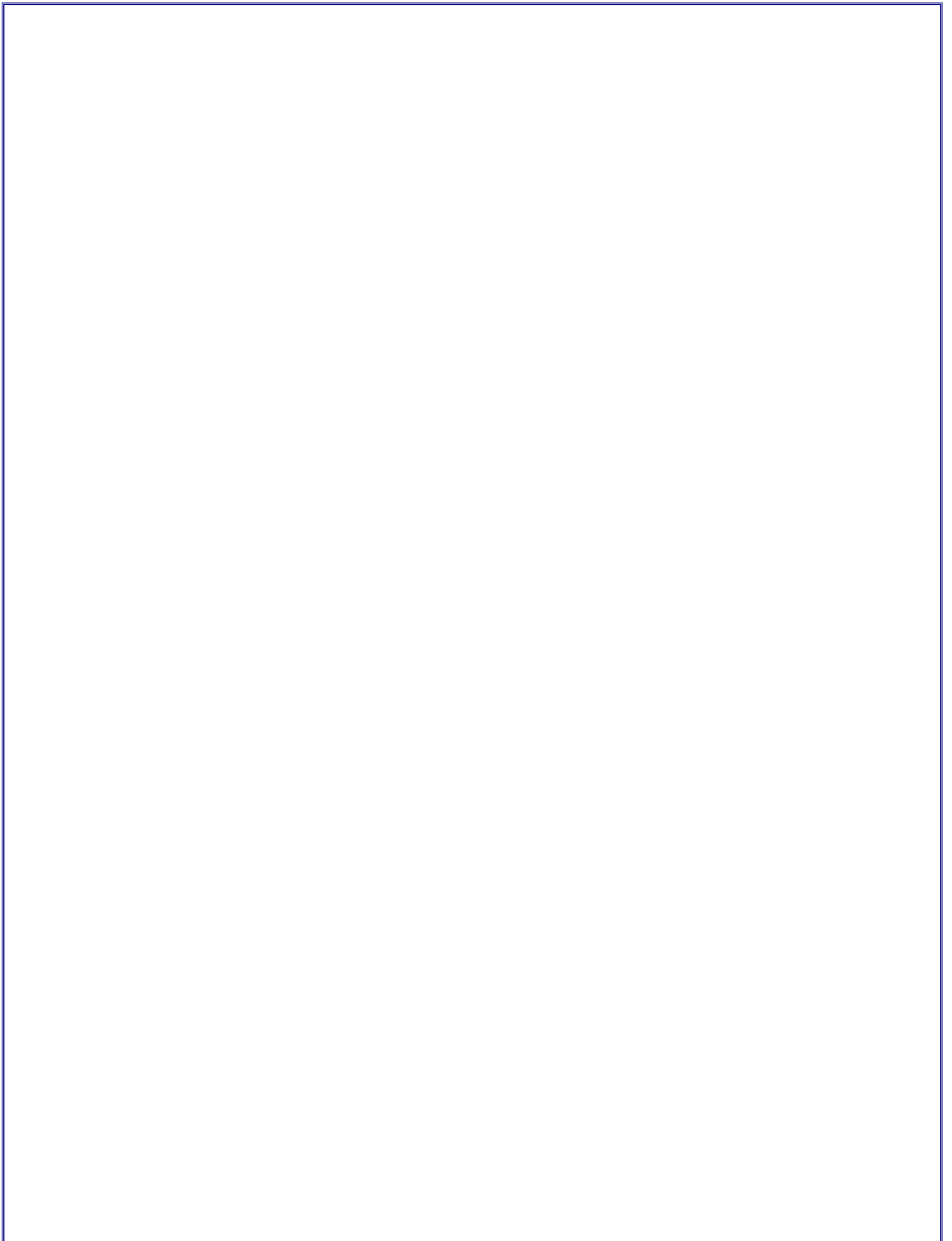




**The Office of the Chief Coroner's  
Death Review of the Youth Suicides  
at the  
Pikangikum First Nation  
2006 – 2008**





# Table of Contents

<b>LETTER TO THE CHIEF CORONER.....</b>	<b>5</b>
<b>PURPOSE OF THE REVIEW .....</b>	<b>7</b>
<b>PROCESS OF REVIEW .....</b>	<b>9</b>
<b>ACKNOWLEDGEMENTS .....</b>	<b>11</b>
<b>EXECUTIVE SUMMARY .....</b>	<b>13</b>
Pikangikum First Nation: The Social Challenges .....	13
Pikangikum First Nation: The Review of the Deaths of the Youth.....	15
Pikangikum First Nation: Health care .....	15
Pikangikum First Nation: Education.....	16
Pikangikum First Nation: Policing Services.....	17
Pikangikum First Nation: The Provision of Child Welfare Services .....	17
Pikangikum: Social Determinants of Health.....	19
Advocate for Children and Youth’s Report: Summary.....	20
The Key Recommendations of this Report.....	21
Summary.....	23
<b>PART A: THE DEATHS OF THE YOUTHS BY SUICIDE .....</b>	<b>25</b>
A1. Introduction.....	25
A2. Method of Review.....	25
A3. The Deaths .....	26
A4. Emerging Themes from Review of the Individual Cases .....	32
A5. The Cumulative Report and Identified Trends .....	33
A6. Discussion .....	35
A7. Concluding Remarks.....	40
<b>PART B. SUICIDE .....</b>	<b>41</b>
B1. Definition of Suicide .....	41
B2. History of Suicides in Pikangikum.....	41
B3. Adolescent Suicide in Canada .....	41
B4. Canadian Suicide Rate Statistics.....	43
B5. Suicide Among Aboriginal People .....	43
B6. First Nations Youth Suicide Rates.....	44
B7. Suicides in Ontario and in Pikangikum, 2006 - 2008.....	44
B8. Concluding Remarks.....	45
<b>PART C: HEALTH IN PIKANGIKUM.....</b>	<b>47</b>
C1. Introduction.....	47
C2. The North West Local Health Integration Network (LHIN) .....	47
C3. The Sioux Lookout First Nation Health Authority (SLFNHA) .....	48
C4. Sioux Lookout Regional Physicians’ Services Inc. ....	49
C5. Sioux Lookout Meno-Ya-Win Health Centre (SLMHC) .....	50
C6. The Pikangikum Health Authority (PHA) .....	51
C7. Challenges .....	53
C8. Recent Successes .....	54
C9. Land-based Solvent Abuse Program .....	54
C10. The Nursing Station.....	56
C11. Relationship with the Federal Government.....	57
C12. Concluding Remarks .....	77
<b>PART D: EDUCATION .....</b>	<b>79</b>
D1. Introduction.....	79
D2. Education Governance: The Pikangikum Education Authority .....	79
D3. Truancy .....	82

D4. Overcrowding and the Inadequate Physical Plant .....	87
D5. Federal and Provincial Involvement in Education Delivery .....	90
D6. Concluding Remarks .....	94
<b>PART E: POLICING SERVICES IN PIKANGIKUM.....</b>	<b>97</b>
E1. Introduction .....	97
E2. Pikangikum First Nation .....	97
E3. Community Expectation of Policing .....	99
E4. Governance Structures.....	100
E5. Pikangikum Policing Statistics.....	100
E6. Concluding Remarks.....	102
<b>PART F: THE PROVISION OF CHILD WELFARE IN THE NORTH AND TO PIKANGIKUM.....</b>	<b>103</b>
F1. Tikinagan Child and Family Services .....	103
F2. Pikangikum: A community in crisis.....	109
F3. The Development of Child Welfare in Ontario .....	109
F4. Cultural Tension.....	110
F5. The Functions of a CAS .....	112
F6. Children in Care (CIC) .....	112
F7. Funding.....	114
F8. Concluding Remarks.....	118
<b>PART G. THE SOCIAL DETERMINANTS OF HEALTH .....</b>	<b>121</b>
G1. Introduction .....	121
G2. Definition.....	123
G3. First Nations Health .....	124
G4. Colonization, Social Structure, Residential Schools and First Nations Health ...	129
G5. Social Determinants of Health and Pikangikum.....	131
G6. Proximal Determinants of Health.....	131
G7. Intermediate Determinants of Health.....	140
G8. Distal Determinants of Health .....	142
G9. Concluding Remarks .....	144
<b>PART H. ADVOCATE FOR CHILDREN AND YOUTH’S REPORT .....</b>	<b>147</b>
H1. Introduction.....	147
H2. Resources and Opportunity .....	149
H3. Schools and Education.....	150
H4. Recreation and Leisure .....	151
H5. Culture and Language.....	152
H6. Family, Community and Leadership.....	152
H7. Final Reflections .....	153
H8. Bibliography.....	155
<b>PART I: CONSOLIDATED RECOMMENDATIONS .....</b>	<b>157</b>
<b>BIBLIOGRAPHY .....</b>	<b>173</b>
<b>GLOSSARY OF TERMS .....</b>	<b>179</b>
<b>APPENDIX 1. Project Charter.....</b>	<b>185</b>
<b>APPENDIX 2. Audit Tool.....</b>	<b>193</b>
<b>APPENDIX 4. First Nations Regional Longitudinal Health Survey (RHS) 2002/03 and Impact of Health of First Nations Adults and Youth.....</b>	<b>203</b>
<b>APPENDIX 5. Pikangikum’s Response to the OCC’s Death Review of Youth Suicides (The “Review”) .....</b>	<b>209</b>

## LETTER TO THE CHIEF CORONER

June 1, 2011

Dear Dr. McCallum,

I submit this report on the review of the deaths by suicide of the youth of Pikangikum First Nation which occurred in the Province of Ontario between January 1, 2006 and December 31, 2008.

The Review Team examined each of the 16 deaths that occurred and the report presents 5 of those deaths as representative examples. The report makes 100 recommendations in the areas of health care, suicide prevention, education, policing, child welfare, and the social determinants of health.

Sincerely,

A handwritten signature in black ink that reads "Bert Lauwers". The signature is written in a cursive style with a horizontal line underneath the name.

Bert Lauwers, MD, CCFP, FCFP  
Project Manager, Pikangikum Youth Suicides  
Deputy Chief Coroner - Investigations  
Chair, Paediatric Death Review Committee  
Office of the Chief Coroner for Ontario



## PURPOSE OF THE REVIEW

This report is a death review of the 16 children and youth between the ages of 10-19 who died as a result of suicide in the years 2006-2008 in the Pikangikum First Nation.

The Purpose of the review was to:

1. Examine the circumstances of the death of each of the children and youth.
2. To collect and analyze information about the deaths in order to prevent further deaths in similar circumstances.
3. To make recommendations directed toward the avoidance of deaths in similar circumstances or respecting any other matter arising out of the review.

The Office of the Chief Coroner has observed, with increasing alarm, the rising toll of First Nation teenage death in northern Ontario youth living on reserve. As a result, a first review of 9 deaths in Pikangikum was completed in 2009, and was presented in the Annual Report of the Paediatric Death Review Committee and Deaths Under Five Committee. A recommendation arising from that review was that a community inquiry be convened to review:

- The understanding and response of the Chief and Council to conditions in the community, which has led to the high rate of suicide.
- The role that education, health and other community services could play in preventing the hopelessness, desperation, and ultimately, suicide of these young children.
- The contributions of community members and natural leaders to the development of strategies to prevent youth suicide.
- The community-wide suicide prevention strategies.
- The development or results since the Sakanee Inquest into aboriginal youth suicide in 1999.

This death review considered and examined these issues.

Bert Lauwers, MD, CCFP, FCFP  
Deputy Chief Coroner-Investigations  
Chair, Paediatric Death Review Committee  
Project Manager, Pikangikum Youth Suicides





## PROCESS OF REVIEW

The Office of the Chief Coroner (OCC) was a subject of the Inquiry into Paediatric Forensic Pathology presided over by Justice Goudge, whose report was received in October 2008. During the Goudge Inquiry, our office listened with great interest to the concerns of First Nations peoples represented by the Nishnawbe Aski Nation and the Aboriginal Legal Services of Toronto alliance (NAN/ALST). A clear message we received was that First Nations people living on reserve who died were not receiving the same scrutiny that our office brought to bear on other deaths occurring in the province, despite many compelling social and health-related issues that existed in these remote, fly-in communities. This report responds to that message. The OCC is very concerned about the surging death toll of children and youth taking their own lives by suicide in First Nations communities in the North West, and most recently, the North East of Ontario.

As the scope of this review was being developed, early consultation was obtained from the Chief of Pikangikum and the Nishnawbe Aski Nation. We were asked to conduct this review, not within the context of an inquest, but utilizing some other format. A death review was chosen, and as the scope was evolved, it became clear that a simple death review would be insufficient, given the breadth of issues that are encompassed within the rubric of First Nations youth suicide deaths. Therefore, this review focused on the community itself including infrastructure, policing, health, education, the delivery of child welfare as well as the social determinants of First Nations' health.

The review has five contributing parts. The reader is referred to Appendix 1, the Project Charter for the details. Two trips with stops in Sioux Lookout and Pikangikum occurred in March and again in October, 2010. Accompanying the Office of the Chief Coroner on the trip in March were Mr. Jason Beardy from the Nishnawbe Aski Nation, Ms. Thelma Morris, Assistant Director of Service with Tikinagan Child and Family Services, Ms. Linda Nothing-Chaplin, formerly of the North-South Partnership, Sgt. Chris Amell with the Red Lake Detachment Ontario Provincial Police, and Ms. Susan Abell.

In part one, the OCC met with the Chief and Council, and conducted interviews with members of policing, healthcare, education, and child welfare organizations.

Part two was conducted by Mr. Irwin Elman and Ms. Laura Arndt from the Office of the Provincial Advocate for Children and Youth, utilizing his office's expertise to represent the views and concerns of the living First Nations children and youth. Their observations are reflected in the section on the Child Advocate's Report.

Part three was the Psychiatry, Child Welfare, and Coroner's Death Review Panel which conducted an in-depth systematic review of each of the sixteen youth who died. The reader is referred to Appendix 2, the Audit Tool, for the details of each of the deaths which was examined. This panel consisted of a coroner, child welfare specialists Ms. Karen Bridgman-Acker and Ms. Susan Abell, and three psychiatrists including Dr. Richard Meen, a paediatric psychiatrist who has provided care in Pikangikum, Dr. Paul Links, the current Arthur Sommer Rotenberg Chair in Suicide studies at St. Michael's Hospital in Toronto, and Dr. Cornelia Wieman, a First Nations woman who is also Canada's first female First Nations psychiatrist. The panel also included Dr.

Peter Menzies, a First Nations man who is the Clinical Head, Aboriginal Services at the Centre for Addiction and Mental Health (CAMH), as well as Ms. Sabrina Squire, a nurse of Métis heritage and currently a medical student at the University of Ottawa, who has provided primary health care service to 18 different First Nations remote communities in the North. The findings of this panel are presented in the sections, The Deaths of the Youths by Suicide, and Medical Care in Pikangikum.

In part four, Dr. Judy Finlay from the School of Child and Youth Care, Ryerson University, and Ms. Anna Nagy, Instructor, Department of Psychology, University of Toronto - Mississauga, provided a paper on the social determinants of health. Concepts arising from this paper are reflected in the section on the Social Determinants of Health.

In part five, Dr. Don Auger, a First Nations man who is a lawyer and the current Executive Director of Dilico Anishinabek Family Care Children's Aid Society, provided a discussion paper on the challenges of providing child welfare in the north. Sections from his report and the observations of Ms. Bridgman-Acker comprise the majority of the section of this report on The Provision of Child Welfare in the North and to Pikangikum.

Recommendations arising from each of these five parts of the review are provided and presented throughout the report and in the consolidated recommendations. The recommendations are both of a systemic nature, and of a local community nature. It is the belief of the OCC that the recommendations directed at the community level to assist in abating the rising tide of youth suicide, if implemented, will be successful in Pikangikum. Further, these same recommendations could successfully be incorporated into any First Nation in Ontario, to assist in dealing with their community suicide surge. Prevention, intervention and postvention strategies are provided at the individual, family, community and regional level. The larger systemic recommendations speak to the need for system integration and seamless, coordinated care delivered to First Nations on reserve to restore mental, physical, emotional and spiritual well-being. Solvent abuse in the youth and alcohol abuse in their parents are major contributors to youth suicide, as the compelling stories of the youth will depict. These too, are addressed in recommendations.

The OCC would like to acknowledge our gratitude for the many contributions of the talented and knowledgeable people listed above who so willingly, and with interest, provided their time, thoughts and wisdom to this project to ensure its success.

## ACKNOWLEDGEMENTS

It is most appropriate to begin acknowledgments with the children and youth of the Pikangikum First Nation. Their lives are a testimonial to stamina, endurance and resilience, and their futures hold great promise. The key is for those who are empowered to change their situation, to act. This concept is well captured in the Royal Commission on Aboriginal Peoples Final Report (1996):

*“Aboriginal youth want to be the solution, not the problem. Healing youth today will lead to their empowerment tomorrow. With empowerment, they will have the mental, physical, emotional, and spiritual energy to help those around them: their peers, their parents, and their communities. The circle of wellness will grow.”<sup>1</sup>*

The Investigators, Dr. Bert Lauwers, Ms. Susan Abell, Ms. Karen Bridgman-Acker, and Ms. Doris Hildebrandt, would like to acknowledge the following for their invaluable contributions to the Death Review:

- Grand Chief Stan Beardy of the Nishnawbe Aski Nation for his guidance and patience in explaining First Nations’ perspectives.
- Chief Jonah Strang, Deputy Chief Lyle Keeper and members of the Pikangikum First Nation Council as well as their legal counsel, Mr. Doug Keshen, for his advice and guidance and for supporting this initiative.
- The Pikangikum Health Authority, specifically Mr. Billy Joe Strang and Mr. Brian Keeper, for their cooperation and assistance.
- Mr. Jimmy Keeper of the Pikangikum Education Authority for his cooperation and assistance. Former principal Mr. Phil Starnes, current principal Ms. Joanne Donnelly, and teachers Mr. Kurtis MacRea, and Ms. Colleen Estes for their candour in discussing educational and community-based challenges.
- Former Commissioner of the Ontario Provincial Police Mr. Julian Fantino, Superintendent Brad Blair, and Sgt. Chris Amell for their dedication to ensuring the success of this review, including providing logistical support and communication expertise, and their invaluable written submission on the provision of policing services in Pikangikum, which is reflected in the report on Policing in Pikangikum.
- Ms. Jeanette Lewis, former Executive Director of the Ontario Association of Children's Aid Societies (OACAS) and former member of the Paediatric Death Review Committee, for her persistence and encouragement in promoting a review of First Nations’ youth suicide by the Office of the Chief Coroner. Also, Ms. Mary Ballantyne, the current Executive Director, for her continuing guidance and sharing of her expertise and knowledge to further the success of this report.
- Mr. Micheal Hardy, Executive Director of Tikinagan Child and Family Services, and the employees of Tikinagan as well as their counsel, Ms. Catherine Beamish of Beamish McKinnon Aboriginal Law Firm, for their thoughtful representations to the Office of the Chief Coroner about First Nations child welfare.

---

<sup>1</sup> The Royal Commission Report on Aboriginal Peoples (1996), Volume 4, Perspective and Realities, Chapter 4, The Search for Belonging: Perspectives of Youth. <http://www.ainc-inac.gc.ca>.

- Mr. James Morris, Executive Director of the Sioux Lookout First Nations Health Authority, and Mr. Kevin Berube of Nodin Child and Family Intervention Services, for explaining mental health services in the north.
- Representatives from the Sioux Lookout Meno Ya Win Health Centre including Ms. Barb Linkewich, Vice President Health Services, Ms. Helen Cromarty, Special Advisor for First Nations Health, Dr. Bob Minty, Staff Physician, and Dr. Terry O’Driscoll, Chief of Staff, for explaining the complexities of primary, secondary and tertiary health care provided to First Nations in the Sioux Lookout Zone.
- Dr. Peter Braunberger for explaining the challenges of providing child psychiatry services in the north.
- Dr. Mark Lachmann, psychiatry resident and former First Nations primary care physician in the north, for sharing his views and experiences with respect to First Nations youth suicides.
- AMDOCS, including primary care physicians Dr. Anton Meyer, Dr. Ekow Barnes, and nurses from the Pikangikum Nursing Station including Head Nurse Melanie Turpin and others, for explaining the provision of health services and the challenges of care in the community of Pikangikum.
- Mr. Lachie Macfadden for explaining the prevalence and challenges of solvent abuse in Pikangikum.
- Ms. Susan Pilatzke of the North West Local Health Integration Network (LHIN) for sharing the evolving vision of the LHIN for the provision of health services.
- Ministry of Education, Ministry of Training, Colleges and Universities, French Language, and Aboriginal Learning and Research Division, for the provision of information about provincial aboriginal education strategies, provision of resources and challenges.
- Ministry of Aboriginal Affairs for their encouragement and sharing of information.
- A special thanks to Ms. Deborah Richardson who reviewed early and successive drafts of the document and provided valuable feedback.
- Dr. Donald Auger for his thoughtful provision of published materials which greatly assisted the project.
- Ms. Rowena Cruz for her administrative and formatting expertise.
- Ms. Dorothy Zwolakowski and Ms. Kathy Kerr from the Office of the Chief Coroner for their review and providing editorial suggestions.
- The Project Manager would like to thank Ms. Doris Hildebrandt for her valuable edits.

The investigators would also like to thank Dr. Andrew McCallum, Chief Coroner for Ontario, for his insight and belief that a physician-coroner led death investigation system can and should properly focus on social justice issues to improve the health, safety, and well-being of the citizens of Ontario, *all citizens*, whether Aboriginal or non-Aboriginal.

## EXECUTIVE SUMMARY

In the years from 2006-2008, 16 children and youth between the ages of 10-19 killed themselves by hanging in the Pikangikum First Nation. The Office of the Chief Coroner undertook a review of these tragic deaths.

### Pikangikum First Nation: The Social Challenges

The Pikangikum First Nation is a remote community approximately 100 kilometres north of Red Lake. It can only be accessed by winter roads across Lake Pikangikum, or by aircraft as it is a fly-in community. It has approximately 2,400 residents, with a high birth rate. Teen pregnancy is common, and about 70-90 babies are born there each year.



Picture 1. Map of the Province of Ontario.

There are approximately 450 homes in the community. Of these, 340 have no indoor plumbing or running water. The school, government buildings, and 43 houses are connected to a sewage lagoon. A water treatment system exists that is 16 years old. Through underwater pipes, it delivers water to distribution posts where people collect their drinking water in containers. On Death Review of the Youth Suicides at the Pikangikum First Nation, 2006-2008

April 15, 2011, the First Nation declared a state of emergency due to a lack of potable and running water. This crisis challenged the financial resources of the community, posed a potential health risk and required an integrated and dedicated response.

