other people how that work touches on you and what it creates within you and have some form of support in order to work things through.

I usually recommend for people who

cannot have their own clinical supervisors, because that is not a reality in Indian communities, is that you do peer supervision with each other. There is training available for people to learn how to do that. The thing to do is hook yourself up with a good mentor or elder who can put you in touch with the reality of being a human being, which is what a worker needs to do when things are getting out of hand.

My experience started in the CHR Program and from there I graduated into alcohol and drug abuse and from there I graduated in social services. So, I guess you would call me an upwardly mobile Mohawk.

In 1990, when the crisis hit our community, that was my first real experience with trauma in itself. I had been working with people who had various degrees of unwellness in the community, but until that point I had never tended to look at things from a traumatic point of view.

One of the events that did it for me is I was responsible for the coordination of the evacuation. We evacuated approximately 2,500 people from our community. So, our services had to split, half staying in the community and half staying out.

The incident that stays in my mind was the incident of the rock throwing -- the stoning of the caravan. What was really interesting is that when we were functioning at the hotel preparing workers daily to meet with these people who were evacuating, we were doing a lot of debriefing with people coming off the boats and through the cars and then from there relocating them and hooking them up with resources elsewhere. Therefore, it became very traumatizing to us in the course of preparing that day because we knew the caravan was coming over.

All of a sudden -- because we were using the television to monitor a lot of the situations that were happening in the community, we saw this event actually taking place and knew that within minutes those people would be at our door step and we would have to respond to their needs.

In order for us to do that -- and I need to remind people here that we had grandmothers, grandfathers, uncles, aunts, brothers and sisters, sons and daughters in that caravan -- the workers who were preparing to receive those people. In order to meet their needs what we had to do was suppress those things we witnessed and the feelings we were feeling in order to

be there for them, not realizing at the time what we were doing.

What happened is in October we started debriefing sessions for our staff and we were fortunate to pull in some very good support people who started working with the staff on debriefing sessions. In the course of those debriefing sessions we started to come to realize how much the workers had been traumatized by these events, in that they experienced the trauma by witnessing it and then having to not deal with the energy created by the feelings that were made, pushing them down in order to respond to somebody else's needs.

I started making the connection because I realized as we were going through this that quite often I had to do this on a regular basis when I had to do a suicide intervention. It pulled feelings within me because the other reality in working in our communities is we work with relatives, friends, relatives of friends.

So there is a lot of pressure put on you to respond and to intervene in a good way because you know damn well if you are not successful what the consequences are going to be. They're going to be towards people that

you know and care about and that is really hard. That's another reality of Indian country.

At that time I actually had a flashback because I remembered doing an intervention. I had worked in a local youth centre so I had a good connection with a lot of young people who had grown up, were getting married, and gone on to their own relationships.

So, as an on-call worker I was called in one weekend by our police and I had to do an intervention with a young woman who had two children. She was six months pregnant. It was February. It was below zero weather. Her husband had come home -- I don't know if you're familiar with the iron work trade, but we have a tool called a spud wrench. It's quite a large piece of iron. Anyway, her husband had gone home under the influence and battered her with this spud wrench and then threw her out of the house and locked the door at 4 o'clock in the morning. The two children had witnessed that.

So I was called to intervene and had to work with this woman for the next couple of weeks to try and do some support work with the children who had been traumatized by this event. What became really interesting to me in our debriefing sessions in 1990 is I recognized

that I had been traumatized by having to do that intervention because I knew the woman, I knew the things that she had experienced because I felt for her, but I had to suppress my feelings and how I felt about the perpetrator in order to be able to effectively deal with the community.

One of the things -- 1990 was a horrendous year for us in some respects, but out of it a lot of healing is going to come out for my community because we came to terms with our humanity, we came to terms with ourselves as workers and we are confronting things and issues we had to address. So, as a result we have been forced to look at our own wellness.

I think one of the important things is that if you don't deal with this energy, these feelings that are created and you keep suppressing it, you suppress a high degree of work energy that makes you even less functional. Maybe you can do more advocacy, more public speaking, more self-development and because you're not doing that you are not honouring the gifts the Creator has given you, of which wellness is one of them, as well as the other skills that he has chosen to provide us with.

The other thing, too, is you provide role

modelling for your community because if you're not prepared to lead the way and do what you are expecting your people to do then I don't think we've honoured them very well as interventionists.

So, when I talk about worker wellness I talk about us being role models for the community in our own healing and taking those first steps to first deal with our issues in a good way, seeking therapy when it's necessary, recognizing that when we deal with traumatic events that there is a debriefing process that needs to happen and looking to provide supervision for ourselves so that in times of crisis that we are supported as well.

I guess with that I will turn the floor back over to Maggie and thank you for your attention.

MAGGIE HODGSON, CHAIRPERSON: I would like to open the floor for questions of Rheena with regard to the post-trauma work that was done with Khanawake or any comments, please.

If you could go up to the microphone and identify yourself and then put forward your question.

We will have a few minutes to do that and then we'll go to coffee. Hopefully, we will be back on schedule.

Marlene, please.

MARLENE CASTALANO: Marlene Castalano from the Royal Commission.

Rheena, as you were talking I was realizing very powerfully how the professionalism of Aboriginal people working with our own relatives and friends in our communities, it's often cited, talk about training as a problem that we're on call 24 hours a day and related to everybody. You have put it in a different sense about becoming aware of what's going on and turning that into a strength.

I'm wondering, is there in the training opportunities that you are aware of -- is this being built into the professional use of self, the creative use of self and relationships in that unique Aboriginal environment? Is that being built into training?

RHEENA DIABO: First of all, I'm not familiar with all the training that's going on, I can just share from my experience of the programs that I've been involved in.

Not, I would say, in the last 10 years across the country have I seen much of it happening, but I am aware that Maggie does some within the Nichi (PH)

components. When I go out and do training in communities I do address some of that, whether it's on suicide, family violence or whatever. I think the reality is that we haven't been confronted with that before.

I was sharing with Maggie that it's been my experience, and it's really an amazing thing that I see happening, is that a lot of us who play what you'd call key roles in Indian country and the healing areas have been confronted on a personal level with some very heavy duty major issues in the last year and a half.

So, we've been actually forced to walk our talk and to explore how we've been approaching things because, you know, you're quite content when you're doing it for somebody else, but when you all of a sudden have to do it, it puts a different light on things. I think that that is what's happening in most Indian communities is people who are working in the area of healing have started to walk their own talk and by doing that have had to look at establishing boundaries for responsibility.

As I said earlier, the Creator gave us responsibilities. My responsibility is to intervene to a certain point, but you also have the responsibility as a client to meet me half way. So, I think more and more

one of the things that will happen is we are going to connect more and more with our spiritual components because responsibility is highly tied into the spiritual aspect of healing.

RODA GREY: I have a question for you. Sorry I'm short, do you see my face? I'm a real Inuk.

I have a question: Do you ever come across that training to teach you Native -- like for the Inuit, we will always have trouble with the lack of confidence in ourselves. I think we were taught that if white people can do it then we can do it. When it comes to social workers, nurses and doctors -- there is no doctor in the north, no nurses, there are some social workers now, but we don't have people -- I have never ever come across an Inuk telling me, "I am confident, I can do it."

There are Inuit people in the north who are trying to teach about AIDS or sexual abuse, but they also ask me, "Did I speak okay? Was the message okay?" They do not have that kind of confidence. I always wanted there to be some kind of training for us to learn how to be confident, just like white people, because a lot of white women have so much confidence. They have university degrees. They have much training and they have

confidence. They have beautiful homes and they are beautiful. They don't have any trouble with themselves like we do coming from the -- families. We are trying to do some work and we have our doubts.

When I'm going to make a speech, I'm always thinking, "I wonder how I could do it and have that kind of confidence." I think it's really neat. That's my opinion.

Thank you.

RHEENA DIABO: I no longer approach things like that from a competency perspective because competency is what gets in the way of your confidence because you're always wondering if you're competent enough to do something and that influences your confidence.

Again, I have to thank an elder who put it into perspective for me. Whenever I come to do presentations like this or training or I'm asked to speak, I focus on the ethic or the place of responsibility. I think that word is not used enough and it has such a wealth of meaning and it can be such a support. So, when I do something I don't look at how well I'm going to do it, I look at it more like I will try to do it to the best of my ability, but that it is the responsible thing to

do.

Our elder identified this morning that we were meant to be here. So there is a reason why I was asked. He knows what the reason is so I have to respect and honour that and in doing so I just act from a responsible area. I find if I do it that way, if I put myself in the head space of "this is the responsible thing to do", then the issue of competency or confidence doesn't get in the way of getting my point across and really connecting with people.

MAGGIE HODGSON, CHAIRPERSON: Rheena looks at that from a philosophical standpoint.

One of the practical things that I think needs to happen in our communities is that we need to invite our own people to speak to us. We need to have our people be involved as co-facilitators in workshops.

One teacher I had said, "If you want to learn how to write, write. If you want to learn how to talk, talk." If you look at yourself and the more you talk the more confidence you develop in the process.

Often our communities look to the white outside experts or Indian outside experts. When we have people who have resources and who can have something to

share with us from the community level, we have to help support them and hold them up and encourage them in small ways and help them to build.

I think what Marlene was saying that are greatest strength is our greatest potential weakness -- we have to know what our strengths are -- and that's from people in our community -- and consistently do that.