The community is not connected to the hydro grid. Power in the community is at its capacity, is diesel generated, and can be unreliable. Efforts are being made to connect to the grid.<sup>2</sup> In 2008, there were 170 jobs in the community, with 50 held by persons from outside the community such as teachers and nurses. The 170 jobs are dedicated to teaching (50); Band office (40); health (30); buildings, renovation (20); trades, roads, power, IT (20); and the White Feather Forestry Project (10). There are 542 heads of households receiving social assistance. “Virtually all of the Band’s financial resources come from the Federal Government.”<sup>3</sup>

Pikangikum is an impoverished, isolated First Nations community where basic necessities of life are absent. Running water and indoor plumbing do not exist for most residents. Poverty, crowded substandard housing, gainful employment, food and water security are daily challenges. A lack of an integrated health care system, poor education by provincial standards and a largely absent community infrastructure are uniquely positioned against the backdrop of colonialism, racism and social exclusion arising from the historical plight of First Nations people including the effect of residential schools. These all contribute to the troubled youth, who appear to exist in a dysphoric state, caught between the First Nations traditions and cultures of their forefathers, and contemporary society which they are poorly equipped to navigate and engage.

*“Many Nishnawbe Aski young people are struggling with questions of who they are and where they belong. They are exposed to lavish lifestyle through the media, while attending urban high schools, and when travelling to larger centres; but the living conditions of the families and communities leave them with only the reality of extreme poverty. They are called “Indians” but they know that they are not “Indians.” They know that their lifeline should be connected to the land and its resources, but nothing in the mainstream education system or the media helps them build this connection. They wonder who they are or why they exist. Coupled with the physical, emotional and/or sexual abuse that has become intergenerational as a result of residential schools and loss of identity, it is not surprising that some young people decide it is easier to leave this world than to live in it. Suicide comes to be a viable alternative when there seems to be no hope of finding help or relief from an unending cycle of poverty and abuse: social, racial, physical and sexual.”<sup>4</sup>*

An environmental scan of the First Nation is well captured by the report of the North South Partnership for Children. That report stated, “The community experiences significant social, health, infrastructure, economic, capacity, and governance deficits. These deficiencies are not minor. They are linked, they contribute to and compound each other and they are not susceptible to quick fixes.”<sup>5</sup>

---

<sup>2</sup> North South Partnership for Children and the Pikangikum Community Members Participatory Assessment of Pikangikum, February 2008, p. 12.

<sup>3</sup> Ibid., p. 14.

<sup>4</sup> Horizons of Hope: An Empowering Journey. Youth Forum, Final Report, Nishnawbe-Aski Nation Youth Forum on Suicide, 1996, p. viii-ix.

<sup>5</sup> Ibid., p. 14.

## **Pikangikum First Nation: The Review of the Deaths of the Youth**

Striking characteristics and details emerged as a result of this review:

- The suicides occurred largely in clusters.
- The youth were very young when they took their lives, many being less than 15 years of age.
- All of the deaths were due to hanging.
- None of the children had sought help from a trained professional in the month before they died.
- Many had a history of mental health problems.
- Almost all of the children were solvent abusers.
- Over half of the children had a history of exposure to suicide in their families, including parents and siblings.
- School engagement and attendance appears to have been very limited.
- Domestic violence was common in their families.
- Substance abuse in parents was common.
- Being victims of violence, and/or perpetrating violence on others were common occurrences.

Most troubling is the solvent abuse problem. In Pikangikum, young girls in grades 3 and 4 recently self-reported that as many as 27% had tried sniffing gasoline. Exact numbers are unknown, and it is estimated that there are as many as 300 solvent abusers in the community of 2,400.

## **Pikangikum First Nation: Health care**

Healthcare services to First Nations on reserve are provided by a myriad of providers, federally and provincially, in multiple jurisdictions. For example, in the Pikangikum Nursing Station, AMDOCS provides different physicians, although continuity is attempted. When a patient is sent out of the community, a different and usually unknown physician will assume the care of the patient in hospital, usually in Sioux Lookout. There is no case management. There is no electronic file which is readily reproducible and transferable between healthcare providers involved in the circle of care.

Health care is provided in a fragmented, chaotic and uncoordinated system. Also, there are clear gaps in service, and in some cases, qualified people to deliver that service. The community has arguably the most significant mental health and substance abuse issues in the entire province. The Pikangikum Health Authority has evolved a model which is seeking to integrate services through the Pikangikum Social Health, Education and Elders (SHEE) Committee. The Health Authority's efforts to provide for integration of services represent a promising path.

However, several key themes emerge:

1. Jurisdictional issues exist between federal and provincial providers, and these issues can impact service provision.
2. Accessing necessary programs and services can be challenging in this remote First Nations community.
3. Even if a service is reported to exist within the community, the benefit to the individual client/patient at the community level may be minimal to nonexistent. (See solvent abuse and NNADAP programs, page 57).
4. This First Nations community has unique mental health and substance abuse issues amongst its youth.
5. Services are best characterized as existing in silos with lack of integration and coordination.

## **Pikangikum First Nation: Education**

The school burned down in 2007, and has yet to be replaced. A cluster of deaths by suicide occurred shortly after the destruction of the school. The community needs a school with all of the opportunities a fully functioning physical plant has to offer. Indian and Northern Affairs Canada has reportedly committed to building a new school.

Truancy remains a significant problem in the community. There are currently 520 children enrolled in school for 2010-2011. There are another 300-500 children of school age who are likely eligible for school. The exact number is unknown. Children not attending school will experience increasing isolation from mainstream Pikangikum society, lack of programming and healthy activity, and could easily fall into the lure of solvent abuse. As noted by First Nations' leadership, children need to attain education to have marketable skills and therefore, hope for the future. They must attend school to do this. The Pikangikum First Nation needs to meaningfully decide the role their school should play in the lives of their children.

Pikangikum graduates just 8 or 9 youth from a high school stream each year. These children are largely not equipped for post-secondary education, and in fact, none of the youth who graduated in 2009 sought college or university educations following graduation. Children who demonstrated academic aptitude were previously given the opportunity to obtain a high school education at a First Nations' High School located in Pelican Falls. These children have been identified as bright and motivated, and might have the ability to obtain a college or university education, if exposed to a quality high school education. Currently, the only option is to obtain their education at Pikangikum. The Office of the Chief Coroner was told that the privilege of attending an advanced First Nations' high school has recently been revoked by the Northern Nishnawbe Education Council (NNEC). If possible, it should be re-instated. Pikangikum needs its children and future leaders to be exposed to the best high school educational opportunities.

The funding disparity that exists between what the federal government spends and what the Province of Ontario spends per student leaves First Nations children receiving education on reserve at a significant disadvantage. Most concerning, they represent the very students at greatest need within the province. This should be addressed. The provincial Ministry of Education also has genuine expertise in the delivery of education. The constitutional and treaty obligations resulting in the fiduciary responsibilities of the federal government to provide education to First Nations on reserve should not be relinquished. However, serious consideration should be given to expanding and utilizing the expertise of the province in the delivery of education. This might include either a committed tripartite agreement between the province, the federal government and First Nations, or alternatively, the complete transfer of this responsibility, from federal to provincial jurisdiction with funding provided by the federal government.

The creation of a First Nations school board for the north, managed and operated by the First Nations on behalf of their own children and youth, should be considered. The school board would have the ability to create its own opportunities for enhanced student achievement, provide models for the effective stewardship of resources, and delivery of education uniquely First Nations respecting culture and tradition.



The Pikangikum Education Authority should create improved health opportunities for young women and their children, including a Day Nursery to care for the children of young women who deliver infants in their teenage years so that they can have the opportunity to continue their educations. Full-day kindergarten would be of great benefit to the community, given the large number of births each year, and the knowledge that children graduating from the Pikangikum School are actually 3 years behind mainstream Ontario students.

### **Pikangikum First Nation: Policing Services**

The OPP has a long history of providing policing to Pikangikum and in supporting the officers who have worked there. Pikangikum is currently policed under the Ontario First Nations Policing Agreement (OFNPA) by First Nations constables employed by the community and supported by the OPP. Pikangikum is the busiest First Nations community in Ontario in terms of policing.

There were approximately:

- 4,700 calls for service in 2009
- 3,000 lock ups per year, and up to 60 persons in cells at one time is not uncommon

Pikangikum has a complement of seven First Nations constables under the OFNPA and one position through the five-year Police Officer Recruitment Fund (PORF). The community is rarely able to maintain its full First Nation constable complement and even if the designated staffing level could be maintained, the community would be critically short of police officers, based on the number of calls for service.

The community wants to see its First Nations constable positions filled with qualified candidates and the OPP supports this position. Recruitment and retention of First Nations constables is difficult given significant challenges ranging from issues of workload, remoteness, housing, accommodation shortages, and the challenges of the stresses inherent where these constables have to police their neighbours, and at times, their families.

The community has a high crime rate compared with other First Nations communities. The OPP has a stabilizing effect and diminishing their capacity to respond has the potential to lead to an escalation of chaos and significant harm, particularly to those who are most vulnerable, such as children, youth, and the elderly. There is a need for police to be allowed to exercise their policing expertise in the absence of local Pikangikum First Nation political interference.

### **Pikangikum First Nation: The Provision of Child Welfare Services**

Provincial child welfare services were extended to Indian Reserves following major changes to the Indian Act in 1951. The changes included a section (now Section 88) that provided for the application of provincial laws of a general nature to “Indians on reserve.” This change allowed Children’s Aid Societies (CAS) to apprehend children from Indian Reserves. As a result of this change, there were exceedingly large numbers of Indian children who were taken into the care of a CAS. Many of these children were eventually placed for adoption with non-aboriginal parents around the world. This is generally known as the “60’s scoop” even though it occurred throughout the period from 1951 to about 1980. For example, in 1980, there were just over one

thousand Indian children in the care of CAS's, with more than half of them in the care of Kenora-Patricia Children's Aid Society.<sup>6</sup>

Aboriginal leaders thought it important to stop this process and take control of child welfare themselves. They wanted to stop the loss of children, and the destruction of the family, the community social fabric, and culture that occurred through this process. In 1981, the Chiefs of Ontario Indians passed a resolution denouncing these laws and calling for a means for Indian communities to look after their own children. In 1984, the Child and Family Services Act was amended and the new Part X of the Act allowed for the creation of First Nations child welfare authorities and societies. Not long after, several incorporated groups were recognized under Part X as "child welfare authorities" and later, as societies.

When parents drink, they sometimes abandon, neglect, and abuse their children. When this occurs, CAS workers step in to care for the children. The result of this involvement is that the number of Aboriginal children across the north that are in care is much higher than the provincial average. There are a disproportionate number of Aboriginal children in care (CIC's) in all areas of Ontario. Seventeen per cent (17%) of all children in care in the province are of Aboriginal descent. The rate per hundred thousand of Aboriginal children in care in Ontario is 2,875 while the rate for all children in Ontario is 640. Thus, the rate for Aboriginal children is about four and a half (4.5) times the provincial rate.

Tikinagan Child and Family Services is a First Nations children's aid society required to provide service to extremely challenging clients in Pikangikum. The clients themselves often do not have even the basic necessities of life such as adequate housing, running water, and safe, affordable food sources. Added to this, is the complexity of trying to administer child welfare services where the client may not speak English, in a community that can only be accessed by airplane, or winter road. Tikinagan has encountered great difficulty in identifying and retaining adequately trained staff. Resources, both human and fiscal, have been traditional areas of great tension. The Ministry of Children and Youth Services should ensure that children's aid societies providing service to First Nations communities, have unique and adequate funding to provide that service equivalent to provincial standards, or as closely approximating the level of service provided in other jurisdictions in Ontario as is reasonably possible.

Tikinagan is but one of a few available service providers to the community. They find themselves in the unenviable position of trying to mitigate a series of compelling difficulties such as domestic violence, crime, parental substance abuse, or solvent abusing suicidal youth, with limited to no community resources or supports to assist them. They have become the default provider for many absent services, which are easily accessible and exist in southern Ontario.

Currently, there are approximately 200 open files with approximately 80 children in care in Pikangikum, a community of 2,400. Lack of adequate housing and overcrowding has created a situation whereby children in care must be sent out of the community to foster homes far away. This has been a source of ongoing tension between the First Nation, Chief and Council and the Society.

---

<sup>6</sup> Brubacher, Maurice. *Coming Home, The Story of Tikinagan Child and Family Service*. Sioux Lookout, Tikinagan Child and Family Services, 2006.

## **Pikangikum: Social Determinants of Health**

The social determinants of health are the economic and social conditions under which people live which determine their health. A contemporary Aboriginal view of the social determinants of health considers the following:

- Proximal determinants of health include health behaviour, physical environments, employment and income, education, and food security.
- Intermediate determinants of health include healthcare systems, educational systems, community infrastructure, resources and capacities, environmental stewardship, and cultural continuity.
- Distal determinants of health include colonialism, racism and social exclusion, and self-determination.

The tangible and readily achievable goals would include such rudimentary items such as having running fresh and safe water delivered to their homes, hook-ups to a viable and safe sewage system, and linking to the power grid. This would address such issues of lack of water in homes, the use of pit privies for toilets, and reliance on a diesel fuel generated power system. The most important social determinant of health, however, is education. There is no greater barrier to improving the health, mental health, and suicide rate in Pikangikum than through its education system. Many of the children do not go to school. Many of these children sniff solvents. Those that do go to school are not being given the quality of education which prepares them for the contemporary world outside of Pikangikum. Almost none of these children seek post-secondary education.

The Whitefeather Forest Management Corp. is Pikangikum owned and has been working in close co-operation with the Ontario Ministry of Natural Resources (MNR) to meet the terms and conditions for acquiring the Sustainable Forest License (SFL). A conditional SFL based on the work that has been completed to date included an approval for an Environmental Assessment coverage for Forest Management Planning. The sole work to be completed is the Forest Management Plan (FMP), which is on schedule for completion in early 2012.

Once the Forest Management Plan (FMP) is completed, (projected for the spring of 2012), Pikangikum will have management control over approximately 1.3 million hectares of Crown lands (traditional ancestral lands of the people of Pikangikum known as the Whitefeather Forest), and will have approval to commence commercial forestry operations. It is estimated that approximately 350 jobs, on a sustainable, permanent basis, will be generated, both in the woodlands operations and in the opportunities that will be created in the sawmill and plants that will produce value-added products.

To position its youth to secure the Whitefeather Forest Project employment opportunities, Pikangikum has committed to the strategic purchasing of LKGH, a market logging business. This will provide immediate employment opportunities in the forest area adjacent to the projected Whitefeather Forest lands. In addition to the acquisition of an annual timber harvest, the purchase includes woodlands harvesting equipment and an option for a lease-to-purchase of the sawmill owned by LKGH in Red Lake.

The youth of Pikangikum need hope and promise for their future. Health is intimately linked to economic prosperity. If successful, the Whitefeather Forest Project has the potential to be transformative for the youth and future generations of Pikangikum. Significant and sustainable

employment for the youth and community of Pikangikum is integral for the success of the many health-related recommendations to prevent youth suicide.

Pikangikum must educate a critical mass of its young children and youth, and adequately prepare them to face the world and lead Pikangikum to a better and brighter future. As education increases, relative income and health increases. Education enables capacities and resiliencies to withstand life's stressors. Education will contribute to health and prosperity of Pikangikum's people by giving them the knowledge and skills to control their life circumstances and problem solve. When this happens, the unfathomable deprivation they face through poverty, lack of running water, crowded inadequate housing, lack of a sewage system, and the death of their youth through suicide will finally abate.

## **Advocate for Children and Youth's Report: Summary**

### **Overview: The Office of the Provincial Advocate for Children and Youth**

The Office of the Provincial Advocate for Children and Youth (OPACY) is an Independent Commission of the Legislature of Ontario established under the Provincial Advocate for Children and Youth Act, 2007. The mandate of the Office, outlined in the opening paragraphs of the legislation<sup>7</sup>, is to:

- Provide an independent voice for children and youth, including First Nations (FN) children and youth and children with special needs.
- Encourage communication and understanding between children and families and those who provide them with services.
- Educate children, youth and their caregivers regarding the rights of children and youth.

The Office provides direct advocacy support to children and youth, as well as systemic advocacy focused on improving the delivery of services and supports to children and youth in Ontario. As part of its duties, the Office conducts reviews of programs in its mandate and/or creates and participates in the development of reports to governments and the public.

In the spring of 2010, the Advocate's Office was asked by the Office of the Chief Coroner's Deputy Chief Coroner, Investigations, to prepare a submission for a report into the catastrophic impact of suicide in one of Ontario's on-reserve First Nations communities. It was hoped that a submission from the Office of the Provincial Advocate for Children and Youth would link the voices of First Nations youth to a review of the issues directly impacting their lives.

This request came at the same time that the Advocate's Office was engaged in two key activities. The first was OPACY's discussions with the Chiefs of Ontario, Nishnawbe Aski Nation and meetings with on-reserve communities and services in remote and fly-in communities across Northern Ontario. The second was OPACY's involvement in the development of the Canadian Council of Provincial Child and Youth Advocates position paper, "Aboriginal Children and Youth In Canada: Canada Must Do Better."<sup>8</sup>

---

<sup>7</sup> Provincial Advocate for Children and Youth Act, 2007, S.O. 2007, c. 9  
[http://www.e-laws.gov.on.ca/html/statutes/english/elaws\\_statutes\\_07p09\\_e.htm](http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_07p09_e.htm)

<sup>8</sup> Canada, Canadian Council of Provincial Child and Youth Advocates, "Canada's Aboriginal Children and Youth Must Do Better" (2010) <http://provincialadvocate.on.ca/documents/en/Position/20Paper/20-Canadian Council of Provincial Child and Youth Advocates.pdf>

The decision to write the submission was contingent upon assurances that the independence of the Advocate's Office in this work would not be impeded upon and that the views and voices of young people would be given equitable consideration as part of the broader review into the suicide deaths of First Nations young people in one of their communities. Ultimately, the decision to participate in this work was supported as we believe the inclusion of the voices of First Nations young people is of critical importance when seeking solutions to a broad scope of issues impacting their lives, issues that can contribute to the decision by some First Nations youth to end their lives.

Wherever possible direct quotes from young people are incorporated in the submission in order to accentuate and reinforce the depth of feeling and intensity of commitment to changing the status quo these youth bring to discussions about their life situations.

### **The Key Recommendations of this Report**

The Pikangikum First Nation has comprehensively reviewed the report. Their views are presented in a letter sent to the Office of the Chief Coroner and can be found in Appendix 5, as well as throughout the report. They have identified 7 main priorities for implementation of the recommendations of the report. These are presented below:

1. INAC should fulfill its commitment to build a new school in Pikangikum as soon as possible. The school should be built to:
  - accommodate all children currently of school age and projected future enrolment,
  - include children's playgrounds, soccer fields, baseball diamonds, and basketball courts,
  - include an auditorium where community members can gather for traditional and cultural community events; and
  - include a daycare facility.
2. INAC should be a stakeholder in the housing strategic study (see recommendation #89) and plan for the building and upgrading of sufficient housing units to address the critical housing shortage and overcrowding that exists in the Pikangikum First Nation. It is the belief of the current Chief and Council that to effectively alleviate overcrowding, 50 new homes are required.
3. INAC and the Pikangikum Housing Authority should ensure that all homes built in the future are connected to water for indoor plumbing, and the sewage disposal lagoon. In addition, the Pikangikum Housing Authority should study and determine which homes could be retrofitted to allow for indoor plumbing and sewage. Funding for the projected improvements to the homes which could be retrofitted for indoor plumbing and sewage disposal should be provided by INAC.
4. Indian and Northern Affairs Canada (INAC) and the Pikangikum First Nation should complete its earlier project to connect the First Nation to the hydro grid. Funding for this initiative should be provided by INAC.
5. The Government of Canada, Indian and Northern Affairs Canada should support the Pikangikum First Nation's Whitefeather Forestry Project.
6. Pikangikum First Nation should develop a community Healing Treatment Centre with funding provided by Health Canada, Inuit and First Nations Health Branch. The Centre could house multiple providers of health services under one roof including Tikinagan Child and Family Services, the community mental health workers, NNADAP workers and the solvent abuse workers. Children who are apprehended by police for solvent

intoxication would not be lodged in police cells overnight, but rather, would be brought to a safe sheltered environment in the Centre to be monitored by peace keepers until they are no longer intoxicated. The comprehensive in-community Solvent Abuse Program after-care could be delivered at this location.

7. The Pikangikum Housing Authority should clearly identify its future land needs as a product of its study (see recommendation #89) and with the assistance of Indian and Northern Affairs Canada, obtain reserve lands to allow for sustained population growth in its membership.

The Pikangikum First Nation recommended that the Social Health Education and Elders Committee (SHEE) implement the balance of the recommendations referencing recommendations #1-99, and further, that a semi-annual meeting take place between the Office of the Chief Coroner, the Pikangikum First Nation, the Province of Ontario and Government of Canada.

The Office of the Chief Coroner has identified the following recommendations in addition to those of the First Nation which it considers vital:

8. The Pikangikum Health Authority should develop a Comprehensive Mental Health and Addictions Program for children, youth and adults. This program should consider:
  - A Comprehensive Community Suicide Prevention Program.
  - Developing plans to address the solvent and alcohol abuse crises.
  - The need for integrated provision of mental health services including models which incorporate traditional practices as defined by the Pikangikum First Nation.
9. INAC and the Pikangikum First Nation should review the current water treatment system and identify the need for any upgrades to ensure that Pikangikum has access to safe healthy potable water, immediately and in the future. Funding for the projected improvements to the water treatment system should be provided by INAC.
10. INAC and the Pikangikum First Nation should review the sewage disposal system and identify the needs for any upgrades to ensure that Pikangikum has a safe, healthy sewage disposal system in the future; one which will not compromise the First Nations drinking water supply. Funding for the projected improvements to the sewage disposal system should be provided by INAC.
11. The Federal Government, Indian and Northern Affairs Canada should develop an antipoverty strategy for Aboriginal people, particularly focusing on those living in remote and isolated First Nations reserves such as Pikangikum. This strategy could be modelled after provincial strategies such as Ontario's Poverty Reduction Act, 2009 or Nova Scotia's Poverty Reduction Strategy.
12. A Committee should be struck called the Pikangikum Steering Committee:
  - Joint chairs should be named from a Provincial Ministry and the Federal Health Canada, First Nations and Inuit Health Branch.
  - The Province of Ontario should have inter-ministerial representation at the Assistant Deputy Minister level from the Ministries of Health and Long-Term Care, Aboriginal Affairs, Children and Youth Services, Community Safety and Correctional Services, Health Promotion and Sport, and Education.
  - The Pikangikum First Nation should be represented on the Committee by the Chief, Deputy Chief, a youth leader and an Elder.
  - Federal Government representatives on the Committee should include Indian and Northern Affairs Canada, and Health Canada, First Nations and Inuit Health Branch.

- Invited members might include the North West Local Health Integration Network, the Sioux Lookout and First Nations Health Authority, the Nishnawbe Aski Nation, the Sioux Lookout Meno-Ya-Win Health Centre, Nodin Child and Family Intervention Services, Tikinagan Child and Family Services, the Ontario Provincial Police, the Ontario Child and Youth Telepsychiatry Program, and a paediatric and adolescent psychiatrist providing services in the North West of Ontario.
- The purpose of the Pikangikum Steering Committee would be to advance the recommendations included in this report.

## Summary

The children and youth of Pikangikum have been taking their lives at an extraordinary rate for a number of years. This death review focused on 16 of the deaths that occurred between the years 2006-2008. The themes that emerged from a review of the circumstances of the deaths and the lives of the youth, was not a story of capitulation to death, but rather, a story of stamina, endurance, tolerance, and resiliency stretched beyond human limits until finally, they simply could take no more.

This review has endeavoured to examine, as an alternative to an inquest, the deaths of the youth, and the societal factors that contributed to the deaths. The mental health and well being of these children and youth is a complex, multifactorial integrated response to many factors in their lives, including social determinants of health, which consists of amongst other factors, the poverty and deprivation in which they exist.

Practical recommendations are provided, and the Office of the Chief Coroner believes that the implementation of both the systemic and health service delivery recommendations in this document have the potential to address suicidal behaviour of First Nations youth and children both in Pikangikum, and in other First Nations communities suffering with surges in suicide and parasuicidal behaviours in their youth.

The tragedy of the deaths of these children and youth presents a universal challenge. Meaningfully addressing these deaths goes to the leadership of all who are involved at a community level, regional level, provincial level, and federal level, both for First Nations and non-First Nations Canadians.

*“But we also know that the health of any society or collectivity depends upon a series of vital processes that allow individuals to grow, discover their identity, and learn the skills and ways of knowing their people. When these processes have been disrupted or are absent, the young people of the community not only are extremely vulnerable to negative pressures from the outside but can become so demoralized that they also commit themselves to a kind of death. “Where there is no vision, the people perish (Proverbs 29:18).”<sup>9</sup>*

---

<sup>9</sup> Shkilnyk, Anastasia M. *A Poison Stronger Than Love, The Destruction of Ojibwa Community*. Yale University Press, New Haven, 1985, p. 231.





## **PART A: THE DEATHS OF THE YOUTHS BY SUICIDE**

### **A1. Introduction**

The principal activity of this death review was to examine the deaths of the Pikangikum children individually, utilizing a variety of different sources of information that were available to the coroner, which might not ordinarily be available to others examining the deaths. (Please refer to The Project Charter, *Appendix 1.*)

### **A2. Method of Review**

Documents related to the children were examined by four reviewers from the Office of the Chief Coroner. The compiled documents, some obtained exercising the Coroner's Authority to Seize, included:

- The original investigating coroner's report of the death, the Coroner's Investigation Statement.
- The Report of the Post Mortem Examination, as prepared by the pathologist.
- The police reports of the death.
- The health record of the deceased.
- The Serious Occurrence Report of the Tikinagan Child and Family Services.
- The Child Fatality Case Summary prepared by the Tikinagan Child and Family Services.
- The Internal Review (if completed) prepared by the Tikinagan Child and Family Services.
- The Paediatric Death Review Committee's report of the death.
- The educational records of the deceased.

The Office of the Chief Coroner was successful in obtaining all of the records with the exception of the educational records, which were not released to us by the Pikangikum Education Authority, despite repeated requests.

One of the limitations noted was that First Nations people living on reserve obtain their health care through a variety of different sources, both federal and provincial, and further, in different provinces on occasion. In each case, Health Canada did provide their existing records for the children, however, these records often did not contain medical treatments or interventions that occurred in provincial hospitals, or in drug treatment programs in other provinces.

The Office of the Chief Coroner assigned four reviewers to the cases. Each reviewer then completed an extensive audit tool surveying 48 different items.<sup>10</sup> Each reviewer was required to review four of the deaths. These items broadly surveyed the following thematic areas:

- Demographic data: Age, sex, place of death, date of death, age at death, cause of death and manner of death.
- Risk factor identification: Mental health history, hospitalizations, history of threatening self-harm, previous suicide attempts, substance abuse, use of psychotropic medications, medical problems and sexual orientation.
- Familial risk factors: Family history of suicide completion, mental illness, substance abuse, separation, divorce, domestic violence, child abuse, ongoing parent-child conflict, history of residential schools in the parents of the children.

---

<sup>10</sup> See Appendix 2: Youth Suicides in Pikangikum 2006 – 2008, Audit Tool.

- Biological risk factors: Evidence of Foetal Alcohol Spectrum Disorder (FASD).
- Socio-Environmental risk factors: Reports that the decedent was a victim of violence, involved in criminal activity, assaults on other people, had an upcoming court date. Evidence of school attendance problems, learning disabilities, poverty, overcrowding, homelessness.
- Psychological risk factors: Recent death of boyfriend, girlfriend, family member or friend in the previous month. Was the death due to suicide, recent romantic break-up, or ongoing romantic conflict?
- Child welfare involvement: Was the file open to CAS at the time of death or within the previous 12 months and the reasons why? Was the child's mental health monitored by a CAS? Were efforts made to procure mental health services for the deceased by the CAS?

Upon completion of the Audit Tool, the primary reviewer then completed a narrative summary of the death of the child.

On November 10, 2010, an expert panel was convened at the Office of the Chief Coroner for the purposes of reviewing all of the deaths. A summary report of the Audit Tool for the 16 deaths was compiled, and the document was reviewed to examine whether or not certain trends or observations contained within the compiled document might shed some light on causes, or potential direction for recommendations directed to the avoidance of death in the future. Following this, each one of the 16 deaths was reviewed individually, upon which issues arising from those deaths were identified, and recommendations developed.

The panel members are identified in *Appendix 3*.

### **A3. The Deaths**

The following five deaths are provided to the reader as representative of the deaths which were reviewed by the panel. Each has a constellation of issues which reveal the difficult challenges the children faced. The themes and the tensions in their lives are recurrent and repetitive.

A repeated comment from the panel was that these children had demonstrated, time and time again in the face of overwhelming challenges and assaults on their physical, emotional, mental, and spiritual well-being, genuine resilience. Their tenacity and their ability to cope in their youthful troubled lives were viewed as strengths from which to build. Ultimately, they did succumb to an impulse in a suicidal act. The names in each case have been changed as have the dates for the purpose of confidentiality.

#### **Case #1**

Vanessa was 16 years 2 months of age when she was found hanging in the laundry room of the family home where she was suspended in a near sitting position by a shoelace. Vanessa had that evening, broken up with a boyfriend of six months. She left a note to him on her Internet webpage indicating that he would be sorry she was gone and he would miss her. Prior to committing suicide, she had telephoned a girlfriend and indicated that she was going to “do something” to herself. She was attending school at the time of her death, and was not a sniffer. She was however, an alcohol abuser who had been arrested on two occasions and placed in jail overnight.

There had been seven children in the family. Tikinagan Children's Aid society (CAS) became involved with the family in 1999 when a brother was apprehended for being intoxicated with solvents. This older brother, who was a solvent abuser, hanged himself in 2002 with an electrical

cord. Vanessa's parents had several issues which were epidemic in the community. They were alcoholics who would frequently binge drink. On one such occasion in March 2002, they left the home while intoxicated having made an arrangement for a family friend to pick up the children later in the day. This occurred several hours later. The friend picked up 10 year-old Vanessa, who was caring for her 4 month-old brother. They were brought to the home of the family friend, fed, and put to bed for the night at 22:30 hours, together in a single bed. The 4 month-old awoke at 03:00 hours, and Vanessa rocked him back to sleep. The following morning, he was found dead on a foam mattress beside the single bed. He died while sleeping in an unsafe sleep environment.

In June that year, both parents were jailed for domestic violence when Vanessa's father struck her mother with a piece of wood. In the absence of the parents, the children were looked after by their grandparents. In the late summer that same year, her older brother, a known sniffer committed suicide as previously described. The following year, in 2003, Vanessa's mother attempted suicide by overdosing on Tylenol and Motrin. By 2005, both parents were sober and abstaining. CAS reviewed the household and all of the children and the house were in good order.

Growing up in a household with both domestic violence and alcohol abuse, Vanessa began to abuse alcohol, and was a witness to significant assaults in the community. She also began socializing with a group of girls who were charged on occasions with swarming and beating other young girls. In addition, she herself was assaulted in the community.

At 14 years 2 months of age, she was attacked and assaulted by an intoxicated sniffer. At 14 years 7 months of age, she was assaulted by a male at school. At 15 years 3 months of age, she was physically assaulted by another girl.

In May 2006, while with a gang of girls, she participated in an assault on a girl who was pushed to the ground, kicked, and punched. Later that same month, she was charged when she threw a hockey stick at a peacekeeper's vehicle. In July of 2006, again while with a gang of girls, she attacked another girl with a shovel. In addition to these acts of violence, she witnessed two assaults: in one, a male struck another in the head with a chair, and in another, a male struck another male in the head with a hammer.

Four months before her death, she was found publicly intoxicated and lodged in the police cells overnight. Three months later and one month before her death, she was again found to be publicly intoxicated and lodged in the police cells overnight.

In many ways, Vanessa's family suffered with the same recurrent problems as other families:

- Alcoholism in the parents.
- Abandonment, neglect and lack of supervision of the children by the parents while under the influence of alcohol.
- Domestic violence.
- Suicide attempts in the parents.
- The deaths of siblings: one at 4 months of age sleeping in an unsafe sleep environment, the other, by suicidal hanging while solvent sniffing.

Although she remained in school and was not a solvent abuser herself, she was both the victim of violent acts and a perpetrator as she became involved in female gang activity. Towards the end of her life, it was clear she was developing a pattern of alcohol abuse.

## **Case #2**

Janice was 16 years 5 months of age when she died after being discovered hanging in the home she shared with her grandparents. Earlier in the day, she had been drinking alcohol with her friends and at the time of her death, she smelled of gasoline. It appeared that she had removed the ceiling tile exposing a rafter from which she attached a sheet. She was found by her brother. The cause of death was hanging, and the manner of death was suicide.

At her autopsy, she was noted to have a healed cigarette burn and a more recent one on her right forearm. These appeared to be self-inflicted.

Janice had endured a challenging life. She was one of 10 children, none of whom were actually raised by their biological parents. Her mother, at different times, did reside with her children, but this generally occurred only when the children were in Customary Care of the grandparents. The family first came to the attention of the CAS when Janice's older brother stopped residing in the family home, and began living in a vacant residence inhabited by solvent sniffers. He ultimately was apprehended and brought into care of the CAS.

Janice was brought to the attention of the CAS by her mother, who was living with her common-law and not residing in the home where Janice lived with her grandparents. Her mother reported that Janice had become addicted to solvents, which she began using at 10 years of age. Her mother stated that she could not look after her. Janice was picked up by police and lodged in the police cells overnight at 10, 11, 12, and 13 years of age. When she was 13, she was apprehended six times for public intoxication due to solvent abuse from gasoline sniffing. She was taken into care and placed in several different foster homes in Sioux Lookout, Kenora, Poplar Hill, and Wabigoon until placed at the Selkirk Healing Centre in Manitoba from August 2003 until February 2004. Janice returned home under a Customary Care Service Agreement involving extended family members and community resources.

In May of 2004, at 12 years of age, Janice was found by her grandmother hanging in their home by a tee shirt and was cut down by an uncle. She was brought to the Pikangikum Nursing Station by her family. There she reported that this was in response to the death of her best friend by suicide two weeks before. She was also one of eight girls who had made a suicide pact. During the interview, she ran out of the Nursing Station, and was found by police two hours later. When brought to the Nursing Station, she was high on gas and was sent to jail for the night to detoxify and return to the clinic for a reassessment in the morning. This was reported to Tikinagan Child and Family Services. She was ultimately transferred to the Sioux Lookout Hospital, admitted with a diagnosis of suicide attempt, substance abuse (gasoline) and behaviour problem. She was referred to Nodin Child and Family Intervention Services, and ultimately, to a treatment centre in Saskatchewan.

Janice was engaged in high risk behaviour. She was sniffing gasoline, staying out all night and not attending school. She was charged with assaulting another girl at 14 years of age. It was reported that she pushed the girl to the ground and kicked her in the face. She claimed to have no recall of the event. She was placed in care from May 2004 until May 2005. While in care, she was referred for treatment to the White Buffalo Treatment Centre in Prince Albert, Saskatchewan from May until August 2004, and in the Selkirk Healing Centre in St. Norbert Manitoba from August 2004 until March 2005. Janice returned to Pikangikum in March 2005 to live with her mother who was then residing with her grandparents.

In June 2005, a family services worker observed her mother intoxicated and unconscious on the floor of the home. As a result, Janice was placed at Mary Homes in Orleans, Ontario from July until September 2005. In October 2005, the Chief requested that Janice be removed from the community for beating up her grandmother. She was placed in care again from October 2005 until April 2006. She then returned to her grandparents' home.

In February 2007, Janice, at 15 years of age, was assaulted by her boyfriend. She smelled of gasoline when brought to the Nursing Station. There was a concern that she was pregnant. That same year, she was involved in a very serious assault and charged. Apparently, she critically injured another girl by stabbing her with a knife. She was arrested and charged with aggravated assault and remanded to the Kenora District Jail. She was released on an undertaking to keep the peace. Janice was admitted to Portage Youth Centre in March of 2007. Janice returned home, and her case file was closed with the Tikinagan Child and Family Services in October 2007. It was assumed that she lost the suspected pregnancy, but the details are unknown. She had repeated pregnancy tests when followed by Tikinagan, and had tested positive for a sexually transmitted disease.

The following year, Janice was arrested for assaulting her boyfriend. Two weeks following that arrest and pending a court date, she hanged herself.

Janice does not appear to have been seen by a counsellor while in Pikangikum, or to have had a psychiatric diagnosis aside from solvent abuse. She was not engaged in any form of ongoing therapy, and abused alcohol and solvents until the day of her death.

### **Case #3**

John was 12 years and 5 months of age when he hanged himself from a poplar tree outside his grandmother's home. He was found suspended from a branch by a nylon cord, by two ten-year-old boys. Just prior to the event, he had visited his mother's gravesite situated 100 feet away, outside his home.

His cause of death was hanging. His manner of death was suicide. His autopsy described him as a prepubescent male.

His mother had been a chronic alcoholic who had killed herself by hanging 11 months before. She was in her early thirties. Following her death, John had suffered visual and auditory hallucinations and expressed suicidal ideation.

John's mother had abstained from alcohol during her pregnancy with him. He was born full term, but was thought to have suffered from congenital toxoplasmosis. He suffered global developmental delay, he was hearing impaired and speech delayed. He was not toilet-trained at 5 years of age, and his primary language was Ojibwa.

Both John's parents were severe alcoholics. They drank regularly and frequently. There were four children in the family. He had a younger and an older brother, as well as an older sister. His file was open to the Tikinagan Child and Family Services due to caregiver capacity. John's father was his only surviving parent and his father's alcoholism worsened after the death of John's mother. The family were initially referred to CAS when John's father was found passed out from alcohol intoxication while caring for John's older brother in another town. His older sister had repeatedly attempted suicide, and was a solvent abuser. His older brother had been referred out of town for therapy for solvent abuse. Service plans were developed with the CAS, in which "...the caregivers were to learn appropriate parenting skills to deal with a teenager, and, caregivers were to provide appropriate supervision for children." It was common knowledge in the community that both parents were frequently intoxicated and there was poor attendance of the children at school.

In January of the year of his death, when John was 11 years of age, Nodin Child and Family Intervention Services referred John again to Tikinagan. They expressed concerns that he had been having hallucinations about his mother and the devil, and had been drinking with his father and his father's girlfriend. A child protection investigation was undertaken and it verified concerns about lack of supervision and substance abuse on the part of the father. A few months later, his younger four-year-old brother was found wandering the streets alone at 08:30 in the morning.

John was a solvent abuser. He was arrested and lodged in the police cells overnight having been picked up for intoxication from gas fumes, shortly after his 12th birthday. At the time of his death, John had been residing at his grandmother's home while Tikinagan staff was attempting to locate a residential treatment program for him for his solvent abuse and suicidal ideation. John was a heavy sniffer and had not been attending school in the months prior to his death.

The sole steadying influence for John was his paternal grandmother, who provided support and protected the children in the family. Prior to the death of his mother, the children had suffered years of neglect and emotional abandonment as a consequence of their parents' alcoholism.

#### **Case #4**

Donald was 15 years and 10 months of age when he was found hanging in his parents' home. He had suspended himself from a rafter to which he had affixed a bed sheet. His father found him in the morning. When asked why he thought his son had killed himself, his father responded that perhaps it was because he had told him to go to school the next day.

The cause of death was hanging. The manner of death was suicide. At autopsy, there was evidence of self-harming behaviour such as cigarette burns on his right forearm, as well as linear and oblique scars on both forearms (consistent with self-inflicted cutting).

Donald had a long history of solvent abuse, and on the evening before his death, his father had found him in the bushes behind the house and asked him to come inside. At the time, he smelled of gasoline.

The family were first referred to Tikinagan Child and Family Services in 2001 by the police due to:

- Domestic disputes between the parents.
- A suicide attempt by Donald's mother.
- Lack of supervision of the children.
- The children not being in school.

In 2003, Donald required hospitalization due to burns received while sniffing gas. Apparently, his younger brother had poured gas on his leg and lit the gas on fire. While he was hospitalized, attempts were made to communicate with him, but he was non-communicative, and spoke Ojibwa almost exclusively. At 13 years of age, he had been out of school for two years, and it was suspected that he suffered with Foetal Alcohol Spectrum Disorder (FASD).

In 2004, the police remained concerned about sniffing in the children, and the parents were not engaged in parenting, as there was an ongoing domestic dispute. The CAS began to monitor the family once per month. In 2005, the father threatened to kill the mother with an axe, and the children were heavily involved in sniffing. Donald told his sister on one occasion that he would kill himself if his parents continued to drink. Donald was arrested for being intoxicated under the influence of solvents six times in 2003, ten times in 2004, and four times in 2005. In each instance, he was arrested and placed in jail overnight for safety reasons.

Donald and his brother were placed in care, but returned after two months as the grandmother opposed the placement. They returned in the early fall of 2005. While in care, Donald could not be tested due to lack of communication. He did not understand the reasons why he was in care.

Later that fall, Donald contacted his father when he wanted to use the snowmobile. He told his father that he would kill himself if his father did not return home promptly.

Ultimately, Donald was emotionally deprived and his parents, who were known to be heavy consumers of alcohol, were detached and uninvolved with him. His mental health needs were unknown and his substance abuse continued unabated until his death. He was a youth who was lost with no supports. His friends, when interviewed after his death, described him as quiet.

### **Case #5**

Margaret was 18 years of age in 2008 when she was discovered suspended by a rope from a tree behind her home by her father. She resided there with her parents and several siblings. She had spent the day before solvent sniffing with her brother. He had noticed a rope in her pocket and had notified her father, who called the police. When the police arrived, Margaret fled and could not be located. The following morning, she was found by her father.

She had expressed feelings of depression and suicidal ideation many times in her young life. She was viewed as a high risk for suicide. Her companions, who were also sniffers, called her fat and ugly which she found very hurtful. In 2006, she informed a counsellor that she was hearing voices telling her to hang herself. She had made at least four suicide attempts in the past, including one month before her death and the very weekend before her death, when she was found hanging and cut down by a family member. She was not referred for any treatment on either occasion. She was under the influence of solvents each time.

In 2004, one of her brothers had committed suicide by hanging. His name was tattooed on her left forearm. In the year prior to her death, her younger brother had died and her good friend had committed suicide. She had recently lost a job that she had in town, and a suicide note dated the day of her death, stated that the reason she was committing suicide was because she wished to be dead as people hated her.

Four years before her death, she became involved with substance abuse and suicidal ideation. She was taken into care by Tikinagan Child and Family Services and placed in Winnipeg. A safety plan and good behaviour contract was signed by Margaret and her parents and it outlined expectations for her behaviour. These included keeping the peace, no mischief, violence or fighting and complying with her parents, police and Tikinagan.

In 2004, she was convicted of assault and sentenced to six months probation. In 2007, she was again convicted of assault, and served 66 days pre-sentence and was given another five days. Later that year, she was placed on four months probation for Failure to Comply with a Recognizance.

She herself was also the victim of violent assaults. In 2005, while intoxicated, she was struck in the head with a hockey stick, requiring suturing and a 3-day hospital admission. The following year, she was assaulted by two girls. She was sexually assaulted in 2006 and again in 2007 for which she received treatment. In 2006, she was alleged to having been beaten by her father, and in 2007 and 2008, by a sibling.

In 2006, she was transported via Medevac to Winnipeg and sent to a 16-Week Addiction Treatment Program due to her suicidal ideation and solvent abuse/addiction. In August of 2007, she was referred to Nodin Child and Family Intervention Services for mental health counselling. It is unknown if she was receiving any mental health supports at the time of her death.

Margaret's life demonstrated a theme of feeling unloved and unwanted. She was a victim of both physical and sexual assault. The physical assault occurred both within and outside her family, and she herself became an aggressor. She abused solvents and despite being at extraordinarily high risk following an attempted hanging from which she was cut down by a family member, no medical intervention was sought. In addition, she had an undiagnosed mental illness, in which she suffered with auditory hallucinations. She had suffered many losses in her life including her brother, another infant brother, her friend, and her job at the time she ended her own life.

#### **A4. Emerging Themes from Review of the Individual Cases**

The following trends were observed in the 16 deaths reviewed:

1. The children were heavily involved in substance abuse, mostly solvent sniffing, but alcohol as well.
2. The children appear to have become attached to a subculture of sniffers in the community to whom they became emotionally attached.
3. Although they were placed in detoxification programs outside of Pikangikum, it does not appear that they were involved in active counselling or therapy for solvent abuse within the community, or upon their return to the community.
4. Their rate of recidivism for solvent abuse was 100% following detoxification at outside programs.