What amazes me is that we're willing to pay white consultants $1000 a day and they can make any kind of mistakes during workshop that they want just because we pay them $1000 a day. If we invite our community people to do a workshop and they make mistakes then we shouldn't have invited her because she doesn't know that much anyway.

RHEENA DIABO: Maggie has just asked me to address a bit about post-trauma resources and maybe share a bit with the people on how we responded after the 1990 crisis. Of course, no community plans for such an event when they're developing you as a CHR, NADAP or social worker and you're not trained to respond to that type of activity.

So, in September of 1990 after the barricades came down, one of the things we had to look

at was how are we going to respond to the community because we knew damn well they were in crisis.

One of the things I would like to add here is that I have a really strong belief that had things not happened the way they had in our community, where are young people were allowed to project their anger outwards, we would have had an epidemic of suicides among our young men because they were sitting on a lot of anger and they needed to respond in some way and so they chose the barricades.

Now, the sad part about this is our spiritual and elder people did not support the violent use and methods because according to our traditions we are operating under what is called a Great Law of Peace.

After the barricades came down the thing we had to contend with was that they had gotten their anger out, but in doing so had gone against some of our basic traditions. So, they had to sort of disconnect and we had to respond to that, as well as to the workers. We didn't know how we were going to do it or what we were going to do, we just knew that the community was in crisis.

Fortunately, a person from Ottawa called us and identified that Medical Services has what they call

Emergency Services Funding and it is open to the whole of the country, and it's specific to communities whether you're Indian or non-Indian. The purpose of these monies is to help communities respond to events that happen outside the normal range of what you'd call normal events.

The monies are usually tied into more natural disasters like floods, tornados, hurricanes and such, but they have also been used more recently for environmental accidents where you have toxic spills, like in Quebec where they had Ste. Basil Le Grande where you had a tire refuse yard burn up and the community had to be evacuated.

So, what happened is one of our psychologists who actually lives in the area was aware of services they received and we did a little bit of research and found out where we could go for the monies. We put together a proposal for a two-year period and submitted it and we were able to get -- I'm not quite sure, I think it's approximately $500,000 for a two-year period to bring in additional resources to respond to the aftermath.

What we did was once we had the monies verified then we had a couple of strategy sessions on where

we were going to utilize our own resources. We had to look at getting the workers taken care of and see if we had to hire additional workers while we were giving some workers time off, because also within the two-year period following 1990 we had several of our staff take extended leaves of absence for their own wellness because of what they had to respond to during the crisis.

As well as that, we brought in these high priced consultants that Maggie was talking about and ---

MAGGIE HODGSON, CHAIRPERSON: Don't look at me when you say that.

RHEENA DIABO: She offered to come for free.

I have to say at this point that there are some that are good, but you have to do your homework. You have to negotiate and you have to know what you're looking for when you bring these people in. You have to also let them know that you're calling the shots, that these are your people so you are going to structure what you want the intervention to look like. Basically, there has to be a high degree of responsibility with whoever organizes this.

So, there are funds available through

Health and Welfare, but there has to be a lot of pre-planning before your proposal goes in and a lot of planning afterwards because, of course, the proposal you send in never gets fully funded so you have to make some adjustments and adaptations to it.

I guess that's about it.

Are there any other areas?

MAGGIE HODGSON, CHAIRPERSON: I'm going to close the floor to questions and have one presentation that is going to cut a bit into the coffee break time, but we're only about 10 minutes behind at this point, Myrtle, is that okay with you?

I only look like I'm the boss. The real boss is at the back of the room.

We had asked the different groups to have a representative speak about a particular project in the area of suicide prevention and wellness or intervention from their particular jurisdiction.

The first group that I would like to ask to speak is the Native Women's Association.

Bev Julian, please. If you would like to come up.

I'm from B.C., so I am really happy when

we have B.C. Indians presenting. So, I'm particularly pleased that you were able to come, Bev.

BEV JULIAN, NATIVE WOMEN'S ASSOCIATION OF CANADA: Good morning, everyone. Welcome elder. Thank you for your prayer this morning, it was beautiful.

I guess where I'll start out this morning is to kind of give you a little background of who I am and the type of work I do.

I started working as a community health rep in 1979 and worked for 11 years. I did a lot of work -- I went into training for suicide prevention, which was very difficult for me because I had lost a sister in 1980, and I had a very hard time accepting that. I raised her son who was 14 months old and he is now 13. So, I have an everyday reminder of my younger sister.

Since then, I have lost a niece, a nephew and a cousin through suicide, so it has been very difficult for me to be able to work with suicide prevention.

I am also a traditional healer. It's another difficult project to work with because when you are related to somebody that close and you love them dearly, it's hard to work with them and you can't see what's going on with them, but it's hard to work with them.

Last year, one of my nieces was attempting suicide and I had to go all the way to North Van to pick her up with her mother and her mother's mate. The mother and the mate started to scold her about the attempt that she was trying and I sat in the back seat with her and I never said a word. I just held her hand all the way to Abbottsford. Then when we arrived there they brought her into the hospital and the doctor spoke to her and they called me in to listen. I did. From there I picked up how I could work with her for the rest of the journey home.

At that time I didn't know what I was going to say at all and then I just held her in my arms and I talked to her all the way to my house. I asked her if she was going to be okay and she said, "Yes, she would promise she wouldn't do anything." So, that started me off into suicide prevention as a healer. I finally figured out a way that I could work with somebody that close to me.

Over the past years I've had a lot of healing to do within myself to be able to do this kind of work.

I'm a traveller. I go all over the place

and I work in Tofino (PH) and Port Alberni and all through Canada. I have just been on the road. I carry a suitcase all the time and drive my car wherever I can drive it to to try and help the people.

In one of the areas I worked with a Native man who attempted suicide and they asked me to go into the hospital to work with him. I went in there. It was a lot easier to work with somebody I didn't know at all because I had the heart and the feeling for him, yet I didn't know who he was.

When I walked into the room this man had very thin eyes. You couldn't see the white part of his eyes. All you could see was the brown and it was very shallow and dark. He looked very grey. This man had shot himself through the chest and it missed his heart and his lung and went right through.

When I started to work with him he wouldn't talk to me very much and when I did my healing work with him I asked him how he felt inside, if he felt empty and like rubber. He said, "Yes". I said, "Okay".

I finished working with him to take all the pain away and when I finished that then I started

working on getting his spirit back, because that showed me that his spirit was gone with the shallowness of his eyes.

I was standing there holding his shoulders and praying that the spirit would come back, when it started to enter him I could see it coming in and when it reached so far, he would say, "I can feel it." When it went a little farther, he said, "I can feel it." When he yelled really loud, "I can feel it", I let him go and we were finished working with him to heal his spirit.

I couldn't talk to him after because every time I said anything he would just burst out laughing. He felt so good inside. When he opened his eyes you could really see the whites of his eyes. It was a good feeling for me that I had brought this man back together in that little while.

When I went to his reserve about a month later, he just waved at me. They say when they mention my name he starts laughing. So, it really did work for him. I kind of believe that this man will probably be one of your most important suicide prevention workers in a few months or a year or so because he has gone through it. I think he will be one of the top workers. I'm hoping

that my intuitions will work.

There were a couple of teenagers that I worked with in Seabert (PH) Island and they were attempting suicide because they were young lovers and they split up and they couldn't make ends meet. They were both on the borderline.

It was my first day filling in for this drug and alcohol counsellor. They came to me and they said, "You have two people you have to see today and they are both suicide attempts." I thought, "Oh, my gosh, what am I going to do here?" I sat there and said a few prayers and then I went in and listened to their story.

I explained to them that if they decided to take their lives at that time they would have to work on the other side because they wouldn't know where they were going. They would have to continue their work to help the spirits on the other side. I said, "I sat down and listened to people who have had dreams and have dreamt about people that have passed away. I believe in those dreams because I believe that those people will come back and tell you where they are and how they are doing and what they have to do."

When I explained this to this young

couple they just sat there and looked at me for a long time and they started crying. When I had them crying I knew that I had the best part of them again. I have seen the girl a few times and she just waves and smiles and walks by me, but the boy I haven't seen him since, but he is still around with us and going to school. So, I guess I came across with him as well.

I guess what I'm trying to get across is that workshops are very important to our people. Like my sister's son who committed suicide, she was really having a hard time and I couldn't help her because she couldn't listen to me. I gave her all the love I could and I tried to talk to her about her son, but she wouldn't listen.

So, I had to get somebody else to come in. It is one of our own Native people that do the workshops and he is fairly good at it. He gets through to the people and she has really come a long way since then. I think my nephew has been gone about four years. She doesn't cry as much as she used to. It's really hard on the families that are left behind. This is what we tell the young people that are trying to attempt it.

One of the reserves that I lost these

people in was -- the young niece that was attempting suicide, they called it -- they were starting a pact of suicide people. The first niece I lost was part of that pact. A young man was the leader of it and he would go out with these girls and tell them that he loved them and then he would two-time her and go out with somebody else. Then the niece went over and he said, "Well, you'd kill yourself over me anyway." So, this was the beginning of the suicide pact, they called it. I don't like that word, but we had to break it.

We belong to spiritual dancing and there is spiritual dancing on the reserve so many years ago they said that suicide that was done on that reserve -- this man had hung himself close to the cemetery and they had to give offerings to this man to break the suicides.

We are hoping that this will work with our people in B.C.

My time must be up because I can't think of anything else to say.

Thank you very much.

MAGGIE HODGSON, CHAIRPERSON: Thank you very much, Bev.