5. Their immediate family members were heavily involved in substance abuse, their parents in alcohol abuse, their siblings in solvent sniffing.
6. The children had lost immediate family members to suicide, including siblings and parents.
7. The children were subject to physical and emotional abandonment, neglect, and lack of supervision while their parents were under the influence of alcohol, which occurred commonly.
8. The children resided in homes where domestic violence was common.
9. The children were sometimes victims of physical and sexual abuse. At times, the perpetrators of the physical abuse were immediate family members.
10. Some of the victimized children of physical abuse became abusers themselves.
11. Many of the children had been arrested and charged with assault themselves.
12. Most of the children had been arrested multiple times for solvent or alcohol intoxication and were then housed in jail for the night. Many had multiple episodes of incarceration.
13. Many of the children had attempted suicide in the past.
14. There was evidence in several of the children of self-inflicted injuries at autopsy.
15. Grandparents had a significant stabilizing influence in their lives.
16. Many had extensive involvement with CAS, and had been in the care of the CAS during their lives.
17. Several had foster care placements for periods of time.
18. Few of the children had any involvement with school at the time of their deaths. Their lives were occupied by sniffing at night, sleeping during the day and truancy from school.
19. The children had ceased to be active in school at very early ages.
20. Their levels of academic achievement ensured that they were ill prepared to face the rigours of adult life in contemporary society, either a First Nations' society or otherwise.
21. Some of the children had suffered with auditory and visual hallucinations and did not appear to have received a psychiatric assessment, diagnosis, or treatment for these symptoms.
22. Episodes occurred in which the children were rescued from substantive parasuicidal events, such as being cut down while hanging. In some instances, no medical care at all was sought. At other times, the medical care needed could clearly not be obtained. An understanding of the gravity of the attempted hanging as a predictor of future successful suicide was under appreciated by community members.
23. A recurrent theme was the negotiation between the family, the First Nation and Tikinagan Child and Family Services for where, and with whom, the child would reside. At times, it appeared that a child was returned to a family despite the presence of a fragile safety plan, at the insistence of the family or the First Nation. The preference of the child, the family, or the First Nation, however well-intentioned, was substituted for the professional judgement of the CAS. The outcome was ultimately the death of the child.
24. In some cases, the police had apprehended children for public intoxication due to solvent abuse, but the CAS did not appear to have been notified or subsequently engaged with the family.

## **A5. The Cumulative Report and Identified Trends**

There are some trends that emerged from this compilation of data that might readily lend itself to recommendations directed toward the avoidance of death in the future.

### **Demographic Data**

- Of the 16 deaths, eight (50%) occurred in each of both males and females.

- A surprising finding was that fully ten of the 16 deaths appeared to have occurred in three clusters:
  - a. Cluster #1: three deaths in five days in January 2006
  - b. Cluster #2: four deaths in 27 days from May - June 2007
  - c. Cluster #3: three deaths in 19 days in August 2007
- The location of the death in seven instances was where the decedent was residing, in either their own homes, or those of their grandparents. The remainder occurred in the rural outdoors.
- The age of the 16 children at death included:
  - a. four at 12 years of age (25%)
  - b. two at 13 years of age (12.5%)
  - c. one at 15 years of age (6.25%)
  - d. three at 16 years of age (18.75%)
  - e. three at 17 years of age (18.75%)
  - f. three at 18 years of age (18.75%)
- All of the deaths were due to hanging (100%).

### **Individual Risk Factors**

- Nine (56.25%) of the children had suffered with some form of mental health history including depression, eating disorder, anxiety, psychotic disorder and/or undiagnosed disorders.
- None (0%) of the sixteen had a previous hospitalization, short-stay, or visit to a healthcare practitioner or social worker in the month prior to death.
- Nine (56.25%) had a history of threatening self-harm.
- Six (37.5%) had suffered self-harming injuries, including cutting, burning themselves with cigarettes or self inflicted abrasions.
- Eight (50%) had previous suicide attempts.
- 14 (87.5%) were known to abuse substances, and the history of 2 was unknown. These 14 were solvent abusers.
- 11 (68.75%) were abusing substances at the time of their deaths, including solvents in 10 cases, alcohol in 1 case, and both in 2 cases.
- None (0%) of the children were taking psychotropic medication.
- Six (37.5%) of the children had recorded medical problems.
- Sexual orientation was implied by inference from relationships, but was thought to include 12 heterosexuals, and four whose orientation was unknown. This data is soft at best.

### **Familial Risk Factors**

- Nine (56.25%) of the children had endured a family history of suicide, including parents (two), sibling (six) and aunt/uncle in three.
- Five (31.25%) had a family history of mental illness.
- 13 (81.25%) had a family history of substance abuse including parents (nine), siblings (eight), grandparents (four) and cousins (two). Some had more than one.
- Parental separation had occurred in three (18.25%), but none were divorced.
- Domestic violence occurred in seven (43.75%), was absent in two, and in seven instances was unknown.
- In nine (56.25%) cases, there was evidence of child abuse, in two cases there was not, and in five cases it was unknown. The forms of abuse did overlap, however, there were nine cases

of neglect, two of sexual abuse and one of physical abuse. Forms of abuse with respect to neglect included supervision, nourishment, and hygiene.

- In seven (43.75%) cases, there was a history of ongoing parent-child conflict. These conflicts concerned gas sniffing behaviour in the children and general behaviour management.

### **Biological Risk Factors**

- One child had evidence of Foetal Alcohol Spectrum Disorder.

### **Socio-Environmental Risk Factors**

- Nine (56.25%) of the deceased had been victims of violence in the community.
- Nine (56.25%) had been involved in criminal activity themselves, including such items as break and enter, theft and assault.
- Six (37.5%) had a history of serious aggression toward another person and four were involved in episodes of bullying.
- Two (12.5%) had upcoming court dates.
- Nine (56.25%) had school attendance problems and had dropped out. Only one did not, and the Office of the Chief Coroner was unable to determine the school status of the other six.<sup>11</sup>
- One child had an identified learning disability.<sup>12</sup>
- Seven (43.75%) of the children resided in overcrowded conditions; one residence had 16 people living in it, two residences had eight people living in it, two had a minimum of six residents and one had five people living in it.
- None (0%) of the children were homeless.

### **Psychological Risk Factors**

- Three (18.57%) had suffered the death of a friend in the month prior to their death.
- In all three (18.75%) cases, the death of the friend was from suicide.
- In three (18.75%) cases, the decedent had suffered a recent romantic break-up.
- Four (25%) of the decedents had an ongoing conflict in a romantic relationship.

### **Child Welfare Involvement**

- In nine (56.25%) cases, the file was open or had been open to the CAS in the previous 12 months.
- In 11 (68.75%) cases, the file had been open to the CAS in the past.
- The reasons that files had been opened included inability to manage behaviour, parent-child conflict, lack of supervision, neglect, home conditions, sibling gas sniffing, suicide attempt in mother, alcohol abuse, children not in school, parental substance abuse, child abuse, questions about caregiver capacity, death of a sibling and solvent abuse.
- In four (25%) cases, the youth's mental health was being monitored by the CAS.
- In five (31.25%) cases the CAS had attempted to obtain mental health services for the youth.

## **A6. Discussion**

The most compelling trend arising from the review was the identification of the youth suicide occurring in clusters. There were three clusters of death: one in January 2006, another in

---

<sup>11</sup> The school records had been the subject of an Authority for Seizure. The Pikangikum Education Authority declined to provide these.

<sup>12</sup> Again, this information is likely inaccurate as access to school records was not obtained.

May/June 2007 and a third in August 2007. A cluster, as related to suicide, is a grouping of suicides occurring within a specified period of time. This concept has been further defined by Davidson, who restricts the use of the term to "...three or more suicides occurring within a defined space and time."<sup>13</sup> Contagion is a process whereby one suicide facilitates another.<sup>14</sup> O'Carroll has estimated that 5% of teenage suicides in the United States are due to clusters. Referencing a period of one month within Pikangikum, there were three such clusters.

Youth exposed to suicide will be affected by that exposure in different ways. There is evidence that a suicidal event will profoundly affect those with a previous history of suicidal ideation; depression, substance abuse, personality disorders, recent losses and legal problems are further known risk factors for suicide.<sup>15</sup> Virtually all of the youth involved in the deaths at Pikangikum had several of these risk factors. The report of a youth conference conducted in Pikangikum on March 25-27, 2008 stated the following:

*"Following the suicide of a 16 year old student in Nov. 2007, a debriefing was held with three groups of students (N=50). Of these students, 41 said they were unable to resolve the loss of a loved one, friend, or relative; 26 think of suicide and have tried it."*<sup>16</sup>

The trend for suicides to occur in clusters underscores the need for a postvention program where survivors are assisted in coping and individuals at risk for suicidal behaviour are identified and referred for counselling. Postvention is a strategy directed to the prevention of a cluster when a community has been exposed to a suicide.<sup>17</sup>

Another trend was the surprisingly young age of the children who took their lives. Six of the children were under the age of 15 for the years 2006-2008. When one reviews the entire population of Ontario for the same period of time, there were 24 total deaths by suicide of children in a population of approximately 13,000,000.

Suicide in youth of this age is extremely rare. Despite this, Pikangikum youth contributed to 25% of all suicide deaths in the province for children less than 15 years of age during this time period. This suggests that primary prevention programs need to be tailored to the "young" youth, those from 10-14 years of age.

All of the children killed themselves by hanging. It may be that hanging was the most accessible method. Typically, suicides are completed in a variety of ways including: lethal intoxication, either drugs or carbon monoxide, descent from a height, blunt force trauma due to walking/jumping in front of a train or subway, self-inflicted gunshot wounds, self-inflicted sharp force injuries as with a knife, and hanging. All of the 16 deaths at Pikangikum were by hanging. This represents a copycat or imitation phenomena.

None of the 16 children had a visit to a physician, nurse, mental health worker, hospital, or clinic in the month before their deaths. Three possible explanations exist that may explain this result.

---

<sup>13</sup> Davidson L., Suicide clusters in youth. In: Pfeffer CR, ed. Suicide among youth; perspectives on risk and prevention. Washington DC: American Psychiatric Press, 1989:83-99.

<sup>14</sup> Hazell, P., Adolescent suicide clusters: Evidence, mechanisms and prevention, Australian and New Zealand Journal of Psychiatry 1993; 27:653-665.

<sup>15</sup> Ibid., p. 657.

<sup>16</sup> Macfadden, Lachie, Pikangikum Youth Conference 2008, April 6<sup>th</sup>, p. 2.

<sup>17</sup> Hazell, P. Adolescent suicide clusters: Evidence, mechanisms and prevention, Australian and New Zealand Journal of Psychiatry 1993; 27:p.660.

The first is that they simply did not seek care, choosing to quietly endure their personal turmoil. The second is that they could not access care. However, the presence of a nursing station within the community operating 24/7 would not support this reasoning. The third is that despite good evidence that they were fragile, given that:

- Nine (56.25%) had a history of threatening self-harm,
- Six (37.5%) had suffered self-harming injuries, including cutting, burning themselves with cigarettes or self inflicted abrasions,
- Eight (50%) had previous suicide attempts,

it appears that family, friends, and companions did not compel them to seek care. In one of the cases, the decedent had attempted suicide in the week before her death and had been cut down by a family member from an attempted hanging. She clearly presented a serious risk. However, she was not brought to a qualified professional for care. Pikangikum is a community in which suicide is a known occurrence. It may be that the community has been desensitized to parasuicidal behaviour, due to its frequency. It may be that there has never been instructional education made available to its constituents to assist them in recognizing very serious symptomatology that necessitates the observer to compel the child/youth to obtain medical care. An opportunity for education in a primary prevention program clearly exists.

Nine (56.25%) of the children had suffered with some form of mental health history including depression, yet none of the children were taking psychotropic medication. There is a strong correlation between psychiatric illnesses and suicide. It is believed that 90% of suicide victims are suffering with a psychiatric illness at the time of their deaths.<sup>18</sup> However, for younger victims, the same does not necessarily hold true.

*“...in the controlled psychologic autopsy studies of suicides ages 15 and younger, Brent and colleagues found that 40% did not have any detectable psychopathology. In comparison, 90% of youth suicides aged up to 19 years had a psychiatric disorder. These findings deserve attention. In adolescent suicides, those who have no evidence of psychopathology have had disciplinary or legal problems, and particularly, greater prevalence of a loaded gun in the home. Furthermore, Brent noted that youngsters aged 15 years and younger who had no diagnosable disorder might have had subsyndromal difficulties, excessive stress, and available means. Foley and colleagues noted that suicidal youth aged 16 and younger who had no diagnosable disorders had subthreshold, most commonly disruptive disorders; disabling relationship difficulties; or psychiatric symptoms with no associated impairment.”<sup>19</sup>*

In a few of the cases examined during the Pikangikum review, the children were suffering auditory and visual hallucinations. In one case, the hallucinations were telling the youth to kill herself by hanging. These symptoms were reported to others, but acute intervention through immediate psychiatric referral was not contemplated, and the children, who may have been suffering with treatable psychosis, did not receive either a medication that may have helped, or an urgent/emergent psychiatric consultation.

In the evolution of suicide prevention plans, targeted strategies based on this information might suggest that children and youth expressing suicidal ideation or exhibiting parasuicidal behaviour such as attempted hanging, should be brought promptly to a healthcare facility for a formal evaluation by a psychiatrist. The potential benefits of medication should be realized. However,

---

<sup>18</sup> Links, P, Ending the Darkness of Suicide [editorial] Can J Psychiatry 2006;51;(3):129-130.

<sup>19</sup> Dervic, K, et al, Completed Suicide in Childhood, Psychiatr Clin North Am (2008), p.282.

for those less than 15 years of age, there may be an absence of psychopathology and the same generalizations about the benefits of medications may not be true. Importantly however, is that none of the cohort of children examined in the review was being treated with medications.

A concerning finding was that of the children who took their lives, 14 (87.5%) were known to abuse substances. These 14 were solvent abusers. In addition, 11 (68.75%) were abusing substances at the time of their deaths, including solvents in 10 cases, alcohol in 1 case, and both in 2 cases.

Solvent abuse is an extremely compelling social and public health issue in Pikangikum. A recently completed self-reporting survey of school age girls in grades 3 and 4 (7, 8, and 9 years of age) revealed the following:

- 27% reported that they had sniffed
- Of the sniffers, 19% reported that they had sniffed a lot since school had started
- The five most common reasons for sniffing:
  - a. So my friends will like me
  - b. To have fun
  - c. I was bored
  - d. To stay warm
  - e. To stop the pain and sadness inside of me

“Sniffing” is nasal inhalation; “huffing” is breathing fumes from a solvent soaked rag stuffed into the mouth; and “bagging” is breathing fumes from substances placed in a plastic bag held tightly around the mouth.<sup>20</sup>

Sniffing is a common problem worldwide and it is a group activity. The typical user is an adolescent male, with low self-esteem and a family background of alcoholism and physical aggression.<sup>21</sup> Approximately 3-5% of adolescents in Canada have tried inhalants.<sup>22</sup> Children who are intoxicated using volatile substances such as gasoline, resemble alcohol intoxication characterized by stimulation, loss of inhibition and depression at higher doses. Chronic solvent abuse may cause paranoid psychosis, permanent epileptic foci, and cognitive impairment. Some may develop one or more of the following symptoms:

- Schizophreniform illnesses with visual hallucinations.
- Temporal lobe epilepsy manifested as recurrent explosive behaviour.
- A decrease in intelligence quotient.<sup>23</sup>

Some of the children reviewed exhibited the described behaviours, namely visual hallucinations and repeated episodes of explosive violent behaviour, which they subsequently had difficulty recalling.

Treatment is very challenging. Pikangikum has offered a land-based detoxification program. The program is offered over 12 days, involving four workers and about eight children per rotation aged eight to 18. The treatment involves the assignment of activities in shifts, and includes

---

<sup>20</sup> McGarvey, E et al, Adolescent inhalant abuser: environments of use. *Am J Drug Alcohol Abuse* 1999;25:731-41

<sup>21</sup> Howard, M, et al, Inhalant use among urban American Indian Youth. *Addiction* 1999;94:83-95.

<sup>22</sup> Dinwiddie, SH, Abuse of inhalants; a review. *Addiction* 1994;89:925-39.

<sup>23</sup> *Ibid*, p. 397.

chores such as: drawing, writing, traditional outdoor activity, trap line, cutting wood, crafts, a sharing circle, playing hockey, broom ball, and volleyball.

The program Director, Lachie Macfadden estimated that 95-100% of the participants sniff when they return home, and it may be closer to 100%. Upon discharge from the program, the children go directly back to the environment from which they came. Following the program, the participants have difficulty re-integrating and it was reported that parents do not provide guidance. Residential treatment programs outside of the community frequently accessed include:

- Whiskyjack Treatment Centre, Norway House, Manitoba
- Ka-Na-Chi-Hih Specialized Solvent Abuse Treatment Centre, Thunder Bay, Ontario
- Nimkee NupiGawagan Healing Centre, Muncey, Ontario
- White Buffalo Youth Inhalant Treatment Centre, Saskatoon

Given the correlation between substance abuse and suicide, the high prevalence of solvent abuse in the community, and the prevalence of solvent abuse in the children examined in this death review, where 14 (87.5%) were known abusers, effective treatment strategies must be evolved.

In March 1999, during a joint health policy forum, Phil Fontaine, then National Chief of Assembly of First Nations identified issues contributing to the malaise of First Nations; "...three national components that must be taken into account; poverty, the effects of poverty and actions to eradicate poverty."<sup>24</sup>

Review of familial risk factors revealed some compelling findings around exposure to suicide, family history of substance abuse, the presence of domestic violence and child abuse.

Nine (56.25%) of the children had endured a family history of suicide, including parents (two), sibling (six), and aunt/uncle (three). According to Hazell, the relationship between exposure to suicide and suicidal behaviour is that, "...direct exposure to suicide and subsequent suicidal behaviour is that exposure encourages imitative behaviour."<sup>25</sup> One child who hanged himself was seen visiting his mother's grave site, approximately 100 feet from where he took his own life, immediately before he was found. She too, had died by hanging the previous year.

Also, 13 (81.25%) had a family history of substance abuse, including chronic alcoholism, and was a common finding amongst the parents of the deceased.

Domestic violence occurred in seven (43.75%) of the families of the children and in nine (56.25%) of the cases, there was evidence of child abuse.

Effective community strategies which provide in-community counselling regarding alcohol abuse for parents, as well as education for children and families around domestic violence should become a component of a comprehensive community-based suicide prevention strategy.

With respect to socio-environmental risk factors, our data around school attendance was incomplete as it was not provided by the Pikangikum Education Authority. However, the files themselves were revealing in that they suggested a pattern of behaviour in which the children

---

<sup>24</sup> Weir, E, Public Health; Inhalation use and addiction in Canada, CMAJ, Feb. 6, 2001; 164(3).

<sup>25</sup> Hazell, P., Adolescent suicide clusters: Evidence, mechanisms and prevention, Australian and New Zealand Journal of Psychiatry 1993;27:p. 658.

were heavily involved in solvent abuse, slept during the day and went out at night. Interviews with educators suggested that children drop out of school beginning at approximately ten years of age. They become involved in solvent abuse and are otherwise disengaged with programming in the community in terms of recreation.

### **A7. Concluding Remarks**

Our limited information is that 56.25%, or nine of the 16 children, had school attendance problems and had dropped out. Only one of the children who died was known to be in school, and was not a solvent abuser. The Office of the Chief Coroner was unable to determine the school status of the other six children.

Anecdotal interviews with a former principal suggested that he was aware of only one child in seven years that had taken her life by suicide, and was actively going to school at the time.

Programs directed by the First Nation to improve school attendance and to keep children and youth engaged in education would appear to have the most potential for benefits in preventing youth solvent abuse and suicide.



## **PART B. SUICIDE**

### **B1. Definition of Suicide**

Suicidal behaviour essentially refers to a group of self-destructive behaviours, which encompasses terminology such as suicide, attempted suicide and parasuicide.

Emile Durkheim provided the following definition of suicide: “Suicide is applied to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result.”<sup>26</sup> An alternative definition of suicide includes: “The act or an instance of taking one's own life voluntarily and intentionally especially by a person of years of discretion and of sound mind.”<sup>27</sup>

The World Health Organization has defined parasuicide as: “An act of nonfatal outcome, in which an individual initiates a nonhabitual behaviour that, without intervention by others, will cause self-harm, or ingests a substance in excess of the prescribed or generally recognized therapeutic dosage, and which is aimed at realizing changes which he/she desired via the actual or expected physical consequences.”<sup>28</sup>

### **B2. History of Suicides in Pikangikum**

In 2000, Pikangikum First Nation was reported to have the highest suicide rate in the world.<sup>29</sup> The following excerpt is taken from an article which appeared in the Canadian Press on November 27, 2000 regarding Pikangikum:

*“In Pikangikum, eight females - five of them 13 years old - have killed themselves this year. But Pikangikum, a community of 2,000 people 300 kilometres northeast of Winnipeg, has an eight-year average of 213 suicides per 100,000 people between 1992 and 2000, and a nine-year average of 205 suicides per 100,000 people in the period between 1991 and this month, two independent Canadian experts said this week. The latest Pikangikum suicides have sent this year's rate soaring to 470 deaths per 100,000. That's 36 times the national average of 13 per 100,000, and in a city of three million people, would mean 14,100 deaths this year.”*

Clearly, there is a long history of suicide amongst residents of Pikangikum that now dates decades. These deaths have touched virtually every member of the community.

### **B3. Adolescent Suicide in Canada**

Suicide is the second leading cause of deaths for children age 10-18 and is the focus of this report. Young people often do not present for care to their health care providers with suicidal ideation. Canada experiences >500 suicides per year amongst those 15-24 years of age, and it is estimated that for each completed suicide, there are 400 attempts.<sup>30</sup>

---

<sup>26</sup> Kirmayer, J.K., et al, Suicide Among Aboriginal People in Canada, Aboriginal Healing Foundation, 2007, p.3.

<sup>27</sup> <http://www.merriam-webster.com/dictionary/suicide>

<sup>28</sup> Kirmayer, J.K., et al, Suicide Among Aboriginal People in Canada, Aboriginal Healing Foundation, 2007, p.3.

<sup>29</sup> [http://en.wikipedia.org/wiki/Pikangikum\\_First\\_Nation](http://en.wikipedia.org/wiki/Pikangikum_First_Nation)

<sup>30</sup> Kostenuk, M., et al., Approach to adolescent suicide prevention, Canadian Family Physician, Vol. 56, August 2010, p. 755.

There has been a four-fold increase in teen suicides in the past 40 years.<sup>31</sup> Living in a single parent family as a divorced youth, contagion behaviour, and the black box warning by the Food and Drug Administration with subsequent diminished use of selective serotonin reuptake inhibitors (SSRI's) with increases in completed suicides are considered amongst contributors to the rise in youth suicide.<sup>32</sup> An example of an SSRI is Prozac, also known as fluoxetine hydrochloride. For SSRI's, "current evidence suggests that the risk of not treating depression outweighs the risk of using SSRI's in this population."<sup>33</sup> It is difficult to know how relevant this information, representing both Aboriginal and non-Aboriginal populations, is to First Nations youths.