I think that the points in relation to

traditional healing approaches and our ceremonies is -- grieving ceremonies are difficult to identify in a Royal Commission report because they don't cost any money. I think that is the richness in what we have to offer one another.

The work that you do with your hands in healing is different and a difficult phenomena to explain to people like Mr. Dusseault. It's a little bit easier with Georges and some of the Native Commissioners, but I think it's important, what you're talking about, because so many of the presentations have to do with programs. So, I really appreciated your presentation.

I would like to break for coffee for the next 15 minutes, please. If we could come back at 11:10.

Thank you very much.

--- Short recess at 10:45 a.m.

--- Upon resuming at 11:00 a.m.

MAGGIE HODGSON, CHAIRPERSON: If we could have Connie Chartrand from the Métis National Council, please, to present their project.

It's good, Connie, that we have young people like yourself. I was at a suicide prevention planning workshop in the Albert region and these young

people were addressing the fact that so many of the old people that were there -- and they said, "You people, you're a bunch of dinosaurs." I found out I fit into a new category. So, I'm glad that we have youth that can speak to the developments that are happening in our communities.

CONNIE CHARTRAND, METIS NATIONAL COUNCIL: Thank you very much for the really positive introduction.

Actually, the kind of work that I do -- I'm a little bit concerned about the fact that I am so young because I do end up working with older women and I'm not sure how comfortable they are in talking to a younger woman like myself. I think it would be actually a really good thing if there were more older women doing this kind of work that I've been doing.

On that note, I guess I will say what I have been doing. I work for the Métis Women of Manitoba. I'm the family violence project coordinator. I was hired two and a half months ago to do family violence workshops around the Province of Manitoba in various Métis communities.

Originally I was supposed to be -- the objective of this project was to train women to be self-help

group facilitators. What I've been doing is actually just going to each community and doing a one-day presentation in each of the 14 communities. I realized that in order to train women to be self-help group facilitators -- obviously it is not possible to do in one day.

So, instead of making it a training workshop I changed the focus more to a workshop aimed at increasing awareness of the family violence issues, and hopefully to stimulate an interest in doing self-help groups.

The project that I've been doing has been funded for three months only, so the funding has just about come to an end. Now what I'm doing is looking for more funding to not only continue my job, but also hopefully to start a new program that would involve training women in Métis communities to be community development workers.

Their responsibilities would include running self-help groups, as well as other things, because I'm not sure if it's fair to expect women to run self-help groups on their own after my being there for one day and then leaving. I'm basically leaving them on their own and maybe I would pop in every now and again to see how they're doing.

So, I really think it's important that I get a training program in place so that women can be paid to do this kind of thing. So far everything is up in the air. I'm not sure if I'll have a job in a couple of weeks. I'm very concerned about that because what I've been doing is opening up a lot of old wounds.

In one sense these workshops have been very productive because women have been talking a lot about family violence that they've experienced, whether it was being abused as children or being abused by partners or being mothers of children being abused by their partners.

There is certainly a lot of pain that's been expressed at these workshops. I'm really concerned that what I've been doing is going into the communities and leaving inadequate support for these women.

Another thing is, certainly with all the pain that has been expressed, I'm concerned that there are women who are feeling suicidal. So, I really am hoping that I will be able to get a new program in place so that these self-help groups will get off the ground.

I guess that's it. I hope I haven't depressed you too much, but hopefully this will come about

and we will all get some self-help groups running in the Métis communities of Manitoba.

Thank you.

MAGGIE HODGSON, CHAIRPERSON: Thank you very much, Connie.

If you think about the different resources that are available in the different parts of Canada and the work that she's doing, maybe this is an opportunity, for some of us who have training packages, to share those packages with her. There are women, so even if her project doesn't continue, the women can continue their initiatives at the community level.

I know that it's not necessarily the intention of the Commission, but I think it can be part of the process where we could support what you're doing in Manitoba. Thank you.

Joey, you wanted to say something?

JOEY HAMELIN, METIS NATIONAL COUNCIL: Actually, it's not that we're disorganized, it's that we're flexible. I notice that we just discussed this during our break in terms of the national initiatives that are specific to Métis.

Thank you, Connie. It's good to see

that we have young Métis women that are working in their communities. A major issue that you touched on is the issue of funding, in that funding that is designed specifically for the Métis nation is not there.

For example, there are some initiatives -- the true family violence -- Health and Welfare, and we do have access to funding, but we're in competition with other organizations that sometimes they are further developed than we are in our communities. Sometimes we find, as community workers, that we are busy dealing with crisis intervention and that a lot of our energy gets used during crisis. It takes a lot of time to do the planning and proposals and things like that.

So, funding is an is issue for Métis and I hope that we can be recognized and be able to access funding to address family violence.

In the Province of Alberta we have the Office for the Prevention of Family Violence. There are limited dollars, and again, high competition with other organizations to access these dollars.

In Alberta one of the initiatives that we have is a Métis Child and Family Services. Actually in 1984 -- I mentioned Richard Cardinal who hung himself,

as a result of this there was a public out cry. The government and the Métis communities and the Métis organizations felt that, yes, we must start addressing this and we must look after the Métis children, particularly, a lot of the Métis children who get lost in the Child Welfare System because there are no policies specific to Métis. Once the children are apprehended and get lost in the system it makes it harder for us to trace or track down where all of our Métis children are in the system.

There have been policies in Manitoba in which a lot of these children were transported or exported to the United States. We have children all over the world that we need to find. Those children that have lost their identity as Métis people can be a cause for suicide or suicidal behaviour. It is very important that we stress that we maintain our Métis identity, our culture.

Like I mentioned, we have a Métis Services Organization in Alberta that was initiated through Métis Local 1885. Today, eight years later, they are celebrating their eighth anniversary on June 9th. Eight years later they now have a provincial mandate from the Métis Nation of Alberta.

That organization with its sisters and brothers, with the Manitoba Métis Federation and with the other provinces hosted a first and a second National Métis Child Care Conference. Again, having been involved with those conferences, funding was very limited and there were some wonderful recommendations that came out of both of those conferences, but again, we need to take action. It is our responsibility to follow up with those recommendations that will assist us in our planning so that we can prevent further suicides for our children who do go through the Child Welfare System and also, who do end up in jails.

Just a brief note. Two years ago we did research province-wide and we visited the prisons through the Native Brotherhood. We found that a lot of the men that were Métis had lost their identity and there were a number of suicide attempts. One of the men shared with us that he would be in jail for life. He had been in there since 1954 -- this was at the Edmonton max -- and that he had attempted suicide on a number of occasions. This one time he swallowed a bunch of razor blades. He ended up surviving to tell us his story.

We heard many stories like that of the

many suicide attempts and some that were -- I don't think you would use the word successful, but that were completed suicides. Again, when we look at suicides we are looking at it from the Métis community as a community responsibility, but also we need to look at it from a holistic -- a lot of that was mentioned this morning -- and socio-economic part or the social economy.

One of our major issues is poverty and when we begin to address the issue of poverty and meeting basic needs then that also helps us to feel good about ourselves so that we can be contributing members to society.

I would just like to end with an incident where I was working in the community in the north and a young boy -- actually, there were several young boys who were sexually abused by the school principal. One of the young boys was ten years old and he hung himself in November.

Those are some of the issues as technicians that we do become traumatized with through that process. We do need to go and reach out and say, as technicians, that we need that extra strength to continue on in the communities that we work with, and at

the same time to push and promote and educate our politicians, our leadership to make sure that suicide prevention and social issues are again as equal a priority as the Constitution.

Again, the Métis National Council is planning on a third National Conference, again, to follow up with our recommendations that we have made in both of those National Conference reports.

I guess that's everything. Thank you.

MAGGIE HODGSON, CHAIRPERSON: Thank you very much, Joey.

I believe that Joey is a representative of urban initiative when she talks about the suicide by Richard Cardinal which resulted in a Native Child Welfare Advisory Committee being developed by the province. Out of that Committee we recommended to the province that they set aside $100,000 per year so that Métis students could work on an undergraduate program in social work.

To date, I believe that they have had about 20 graduates from BSW Programs. The bursary each student gets is approximately $20,000 per year, plus their books, which is not a lot of money, but it is better than having to go out and get a loan.

Joey was one of the graduates from that program. She is part of what I was talking about, the reciprocity, because she is a leader within the Métis community and she was on the first Board of the Métis Children's Services. She is a leader in her own right.

I'm sure she doesn't like to blow her own horn, but I think that those kinds of initiatives where provinces do set funds aside for people going to post-secondary -- it can happen. It has happened in Alberta.

So, if we could move to the next speaker. What we will do is move to the speakers first and then we will leave the floor open to questions. If you could write your questions down for each respective speaker.

I apologize for using that process, but we also have a luncheon speaker coming at 12:00.

Sharon Jinkerson from the Native Council of Canada.

Sharon, please.

SHARON JINKERSON, NATIVE COUNCIL OF CANADA: Good morning. My name is Sharon Jinkerson and I'm the Supervisor of the Family Support Program for

Vancouver Aboriginal Child and Family Services. It was an initiative begun by the United Native Nations. We've been going for two years now and it's been a long journey. Originally, I was on a team of crisis workers.

First of all, I would like to take a moment to acknowledge the pain in this room. You can just sense it as people are talking about all their losses. I know that each and every one of us has been impacted by suicide.

When I first began work at the crisis centre we took crisis calls from 9:00 to 5:00 on our crisis team. We started a program at the local hospital, the Vancouver General, and I was the liaison worker for the hospital.

There was a 14 year old -- we're all telling our suicide stories now. This young woman had tried to commit suicide four times. The last time she jumped from a bridge and survived. That was when I went in to see her. We talked about her story and she was a foster child. Like Richard Cardinal, she had been in and out of various homes, group homes, a variety of care settings. The Ministry had made attempts to place her with her own people, but those attempts broke down.

I wrote a 14 page report on this young child. I was so compelled and I was so angry because there seemed to be no resources which would connect her to her community which I felt would provide the life line. What began to emerge, and what I had noticed from my work on the crisis team, was an issue of belonging for these children, the fact that they didn't belong anywhere. They were just sort of floating. I think that it one of the core issues for our people. If you don't belong anywhere there's not a lot of reason to stick around. So, I saw this young girl.

They flew me up north for a big fancy case conference and all of the suggestions and recommendations that I made at the end of the report we were unable to address, simply because there weren't any resources. We were hung up by bureaucratic red tape and the fact that she was non-status. That impaired us quite a bit.

Something that we face as urban agencies is not being able to get funding. If you have a case load which includes Métis people or non-status Indians, you're unable to get federal health dollars to get proper counselling and facilitators for your clients. They rule

you out right away, even though the majority of your people are status.

We worked along and we eventually emerged from the crisis centre into a family support program. We just began to develop child welfare initiatives in the City of Vancouver.

What we do as a team is deliver services to families with child protection concerns. We saw a large gap in the system for addressing foster care issues and adopted Native children. For any of you that have received statistics, it's a very difficult thing to do, but we know that many of these children are suicidal.

You are looking at a survivor right now. I grew up in the foster care system and made two suicide attempts. My first one was at the age of 12. So, I was very sensitive to this sector of our population.

I began to work with a therapist by the name of Arden Henley and Arden Henley is a specialist in belonging. We came up with a concept of a camp which would welcome these children home to their community. It was a marvellous experience. We held it last October and the idea was that if we could reconnect these kids and give them a sense of belonging, they might not use the option

to just rule themselves out of this life.

I would like to read a bit. I just happen to have the article with me -- a little bit about the camp, describing it, and some of the interventions and a little bit about the theory. A lot of it is belonging and attachment, but I will read the first part.

> "Susan, a First Nation's adolescent, first felt free to talk about the drums in a group of First Nations teens organized by First Nations social workers and elders. Since her earliest memories Susan heard the loud beating of drums in her dreaming."

This was one of the first readings that we held with these teens. They were powerful. I thought I had a powerful story to tell until I started to hear these teens. They were truly the light in a tunnel of darkness. They shared and talked about their experience, the loneliness that they felt and they couldn't describe to anyone until they were with us.

Give me a second here to find the last page. I will read to you a little summary about the camp.

This is written by the therapist and it was published in the Western Therapist Journal this past spring.

"On Thanksgiving weekend this past year I was involved in a ritual of inclusion that was described as a cross-cultural camp. Twenty caucasian adoptive and foster care families, with their First Nations children in their care, gathered with First Nations community workers and elders for the weekend. It began and ended with the smoking of the sacred pipe in a circle and was replete with First Nations art and rituals.

Two traditional Thanksgiving meals were prepared. One of venison and salmon and one of turkey. Sharon Jinkerson and I hosted an adolescent caucus on belonging during which many young people acknowledged for the first time the

pain and bewilderment of their separation from their heritage. In a subsequent group, held for both parents and young people, they were able to speak of this sense of isolation while at the same time expressing their love and appreciation for those who cared for them."

In such moment, a vision of multiple belonging emerges in the context of which the young person is free to belong with their adoptive and foster care families and connect with their heritage. Perhaps as importantly, these families were incorporated in the young persons broader heritage as a First Nations person.

The weekend closed with a traditional potlatch, a ceremony in which gift giving and speeches complimenting the participants are combined. A

button blanket had been made especially for the occasion on which was sewn a tree of life. On the branches of this tree small velcro patches were scattered awaiting the buttons that were distributed amongst the young people. One by one they were called forward by the elders and honoured guests to place their buttons on the blanket re-authoring the story of their connection to their people."

I want to say right here that we realize in our agency that we are reliant on the non-Native care giver simply because the resources don't exist within our own community. Our primary objective is to keep children within their own community, but in instances where children are forced to live outside our community we realize that it's up to us to be the bridge, as an urban agency, and to bring these kids home to keep them connected, and eventually to facilitate their return to their home communities as young adults, as I did in my personal

journey.

This is one of the interventions that we've used, but we need a lot more. We need to have on-going counselling for these children. We need to develop this theory a lot further. We are starting to look at relating this theory and therapy to the youth in our community so that we can begin to incorporate these rituals of inclusion for teens, even if they are living with their families.

Often times in the urban settings these teenagers lose track of their roots, of their communities, so we envision a community within the urban setting where we include -- because the ceremonies of our people are so potent we have the ability to heal ourselves within our own community.

I don't think any of us really understand exactly what happens, even the telling of a traditional story can unify and a group of our people will just belong to each other upon hearing these stories. We intend to use these with our youth.

We have an initiative right now to run a youth program. Our primary focus for that will be belonging as well as traditional culture. We intend to

use the healing arts of our people, like story telling, to begin to work with these youth because the statistics are just staggering in suicide and violent deaths. They are all very very high.

We have another initiative for a home in which we don't apprehend children from families where there are child protection concerns, but rather take the whole family into care. It is the kind of concept where the community parents the family. That way we hope to reduce the trauma on children so that we can work with the whole family.

We hope to reduce that shame that happens to our people when their children get apprehended, to work with a community committee to bring the whole family into a process of healing. It will be done with the care, generosity and kindness, of our people.

This camp that we had included children from all nations, Métis, non-status and status children and it was just wonderful. In the follow-up, I have kept in touch, many of the teens still see me on an ongoing basis. They come in for weekly appointments and they're doing marvellously. Many families are planning to bring their children home to their home communities.

Parents are beginning to realize that these children will forever be First Nations children. A piece of paper in a court of law will never change their ancestry. Parents are beginning to get a hold of that and work with our community to have their children re-belong. So, it has been a wonderful process.

I really feel that an initiative like this camp will reduce statistics in the future. I know that that was part of the issue for myself growing up, was not having anyone to communicate what was happening inside.

We are running a few other programs as well, teaching communication skills for teen groups, et cetera.

I thank you for your time.

MAGGIE HODGSON, CHAIRPERSON: Thank you very much.

I think it is awesome in terms of the ceremony, ritual and story telling.

The last speaker is Joe Karetak from the Inuit.

Joe, you have to bring a little balance here, we have too many women.

JOE KARETAK, INUIT TAPIRISAT OF CANADA: Thank you.

I have a lot of people to thank for being here and I might just go briefly to the Royal Commission, I think, for at least going to the north and hearing the people. We thought that we were being heard when we all went to the Royal Commission and some of the programs that they have been involved in. I'm very pleased.

I think with the Keewatin Region where I'm from we have a lot of problems because some of the things that we felt would help prevent suicide are the things that -- I'm not quite clear on how to put it, but some of the things that I wanted to bring up in this workshop is the Baffin Crisis Line, which has already been there for a few years. I think it started off a lot of these things that we're doing. We are now called the Keewatin Crisis Line and we used the Baffin Crisis Line as an example of what we would try and produce.

One thing that we wanted to try and do in our area is because a lot of Native people don't speak English, and not only youth are troubled, we wanted to try and produce a program that would train people in the Native language and, not knowing, we came across a few

problems mostly language-wise. There are a lot of expressions that are very easy to do in English that you would never find in the Inuit language. The only way we thought we could do this is if we invented new words to try and interpret some of the programs the way the crisis line is normally programmed.

So, what we did was we had an adult education teacher who had been living in the north for a long time as one of the people to set up the program. There was a social services representative on suicide who helped us with the program. We had an Inuk teacher and myself and another Inuk person to try and put this program together.

We held one in February and some of the things that we came across, and some of the problems we had, were that the Inuit people's normal behaviours tend to go against a lot of what the crisis line people try to train you not to do. As far as the crisis line guidelines, we were training people in English, but we had trouble putting them into the Inuit understanding.

I'm not sure if that's why the training was successful or not. It's hard to rate it. So far most of the calls are still from people who are bilingual, and

there's been some cases where there have been suicides and we know those people didn't speak any English at all. That has always been a very big concern for us. We are trying to address it.

We are going to try again in the fall because a lot of the people that come up north work up there for a while and then they go back down south, but they are the only ones who seem to have the time to be on the crisis line. We have now been running for a couple of years and the same people that started the crisis line program are the same people still in there.

With the high turnover, and a lot of people leaving and things like that, we've had to probably provide more training than what we are producing right now. We are trying to produce two training sessions a year. The problem is getting the program translated. We are still trying to adjust so that this fall, when we do try again, we will see how that goes.

We do recognize that as far as the crisis line goes a lot of the problems are self-esteem. Some of the problems they indicate is that they don't feel they have a purpose or a role within the community. We think it's true. We need to see more of a role for everybody

to have.

It's almost like, for example, we're all just riding on a sled and a skidoo is pulling us and we're going somewhere. We're all just riding and when the snowmobile starts going through a trouble area, where the load is heavy, I think some of the people feel that "I'm just a load anyway, maybe I should just get off". I think that might be one of the feelings that they get when they are from a large family and there's always a shortage of money. I think that adds to a lot of the pressure that we felt shouldn't really be there or should be addressed in some way.