### **Risk Factors<sup>34</sup>**

A host of well recognized risk factors exist and are summarized here:

- A. Mental illness
  - More than 90% of suicide completers have psychiatric illness at the time of their death
- B. Previous attempts
  - A previous attempt confers a 21% risk of committing suicide over the next five years
  - The highest risk is in the month after the initial attempt
  - Substance abusers, those with hallucinations or a plan, are at greatest risk for repeated behaviours
- C. Precipitants
  - Conflict with parents or the end of a relationship may be precipitants
  - Rejection
  - Public disparagement or feelings of humiliation
- D. Impulsivity
  - These youths are more likely to act on their suicidal ideation
  - Physical aggression, fights at school and risk taking behaviour can be markers for impulsivity
  - Substance abuse can impair judgement and exacerbate impulsivity
- E. Family history
  - Family history of suicide, depression, addiction and other mental illness
  - Poor family communication
  - Low parental monitoring
- F. Contagion behaviour
  - Suicide in a friend or family member can lead to a two to four fold increase in suicide risk in teens aged 15-19<sup>35</sup>
- G. Physical and sexual abuse
  - Common amongst youth who present with suicidal behaviour
- H. Other risk factors
  - Trouble with police

---

<sup>31</sup> Canadian Taskforce on Preventative Health Care. Prevention of Suicide. London, ON. Canadian Task Force of Preventative Health Care; 2003.

<sup>32</sup> Kostenuk, M., et al., Approach to adolescent suicide prevention, Canadian Family Physician, Vol. 56, August 2010, p. 756.

<sup>33</sup> Ibid., p. 756.

<sup>34</sup> Taken from Kostenuk, M., et al., Approach to adolescent suicide prevention, Canadian Family Physician, Vol. 56, August 2010, p. 757-758.

<sup>35</sup> Gould MS., et al, Time-space clustering of teenage suicide. Am J Epidemiology 1990; 131(1):71-8.

- Difficulties in school, poor school functioning, lack of academic motivation, perceived poor school performance (independent of intelligence)

Prevention, screening, and treatment are paramount to success in dealing with suicide. Parents are unaware of 90% of suicide attempts made by their teenagers.<sup>36</sup>

#### B4. Canadian Suicide Rate Statistics

The table below lists suicide rates for all Canadians broken down by age from Statcan. This review concerns the ages from 10-19, and are included in bold.<sup>37</sup>

Suicides and suicide rate, by sex and by age group					
(Both sexes for Canada)					
	2001	2002	2003	2004	2005
Both sexes					
Suicide rate per 100,000 population					
All ages	11.9	11.6	11.9	11.3	11.6
10 to 14	<b>1.3</b>	<b>1.7</b>	<b>1.3</b>	<b>1.3</b>	<b>2.0</b>
15 to 19	<b>9.9</b>	<b>10.1</b>	<b>10.2</b>	<b>9.9</b>	<b>9.9</b>
20 to 24	14.0	12.9	14.0	12.1	13.2

#### B5. Suicide Among Aboriginal People

In 2003, Statistics Canada identified that there were about 1 million Aboriginal People in Canada consisting of four groups, namely, status Indians under the Indian Act, First Nations non-status Indians, Metis, and Inuit. First Nations make up 62% of the Aboriginal population.

There are over 600 First Nations communities, 11 major language groups and 50 distinct dialects. The median age for the Aboriginal population is 24.7 years, 13 years younger than the non-Aboriginal population. Aboriginal groups have higher mortality rates, with life expectancy 10 years shorter than for the average Canadian.

In 2001, the overall rate of suicide was 11.9 per 100,000 in Canada, which is down from 16.7 in 1979. The First Nation suicide rate in 2000 was 24 per 100,000. However, these statistics are an aberration when considered in isolation.

Chandler and Lalonde, in studying youth suicide amongst First Nations in British Columbia, found rates in the 196 communities in that province varied from zero to 120 per 100,000 over an eight year period. Although not studied and available for Ontario, there is evidence to suggest that there are marked differences in rates of suicide in First Nations communities in Ontario as well, even when they exist in close geographical proximity. For example, Pikangikum has been characterized as having the highest suicide rate in the world. In 2007, there were ten suicides in the community of 2,400. This translates into a rate of approximately 417 per 100,000 per year. Lac Seul, a First Nations community located south east of Pikangikum, has documented six

<sup>36</sup> Friedman RA., Uncovering an epidemic-screening for mental illness in teens. N Engl J Med 2006; 335(26):2717-9.

<sup>37</sup> <http://www40.statcan.gc.ca/l01/cst01/perhlth66a-eng.htm>

suicides in 10 years.<sup>38</sup>

## B6. First Nations Youth Suicide Rates

Suicide occurs roughly five to six times more often among First Nations youth than non-Aboriginal youth in Canada. The rate of First Nations youth suicide is extremely high (Figure 1). Among First Nations young men between the ages of 15-24 years it was 126 per 100,000, compared to 24 per 100,000 for Canadian men of the same age group. Young women from First Nations registered a rate of 35 per 100,000 versus only 5 per 100,000 for Canadian women.<sup>39</sup> Although this information is currently dated, it retains its relevance.

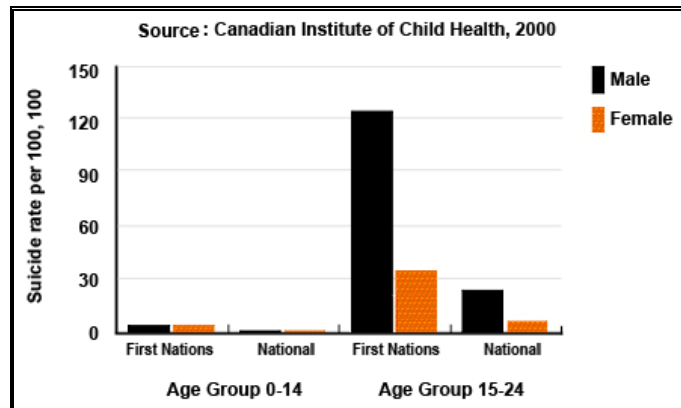


Figure 1. Suicide Death Rates by Age Group: First Nations and Canadian Populations, 1989-1993.

Worldwide studies have demonstrated that women are more likely to make attempts, but men are more likely to die by suicide. The difference is accounted for by the lethal means, with men using firearms, jumping from a height and hanging, and women using drug overdose or wrist slashing. In Pikangikum, the female youth use hanging as the method of choice for suicide. Trends in suicide also demonstrate that overall, they are going down, with the exception of youth.

In the Nishnawbe Aski Nation (NAN):

- from 1986 to 1995, there were 129 suicides of all ages;
- the number rose dramatically over the ten years, with five suicides in 1986 and 25 in 1995;
- the vast majority of the suicides were male;
- of the 129 suicides, 79.8% were youth between the ages of 10 to 25;
- 20.4% were children between the ages 10 to 14; and
- the NAN rate of suicide was 28 per 100,000 in 1995.<sup>40</sup>

## B7. Suicides in Ontario and in Pikangikum, 2006 - 2008

It must be borne in mind that the actual suicide attempts as reported below are likely much, much higher. There is research on the prevalence of suicidal ideation and attempts. The 2002/2003

<sup>38</sup> Personal communication, Police Chief Rick Angeconeb, Lac Seul, October 14, 2010.

<sup>39</sup> Hettinga, P., et al, Acting on What We Know: Preventing Youth Suicide in First Nations, Health Canada, 2003.

<sup>40</sup> Horizons of Hope: An empowering Journey. Youth Forum, Final Report, Nishnawbe-Aski Nation Youth Forum on Suicide, 1996, p.3-4.

Regional Longitudinal Health Study of 10,962 First Nations adults found that 15.8% had made a suicide attempt in their lifetime, and 30.9% reported having suicidal thoughts at sometime during their lives.

The following information was obtained from the Ontario Provincial Police regarding police calls for suicide or parasuicide in Pikangikum.<sup>41</sup>

Year	Suicides	Attempted Suicides
2001	8	35
2002	3	17
2003	7	40
2004	4	27
2005	5	41
2006	6	48
2007	10	98
2008	7	78
2009	8	97
<b>Total</b>	58	481

The table below shows the Contribution of Pikangikum Youth Suicides to all Youth Suicides in Ontario, 2006-2008:

Year	Total Suicides in Ontario (All Ages)	Suicides 0-18 Years of Age	Suicides in Pikangikum 0-18 Years of Age	% Contribution of Pikangikum Suicides to Total Ontario Suicides 0-18 Years of Age.
2006	1,109	39	4	10.2%
2007	1,121	53	8	15.1%
2008	1,074	36	4	11.1%

Source: Office of the Chief Coroner

## B8. Concluding Remarks

This data demonstrates a striking and concerning trend. Despite its population of approximately 2,400 residents, and Ontario's population of 13,069,182<sup>42</sup>, the proportionate contribution of the suicides of Pikangikum to youth suicides in the province is extraordinarily high. These statistics are a notable aberration and should serve as a call to action by Ontarians to develop a plan and strategy to address the high rate of suicide in the Pikangikum First Nation. Healthcare providers need the ability to identify communities where high rates of suicide exist so that intervention plans can be developed.

<sup>41</sup> Obtained from the OPP, October 2010.

<sup>42</sup> <http://www.fin.gov.on.ca/en/economy/ecupdates/factsheet.html>



## **PART C: HEALTH IN PIKANGIKUM**

### **C1. Introduction**

The healthcare system in First Nations communities in the Sioux Lookout Zone, including Pikangikum, are provided by multiple providers, both federal and provincial, often delivering these services in silos. Lack of integration is a key factor limiting positive outcomes.

*“The federal system of health care delivery for status First Nation people resembles a collage of public health programs with limited accountability, fragmented delivery, and jurisdictional ambiguity.”<sup>43</sup>*

A review of the healthcare system was conducted as a component of the trip to the Pikangikum First Nation, through a series of interviews with the Local Health Integration Network, the Sioux Lookout Health Authority, Nodin Child and Family Intervention Services, the Pikangikum Health Authority, the nursing station, and healthcare providers providing primary, secondary and tertiary care out of the community.

### **C2. The North West Local Health Integration Network (LHIN)**

The North West LHIN is responsible for a total population of 232,135 of which, 19% of this population is Aboriginal. The Aboriginal population is vulnerable. It “...has a high burden of illness, is often located in very remote communities and faces linguistic and cultural barriers to accessing health services.”<sup>44</sup> The North West LHIN has a higher mortality rate at 676 per 100,000 versus the remainder of the province at 559 per 100,000. Of note, life expectancy is shorter by about two years for both men and women. The North West LHIN experiences the following challenges related to healthcare:

- Aging population
- High and increasing numbers of unemployed
- A high burden of illness and chronic disease
- Low socioeconomic status
- Poor health status<sup>45</sup>

There are 24 nursing stations in the North West LHIN. One is located in Pikangikum.

The Integrated Health Services Plan is a plan setting out the priorities of the Ministry of Health and Long-Term Care. One of those priorities is to enhance mental health and addiction services. In setting its strategic directions, the LHIN identified a critical success factor as “integration and redesign of the health system.”<sup>46</sup> To this end, the North West LHIN conducted an Aboriginal Health Programs and Services Inventory.<sup>47</sup>

---

<sup>43</sup> Reading, LP., and Wien, F., Health Inequalities and Social Determinants of Aboriginal Peoples’ Health, National Collaborating Centre for Aboriginal Health, 2009, p.15.

<sup>44</sup> Integrated Health Services Plan, North West LHIN, 2010-2013, p. 9.

<sup>45</sup> Ibid., p. 10.

<sup>46</sup> Leading Health System Transformation in Our Communities, 2010-2013 North West LHIN Strategic Directions, June 2010, North West LHIN, p. 23.

<sup>47</sup> Aboriginal Health Programs and Services Inventory, North West LHIN, June 2010.

### **C3. The Sioux Lookout First Nation Health Authority (SLFNHA)**

The Sioux Lookout First Nation Health Authority is executing the Anishnawbe Health Plan, a process which hopes to bring the healthcare system in the Sioux Lookout Zone under First Nations governance and management.<sup>48</sup>

Their mission is to:

- “help our people to better health through health promotion and disease prevention;
- support communities to deliver quality, community-based primary care and qualified First Nations staff; and
- provide specialized services and regional services not provided by communities and tribal councils.”

Continuity of care has been a significant issue for First Nations communities. There were traditionally different physician groups, all providing service in different manners and with different fee schedules. For example, the Sioux Lookout Zone Family Physicians’ Association provided service to the First Nations for approximately 5 days per month, and would care for these clients when they came off reserve and needed admission to the Meno-Ya-Win Health Centre. Another group, AMDOCS from Manitoba, would provide in-community service for up to 25 days per month for members of the Independent First Nations Alliance (IFNA) including Pikangikum, but would not provide care to their clients when they were transferred off-reserve to the Health Centre. A third group, the Hugh Allen Group Physicians, were community-based in the town of Sioux Lookout and would provide care for the inhabitants of the town, and were increasingly being asked to care for transfer patients from reserves by other physician groups such as AMDOCS. The orphan patient dilemma that has plagued healthcare facilities throughout Ontario has played out in the north as well.

SLFNHA is providing, or in the process of providing, the following services to the Sioux Lookout zone:

- **Health Services**

The health services envision a unified regional primary care system under First Nation governance and management. A goal is to provide increased access and availability of healthcare services in the communities. Most recently, the SLFNA has been successful in assisting with the negotiations for the provision of 24-hour emergency and inpatient care at the Meno-Ya-Win Hospital.

New initiatives which are planned include the creation of a unified electronic medical record, the development of the Public Health System with the First Nations communities, and developing a model of care for dental services.

- Tuberculosis Control and Surveillance Program
- Canada Prenatal Nutrition Program
- Developmental Services Program

The Developmental Services Program works with adults and youths living with developmental disabilities, mental health issues and/or challenging behaviours. In this program, SLFNA partners with Community Living Sioux Lookout and Surrey Place Centre, a multidisciplinary clinical team comprised of a psychiatrist, a psychiatric nurse, psychologists, behaviour therapists, speech and language pathologists and an occupational therapist. This is funded through the Ministry of Community and Social Services. This

---

<sup>48</sup> Sioux Lookout First Nations Health Authority, Annual Report, 2008-2009, p. 4.



program worked with 59 clients in 14 First Nations communities in 2008-2009. Pikangikum was not one of the communities utilizing this resource.

- **Telemedicine Program**  
SLFNHA has partnered with KO Telemedicine partners to support the adoption and use of telemedicine to connect with their clients in communities.
- **First Nation and Inuit Health Information System**  
Collects and retains data on immunization in 29 First Nations communities.
- **Nodin Child and Family Intervention Services**
- **Client Service Programs**  
Provides non-medical healthcare services for First Nations clients travelling to Sioux Lookout for appointments. This includes ground transportation, courier and shuttle service, hotel and private accommodations, client/advocacy support and activity coordination.

An interview with Mr. James Morris, Executive Director, SLFNA, communicated that a further initiative of the SLFNA was the construction of a new hostel next to the new hospital which will have 100 beds and serve as an accommodation and reception centre for northern patients. In February 2009, SLFNHA organized a 3-day meeting with representatives from 33 First Nations communities to discuss the prescription drug abuse problem which strategized local and regional solutions.

The SLFNHA provided community-oriented and specific service to Pikangikum. The Family Healing Program funded through the Aboriginal Healing and Wellness Strategy had three intakes in Pikangikum in 2010. In each intake, four to five families consisting of 10-20 members attended this three week program delivered with facilitators in Pikangikum.

Another very innovative program sponsored by SLFNHA and funded by Health Canada, First Nations and Inuit Health Branch, consisted of the training of two Pikangikum community members in Thunder Bay over two years to obtain a college education in community mental health training. Their graduation occurred in May of 2010 and they are now in the community providing full time service to Pikangikum. These two new graduates have been designated by the Pikangikum Health Authority to work with children less than 17 years of age. They are retained as Nodin Staff, and receive all the educational and training updates, including supervision and accountability reporting to ensure a high level of service.

A key feature of the mental health management of the children of Pikangikum was the lack of qualified counsellors. This situation has recently been vastly improved as noted above. However, the children of Pikangikum present with a variety of mental health, addiction, and likely, developmental problems. SLFNHA seeks to integrate services under the umbrella of the Anishnawbe Health Plan. A vital component to success will be the integrated case management for these children, whereby all mental health and linked health needs such as developmental disorders are identified, addressed, integrated and communicated to stakeholders.

#### **C4. Sioux Lookout Regional Physicians' Services Inc.**

The newly created Sioux Lookout Regional Physicians' Services Inc. (SLRPSI) has amalgamated all primary care physicians groups under one umbrella with a shared responsibility for all patients presenting to the emergency room as well as a hospitalist program to care for the patients once admitted. SLRPSI is governed by a nine member Board with three First Nations representatives, three from Meno-Ya-Win Hospital, and three physician representatives. Among

the individual physician members represented, AMDOCS provides five full time equivalents (FTE's), the Hugh Allan Clinic seven FTE's, and the Northern Physician Group, ten FTE's. SLRPSI is an independent provider of physician services and the SLRPSI Board will ensure that medical services are balanced between community and hospital needs, will provide for an equitable payment plan for all physicians, and ensure that there is accountability and oversight for medical services in the Sioux Lookout Region.

This is a significant enhancement toward seamless care for First Nations in the Sioux Lookout Zone.

### **C5. Sioux Lookout Meno-Ya-Win Health Centre (SLMHC)**

Sioux Lookout Meno-Ya-Win Health Centre was established in 2002 as Ontario's first First Nations' hospital. A four-party agreement was reached to create it, and included Health Canada, the Provincial Government, the Nishnawbe Aski Nation, and the Municipality of Sioux Lookout. It has a unique mandate to respond to the "...unique, significant First Nations needs including integration of traditional healing, medicine and foods into SLMHC programming..." as a core commitment.<sup>49</sup>

The hospital's catchment area is the largest of any hospital in Ontario. It provides services to approximately 30,000 people in 32 communities over an area of 385,000 km<sup>2</sup>, one third of Ontario's land mass. Their staff provides emergency, obstetrics/maternity and paediatric medicine, surgery, as well as diagnostic and therapeutic treatment services. Specialized care is provided in Thunder Bay and Winnipeg. Their staff has a mandate to become a centre of excellence of Aboriginal health care, and have published many articles in peer reviewed journals regarding Aboriginal health care.<sup>50</sup>

SLMHC recently opened a new facility. The new facility has 60 beds, of which, eight are complex continuing care beds. Also, there is a 20-bed extended care facility that looks after 30,000 outpatient visits annually, employs 300 people, and operates two sites.

From a psychiatric standpoint, SLMHC will not look after patients who are suicidal and are being involuntarily admitted to hospital under the Mental Health Act, but will generally admit voluntary psychiatric patients to the general medical service. On April 1, 2011, five withdrawal beds were scheduled to be opened.

This information was provided by Ms. Helen Cromarty, Special Advisor for First Nations Health, Ms. Barb Linkewich, Vice President Health Services, Dr. Bob Minty, staff physician, and Dr. Terry O'Driscoll, Chief of Staff.

There is currently only one paediatric psychiatrist for the North West of Ontario. Other paediatric psychiatric services are provided through the MCYS funded Ontario Child and Youth Telepsychiatry Program and by visiting psychiatrists. Schedule 1 beds, which are for patients involuntarily admitted to hospital due to the severity of their illnesses, such as actively suicidal or patients with very serious mental health disorders, are available in Thunder Bay and in the Lake of the Woods District Hospital in Kenora. Lake of the Woods District Hospital operates a

<sup>49</sup> Sioux Lookout Meno-Ya-Win Health Centre; A backgrounder, First Nations Services, July 23, 2004, p.1.

<sup>50</sup> Meno-Ya-Win Health Centre, Research Compilation, 2007-2009.

24/7 inpatient and outpatient psychiatric service including emergency services for those 12 years of age and older in the Town of Kenora.<sup>51</sup>

In addition, the Thunder Bay Regional Health Sciences Centre (TBRHSC) operates a mental health program. “The mission of acute care adult mental health services at a Schedule 1 facility is to provide intensive inpatient and outpatient care that includes: emergency services; short-term inpatient assessment; assessment, stabilization and short-term inpatient treatment; discharge planning; outpatient services; and, consultation, education, coordination and integration. TBRHSC also houses an independent inpatient Child and Adolescent Mental Health Unit through Paediatric services. This specialized program is designed to treat youth, ages 10 to 17 years, with serious and complex mental health disorders.”<sup>52</sup>

Dr. Peter Braunberger, child psychiatrist in Thunder Bay spoke of his concerns with respect to the provision of paediatric psychiatric service. In particular, he mentioned lack of continuity as a significant issue between;

- hospital and communities,
- Thunder Bay and the regions,
- adult and child psychiatry, and
- the Ministry of Health and Long-Term Care (MOHLTC) and the Ministry of Children and Youth Services (MCYS) and their respective mandates, in the provision of child psychiatric services.

Dr. Braunberger felt that key enablers for the success of paediatric mental health programs would include:

- Effective children’s programming.
- Qualified mental health counsellors in the communities more of the time.
- Empowering primary care clinicians by enhancing their existing skills.
- Integration of mental health services with a team model of delivery.
- Nurse practitioners (NP’s) and physicians must also be recognized as key partners in service design and delivery.
- The creation an integrated Northern Ontario child outreach strategy.
- The expanded use of telepsychiatry.

## **C6. The Pikangikum Health Authority (PHA)**

The PHA reports to the First Nations Band, the Chief and Council, and a Board consisting of three elders. There is an Executive Director, and Health Directors, each with different portfolios under their jurisdiction. Although currently there is a striking paucity of operational programs providing measurable outcomes in terms of child and youth mental health, there is great promise that resides with the PHA. Recently, the Executive Director has become the co-chair of a committee called the Pikangikum Social Health, Education and Elders Committee created in March 2010. This Working Group has members from Indian and Northern Affairs Canada, Tikinagan Child and Family Services, Ministry of Aboriginal Affairs, Nodin Child and Family Intervention Services and the Sioux Lookout and First Nations Health Authority. This group meets generally every two months in Thunder Bay addressing an agenda developed in

<sup>51</sup>[http://www.google.ca/search?hl=en&source=hp&q=lake+of+the+woods+district+hospital&meta=&aq=1&aqi=g10&aql=&oq=lake+of+the+w&gs\\_rfai=](http://www.google.ca/search?hl=en&source=hp&q=lake+of+the+woods+district+hospital&meta=&aq=1&aqi=g10&aql=&oq=lake+of+the+w&gs_rfai=)

<sup>52</sup> [http://www.tbrhsc.net/programs\\_&\\_services/mental\\_health.asp](http://www.tbrhsc.net/programs_&_services/mental_health.asp)

Pikangikum. This group was struck at the request of the PHA, following the PHA's own investigation and review of a Prince Albert First Nations community in August 2008. They are seeking to develop integrated health services following best practices observed in the Peter Ballantyne Cree Nation in Saskatchewan. This is a significant strength and area of promise.