Some of the things that we have encountered, as far as workshops up there, we recognize that there needs to be some form of anger management, I think, with a lot of the people up there. We've not had that much training or anything that ever told us how to deal with anger, and that might account for a lot of the spousal assaults, as far as that goes.

We've had elders concerned enough to try and get something going, but a lot of the things that are able to be ongoing require, as Inuit people feel -- we call it paperwork. We are not very good at it yet, and

we are trying to get better at it. You do need the paperwork to get the funding or to get all these things. That is the area that we are very weak in. We are all concerned and we are all trying to do things as we can, but any time we go any place and ask for certain things, it has to be explained in certain ways on paper in such a way that -- of course, like I mentioned we are weak at that.

Some of the things that we've had to also deal with is that we do try and provide the crisis line for the Keewatin Region which means all the costs have to be long distance. The system we have up there was so bad that we had to have people call in collect. Of course, when you're trying to advertise that it will be confidential -- of course, when you call collect you have to give a name. That sort of goes against the program.

So, we now have just put on the program what is called the reversal call. Now we have to advertise all over again to try and get people to understand what a reversal call is. So, not only are we trying to educate the trainers, we are trying to even educate the people who we are trying to help in order to access this program.

These are just some of the things that

we felt that we wanted to try and get known as far as the situation in the north.

One of the things that I was pleased to hear was the stress and trauma that we encounter as volunteers -- it's true that you almost know the person. Most of the time when it's suicide we do know who it is. I think in other places when you're in a larger area, larger population, you might not know who that person is that you're dealing with. That is a lot easier.

We have, as an example, some of these problems in other communities where they are a bit more remote, we don't know them. They are easier for us to talk to. It seems to be so true that some of the problems that I encounter for myself are because a person I know, or a relative I know, is the person asking for help. It's very hard to stay within that -- keep your distance away a little bit, don't get too involved. So, I'm very pleased to ask that if there is any way of dealing with that we would like to be helped in that area.

I think as far as the rest of the programs, I think I am here more to learn from everybody. We know that if we look to deal with these problems we can't just target one certain group of people. We have

to involve everybody and all the resources that are available to us. One of things where we do need a lot of help is in being able to target the funding that is supposed to be available for these.

Thank you.

MAGGIE HODGSON, CHAIRPERSON: Thank you very much, Joe.

We have a few minutes for questions or comments from the floor. I would ask that when you go to the microphone that you identify yourself for the interpreters and for the recorders.

RODA GREY: Roda Grey, again.

I would like to respond to Joe's statements about our language in Inuktituk. He is really right when it comes to dealing with counselling or that kind of skill. We really have to find the right words. It is really really hard to make that feeling to -- it would be much easier if everyone could speak in English to try to counsel somebody, but because we have to be very careful of what we say when somebody is trying to hang on to the cliff, we don't want to say the wrong word. I want people to realize that Inuktituk is a very hard language and we really appreciate what he is trying to

do.

There was another thing I forgot that was to do with language barrier we have in the north. The other thing is that we don't have all the resources in the north. It is really really hard for us to try to deal with all these things. Like he was talking about someone on a skidoo and they don't have a purpose, they didn't have a role. I mentioned earlier this morning about confidence. If you don't have self-worth, self-esteem, you don't have confidence.

The other thing is closer reality which is another issue in the north. It's very very hard to talk to your own families. I am in the process of healing, but I cannot pass to my mother because she is close to me. I can help others. I can talk to others easily, but it's very very hard to deal with your own families. It's really a struggle. You are surrounded by your own relatives. It's really really hard. I have helped many people who were not my relatives, but I cannot touch my relatives. It's really really hard.

So, we really have not only greater problems in the north, but we have also many many barriers. Also, the other thing that he mentioned was that people

are doing the same thing, the same people. We don't have many many people here. These people coming from the north, it's the second or third time I see them at workshops like this because there are no other people. They are very very special people and they have worked hard and they have their own families.

One of the things that we worry about for the people in the north is there is a lot of risk of burnout because there is so much work they have to do.

The other thing Joe is asking for is if there would be any training on how to deal with your own feelings, so that you can keep your distance when you're counselling your own relatives. That skill is really needed in the north.

Thank you.

MAGGIE HODGSON, CHAIRPERSON: Thank you very much, Roda.

DIANA DELORME: Can I talk from here, I have a loud voice?

MAGGIE HODGSON, CHAIRPERSON: Can the interpreters hear her?

DIANA DELORME: Can you hear me?

In Edmonton I have been working with

people for the last ---

MAGGIE HODGSON, CHAIRPERSON: Your name?

DIANA DELORME: I'm sorry. I'm Diana Delorme. I'm from Edmonton.

I have been working with people for the last 22 years and occasionally I run across foster families whose little children have tried to commit suicide. It's okay for me to walk into their homes and talk with them, but if I suggest that they come to the pipe ceremonies, the healing circles that we have, they say no.

Does anybody have an idea on how I can get around these people so that we can help our own? I leave that for you.

SHARON JINKERSON: I would like to respond to you about that. Working and studying this issue for a couple of years, and being raised in that situation myself, I feel that I can address you.

One of the issues for parents and adoptive parents or foster parents is safety because they feel afraid of the Native community, that they will be viewed as child snatchers. So, one of the keys to the successes of our camp was creating safety for parents.

We did that before the camp by having a series of parent meetings so that there could be a portion of self-direction there, what they needed to feel safe, what topics they needed to have information on before we entered into a project like that. It's so critical to have a level of safety there for these parents.

The other issue that these parents have to face by facing the Aboriginal community is their own loss issues. It means acknowledging that these kids actually aren't theirs. They belong some place else, emotionally and all the rest of it.

Don't get me wrong, I realize they are members of the families that they are being raised in, but there is an awful lot of loss issues. So what parents have to overcome is their own fear of addressing their loss issues and meeting the needs of the child because the child is the primary client. That is something that has to be sort of gently worked on over a period of time.

Thank you.

MAGGIE HODGSON, CHAIRPERSON: Also, in Edmonton there is a Foster Parent's Association that are white foster parents and adoptive parents and sometimes they will make a visit to that family because they have

been in similar situations and they have the fears that she is talking about. That's one of the possibilities.

ARNOLD CHEECHOO: My name is Arnold Cheechoo and I'm representing the Cree's CBC North out of Montreal. I'm originally from Moose Factory, Ontario, James Bay.

I just wanted to respond to the lady from Edmonton. There are a lot of Native people who don't advertise their services and a lot of these people are traditional people. I come in contact with a lot of these people and usually if you offer them tobacco, and you get in contact with them personally, you will find out what their agenda's are, because a lot of these people do have heavy agendas to travel all over the country of Canada.

These people, if you can get in contact with them in your area -- I don't know who the traditional contact people could be, but once you contact one person then you have a whole network all across Canada and the United States.

You can offer tobacco to these people and the arrangement can be made between the individual person that is asking for help for travel arrangements with these people, or perhaps an organization that the

person that is asking for help can approach the organization to say, "I would like this certain person who is a traditional medicine man to come to my community", and the healing process might start from some of these people with that type of experience.

A lot of these people -- like I said, they don't advertise in the newspaper. They don't even have business cards. They are just around and you just have to make the connection with the traditional peoples of Canada and the United States.

Thank you.

MAGGIE HODGSON, CHAIRPERSON: Thank you very much.

Diana is one of those people who doesn't advertise her services. She is one of our medicine women.

Any more questions or comments?

Adamie, please.

ADAMIE SALLUALUK: My name is Adamie Sallualuk from Povungnituk in northern Quebec, Inuit region.

I would like to thank the Royal Commission and all the people I know here.

I just want to say a few words about how

we are doing in our Inuit region. We, from the community of Povungnituk have been on The Journal, it was a deadly summer and the suicide is very high. We've been having training from Suicide Action Montreal. We invited the communities to talk about suicide and we had training in different things like: Why do Inuit kill themselves? We had so many things to say to answer this question. What we found out is that pain kills and the silence. So, we were talking about breaking the silence.

Also, the suicide of people, how we should help? Also, suicidal people are helpless and how do we help them? We also looked at the danger signs of suicide and what do we do to suicidal approach? We had all those and by going through those we learned how to counsel, we learned how to talk to a person who needs help.

Still, there was something missing. So, we lost special people, young people and the age is always about 15 to 17. By looking at 17 or 16 years ago the parents, the community and the family -- you know, there was something wrong.

So, like we say, we learn from mistakes. We went to say that we need to ask young people. What we received was risk factors for suicide among Inuit youth

in Povungnituk. We really wanted to find out how they think when they have problems or when they end up having an attempted suicide.

We had a survey from 100 youth, 100 young people and out of that 100, 35 per cent of the youth had attempted suicide. There is something wrong. We looked on different findings, like they are sniffing, marijuana, students and non-students, unemployment and alcohol with relatives, with no such relatives, youth who watch television more than three hours or, on the other hand, less than an hour, and similarly the findings are touchy.

So, 27 per cent of youths suffer physical abuse, sexual abuse. Young people worry about community violence. Some have been arrested at very young ages because of those problems.

We covered all this -- if I go through it it would take all day. What I found was it's better to work closely with young people by having such questionnaires. The findings are telling us that we should do something about it.

I just would like to thank you for this time.

MAGGIE HODGSON, CHAIRPERSON: Thank you

very much, Adamie.

Would it be possible for you to share that study with the -- give it to some of the Commission people so that they can include considerations that are particularly relevant to the northern community?

ADAMIE SALLUALUK: Yes, I brought some copies. So with this we share, to try to find what is best for the organizations and to work on this.

Thank you.

MAGGIE HODGSON, CHAIRPERSON: With your usual generosity, Adamie. Thank you very much.

If we could break for lunch now and we will be coming back at 1:30 to this room.

Myrtle, is there another -- oh, there's another question.

CAROLINE ENNIS: Could I just make a suggestion?

It seems to me that what everybody here is talking about is a national problem, and what that lady there was talking about, what they did in Vancouver, that could be done on a regional basis. Then we could bring in everybody that is connected to Aboriginal youth, whether they are Métis, non-status, status -- I don't see those

divisions. I just see Indian people as Indian people no matter whether they are from, a reserve or wherever they are from.

So, my suggestion is that they have regional things like what they did with the white foster parents and the elders and then eventually come together at a national level to do pretty much the same thing, but I think the political organizations in Canada should start acknowledging that this is a national problem and that they have to make it a priority. I don't even see any of the -- of course, I don't recognize all the national leaders, but I don't see them here.

I think that things like this are really important and it needs national -- it has to be looked at from a national scope and then be addressed in that way, because these people that are working now in the small Inuit communities or whatever, they are going to burn out. There is nothing there to address that burn-out problem. Like he said, there are only the same people that are working in those areas continuously.

So, I think we need to start looking at it as a national problem and to force the political organizations to get after the government to see it as

a national problem.

SHARON JINKERSON: I would like to respond.

One reason why I differentiated between the groups that we work for was what I outlined earlier, the fact that we can't get any federal dollars for programs if we have non-status people, which happens in the urban settings and our Métis people. So, we are reliant on provincial dollars to get any initiatives like this going. I think it's a shame to rule out funding on that basis.

The other thing I would like to acknowledge here is that our agency was initiated by United Native Nations which is a member of NCC and Nelson Mayer -- because I never put a budget together -- came to my office and helped me to put it together. So I think that our leaders will be there when you call upon them directly and present exactly what you want. I just asked Nelson for about a half an hour of his time to help me finish up this project and get it off the ground.

Thank you.

MAGGIE HODGSON, CHAIRPERSON: I believe that that is the intent of the recommendations that are going to be put forward this afternoon, to look at how

they can be built into a national strategy from the Royal Commission.

So, with that, if we could move -- we are going to reconvene at 1:30 p.m. and then we will direct you from there because we need to have our facilitators being identified at 1:30 p.m.

I would expect the facilitators will honour us and be back at 1:30 p.m.

--- Upon recessing at 12:00 p.m.

--- Upon resuming at 12:20 p.m.

MAGGIE HODGSON, CHAIRPERSON: I would like to introduce our keynote speaker, Dr. Paul King. He is the Chief Psychologist at the North Bay Psychiatric Hospital.

DR. PAUL R. KING, NORTH BAY PSYCHIATRIC HOSPITAL: Thank you very much, Maggie. As we are waiting to eat until I'm finished, I feel this tremendous pressure to be fast. I will do my best on that, but if some of you absolutely can't wait and you want to get up there, I guess you could be forgiven.

I would like to begin by just saying that I've had the pleasure of attending the full session this morning and I was tremendously moved by most of the things

that were said. Yes, there is an awful lot of courage and there are an awful lot of resources right here in this room.

There was mention made about confidence on a couple of occasions. Standing up here in front of all of you now what I would like to say is what might appear to be confidence is often thinly disguised, and particularly in the situation I'm in.

I am acutely aware that I am not a member of the Aboriginal community and for someone like me to be here is sort of a worst nightmare, as I'm going to present you with material that is perhaps not very relevant or worse, down right insulting. Now, I don't think that will happen, at least I hope not.

I would like to begin by thanking you for inviting me to be here today. I am very very flattered to have been asked to address this luncheon and I hope the material that I will be describing is going to be useful to you. I have been told that I have the floor for 45 minutes, but I will try to cut that down some. Like I said, the food is all here.

It definitely means that I should get started. I have the cue cards here. There are 42 of them

and I did some calculating and if I do one card each 1.017 minutes, I believe then we will get the whole thing through in 45 minutes.

This is a conference about suicide prevention and suicide prevention is what I would like to talk to you about. I also want to talk to you about crisis intervention counselling because suicidal feelings and suicidal thoughts usually are connected with one kind of crisis or another.

What I will be saying has been extracted from a half-day workshop on crisis intervention. That workshop covers -- the entire workshop covers the areas on the overhead. What I would like to present this afternoon would be areas D, on suicide and suicide risk assessment, and G, which concerns crisis intervention counselling.

There are 22 of these overheads for the entire crisis intervention workshop and I have arranged for copies of these to be made available to you. They look like this and there are about 55 copies sitting on the table just outside there. Please do help yourselves if you find them useful.

Just before I start into suicide and

suicide risk assessment there is one point I would like to emphasize very strongly, I am not here to tell you how you should be doing it. I don't think that is very respectful and I also think that there have been far too many occasions of people from outside the Aboriginal community telling you how it should be done.

I am here to present some material that I hope will be useful to you. Whether or not the concepts that I present do help you in the Aboriginal community that is, of course, for you to decide. If it turns out that some of this is useful, terrific. If it turns out that it isn't that useful, well I can accept that too. You know your situation far better than I am ever going to be able to.

About suicide and suicide risk assessment, tragically it is the case that suicide is at an alarming level in the Aboriginal community. All of you, I think, are familiar with the statistics so I am going to confine my comments to three recent trends, one of which is directly relevant to the Aboriginal community.

First, as was said many many times this morning, there has been a very very significant increase in the completed suicides among young persons. In terms

of Canadian society generally, suicide is now the second leading cause of death for people under the age of 35.

Second, the suicide rate among women, especially young women, is very much on the rise.

Third, the suicide rate in the Aboriginal community is very high. It is now the highest of any ethnic group in the entire world.

Now, I do recognize that the rate has declined somewhat in recent years, but it is still very very high. For Native males ages 14 to 24, the suicide rate is about 10 times the national average.

Let's look at some of the demographic variables that are associated with suicide risk. This overhead identifies seven demographic variables that have some relationship to risk of suicidal behaviour. I would like to try and be a bit more specific and give you some information about levels of suicide risk within various subgroups of each demographic category.

On the left of this overhead you have the same categories as on the previous overhead. What you can notice is that the left side, has a relatively low risk of suicide. To the right side, you have a relatively high risk of suicide. The way to look at this

chart is kind of like this. In terms of gender, for example, on number E here, there is a relatively low risk of suicide among females and a relatively high suicide risk among males.

Now, in terms of predicting suicide risk on the basis of demographic variables, there are three points that I would strongly emphasize. First, suicide is a very individual phenomenon. Second, because suicide is a very individual phenomenon demographic variables like these ones here, they represent only a very rough indication of suicide risk. Third, in consideration of the two points that I have just made, I recommend that we not be lulled into complacency because particular clients don't have a high risk profile.

History of previous suicidal behaviour is a particularly important indication of current risk in the case of the suicidal client before you. Why? Because suicidal behaviour tends to escalate over time.

Sometimes we have situations of an individual committing suicide and it appears to be out of the clear blue sky. Yes, there are situations like that. More often it's like this, where the person

progresses from suicidal ideation, to making a suicide threat, to making a gesture, an attempt, a serious suicide attempt and then death.

This is why people who commit suicide usually have attempted suicide before because of this phenomenon. Consequently, a current suicidal client with a history of having made a serious attempt is a person who presents a high risk.

Just before addressing some of the clinical predictors of suicide risk, just a few words about the emotional underpinning to suicidal behaviour. In terms of the dynamics of suicide, what we heard this morning, these kinds of issues were emphasized again and again and again in all kinds of very diverse communities, very diverse situations, these kinds of issues kept coming through.

The dynamics of suicidal behaviour can be understood in terms of four "nesses" if you like: aloneness, helplessness, hopelessness and worthlessness. It might be useful to keep those things in mind as we go over some of the critical predictors of suicide risk.

In terms of these clinical predictors there are eight that I would like to tell you about, these

eight here. I will put these in the form of questions, questions that should be considered in the clinical situation of assessing suicide risk.

1. What is the person's intention? Is the person saying, "I want to die", or is the person saying, "I don't want to live like this"? There is clearly more risk if they wish death.

2. Is there a suicidal plan? The presence of a carefully thought out plan increases the risk of suicide.

3. What kind of emotion is the person expressing and how strong is the emotion? The strong emotions, particularly things like anger and bitterness, denote higher risk.

4. Is there a family history of suicide? If so, suicidal behaviour may be seen as more acceptable by your client.

5. How are problems usually handled by the person, with impulsivity and loss of control? If so, this increases suicide risk.

6. Is there a tendency towards violence? This might be suggested by the existence of police contacts. Remember, suicide is a violent act so

a track record of violence is always a sign.

7. Does the person experience his problems as overwhelming? If so, suicide may appear to be a more attractive option for that person.

8. Finally, are supportive resources available or unavailable? The lack of such resources points to social isolation which increases suicide risk. You will remember a few minutes back that the dynamics of suicide -- one of those four nesses was aloneness. Somebody who does have supportive resources available is not alone.

The last thing that I would like to address in this area concerns ambivalence. I personally believe that ambivalence with respect to wanting to die is always present. A part of the person wants to live, part of the person wants to die.

In terms of intervening with suicidal clients, ambivalence is perhaps the therapists strongest ally. Intervention should be aligned with that part of the person that wants to live. The kinds of questions she might ask are: Is there part of you that doesn't want to give up? Is that part of you getting stronger or weaker? What are the things that would have to happen to increase

the strength of that part of you that does not want to give up? Those kinds of questions.