### **Operational Programs**

The Pikangikum Health Authority operates 5 overarching programs:

1. Community programs consisting of :
  - Mental Health and Addictions
  - Head Start Program/Foetal Alcohol Syndrome Disorder
  - Aboriginal Diabetes Initiative and Maternal Child Health
2. Primary care
3. Non-Insured Health Benefits Services
4. Infrastructure Maintenance and Security
5. Social Development Strategy

The focus of this review is the deaths by suicide of 16 youth. As such, the Community Program review will focus on Mental Health and Addictions. There are five primary areas of service delivery. These include:

1. Mental health workers
2. Youth Patrol
3. Solvent Abuse Worker
4. National Native Alcohol and Drug Abuse Program (NNADAP) community-based program
5. Crisis Team

#### **1. Mental Health Workers**

There are four workers who have been functioning in the community since June 2010. Two of the health workers work out of the Community Centre and see clients less than 17 years of age. An additional two workers see clients in the Nursing Station Health Centre. The two workers seeing youth clients are employed by Nodin. The other workers are employed by the PHA. Videoconferencing at the Community Centre allows ready access to a psychologist in Kenora since March 2010.

The addition of the two trained mental health workers who are community members, reside in the community, and were trained at community college over two years, has been a tremendous new asset. They will ease, in part, a void that has existed by addressing the needs of the youth. It is contemplated that outcomes for youth will improve. This is a significant area of promise for the community. The client base is growing with assistance from the Tikinagan Child and Family Services and the police.

#### **2. Youth Patrol**

The Pikangikum Youth Patrol Program is funded by the Ministry of Children and Youth Services. In October of 2010, it was not functioning. It provides peer-to-peer support to the youth. In addition, since the 1990s, Health Canada, First Nations and Inuit Health Branch have provided annual funding as well.

#### **3. Solvent Abuse Worker**

Currently, the solvent abuse worker is a part time position. (Children) and youth who are solvent abusers must self-identify. This is a significant barrier to providing care for those in need. The incumbent usually only sees clients who have been referred by a physician or nurse. Her primary activity is to complete applications for federally funded solvent treatment

programs out of the community. The community has a very large, but unknown number of youth solvent abusers. Girls in grade three and four recently completed a survey in which they self-identified that 27% had tried gasoline solvents. There is no formal mechanism for identification of these “at risk” children and youth. It can occur through the police, Tikinagan Child and Family Services and from a referral from the Nursing Station.

4. The National Native Alcohol and Drug Abuse Programs (NNADAP) Community-based Program<sup>53</sup>

The NNADAP is a Health Canada funded program whose purpose is to provide prevention, intervention, aftercare and follow-up services for those suffering with drug and alcohol abuse. Prevention strategies include “...culturally appropriate programs to educate and create awareness about addictions and addictions-free lifestyles.”<sup>54</sup> Intervention provides assessments for entry into residential treatment centres. It also contemplates short-term crisis counselling and out-patient counselling services. Its primary function is to reduce the incidence of alcohol and other substance abuse disorders. The qualifications for service providers depend on the service being provided.

In Pikangikum, few, if any adults seek this type of help. A large number of the children involved in the death review came from families where parental alcohol abuse was a significant issue. The Office of the Chief Coroner was told that adult clients only seek help in Pikangikum before a pending court date, and principally for the purpose of appearing genuine before the courts with respect to seeking assistance to overcome their addictions.

5. Crisis Team

This program is funded provincially by the Aboriginal Health and Wellness Strategy. It provides logistical support where or when a crisis occurs, such as the suicide of a youth. In that circumstance, support would be provided for the grieving family in terms of meal preparation, transportation, homemaking and other areas requiring support.

## C7. Challenges

The members of the Pikangikum Health Authority identified several areas of concern. These included:

1. Lack of integration of services.
2. The difficulty in obtaining receiving facilities in accepting ill clients who need transfer out of the community.
3. The lack of appropriately qualified individuals to provide services within the community.
4. The challenge of obtaining meaningful service delivery from persons who have been retained for programs.
5. A lack of children’s mental health programs.
6. The youth suicides.
7. The epidemic of solvent abuse in the children and youth.
8. Dependency on Tikinagan Child and Family Services for the delivery of mental health services.
9. A general lack of mental health programming in the community for all ages.
10. “Burnout” of mental health service workers.
11. Challenges in completing applications for federally and provincially funded programs.

---

<sup>53</sup> First Nations and Inuit Health Program Compendium, Health Canada, March 2007, p. 12.

<sup>54</sup> Ibid., p. 12.

## C8. Recent Successes

There were a number of recent initiatives that were moving forward and were a source of much promise. These included:

- The contracting of AMDOCS to provide primary care in the community. Within six months of being retained, backlogs for patients waiting to be seen were addressed.<sup>55</sup>
- The creation of the Pikingikum Social Health, Education and Elders Committee.
- The addition of the two community members that had been sent to college to obtain certificates in mental health, and are currently living in the community providing full time services to the youth.
- The recent addition of videoconferencing services to access psychologists out of the community.

## C9. Land-based Solvent Abuse Program

Pikangikum First Nation is reported to have experienced solvent abuse since approximately 1990. In 1997, 147 solvent abusers were identified in the community.<sup>56</sup> The number, at present, is anticipated to be significantly higher.



Picture 2. Sign on Council Meeting Building, Pikingikum First Nation, March 6, 2010.

A land-based solvent abuse program has been operational for a number of years. It has core objectives which include:

- A focus on the health needs of the youth.
- Healing and learning of the youth of traditional skills and knowledge from elders in a traditional setting on the land.
- A holistic program which restores the youths' physical, mental, emotional and spiritual well-being with traditional practices.
- Provision of support for the client's home community.<sup>57</sup>

<sup>55</sup> <http://www.wawataynews.ca/node/12374>

<sup>56</sup> Macfadden, L., Pikingikum First Nation, Land Based Traditional Healing Program Proposal, 1997/98, submitted to Health Canada, Medical Services Branch, Ontario Region, December, 1997.

<sup>57</sup> Ibid., p.6.

In 1998, the creator and Director, Mr. Lachie Macfadden, M.A., wrote the following to the Chief and Council in Pikangikum:

*“The work on the solvent abuse problems is just beginning in Pikangikum. It is at least a second generation problem. Many adults that I met reported that they themselves were solvent abusers as youth. Many said that they had severe problems and their use of solvents went on for several years. The danger with this is that many of these parents feel that no harm came to themselves. Many believe that there is not such a big problem in Pikangikum. The problem rests with only a few children. Some adults have the tendency to laugh at the problem with amusement and recall their own old “war stories” about what happened to them when they were high on gas. Some feel that these children should be left alone because they will just grow out of it. They feel that interference puts these children at greater risk.*

*It would appear that gas sniffing has come to be seen as a “right of passage.” i.e. just something you do at one point of your life, like getting drunk your first time, or having sex your first time. They think gas sniffing will not really harm you and everyone does it at least once in their life. If you leave the youth alone, they will just grow out of it.”*

Mr. Lachie Macfadden has been operating a land-based program for solvent abusers in Pikangikum for a number of years. It is operated out of a 1200 square foot cabin which is across Lake Pikangikum. Over 3 years, 235 youth have enrolled in the program, 135 of them being children under the age of 12.

The program is a short term brief intervention. The camp is run for 4 seasons, with the exception of freeze up or thaw. A sharing circle is utilized, and 90% of those enrolled in the program are sniffing gas and abusing alcohol.

Macfadden reported that sniffers are ostracized by their schoolmates. They are made to feel different. Themes from them included:

- Loss of friends (suicides)
- Grief
- Drinking and violence in their homes
- Feeling not loved and not wanted
- They sniff to “get even” with their parents
- It is “unfashionable” to drink, but acceptable to sniff

Fellow sniffers become their friends and peer group.

The program is a 12-day program, involving four workers and about eight youth per rotation. The children and youth are between eight and eighteen years of age. They are assigned traditional roles in the camp including chores which are assigned in shifts. The assigned chores consist of drawing, writing, traditional outdoor activity, trap line, cutting wood, crafts, participating in a sharing circle, playing hockey, broomball and/or volleyball.

Elders are involved in the program. Upon program completion, 95-100% of the children and youth return to sniffing when they go home. They return to the same circumstances from which they came. Following the program, kids have difficulty integrating with their former peers and reportedly, parents do not provide guidance. The global effect of the program is as a respite, until placement at outside community residential treatment programs can be procured. Solvent abuse

is a very difficult addiction to overcome. At 18, the youth begin to turn to alcohol as their substance of abuse.

The program was shut down at Christmas of 2009, due to lack of funding, traditionally provided through INAC. The program became operational again in 2010, but requires a sustained source of funding. For 2009-2011, one time funding was provided by Health Canada.

## **C10. The Nursing Station**

### **Basic Operations**

The Nursing Station operates 24/7 and has a complement of nine full time nurses. The nurses are retained on behalf of Health Canada.

The physicians are hired through a company called AMDOCS. Currently this service is supplied to the communities aligned with the Independent First Nation Alliance (IFNA) in the First Nations of Pikangikum, Kitchenuhmaykoosib and Muskrat Dam. In the past, physician services to Pikangikum were outreach programs, with a family physician visiting perhaps a few days a month or a week at a time from such locales as Sioux Lookout. The First Nation Family Physician Health Services Branch of the Independent First Nations Alliance (IFNA) contracted AMDOCS for three years.<sup>58</sup>

The physicians are available 25 days per month in the community and after hours for call-backs if necessary.

The Nursing Station Staff reported that suicidal patients rarely present for care. When patients do present with crisis, there is limited ability to access care in the community.

### **Themes**

Common themes heard from nurses in the Nursing Station included:

- The community had lost its culture.
- There were two generations of parents who can not parent.
- Parents are intoxicated; there is no food in homes; children are hungry and helpless.
- For those seeking mental health care, profound confidentiality issues exist and bullying and teasing are prevalent.
- There is likely a high prevalence of Foetal Alcohol Spectrum Disorder (FASD).
- Opportunities exist for enhancement of services provided by the National Native Alcohol and Drug Abuse Programs (NNADAP).

A concern raised by a physician was the prevalence of incest or sexual abuse amongst female youth between the ages of 10-12. Although he could not provide hard data, he suggested that it may be playing a role in the suicide epidemic. According to a Northwest Territories survey, "...80% of girls and 50% of boys under the age of 8 had been sexually abused."<sup>59</sup> This was referencing First Nations in the Northwest Territories.

---

<sup>58</sup> <http://www.wawataynews.ca/node/12374>.

<sup>59</sup> Brown, Ian. Main Problems in Aboriginal Mental Health, [www.niichro.com/mental%health/men\\_2.html](http://www.niichro.com/mental%health/men_2.html).



## **Theoretical Placement for a Suicidal Youth**

Should a youth be brought to the Nursing Station with suicidal ideation, the nurses would perform a risk assessment, determine if the youth was intoxicated or not, attempt to contact collaterals such as the Children's Aid Society, and determine the capacity for support and monitoring in the youth's home. A physician would likely be called thereafter, and telephone support is available 24/7.

If the youth was intoxicated, he/she would be lodged in the police cells overnight until they were sober. Then, they would be brought back for a reassessment. The nurses commented that after becoming sober, the youth seldom express any further suicidal ideation.

If the youth was sober and had many risk factors or had been observed in a significant suicidal attempt such as being found with a rope around their neck, hospitalization might be necessary. If the youth were co-operative and agreed to the hospitalization, it could be facilitated in Sioux Lookout.

If the youth were uncooperative and refused hospitalization, a Form 1 would have to be completed by the physician under section 15 of the Mental Health Act to affect an involuntary admission to hospital.<sup>60</sup> A search for a Schedule 1 bed under the care of a psychiatrist would begin. This might occur in either Thunder Bay or Kenora.

The complexities of placing a youth in a hospital inpatient bed from Pikangikum are complex. Transportation must be approved prior to transfer by the Non-Insured Health Benefits (NIHB) program. These benefits provide for "...medical transportation to access medical services not available on reserve or in the community of residence..."<sup>61</sup> It was reported that at times, NIHB will decline requests to fund transport of certain patients. NAN reported that the Assembly of First Nations has passed a resolution in December 2010 calling for a review of the NIHB's patient medical transportation health policy. An escort may have to accompany the patient, and would have to be found. The patient and the escort would then have to fly to the town where the hospitals were located.

The placement of youth with serious mental health disorders out of the First Nations community faces significant obstacles. This is juxtaposed to accessing care for a patient in southern Ontario.

## **C11. Relationship with the Federal Government**

The nature of the federal government's relationship with First Nations is complex and beyond the scope of this death review. The following information is provided to assist the reader in understanding briefly, Indian and Northern Affairs Canada's mandate.

*"Canada's economic and social well-being benefits from strong, self-sufficient Aboriginal and northern people and communities.*

*Our vision is a future in which First Nations, Inuit, Métis and northern communities are healthy, safe, self-sufficient and prosperous - a Canada where people make their own decisions, manage their own affairs and make strong contributions to the country as a whole.*

---

<sup>60</sup> Mental Health Act, R.S.O. 1990.

<sup>61</sup> First Nations and Inuit Health Program Compendium, Health Canada, March 2007, p. 57.

*Indian and Northern Affairs Canada (INAC) supports Aboriginal people (First Nations, Inuit and Métis) and Northerners in their efforts to:*

- *improve social well-being and economic prosperity;*
- *develop healthier, more sustainable communities; and*
- *participate more fully in Canada's political, social and economic development - to the benefit of all Canadians.*

*INAC is one of the federal government departments responsible for meeting the Government of Canada's obligations and commitments to First Nations, Inuit and Métis, and for fulfilling the federal government's constitutional responsibilities in the North. INAC's responsibilities are largely determined by numerous statutes, negotiated agreements and relevant legal decisions. Most of the Department's programs, representing a majority of its spending, are delivered through partnerships with Aboriginal communities and federal-provincial or federal-territorial agreements.*

*INAC's mandate and wide ranging responsibilities are shaped by centuries of history, and unique demographic and geographic challenges. INAC is one of 34 federal departments and agencies involved in Aboriginal and northern programs and services.*

### **Who is eligible to receive benefits?**

*The answer is in the federal Indian Act. It defines an Indian as "a person who, pursuant to this Act, is registered as an Indian or is entitled to be registered as an Indian." To be eligible to receive benefits under the Indian Act, individuals must be registered in the Indian Register, which is maintained by the Department of Indian Affairs and Northern Development (DIAND). The recognition by the federal government of persons registered under the Indian Act is referred to as Registered Indian Status."<sup>62</sup>*

### **Federal and Provincial Government Roles**

#### **Federal Government**

Under the Constitution Act, 1867, the federal government has jurisdiction over Aboriginal peoples and lands ("Indians and Lands reserved for the Indians").

#### *Distribution of Legislative Powers*

*91. "...it is hereby declared that (notwithstanding anything in this Act) the exclusive Legislative Authority of the Parliament of Canada extends to all Matters*

*Coming within the Classes of Subjects next hereinafter enumerated; that is to say,--*

*24. Indians and Lands reserved for Indians."<sup>63</sup>*

Section 35 of the Constitution Act, 1982 "recognizes and affirms" the "existing" Aboriginal and treaty rights in Canada. These Aboriginal rights protect the activities, practice, or traditions that are integral to the distinctive culture of the Aboriginal peoples. These rights extend to people who make up First Nations, Inuit and Métis peoples.<sup>64</sup>

---

<sup>62</sup> Indian and Northern Affairs Canada [website] Ottawa, ON: Indian and Northern Affairs Canada; 2009. Available from : [www.ainc-ainc.gc.ca/index-eng.asp](http://www.ainc-ainc.gc.ca/index-eng.asp).

<sup>63</sup> The Constitution Act, 1867.

<sup>64</sup> Ministry of Aboriginal Affairs, December 2010.

## **Provincial Government**

The provincial government must ensure all citizens, including Aboriginal peoples, have access to provincial programs and services. Traditionally, Ontario does this by cost-sharing delivery of programs and services with the federal government (e.g. delivery of policing in First Nation communities). Ontario can also develop policies and programs specific for Aboriginal peoples, as long as they do not infringe on Aboriginal and treaty rights.<sup>65</sup>

## **Recommendations**

### **Government of Canada, Health Canada**

- 1. The Government of Canada, working with the Provinces, Territories and Aboriginal Leadership groups such as the Assembly of First Nations, should create a National Suicide Prevention Strategy, as currently exists in other developed countries.**
- 2. The Government of Canada, in developing its National Suicide Prevention Strategy, should liaise with Aboriginal Leadership to ensure that the Strategy considers, accepts and respects cultural diversity, and specifically acknowledges the extraordinary excess contribution of Aboriginal Peoples to the Canadian national suicide rate.**
- 3. In developing its National Suicide Prevention Strategy, an exploration of the catastrophic contribution of First Nations mortality of adolescents and youth living on reserve should be considered, the reasons for the excess mortality clearly understood, and recommendations evolved which address this issue.**
- 4. As a component of its National Suicide Prevention Strategy, the Government of Canada should consider the development of population level mental health indicators so that future decisions on mental health strategies will be data driven. An example would be to develop the capacity, through Health Canada, First Nations and Inuit Health Branch of tracking, in real time, deaths due to suicide in Aboriginal communities. This would allow for the identification of those communities including First Nations reserves, where deaths due to suicide occur in excess and therefore, targeted strategies and enhanced resources may need to be provided to assist these communities in crisis.**
- 5. The Government of Canada, through Health Canada, First Nations and Inuit Health Branch should provide targeted funding to communities and reserves experiencing excess cases of child and adolescent suicides, including First Nations reserves to assist in developing solutions directed to the prevention of these deaths. The current National Aboriginal Youth Suicide Prevention Strategy is not apparently meeting the needs of these individual First Nations.**
- 6. This funding should be appropriated to create comprehensive suicide prevention programs in these communities and reserves, led by the local health authority, in partnership with representatives from Health Canada, First Nations and Inuit Health Branch, and the provincial Local Health Integration Network.**
- 7. Qualified expertise to create and implement comprehensive suicide prevention programs in communities and reserves should be retained. Healthcare experts, such as nurses educated to a Masters Degree level in health science with an interest in project management would ensure that the components of the comprehensive suicide prevention programs were implemented, and that the children, youth and families in these communities would benefit from the provision of enhanced resources. Data should be collected, and benchmarks and key performance indicators developed to track and measure outcomes, and accountability targets should be set. (Cross referenced to**

---

<sup>65</sup> Ibid.

recommendations 24, 25 and 29.) Funding for these nurse manager experts could come from the newly created National Aboriginal Youth Suicide Prevention Strategy.<sup>66</sup>

8. **Health Canada, First Nations and Inuit Health Branch should develop an electronic medical record (EMR) which can link health systems to ensure proper transfer of information between all care providers operating in the “circle of care.” This system should be created in consultation with the provincial Local Health Integration Network and eHealth Ontario and is vital to proper care of all Aboriginal peoples who receive components of their health care from both federal and provincial providers.**

Canada, unlike several other industrialized nations has not developed a national suicide prevention strategy to date. Finland developed the first national suicide prevention program in 1986. Norway, Finland, Slovenia, Sweden, France, Australia, Ireland, New Zealand, United States, England and Scotland have developed national suicide prevention programs. Canada is one of the few developed nations without a national strategy.

9. **Health Canada, First Nations and Inuit Health Branch should provide funding to ensure that Pikangikum’s Comprehensive Mental Health and Addictions Program, including the Community Suicide Prevention Program, can be created and function. (Cross referenced to recommendation 24.)**

#### **Government of Ontario, Ministry of Health and Long-Term Care**

10. **The Province of Ontario, Ministry of Health and Long Term Care (MOHLTC) in collaboration with other ministries should create a Provincial Suicide Prevention Strategy.**
11. **The Province of Ontario, Ministry of Health and Long-Term Care (MOHLTC) in developing its Suicide Prevention Strategy, should liaise with Aboriginal Leadership groups to ensure that the strategy considers, accepts and respects cultural diversity, and specifically acknowledges the extraordinary excess contribution of Aboriginal peoples to the national suicide rate. The province should not allow jurisdictional tensions over First Nations between the federal government and the province to delay the creation of its Suicide Prevention Strategy.**
12. **The Province of Ontario, Ministry of Health and Long-Term Care (MOHLTC) in creating its Suicide Prevention Strategy, should liaise specifically with:**
  - **First Nations’ Leadership, including the Chiefs of Ontario,**
  - **The First Nations political leadership for Northern Ontario, specifically the Nishnawbe Aski Nation, Grand Council Treaty #3,**
  - **Health Canada, First Nations and Inuit Health Branch, and**
  - **Local Health Integration Networks, specifically, those in the North West and North East of Ontario,**
  - **Aboriginal Children’s Aid Societies****to identify communities and reserves where the rate of suicide for children and youth is excessively high.**
13. **The Province of Ontario should cultivate its strategic direction with respect to enhancing mental health and addiction services<sup>67</sup> over the next ten years to ensure that this includes the development of a provincial suicide prevention plan, and the reduction of suicides in children and youth. Components of this plan should consider promotion, prevention and early intervention in mental health for children and youth, with**

<sup>66</sup> Borsillino, M., Health Canada on Ottawa’s native health role, The Medical Post, January 18, 2011, p. 31.

<sup>67</sup> North West Local Health Integration Network, Integrated Health Services Plan, 2010-2013

targeted efforts to reduce the stigma and discrimination associated with mental and substance abuse disorders.

**14. As a component of its Suicide Prevention Strategy, the Province of Ontario should develop population-level mental health indicators so that future decisions on mental health strategies will be data driven. An example would be to develop the capacity of tracking, in real time, deaths due to suicides in Aboriginal communities including First Nations on reserves.**

**15. The Province of Ontario, Ministry of Health and Long-Term Care should create a telehealth consulting service for psychiatric care to remote First Nations communities. This service should allow for prompt (same day) access to child and adolescent psychiatrists for children in crisis. To ensure availability of psychiatrists to fulfill this role, the Ministry should provide a significant premium to physicians. The Ministry should partner with academic health science centres to create this service.**

The Ministry of Health and Long-Term Care has set a strategic direction with respect to mental health and addiction services for the next 10 years. These recommendations are synergistically aligned with this Ministry direction, and call for the development of a provincial suicide strategy, such as exists in the Province of Alberta.

“The Alberta Suicide Prevention Strategy document was formally launched in September 2006 and is the result of the commitment of many Albertans, including family members/survivors, service providers, researchers, representatives from government ministries, non-government community agencies and others. The purpose of the strategy is to reduce suicide, suicidal behaviour and the effects of suicide in Alberta over the next 10 years. Significant actions which are aimed at the general population as well as those targeted at identified priority groups are essential to providing a comprehensive approach to suicide prevention.”<sup>68</sup>

Ontario could benefit from a provincial strategy as well.