Interventions should also address the themes presented under dynamics of suicide. Again, aloneness, helplessness, hopelessness and worthlessness.

Earlier in this presentation I mentioned that suicidal feelings and thoughts are usually connected with one kind of a crisis or another. Often if we want to help the suicidal person then we are really helping him or her dealing with the crisis situation.

In crisis counselling -- crisis intervention counselling is the process of intervening with people who are in crisis and the goal of crisis counselling is to help a person return to his or her pre-crisis level of functioning.

I would like to think of crisis counselling as a process that answers seven questions. The seven questions I'm referring to are these ones:

1. What are the problems?

2. What is the priority of each problem?

3. For each problem, what are the available options?

4. For each problem, what is the best available option?

5. For each problem, does the selected option have a deadline?

6. For each problem, what are the steps in exercising this selected option?

7. For each problem, what is the outcome of the selected option?

Now, to give you a flavour for this process I would like to refer to a concrete example. Suppose this is what you hear from your client: "I'm 18 years old and I left home a few months ago because my father was beating me up. When I left there I went to Toronto and lived on the street for a while. Then I met this guy from North Bay and -- I had to stick North Bay in there because that's where I'm from you see -- then I met this guy from North Bay and he said I could come up here and stay with him. We've been having sex and I think I'm pregnant. I should have had my period two weeks ago. I came here today because the guy I was staying with threw me out. I don't have any money and I didn't know where else to go."

Now, let's go back to the seven questions

and see how they might be applied to this situation.

The first one, what are the problems? Well, our girl has actually said five things. She said she is a long way from home. She said her father was often violent with her. She might be pregnant. She has no place to stay and she has no money.

At this point, what we want to do is catalogue the problems as accurately as possible. More than anything else, crisis intervention counselling is an exercise in problem solving. If one is going to engage in a problem- solving process, one had best have a passing acquaintance with the problems.

The second of these questions: What is the priority of each problem? In our example the difficulties are not of equal importance, some issues are very pressing, others don't have quite as much urgency. Again, in crisis counselling you are guiding your client through a problem-solving process. In doing so you want to help a client take this great huge overwhelming terrifying mess and break it up into some more manageable pieces. So, you want to help the client prioritize the problems.

In our example I've heard her mention

five things that are hard for her now. She has said she has no money, she has no place to stay, et cetera, et cetera, et cetera. If you had to pick the one thing that is more urgent than the other four, what might it be? What would the next most urgent thing be and so on? Notice that I did not say the most important thing, I said the most urgent thing.

In our example the most important thing is probably "I think I'm pregnant". The most urgent thing is likely "I have no place to stay". After all, it's January 15th in North Bay and it 30 degrees below zero, not having a place to stay is not an insignificant thing.

You have now helped her to take this huge mess and cut it up into five smaller pieces. You have also helped her identify which mess is the most urgent and which is next, et cetera. What do you do now? Well, what I do now is let you know that I'm going to illustrate the rest of this process, questions 3 to 7 inclusive, with one problem. Other identified problems are handled through the same sort of procedure.

So, let's go back to: What do we do now? The third of these seven questions: For each problem, what are the available options? Basically, how can the

problems be addressed? In this question I have not said: What are the attractive options? I have said: What are the available options?

Let's assume that our girl does conclude that accommodation is the most pressing matter, the idea of identifying options can be introduced with something like this: "You're feeling that accommodation is the most pressing matter, let's try and think about only that issue and never mind the rest for the next little while. Now, what are the possibilities? Let's put them all down on paper without deciding which one is best."

Now ideally you want the ideas to come from her because solving the problems is her trial. So, if she doesn't know, try and help her to look at it from a different angle. If you had a girlfriend in exactly the same situation as you are now and she asked you what she could do, what would you tell her? If you were writing a book about the situation you are in, what would identify as possibilities for the girl in the book? Something like this. This is the counsellor's chance to be creative.

Some of the options in our example: Well, she can call the guy she was staying with and ask him about coming back. You see what I mean by the options

don't have to be attractive. She can sleep at the bus station. She can call a friend of the family that lives here. She can go to a woman's shelter.

The fourth question: What is the best available option? When the list of available options is complete you can look at the attractiveness of each one. Are there any of these possibilities that stand out as the best one? Hopefully, the answer is going to be, "Yes, this one". If the answer is no, then you can ask: Is there one of these that stands out as being the worst? That process of elimination can be used to get rid of all but one option.

Now remember, it is her option, not yours. If the one she chooses really makes you shudder, for example, sleeping in the bus station, you can alert her to this by asking about her decision-making process. What made you chose that one? What are the things that you took into consideration? And so forth.

In helping her select an option, remember that choosing the lesser of two evils may well be her reality. The eventual choice is not likely to be perfectly wonderful and entirely acceptable.

The fifth of these seven questions:

Does the selected option have a deadline? You can go to the bus station anytime. However, if the choice is the women's shelter you had better call right now because the longer you wait the greater the chance that there aren't going to be any beds. So ask yourself how quickly you need to act. Some options can wait a while and others the wheels should be put in motion even before you talk about the most urgent problem.

The sixth of these seven questions: What are the steps in getting from here to the selected option? Maybe there is only one or two, like telephoning the women's shelter and going there if they have a bed. Let's suppose the shelter is full then the next choice is the friend of the family. There's probably a few steps here. It may not be a matter of simply looking up the phone number and calling. The first step is deciding what she will say. What do you want to hear yourself saying when you call? How much explanation of your situation will you give? What exactly will you be asking from the family friend?

So, the first step is deciding what to say. The second might be rehearsing the conversation. The third step would be to call and then perhaps go over.

The last of these seven questions: What is the outcome of the selected option? Basically, how did it turn out? Build in a mechanism to enable the client to let you know. In our example, suppose the family friend does work out and she has been invited to stay for a few days. She could be asked: How about giving me a call a little while after you get there and we can talk about how it's working out? Or, can I give you a call a little while after you get there and we can talk about how it's working out?

Do make sure some sort of follow- up mechanism is built in. After all, suppose the family friend's wife and children departed the scene six months ago and he hasn't bothered to mention this to her. Maybe this would alter the attractiveness of the option.

Let me summarize what this seven question process is intended to accomplish. Where we have started out with a huge overwhelming terrifying mess from the standpoint of the client, the first thing we've done is we've broken this mess down into five problems, five separate pieces. Second, we decided on the priority of each problem. And third, using our highest priority problem as an example, we have identified four options

available to address the problem.

Next, we have made a decision about which option should be pursued. Fifth, we have assessed the deadline of the selected option. Sixth, we have identified and then followed the several steps involved in exercising the option. Seventh, and final, we have identified the mechanism to assess the outcome of the option and constructed some arrangements to enable this to occur.

In general, what we have done is we have taken a large package and we've broken it into several pieces. We then have taken each of the several pieces and reduced them to still smaller steps. As a rule, any time you can take a large package and help a client reduce it to two or more smaller packages the client has been well served.

In conclusion, and yes we are getting near the end of this, let me leave you with some food for thought. We are just about to have some other kind of food, let me give you a bit of a different kind of food first.

Last month I had the opportunity to address the Royal Commission at the Commission's hearings

in North Bay. I offered the Commission two general conclusions about mental health services in the Aboriginal community.

One of these two conclusions strongly emphasized that the mental health services provided to the Aboriginal community should be delivered by Aboriginal personnel. Why? Because the Aboriginal practitioner represents the blend of clinical expertise and cultural background as the situation requires. The Aboriginal practitioner has credibility in the community.

Now, if the desired model emphasizes Aboriginal practitioners serving Aboriginal clients, we have a pragmatic problem. At present there is quite an extreme shortage of trained Aboriginal service providers in the mental health field. One of my students working with me in North Bay, who is a member of the Aboriginal community, tells me that there are only three Native psychologists in all of Canada. That is not very many.

So, what we have then is a rather substantial training issue, but how much training is required to make a meaningful difference? Not to solve every problem that I can put forward to make a difference.

About 10 years ago I had the opportunity

to work at the Crisis Intervention Centre at the Toronto East General Hospital and in that setting volunteers attached to this program were able to provide an excellent crisis intervention service to people presented to the hospital's emergency room after receiving six three hour training sessions. Six.

I would emphasize that the majority of volunteers had little or no prior clinical training or experience. What they did have was interest, concern and a desire to make a contribution. Professional staff provided back-up consultations by telephone when difficult clinical situations arose or when guidance or direction were required.

Even in remote northern communities such professional back-up is potentially available by telephone, notwithstanding the problems we've heard about earlier this morning in terms of language and in terms of collect calls and that sort of thing. It is potentially available.

Let's now ask a little bit about how non-Aboriginal practitioners tend to serve Aboriginal communities at present. Historically I think what has happened is the non-Aboriginal practitioner has been

parachuted into the Aboriginal community to provide one sort of clinical service or another. Now, there are a lot of limitations with this model, including a lack of continuity and care, detachment from the community, detachment from the culture, et cetera.

If the non-Aboriginal practitioner is going to be involved, perhaps that person should have a much more meaningful role as an educational consultant rather than as a clinical practitioner.

In a model like this, training would be provided to members of the Aboriginal community to enable them to offer services on a volunteer basis. What this would require is a curriculum planning process in which the Aboriginal community participates fully. The community would have to tell the practitioner what it is you would hope to get from that person. It would be a partnership between non-Aboriginal practitioners and the Aboriginal community.

Can volunteers make a meaningful difference in the areas of suicide prevention and crisis intervention? They certainly can and I've seen them do it.

I'm sure you're all very hungry. That's

all I have to say.

Thank you for your kind attention.

--- Upon recessing at 12:55 p.m.

--- Upon resuming at 5:00 p.m.

MAGGIE HODGSON, CHAIRPERSON: If we could just have a short report from the four groups, not necessarily reading the recommendations, but if you can talk about some of the common themes and threads that were put forward within your workshop.

If we could start with the Native Women's Association, please. The representative for the Native Women's Association -- okay then we'll move over to the Native Council of Canada.

Nelson, are you out in the hallway?

NELSON MAYER, NATIVE COUNCIL OF CANADA: No, I'm not.

MAGGIE HODGSON, CHAIRPERSON: He always looks so guilty.

Nelson, do you want to come up.

NELSON MAYER: This is just a very short summary of the activity in our group and then we will be working tonight on the full report and providing our report along with the recommendations tomorrow.

In summary, our group first began by reviewing the questions that were in the package. In some of the discussions that came out it was noted that there is a lot of anger still with respect to the issue of suicides, the results of the colonization process, and the impact that it's had on our community because we had front line workers and people who had actual experience on a daily basis of working with people who have been affected and continually they face the issues of suicide.

The other underlying thing as well is the family violence, the sexual abuse and the list goes on and on. So, a lot of the session was on that.

After the coffee break we started into some of the specific recommendations. The common theme that seems to be running around is that government control seems to be number one, with respect to our types of programming. It needs to be designed, developed and delivered by the Aboriginal communities and Aboriginal people.

Another thought was with respect to adequate resourcing to make these programs effective and to make them work. Another thought was directed towards recommendations, towards national leadership. It was

felt that, I think, the summation of the two with respect to national leadership is number one, first and foremost. It is the responsibility of the national leadership to set an example in terms of role models, behaviours and to basically walk the talk when we talk about being responsible and accountable to our communities, and not perpetuating the myths or the images of Aboriginal people in this country where they talk about drunken Indians.

It's unfortunate that some of our leadership, when you see them at meetings -- and this young person who was in our group stated it best when she said that when you see an unhealthy mind how can you expect them to make healthy decisions. So, that was well said by the young person in our group.

The second point would be that in terms of priorities we know that the constitutional issues are important. We know that the economic development issues are important and everything, but it seems that continually the health and wellness of our people is at the bottom of the pile in terms of their priorities. It is stated that if we have healthy people the rest will flow from that.

That would basically be our report.

Thank you.

MAGGIE HODGSON, CHAIRPERSON: Thank you very much, Nelson.

Joey, do you want to do your report for your group or the person that facilitated that session?

JOEY HAMELIN: Cheryl.

MAGGIE HODGSON, CHAIRPERSON: Is Cheryl here?

Cheryl is not here so we will move to the Inuit group, Tapirisat.

DEBBIE KLENGENBERG, INUIT TAPIRISAT OF CANADA: I will try to make this as short as possible and hopefully shorter than our session went because we kind of got bogged down in a few places.

The overall underlying thought was that this whole idea of this get-together was most helpful and a great opportunity for everybody to get together and share ideas, information, experiences, et cetera. It seems that everyone is feeling a lot of pressure to cram everything into a day and a half, so maybe to have another one some time in the future would be most helpful.

Again, it went back down to education at the local level, training local people to deliver the

programs, the support services, and the services offered instead of relying on people to come up from outside and be the resource people.

The lack of funding -- what Nelson said was really what we also said in a different version. We know the Constitution is important and we know that all these things are important, but promoting wellness and providing that actual service to get our people well again is not being looked at. It is not considered an important enough issue.

We talked about what things are working in various communities, such as various crisis lines in some of the regions that are working and promoting spirituality and cultural awareness, et cetera.

We are not nearly finished and we're going to be doing some more work, but that would be the gist of our report and we'll get more in-depth later.

Thank you.

MAGGIE HODGSON, CHAIRPERSON: Thank you very much.

The facilitator for the Native Women's Association.

RUTH NORTON, NATIVE WOMEN'S ASSOCIATION

OF CANADA: I guess we will have a full report of what we've discussed today on the two issues, however the emphasis was on community and community-based programming which would assist the communities themselves.

The underlying message that was talked about and given at our workshop was that community people have to do it themselves. They themselves have to start believing that they are the only ones that can begin the whole process of healing and the whole process of preventing our young people and people from committing suicide.

There were many recommendations that came from the group. What we had was a circle where each one had input into the discussion. A lot of the women that were in our group were front-line workers and we had our elder with us. They all had a lot to contribute.

The other facilitators also talked about some of the things that we touched on, namely the whole history of colonialism and the impact of it, and the fact that our young people are angry and so on. There is a lot of anger out there.

We also talked about processes, a process within the community itself, a process that needs

to occur at the regional level. A process that has to occur throughout the national area and our people to work together in that process. So, we talked about the different levels of what we had to do to prevent suicide among our young people.

The last session we went through three of the major questions. They all had an input into it. Tomorrow we will be providing you with a comprehensive report on what we talked about.

The strong, strong message that came out in our circle was that our own people have to start believing in themselves and they can't look outside to heal what is bothering the people inside the community. The government's role is to provide adequate resources so that sessions like this occur in every community. The government must have resources to provide community-based workshops for every level, every generation, the youth, the very young, the middle age, and also the elders.

Also, a strong message in our group was that our people have their own resources, their own ways of doing things, their own methods of dealing with issues such as suicide and that has to be respected by the government -- both governments. That message was really

loud and clear.

Tomorrow we will have the report, like I said.

Thank you very much.

MAGGIE HODGSON, CHAIRPERSON: Thank you very much.

Is the facilitator for the Métis group back yet?

JOEY HAMELIN, METIS NATIONAL COUNCIL: I'll go ahead.

MAGGIE HODGSON, CHAIRPERSON: Go ahead, Joey.

JOEY HAMELIN: It seems to be a common theme that we're hearing and one of the very strong themes is empowerment. In order to empower our communities we have to begin to respect each other and acknowledge that we have expertise within our own communities.

One of our recommendations was that we need to pay attention to our elders and that we need to connect with our elders in terms of providing us with guidance and direction in our future program planning. Also, vice versa, as technicians we also need to listen to the needs of our seniors and elders in our communities.

The other thing was that we needed to educate our communities, ourselves, towards the acceptance of lesbian and gay people. The other items -- and I will just go through this quickly -- we found that that was very important, that we shouldn't exclude lesbian or gay people.

Also, we highly emphasize female leadership, particularly when we need our issues addressed at other levels, particularly in the political arena, that when we need follow-up or a change in policies or promoting changes within policies that we would strongly promote that our female leadership should keep pushing.

This is not to say that our male leadership shouldn't make our social issues or suicide prevention or sexual abuse and don't treat it as equal as the Constitution, but we felt that female leadership would enable this process.

The other recommendation was a holistic and creative solution to our community problems and that would be developed within our specific communities and not to leave our spirituality out of that process.

Our other recommendation, again as I mentioned earlier, was to count on our own community

resources and our own expertise. Again, it was highly emphasized that we consult and collaborate with our elders.

Our other recommendation was that we need a follow-up by our leadership. When we have conferences or workshops or whatever sometimes we can blame -- when there is research conducted by whomever, the governments or whomever -- that the research is left on the shelves. Sometimes we find that our own leadership can also -- when we do our own conferences we need to ensure that there is follow-up and action to those specific recommendations that affect our communities.

Another strong point was the networking, that we needed to network amongst ourselves so that we can begin to share with each other our initiatives that we've initiated, and to share our limitations with or -- not to use the word failure, but our limitations within our programs that we've designed ourselves.

Also, to share the strengths so that we wouldn't have to duplicate programs or services and to know that we are not out there by ourselves, that there is a large number of us out there and that we need to provide support with each other because of the challenges that this type of field -- the many challenges that we have

to deal with as technicians.

Our other recommendation was that we needed a national strategy with local input and that the community -- we need to consult or collaborate or that it has to be community driven, but that we have a national plan or strategy in place so that we have some guidelines that we can follow.

The other thing was to trust ourselves and to trust our own people, that through this process is the sense of empowerment. To have Métis-specific programs designed, delivered, implemented and evaluated by Métis technicians and that there be funding allotted specifically to design and develop and implement these programs.

We felt very strongly that we needed to conduct our own research, and that kind of ties in with data collection and also ties in with policy development. We need funding to conduct our own research and we felt that we have the expertise within our own communities to conduct this research.

That was about it.

Thank you.

MAGGIE HODGSON, CHAIRPERSON: Thank you

very much, Joey.

I'm going to go over the announcements that I made before because some of the people weren't in the room.

The papers that Adamie Sallualuk offered are out on the table for those people who are interested. It is on suicide intervention from his region and some research that they did.

The sharing circle will be held here at 7:00 a.m..

The facilitators meeting is at 7:00 in the York Room.

We will be commencing tomorrow morning at 9:00 and while we started late this morning because of people having arrived yesterday, et cetera, we are going to be starting at 9:00 sharp tomorrow morning. If you are here, you're here, that's good. If you're not here, we're going to start anyway. So, I know you will be respecting the 9:00 start time.

That's the end of it.

Mrs. Jock, if you could come and say the closing prayer, please.

(Closing Prayer)

--- Whereupon the hearing adjourned at 5:25 p.m.
to resume at 9:00 a.m., Tuesday, June 8, 1993.