**16. The Province of Ontario, Ministries of Children and Youth Services and Health and Long-Term Care should develop an integrated mental health service strategy stressing accessibility and program delivery for children and youth in northern Ontario (Northern Ontario Aboriginal Child and Adolescent Psychiatry Outreach Program). Some stakeholders identified to assist in the development of this strategy would be:**

- North West and North East Local Health Integration Networks
- Health Canada
- Ministry of Children and Youth Services
- A representative from the Sioux Lookout Regional Physicians’ Services Inc. (SLRPSI)
- Representatives from Meno-Ya-Win, Thunder Bay Regional Health Sciences Centre, Lake of the Woods District and Weeneebayko Hospitals
- Representatives from the Sioux Lookout First Nations Health Authority and the Weeneebayko Area Health Authority
- A representative from Nodin Child and Family Intervention Services
- A paediatric psychiatrist who provides service to First Nations Youth in the North West
- Health Canada, First Nations and Inuit Health Branch
- Indian and Northern Affairs Canada
- Non-Insured Health Benefits (NIHB)

---

<sup>68</sup> <http://www.albertahealthservices.ca/2738.asp>.

- **Tikinagan Child and Family Services, Dilico Anishinabek Family Care, and other children's aid societies**
- **A representative from the Ontario Child and Youth Telepsychiatry Program**
- **A representative from the Nishnawbe Aski Nation**
- **A representative from each of the Tribal Councils of the north**

**17. This Northern Ontario Aboriginal Child and Adolescent Psychiatry Outreach Program should be resourced jointly by the Ministry of Children and Youth Services, MOHLTC and Health Canada, First Nations and Inuit Health Branch and should endeavour to deliver culturally competent evidence-based child psychiatry incorporating flexible mixed models of service delivery, including:**

- **Triaging of direct referrals for children and youth in crisis**
- **Indirect referrals including support to family physicians and therapists**
- **Shared-care models**
- **Telepsychiatry, available 24/7, including ready access for children and youth in acute crisis at risk for suicide**
- **Mechanisms for communication between therapists, family physicians and psychiatrists**

The conceptualized model might consider a primary care family physician for each client, as well as an identified mental therapist acting as case manager, with psychiatry consultation available through a visiting psychiatrist, or telepsychiatry through Thunder Bay or Toronto.

#### **North West and North East Local Health Integration Network (LHIN)**

**18. The North West and North East LHIN, working with Health Canada, First Nations and Inuit Health Branch, the Nishnawbe Aski Nation and other political First Nations leadership, should create an integrated and seamless Mental Health and Substance Abuse Strategy. This program should identify all service providers, both federally and provincially, and create care paths for First Nations living on reserve, particularly for youth who require placement out of their home communities.**

**19. The North West and North East LHIN working with Health Canada, First Nations and Inuit Health Branch should endeavour to create a crisis telephone line and/or Internet service for the North West and East regions.**

This line and/or internet service should allow for youth in crisis to access counselling and contacts to discuss their current stressful situations. This service could be identified and made readily available to communities like Pikangikum. This service could be modelled after other existing programs, and should be created with a toll-free number offering commonly spoken First Nations languages.

The lack of the children attempting to access care in the community in the month prior to their deaths suggests that alternate methods of providing services should be evolved. Crisis telephone lines are utilized in locales in southern Ontario. Given the broad expanse of the north, a larger project providing this service to First Nations in the North West and North East may be of benefit. It also could be provided on-line, and would ensure a level of confidentiality and/or privacy not currently available in the First Nation.

#### **Sioux Lookout First Nation Health Authority (SLFNHA), Nodin Child and Family Intervention Services**

Nodin is funded through the Ministry of Children and Youth Services, the Ministry of Community and Social Services, and Health Canada, First Nations and Inuit Health Branch. It provides service to approximately 33 First Nations from Treaties 3, 5 and 9. In addition, it provides service to clients in the Town of Sioux Lookout.

Nodin provides a counsellor to Pikangikum 5 days per month. This counsellor will fly in to Pikangikum, and stay for 5 consecutive days. This has posed a challenge both in Pikangikum and other First Nations communities. Facilities to meet with clients are limited. The demand for service far exceeds Nodin's capacity. In March 2010, the Director of Treatment Services had 18 counsellors and 5 supervisors providing service to more than 1,000 clients, with a waiting list of 1,500 within their entire catchment area. Each counsellor was trying to provide service to as many as 50 clients, with benchmarks to provide service set at approximately 25. Service demand is so great, that crisis counselling is all that can be provided. Counsellors are qualified with college and/or university degrees. A proper qualification for mental health counsellors is a commitment that the Sioux Lookout First Nation Health Authority has made and sustained.

In 2008-2009, Nodin provided counselling to 983 clients in Sioux Lookout, and 1208 in Northern services.

- 20. The Sioux Lookout First Nations Health Authority, Nodin Child and Family Intervention Services should conduct a review of open and waiting list cases, for the purpose of benchmarking with other organizations providing these types of services, to determine an acceptable caseload for its counsellors.**
- 21. Based on this benchmarking exercise, SLFNHA should create a business case to present to the Ministry of Children and Youth Services, the Ministry of Community and Social Services, and Health Canada, First Nations and Inuit Health Branch, who fund Nodin, to ensure that adequate resourcing is provided to address the needs for the enormous backlog that currently exists. This will likely require additional full time equivalents for both counselling and supervising.**
- 22. Nodin Child and Family Intervention Services should consider developing a model, (when adequately resourced), that is not limited to crisis intervention, as currently exists. Given their dedication to ensuring duly qualified staff, with accountability and supervision processes, consideration should be given to Nodin providing overall mental health case management to children and youth from the First Nations communities it currently services, including Pikangikum.**

SLFNHA, with its vision, leadership and menu of integrated services should seek enhancements in its resourcing so that Nodin Child and Family Intervention Services could become the provider of case management services for individual children and youth, working arm-in-arm with community mental health workers and other providers, such as Tikinagan Child and Family Services.

### **Pikangikum First Nation and the Pikangikum Health Authority (PHA)**

- 23. The Pikangikum Health Authority should develop a mission statement and clearly define its vision and values.**
- 24. The Pikangikum Health Authority should develop a Comprehensive Mental Health and Addictions Program for children, youth and adults. This program should consider,**
  - a Comprehensive Community Suicide Prevention Program,**
  - developing plans to address the solvent and alcohol abuse crises, and**
  - the need for integrated provision of mental health services including models which incorporate traditional practices, defined by the Pikangikum First Nation.**
- 25. In developing its Comprehensive Mental Health and Addictions Program, the PHA should retain nursing expertise to assist in the development of the Program. Funding for this nurse manager expert could come from the newly created National Aboriginal Youth Suicide Prevention Strategy, the Health Canada First Nations and Inuit Health**

**Branch, and/or the Aboriginal Health and Wellness Strategy. Invited participants to ensure a truly integrated program might include:**

- **Representatives from the Pikangikum Social Health, Education and Elders Committee**
- **Representatives from the Pikangikum Nursing Station**
- **Representatives from Pikangikum Mental Health and Addictions Programs including a mental health worker, youth patrol, solvent abuse worker, NNADAP, crisis team and community health nurse**
- **A representative from AMDOCS**
- **A representative from the Sioux Lookout Regional Physicians' Services Inc. (SLRPSI)**
- **Representatives from Meno-Ya-Win Hospital**
- **A representative from the Sioux Lookout First Nations Health Authority**
- **A representative of the First Nation Family Physician Health Services branch of the Independent First Nations Alliance (IFNA)**
- **A representative from Nodin Child and Family Intervention Services**
- **A paediatric psychiatrist who provides service to First Nations youth in the North West**
- **Health Canada, First Nations and Inuit Health Branch**
- **Indian and Northern Affairs Canada**
- **Non-Insured Health Benefits (NIHB)**
- **The Ministry of Children and Youth Services**
- **The Ministry of Aboriginal Affairs**
- **The Ministry of Health and Long-Term Care**
- **The North West Local Health Integration Network**
- **Tikinagan Child and Family Services**
- **Ontario Provincial Police**

**26. Until the Comprehensive Mental Health and Addictions Program is functional, the NNADAP, Solvent Worker and Youth Patrol programs should be examined and either augmented or reconstituted to provide meaningful assistance to the community. Job descriptions should be written so that targets and accountability expectations are clearly set out.**

These services are far too critical not to be fully functioning in this community. In addition, Health Canada, First Nations and Inuit Health Branch should provide funding to ensure that the Comprehensive Mental Health and Addictions Program, including the Community Suicide Prevention Program, can be created and function.

**27. The Pikangikum First Nation, Chief, Council and the Pikangikum Health Authority should create a Community Suicide Prevention Program, to be delivered as a community program, under the Health Authority's current Chair and Directorship, funded by Health Canada, First Nations and Inuit Health Branch.**

**28. The creation of the Community Suicide Prevention Program will require nursing expertise in health care and project management that currently does not exist within the community. To achieve the necessary level of expertise, the Pikangikum Health Authority under its current Directorate, should partner with Health Canada, First Nations and Inuit Health Branch, and the North West Local Health Integration Network for the planning and delivery of the program.**

**29. The Pikangikum Health Authority should approach Health Canada, First Nations and Inuit Health Branch to provide funding to retain medical expertise, such as a nurse**



**manager educated to a Masters Degree level in health science with expertise in project management to assist with creating and implementing the Community Suicide Prevention Program. The job specifications, qualifications, accountabilities and contract should be agreed upon by all three members of the tripartite partnership, that is, the Pikangikum Health Authority, Health Canada, First Nations and Inuit Health Branch, and the North West Local Health Integration Network.**

The Pikangikum First Nation was characterized in the press as having the highest suicide rate in the world in 2000. In 2007, the rate was estimated as 417 per 100,000 for its youth, based on 10 suicides occurring in a population of approximately 2,400.

The current membership of the Pikangikum Health Authority has expressed a clear vision, which embraces an integrated model of service delivery. To this end, the Health Chair is currently co-chairing a group called the Pikangikum Social Health, Education and Elders Committee. Members include Indian and Northern Affairs Canada, the Ministry of Children and Youth Services, Tikinagan Child and Family Services, Nodin, the Ministry of Aboriginal Affairs, the Sioux Lookout First Nations Health Authority, and Health Canada. It is without question, an enlightened approach and a significant strength for the community.

The community does not currently have a suicide prevention program. Although the Pikangikum Health Authority delivers several programs in its Mental Health and Addictions portfolio, the level of benefit the clients actually receive is unknown. An expert in program creation and delivery working arm-in-arm with the Pikangikum Health Authority, would provide the requisite expertise to assist the community in developing a comprehensive suicide prevention program, while ensuring the components and delivery of the program were conducted in a culturally acceptable model reflecting the values and principles of the Pikangikum First Nation.

**30. The Community Suicide Prevention Program should be created by the Pikangikum Health Authority and their Nurse Manager Expert incorporating a steering committee model with invited participants and stakeholders including such interests as,**

- **representatives from the Pikangikum Nursing Station,**
- **representatives from Pikangikum Mental Health and Addictions Programs including a mental health worker, youth patrol, solvent abuse worker, NNADAP, crisis team and community health nurse,**
- **a representative from the Pikangikum Education Authority,**
- **a representative from AMDOCS,**
- **a representative from the Sioux Lookout Regional Physicians' Services Inc. (SLRPSI),**
- **representatives from Meno-Ya-Win Hospital,**
- **a representative from the Sioux Lookout First Nations Health Authority,**
- **a representative of the First Nation Family Physician Health Services branch of the Independent First Nations Alliance (IFNA),**
- **a representative from Nodin Child and Family Intervention Services,**
- **a paediatric psychiatrist who provides service to First Nations youth in the North West,**
- **Health Canada, First Nations and Inuit Health Branch,**
- **Indian and Northern Affairs Canada,**
- **Non-Insured Health Benefits (NIHB),**
- **the Ministry of Children and Youth Services,**
- **the Ministry of Aboriginal Affairs,**
- **the Ministry of Health and Long-Term Care,**

- the North West Local Health Integration Network,
- Tikinagan Child and Family Services,
- Ontario Provincial Police,
- Lachie Macfadden land-based detoxification program.

Effective suicide prevention requires prevention, intervention and postvention at the individual, family and community level. It is a complex integrated exercise, which should seek as its outcome, seamless care for the child or youth, family or community in crisis. All of the above parties play a role in some aspect of service provision for mental health and addiction services. These groups need to speak to each other, and work toward a common goal of improved mental health outcomes for children and youth.

**31. The Community Suicide Prevention Program should seek methods to de-stigmatize the seeking of help by clients for mental health-related issues, and improve health privacy. Community members must be ensured of confidentiality in counselling sessions so that they will be more willing to seek out help and confide their concerns.**

Community members will remain reticent to employ services without meaningful changes in policies and practices that ensure that they will have privacy and will not be the subject of ridicule or harassment. This theme was conveyed about Pikangikum from the nurses at the Nursing Station, as well as a paediatric psychiatrist in Thunder Bay, who spontaneously proffered that this was a significant issue at Pikangikum.

Much of what follows is extracted from *Suicide among Aboriginal People in Canada, 2007* by the Aboriginal Healing Foundation, prepared by Laurence J. Kirmayer and associates<sup>69</sup>, and *Acting On What We Know: Preventing Youth Suicide in First Nations, The Report of the Advisory Group on Suicide Prevention*.

To address the child and youth suicide epidemic in Pikangikum, a multifaceted approach should be implemented. As the individual cases demonstrate, the issues affecting the children are trans-generational. Challenges and tensions exist at the individual, family and community level. The essential components of an effective strategy need to involve prevention, intervention and postvention directed at four levels; the child or youth, the family, community and region.

The essence of any suicide prevention approach requires the identification and treatment of an individual at risk before an attempt takes place. Resources do exist within the community, but how they are accessed, and how they are utilized to assist the individual, family or community, needs to be addressed to ensure that children and youth suffering with mental illness, personal crisis, substance abuse and/or family crisis are identified and treated. Many of the themes arising from the review of the deaths suggested that the youth who may have been identified were not referred for treatment.

### **Primary Prevention Strategies**

#### *School-based Prevention: The Pikangikum Education and Health Authority*

**32. The Pikangikum Education and Health Authority should cooperatively develop as a component of the Community Suicide Prevention Program, a school-based student health and suicide prevention program. This program should be a component of the health education curriculum, and should include a variety of health and social issues of which suicide would be one. The program should seek to enhance the capacities of the children in coping with stress, conflict resolution, problem-solving and communication. The fundamental purpose would be to build resiliency and self-esteem in the children,**

<sup>69</sup> Kirmayer, L., et al, *Suicide among Aboriginal People in Canada*, The Aboriginal Healing Foundation, 2007.

so that they would be better able to withstand the rigours of the crises and conflicts that may arise in their lives.

33. **The school-based curriculum should incorporate traditional and cultural knowledge and should utilize the resource of incorporating elders when teaching the youth about such issues as cultural identity and self-pride. It should focus on mental, emotional, spiritual and physical well-being, and particularly discuss the dangers of solvent abuse and emphasize the recognition of suicidal behaviours.**
34. **The school-based health program should address such issues as alcohol and substance abuse, depression and suicide, domestic violence, sexual and/or physical abuse, and bullying. It must convey and communicate, in plain language to the children, strategies for help-seeking where these issues exist in their lives, and de-stigmatize and dispel attitudes and dispositions which portray the seeking of help in a negative light.**
35. **The school-based health program should seek to identify high risk youth for suicide by developing and utilizing a school-based screening program and refer high risk youth for intervention. Intervention for children who are identified as high risk for suicide might include one-to-one counselling, as well as small-group interventions based on skills building.**<sup>70</sup>

A strategy that is delivered through the school system has a variety of advantages. A theme that emerged in interviews was that suicide is a “taboo” topic. Apparent in the deaths reviewed, was that community members did not understand the significance of a meaningful parasuicidal gesture such as being found with a rope around one’s neck. Education is necessary. Delivered by the school as a component of health education, it has the advantage of being relatively inexpensive, year round and consistent, and would be delivered by educators who are experts in reaching the children. However, it requires that the children are actually present at school to achieve the potential benefit.

“For some youth, suicide can be viewed positively as an effective means of protest or a heroic gesture pointing to social wrongs and injustices. Suicide education can challenge this romanticized view of suicide and point to alternate responses to interpersonal crisis and despair.”<sup>71</sup>

A noteworthy strength in the community has been the delivery of a Youth Conference, from March 25-27, 2008 delivered at the Eenchokay Birchstick School. Approximately 360 children from grades 5 to 12 took part, and attended workshops on topics such as grief, impact of family violence, teen addictions, Foetal Alcohol Spectrum Disorder and solvent abuse.

The American Indian Life Development Curriculum was developed for the Zuni Pueblo in New Mexico and seeks to enhance skills to prevent youth suicide. The curriculum covers 7 major areas:

1. Increasing self-esteem
2. Learning to identify emotions and stress
3. Improving communication and everyday problem-solving
4. Identifying and reducing negative thoughts and anger reactivity
5. Information about suicide risk
6. Suicide intervention training
7. Personal and community goal setting.<sup>72</sup>

The format was classroom sessions occurring three times a week for 30 weeks.

---

<sup>70</sup> Kirmayer, L., et al, Suicide Among Aboriginal People of Canada, The Aboriginal Healing Foundation, 2007, p. 88.

<sup>71</sup> Ibid.

<sup>72</sup> Ibid., p. 89.

### Peer Support Programs

**36. The Pikangikum Education Authority and the Pikangikum Health Authority should develop a peer support program operated through the school by senior students, called the Peer Support Youth Council. This program should seek to engage children who are identified as “at risk” for suicide and create bridges and ease for the “at risk” child to seek assistance appropriately. The peer counsellors should be trained in basic listening skills and identified as resource people for the youth in crisis. Oversight, management and debriefing for the Peer Support Youth Council could be provided by Nodin Child and Family Intervention Services.**

One of the compelling findings of our review was that not one of the sixteen children sought care from a qualified professional in the month before taking their lives. It may have been that they did not know how to access help, or that they were simply not disposed to seeking it. Children are far more likely to speak to a peer, than an adult in authority. Youth trained and educated to refer youth to appropriate community resources would be ideal.

### Community-Based Programs: The Pikangikum Health Authority

**37. The Pikangikum Health Authority should develop a community-based program to address suicide as a component to their suicide prevention strategy. The components could consist of:**

- **Education programs for youths and adults on topics including suicide, parenting and life skills. The educational programs directed toward suicide prevention should have mental health literacy tools for parents promoting the identification of undiagnosed or untreated mental health disorders so that professional assistance will be accessed.**
- **Creating peer counsellors to respond to young people in crisis, and bringing them to the attention of healthcare providers.**
- **Outreach to families after a suicide or traumatic death.**
- **Immediate response to a youth at risk.**
- **Creating suicide risk screening programs in mental health, addiction and social service programs.**<sup>73</sup>

A program such as this was implemented in New Mexico in 1990 and involved leaders, healthcare providers, parents, elders and youth. It reported a reduction in suicidal acts immediately upon program implementation and after 12 years, had a 70% reduction in suicidal attempts.<sup>74</sup> As stated in the Royal Commission on Aboriginal Peoples, 1995: “...strategies aimed at community and social development should promote community cohesion and local control, collective esteem and identity, transmission of Aboriginal knowledge, language and traditions and methods for addressing social problems that are culturally appropriate.”<sup>75</sup>

**38. As a component of the community-based program, the Pikangikum Health Authority and Education Authority should develop and deliver workshops on life skills, parenting and problem solving, and communication with the children and youth, to parents and young adults in the community. These should be based on culturally sensitive models of roles and responsibilities.**

---

<sup>73</sup> Ibid, p. 91.

<sup>74</sup> Ibid.

<sup>75</sup> Ibid, p. 92.

A recurrent theme in the lives of the children examined was a lack of engagement of the parents in actively setting boundaries for the children, or addressing their self-harming and destructive behaviours, such as sniffing gasoline.

#### Means Restriction

**39. Given that means restriction, or eliminating access to specific lethal means of suicide has been proven to be effective in reducing suicide rates, and given that hanging was the method used in all the suicides examined, educational programs directed toward prevention should acknowledge the roles of limiting access to items that could be utilized as ligatures in children expressing suicidal ideation. It is acknowledged that given the ready availability of these items in a household environment, for example, shirts, sheets, and shoelaces, it is likely to play a limited role.**

#### Gatekeepers

**40. The Pikangikum Health Authority should develop a role for community gatekeepers, such as elders, community leaders, police, social workers, counsellors, teachers and clergy to be taught to identify youth at risk for suicide, and refer them for treatment. The community-based gatekeeper training programs should seek to improve identification and recognition of suicidal behaviour to allow for prompt referral.**

Two of the children whose deaths were reviewed were suffering with apparent auditory and visual hallucinations, yet were not brought to the immediate attention of physicians. It may have been that they did not understand the magnitude of risk associated with the symptoms of these children. An educational program delivered to individuals within the community whereby they are taught to identify concerning symptoms for suicide risk, and then compel the youth to seek care, may have a positive role.

#### Communication and Media Handling of Suicides in Pikangikum: The Pikangikum First Nation, Chief and Council

**41. The Pikangikum First Nation should convene a committee for the purposes of reviewing and developing policies on how it will communicate to the community the tragedy of suicides when they occur. Invited stakeholders might include the proprietors of the local radio station and newspaper, and representatives from the Pikangikum Nursing Station, the Pikangikum Mental Health and Addictions Programs, Nodin Child and Family Intervention Services, Tikinagan Child and Family Services, and the Ontario Provincial Police. The policy should be directed at diminishing the intense community focus on the death, and promoting mental health and coping strategies around suicide.**

A theme, heard repeatedly from educators, police, and members of the community was that the entire First Nation “shuts down” when a suicide occurs. In a community where cluster suicides are common, service and supports should actually be enhanced when a suicide occurs. Effectively, shutting down services created the impression that the children received a significant amount of attention at the time of their deaths, attention that may have been absent in life. The review of the youth suicide deaths demonstrated that they occurred in clusters. The creation of policies and strategies to handle communication around the deaths should aggressively seek to reduce further suicides. It is well recognized that “news reporting of suicide in the media leads to an increase in the rate of suicide in subsequent weeks, and that this increase is a true addition to the total number of suicides...”<sup>76</sup> Efforts in the

---

<sup>76</sup> Hazell, P., Adolescent Suicide Clusters: Evidence, mechanisms, and prevention.

community should be directed to the avoidance of a contagion effect, particularly so since three clusters occurred which accounted for a majority of the youth deaths at Pikangikum.

*Programming for Children: The Pikangikum First Nation, Chief and Council*

**42. The Pikangikum First Nation should develop a project to create, with the assistance, support and aid from INAC, an athletic field with a children's playground, including a basketball court and baseball and soccer fields to allow for children's programming.**

A key issue identified was a lack of programming for the children. Sporting events are integral, and have been curtailed since the school burned down. These types of programming for children and youth combat alienation and "foster peer support and a sense of belonging."<sup>77</sup>

**Secondary Prevention: Early Intervention and Treatment**

*Health Care Professionals and Mental Health Services: Health Canada, First Nations and Inuit Health Branch*

**43. The Pikangikum Nursing Station should develop an emergency room suicide response protocol. This protocol should contemplate identification of those who require emergent hospitalization and how this will be achieved, and those that can be discharged from the Nursing Station. Where appropriate, discharge from the Nursing Station should consider;**

- notification of the child or youth's parent and guardian,
- creation of a safety plan,
- immediate notification of the community mental health team, and Tikinagan Child and Family Services, where permitted by the Personal Health Information Protection Act,
- provision of the discharge summary to the community mental health team, and Tikinagan Child and Family Services,
- follow-up with the community mental health team within 24 hours.

Stakeholders who should be considered to assist in the development of the emergency room suicide response protocol should include:

- Representatives from the Pikangikum Nursing Station
- Representatives from Pikangikum Mental Health and Addictions Programs including a mental health worker, crisis team and community health nurse
- A representative from AMDOCS
- A representative from the Sioux Lookout Regional Physicians' Services Inc. (SLRPC)
- Representatives from Meno-Ya-Win Hospital
- Representatives from the Sioux Lookout First Nations Health Authority
- A representative of the First Nation Family Physician Health Services branch of the Independent First Nations Alliance (IFNA)
- A representative from Nodin Child and Family Intervention Services
- A paediatric psychiatrist who provides service to First Nations Youth in the North West
- Health Canada, First Nations and Inuit Health Branch
- Non-Insured Health Benefits (NIHB)
- The North West Local Health Integration Network

---

<sup>77</sup> Acting On What We Know: Preventing youth suicide in First Nations. The Report of the Advisory Group on Suicide Prevention.

- Tikinagan Child and Family Services

- Ontario Provincial Police

Review of some of the deaths of these children demonstrated opportunities for enhancement with respect to provision of emergent care to suicidal youth and children. For example, a suicidal youth found with a rope around her neck was ultimately sent to jail for the night, as she was under the influence of solvents.

**44. Nurses working in the Pikangikum Nursing Station should receive specialized training and education with respect to assessing those at risk for suicide, including when patients should be referred for emergent psychiatric inpatient treatment in a Schedule 1 facility. This could be achieved by the nurses obtaining certification in mental health.**

**45. AMDOCS, the principal physician service provider to Pikangikum should develop an educational module for its physicians with regard to suicide prevention and treatment. This program should discuss:**

- **The high rate of mental health disorders in youth that kill themselves.**
- **The utilization of treatment strategies in youth including the effectiveness of antidepressants such as selective serotonin reuptake inhibitors.**
- **The need to effectively treat children suffering with major psychiatric illnesses such as psychotic disorders.**
- **The association of substance abuse disorders and suicide.**

**46. The Pikangikum Health Authority, the North West LHIN and the Pikangikum Nursing Station should develop an agreement with paediatric and adolescent psychiatric service providers whereby prompt consultation for youth presenting with suicidal ideation and/or risk factors can access this psychiatric expertise via telehealth video linkages.**

None of the children involved in the death review had accessed mental health services in the month before their deaths. The reasons for this are not entirely known. Of interest was the fact that not a single youth that took their life by suicide was being treated with a psychotropic medication, despite good evidence of the benefits of this treatment. An opportunity may exist for enhanced education for the nurses and physicians providing care to Pikangikum.

*Crisis Telephone Line: North West and North East LHIN*

See recommendation 19.

*Mental Health Crisis Response Teams*

**47. The Pikangikum Health Authority should develop a Mental Health Crisis Response Team through its Mental Health and Addictions Programs for those identified as suffering with parasuicidal ideation. This service should have the capacity to mobilize counsellors to respond to youth in crisis 24/7.**

This recommendation is resource intensive. Some of the youth had family members who did not bring them to care, even when they were discovered in events clearly indicating self-injury and a desire to die. An alternative method for providing care might have been for the family, friend or community member to contact a Mental Health Crisis Response Team member who could visit the youth in their home, and assess the youth for necessary next steps.

*Solvent and Substance Abuse Treatment*

**48. The Pikangikum First Nation, and the Pikangikum Health and Pikangikum Education Authority should seek to identify all children and youth <19 years of age involved in solvent abuse. This could be facilitated through screening programs in the school, and**

**with the assistance of the OPP and the Nursing Station. All youth and children identified as suffering with solvent abuse, who are age appropriate based on the criteria of the Child and Family Services Act, should be referred to Tikinagan Child and Family Services. All youth, regardless of age, should also be referred to the Solvent Abuse Worker.**

**49. The Pikangikum Education Authority should augment the school's current curriculum on solvent abuse to ensure that education begins in kindergarten with developmentally appropriate modules throughout elementary school.**

Volatile substances such as gasoline when inhaled are absorbed through the blood stream and travel to the brain where they are felt immediately. The user will feel euphoric, light-headed with distorted vision, impulsiveness and lack of inhibition. They may develop ataxia or staggering, dizziness and flushing. Users will usually inhale periodically to maintain a high and avoid the side effects which include a depressant effect and feeling down.<sup>78</sup>

The peak age for inhalant abuse is thought to be about 14 to 15 years. Chronic use tends to be endemic in "...remote communities coincident with unemployment, poverty, substance abuse and dysfunctional families. It is noteworthy that inhalant abuse is epidemic in some remote communities, and virtually absent in others."<sup>79</sup> Chronic inhalant abuse can be associated with school failure, delinquency and an inability to achieve societal adjustment.<sup>80</sup> Chronic abuse leads to central nervous system damage including dementia, cerebellar dysfunction, loss of cognitive and higher brain functions and gait disturbance. Computed tomography will show a loss of brain mass. Death can occur due to asphyxia, suffocation, dangerous behaviour, aspiration and sudden sniffing death syndrome.<sup>81</sup> The hydrocarbon in the inhalants sensitizes the myocardium to the effects of adrenaline, and a startle reflex will cause a surge in this hormone which can lead to a fatal heart arrhythmia.

Of interest, the Canadian Paediatric Society notes that disinhibition while under the influence of inhalants may cause dangerous behaviour. The striking association of suicide with solvent abuse in this death review, where 10 of 16 children and youth were abusing solvents on the day of their deaths suggests that this might at least, be contributory to the reasons why the youth killed themselves. Solvent abusers may suffer with short attention spans, poor impulse control and poor social skills, with impaired decision making skills.<sup>82</sup>

The extremely high correlation between solvent abuse and suicide in the community, where 87.5% of the youth who killed themselves were known solvent abusers necessitates the identification of these youth at risk. The presence of this disorder in the community is staggering. Estimates of 200 and possibly even as many as 300 or more children and youth are suspected of abusing solvents. Fourteen of the youth who took their lives in this review were known solvent abusers, and 11 were under the influence of an intoxicant (10 solvent and one alcohol and two exhibiting both ) at the time of their deaths. Some of the youth had been apprehended by police for being publicly intoxicated with solvents, but were not referred to the Children's Aid Society and hence, not followed.

The likely effects of cumulative stress and trauma, and the resultant impact of hopelessness on children are poignantly depicted in a recent troubling youth survey completed in Pikangikum titled "How do you feel about yourself." Seventy-five percent (75%) indicated that they felt sad most of the time. Seventy-three percent (73%) "felt hurt inside and could

---

<sup>78</sup> Youth volatile solvent abuse, Canadian Centre on Substance Abuse.

<sup>79</sup> Inhalant abuse, First Nations and Inuit Health Committee, Canadian Paediatric Society, [www.cps.ca/english/statements/11/ii97-01.htm](http://www.cps.ca/english/statements/11/ii97-01.htm)

<sup>80</sup> Ibid., p. 36

<sup>81</sup> Ibid.

<sup>82</sup> Inhalants. National Inhalant Prevention Coalition, [www.inhalants.org/guidelines.htm](http://www.inhalants.org/guidelines.htm).



not make that hurt go away.” Sixty-three percent (63%) thought about suicide and 56% had tried to commit suicide or hurt themselves. Another very significant and disturbing finding was that close to one-half of the youth (48%) felt “like nothing will change or get better for them in the future.”<sup>83</sup>

Girls in grade 3 and 4 recently completed a survey in which they self-identified that 27% had tried solvents. Currently, there is no formal mechanism for identification of these “at risk” children and youth. A Solvent Abuse Worker is employed as a part-time position in Pikangikum. The principle function of this worker is to complete applications for residential treatment programs.

A requisite component of healing and education in the community should be the understanding that children and youth that abuse solvents are at risk for death and/or permanent lasting neurological damage. It can be a life threatening addiction, and the gravity of this addiction should be appreciated by all members of the Pikangikum First Nation. It should not be accepted or treated as a minor concern, at any time.

- 50. The Pikangikum Health Authority, with the assistance of Health Canada, Youth Solvent Abuse Program (YSAP), Tikinagan Child and Youth Services, the Ministries of Children and Youth Services and Health and Long-Term Care and the Local Health Integration Network should develop a comprehensive in-community Solvent Abuse Program. Medical expertise on solvent abuse should be retained for this exercise. This program should incorporate support of the children before and after treatment in residential solvent abuse programs, adopting holistic approaches to treatment, including aftercare programs delivered in the community.**
- 51. The Pikangikum Health Authority, Health Canada, First Nations and Inuit Health Branch, Youth Solvent Abuse Program (YSAP), Tikinagan Child and Family Services, the Ministries of Children and Youth Services and Health and Long-Term Care and the Local Health Integration Network, in developing the comprehensive in-community Solvent Abuse Program, should liaise with residential solvent abuse providers such as White Buffalo Youth Inhalant Treatment Centre (WBYITC) to develop comprehensive after-care and follow-up to residential treatment programs. This should include outreach programs delivered at Pikangikum whereby a provider such as WBYITC delivers a community intervention including such items as identifying protective factors in the community such as the school system, community support groups, and connecting with elders.**
- 52. Pikangikum First Nation should develop a Healing Treatment Centre with funding provided by Health Canada, Inuit and First Nations Health Branch. The Centre could house multiple providers of health services under one roof including Tikinagan Child and Family Services, the community mental health workers, NNADAP workers and the solvent abuse workers. In addition, children who are apprehended by police for solvent intoxication would not be lodged in police cells overnight, but rather, would be brought to a safe sheltered environment in the Centre to be monitored by peace keepers until they are no longer intoxicated. The comprehensive in-community Solvent Abuse Program after-care program could be delivered at this location.**
- 53. Social workers, mental health workers and solvent abuse workers will need to proactively reach out to involved families of solvent abusing children and youth, and**

---

<sup>83</sup> Finlay, J, and Nagy, A, Pikangikum – Root Causes of Youth Suicide Within a Remote First Nation, January 17, 2011, p.22, in publication.

**should consider adopting models of home visits to ensure confidentiality and diminish the stigma attached to help-seeking which has emerged in the community.**



**Picture 3. A typical cell, where the youth who are apprehended for intoxication with solvents would be lodged overnight pending release in the morning. A new jail has been opened since March 2010 when this photo was taken.**

Currently, police cells are the only place in the community where safety of intoxicated children and youth can be guaranteed. It is the only available option at this time. This was a common occurrence in children who were the subject of this suicide review.

A recurrent theme in the deaths examined was that even when the youth returned to the community following extensive residential stays for solvent abuse treatment, they became involved in solvent abuse again. The rate of recidivism approached 100%. The reasons for this are multiple.

“A key assumption leading to the establishment of the YSAC programs was that young solvent abusers needed a safe place for detoxification separate from their home communities. This is because it was evident that families were not always supportive and were often highly dysfunctional...the work of Matthew Owen Howard and Jeffrey Jensen found that inhalant users were more likely to have low family support and cohesiveness, low self-esteem and substance abusing parents and peers.”<sup>84</sup>

A recent OPP incident in Pikangikum occurred where an officer entered a residence, and the family was boiling gasoline on the stove.<sup>85</sup>

The National Youth Solvent Abuse Program (NYSAP) was established in 1996 between First Nations people and Health Canada. It is for youth between 12-26 years of age. This residential treatment program operates 9 sites across Canada with 112 residential beds. The Youth Solvent Addiction Committee (YSAC) provides culturally appropriate, therapeutic inhalant treatment and community intervention programming for First Nation youth and their families.<sup>86</sup>

Fundamental to the health of First Nations people is their spiritual, emotional, physical and mental well being. Resiliency is an individual’s ability to cope with significant adversity or stress in effective ways.<sup>87</sup> Solvent abuse programs have identified a range of stresses for their

<sup>84</sup> Dell, AD, et al., Resiliency and Hollistic Inhalant Abuse Treatment, Journal of Aboriginal Health, March 2005, p.8.

<sup>85</sup> Personal communication, Superintendent Brad Blair, October 2010.

<sup>86</sup> Dell, AD, et al., Resiliency and Hollistic Inhalant Abuse Treatment, Journal of Aboriginal Health, March 2005, p. 6.

<sup>87</sup> Ibid., p. 5.

clients, "...parental alcoholism, a range of forms of abuse, multiple losses, and lack of connection to schools and other support networks."<sup>88</sup>

**54. The Pikangikum First Nation and Health Authority should liaise with Health Canada, First Nations and Inuit Health Branch and the Government of Canada to explore the feasibility of introducing Opal fuel in their community, a type of gasoline that will not make users intoxicated when sniffed.**

This fuel, developed by British Petroleum Australia, has been used in Aboriginal populations in Australia, with good effect. It is more costly than traditional fuel, and in Australia, the price has not been passed onto consumers as the government has absorbed the added cost. It is reported that when utilized in Australian communities, "gas sniffing stopped."<sup>89</sup> It is a comparable substitute for regular unleaded gas, and has been effective in reducing rates of sniffing by 94% in communities where it has been introduced.

The community has strengths. Recognition of these strengths and how they could be developed are fundamental to addressing solvent abuse. The solution to Pikangikum's solvent abuse problem is intimately linked to its youth suicide problem. The solutions must be developed and delivered within the community itself.

"Some argue that if the community is not fully engaged in the recovery process and the individual does not recover directly in the home community, the individual is destined to fail."<sup>90</sup>

**Postvention: The Pikangikum First Nation Health Authority**

**55. The Pikangikum First Nation Health Authority, as a component of its Community Suicide Prevention Program should develop a postvention program directed at the youth of the community.**

**56. The postvention program should be developed for delivery both in the school, and in the community. School engagement is a protective factor for preventing suicide and as such, the program should specifically consider addressing the isolated community of solvent abusers, who make up the largest percentage of suicide victims.**

**57. The components of the postvention program might include, but not be limited to, the following elements:**

- **Mobilization of a Crisis Response Team.**
- **The victim's family should be contacted, empathy and support provided, and an inventory of those who are most likely to be affected by the death developed.**
- **A determination of what information is appropriate for release. This should ensure that the victim is neither glorified nor vilified.**
- **Identify those who are most likely affected by the death, including those who discovered the decedent.**
- **The Crisis Response Team should seek to meet all those who have been identified individually, providing support and counselling.**
- **Drop-in counselling centres following the suicide should be established to allow those who are experiencing distress to gain ready access to mental health services.**

**58. The Pikangikum First Nation should establish an appropriate and culturally sensitive approach to funereal and memorial activities. Of paramount importance, is that the**

---

<sup>88</sup> Ibid.

<sup>89</sup> <http://www.cbc.ca/canada/newfoundland-labrador/story/2007/05/24/gas-sniffing.html>.

<sup>90</sup> Ibid., p. 8.

activities do not “...romanticize or sensationalize the death.”<sup>91</sup> Youth “...should not view suicide as a way to obtain incredible amounts of attention”.<sup>92</sup>

**59. The Pikangikum First Nation should consider developing a community cemetery. In this way, permanent physical memorials are placed in an appropriate locale, away from residential areas to avoid the constant recognition and reminder of suicidal deaths.**



**Picture 4. The photo was taken in Pikangikum First Nation on March 6, 2010. This is the yard of a resident who had 14 children, 5 of whom killed themselves by suicide.**

The goals of postvention are to assist survivors of a suicide, including family, friends and vulnerable persons in the community with distress that arises from the suicide. It should also seek to identify those who may be at risk for imitative behaviour and refer them for counselling. The deaths which were the subject of this review were largely a result of clusters of deaths occurring within a contagion. Therefore, postvention exercises and planning are crucial to prevent further clusters of deaths. A resident of Pikangikum spoke of the current practice of death immobilizing the entire community, “Death always takes centre stage, life gets shut down.”

An important component to prevent clusters is to ensure, particularly amongst youth, that their deaths will not generate a significant amount of attention. Panel members were told that for some of the youth, the only time they may view themselves as having significance was at the time of their deaths. The importance of clusters contributing to the deaths of these youth can not be overstated. In the review of the deaths at Pikangikum, 3 clusters accounted for the deaths of 10 of the 16 youth. Recognized risk factors for youth suicide include the presence of mental illness, abusing substances such as solvents, previous attempts, recent loss such as the loss of a loved one through relationship break-ups or death and being a victim of violence or sexual assault. In the United States, local suicide rates in adolescents will increase by 7%, and in adults by 2-3% due to imitation of suicidal behaviour.<sup>93</sup> Although a rare phenomena in society in general

<sup>91</sup> Brock, S.E., Suicide postvention. May 2003 Paper presented at the DODEA Safe School Seminar.

<sup>92</sup> Ibid., p. 4.

<sup>93</sup> De Leo D, Helter T, Social Modeling in the transmission of suicidality. Crisis 29(1) 11-19, 2008.

accounting for about 5% of adult suicides,<sup>94</sup> in First Nations youth in Pikangikum, the contagion of clustering is the method of propagation of suicidal acts. Hence, the extraordinary importance of strategies around preventing the next act, such as Crisis Response Teams.

Pikangikum is unique in that it is the only First Nations community in NAN territory where the dead are buried in the yards of the homes of the living. Consideration should be given to stopping this practice, and constructing a formal cemetery. Permanent physical memorials to deceased victims of suicide mark the landscape of residential areas, and serve as constant reminders of the youth that have passed. There is a profound need for the community to move forward and cease to be mired in constant thought of departed loved ones. In one of the deaths of the youth, the decedent was seen visiting the grave of his mother moments before taking his own life.

Postvention interventions should avoid:

- sensationalizing the death,
- glorifying or vilifying the suicide victim, and
- providing excessive details about the suicidal act.

“Avoiding sensationalism, glorification, and vilification essentially means making sure that unnecessary attention is not given to this act and that information about the death is not presenting in such a way that individuals might identify with the suicide victim.”<sup>95</sup>

## **C12. Concluding Remarks**

This chapter has provided recommendations at both a systemic level, and also at an individual level for the purpose of providing some guidance into areas where the expert panel convened by the Office of the Chief Coroner was of the opinion that opportunities for enhancements existed. The emotional, spiritual, physical and mental well-being of the children and youth and the community are intrinsic to reducing the high rate of suicide. Accordingly, recommendations have been directed with respect to the individual, family, community and region in areas of prevention, intervention and postvention in the hope of addressing suicide and parasuicidal behaviours. The key to preventing suicide in Pikangikum lies in education.

---

<sup>94</sup> Ibid.

<sup>95</sup> Brock, S.E., Suicide postvention. May 2003 Paper presented at the DODEA Safe School Seminar.



## **PART D: EDUCATION**

### **D1. Introduction**

The greatest opportunity to effect change at Pikangikum relates to education. Undoubtedly, education more than any other service, has the potential to have maximal impact on improving the lives of the children and youth of Pikangikum. A robust education which prepares the children and youth for a future both on and off reserve, educated for trades (vocation), colleges or to the university level needs to be the desired outcome for each child. This will never be achievable until children are expected and required to attend school.

When members from the Office of the Chief Coroner visited the community of Pikangikum in March 2010 and asked about the extraordinary rate of truancy, the principle reason provided was the high rate of parental alcoholism. Children were not up and prepared to face the day because their parents were not able to assist them in that preparation.

The school burned down on June 8th of 2007 and was replaced by a group of portables organized as 17 buildings. Many community members pointed to the destruction of the school as a significant negative turning point in the community's history. The school was the venue for a variety of cultural and social events; it was the hub of the community. Of the 16 deaths that occurred at the Pikangikum First Nation in the years 2006-2008, six deaths in two clusters, occurred shortly after the school burned down,. One of the clusters of suicide deaths occurred immediately after the school burned down, with a second cluster occurring shortly thereafter.

<b>Date of Death – Cluster #1</b>	<b>Date of Death – Cluster #2</b>
June 10, 2007	August 9, 2007
June 10, 2007	August 23, 2007
June 17, 2007	August 28, 2007

For some of the vulnerable children, they may have viewed the school as a focal point for activity that provided them with camaraderie, friendship, programming and some reason for hope in their lives. These activities may have been available to them, even though they were not attending school.

### **D2. Education Governance: The Pikangikum Education Authority**

In 1988, the First Nation began to deliver its own education program, and children stopped being sent to residential schools, typically in Poplar Hill, Pelican Falls and Kenora. The governance structure for education consists of the Pikangikum Education Authority comprised of a Chairman, two Directors of Education assisted by four elected members from the Band. The oversight hierarchy in education depicts parents and students having oversight for the Chief and Council, who have oversight for the Pikangikum Education Authority, who then have oversight for the Principal, teachers and school.

When the school burned down in 2007, there were approximately 750 students enrolled. For the 2009 school year, the OCC was told that there were 620 enrolled for whom funding was received.<sup>96</sup> For the 2010 school year, the number was reported as 520, with approximately 300-500 children of school age not enrolled. The exact number is not known. Education funding is provided by Indian and Northern Affairs Canada (INAC) as an envelope to the First Nation for the delivery of the education system. The funding formula is based on a head count coupled with consistent attendance.

The Education Authority meets as necessary in their office. This can occur on a daily basis to deal with the day-to-day events in the school. This might include, for example, an injury to a child. The Education Authority employs in excess of 100 people to deliver the school program.

### **The Education Program**

The school offers a program from junior kindergarten to grade 12. When the school burned down, it was reconstituted with portables and currently consists of 17 buildings, re-opening in late September 2007.



**Picture 5. The current school delivered through a system of portables. Note graffiti on the walls of the buildings March 5, 2010.**

The school employs 28 teachers. There are 22 elementary school teachers, and six secondary school teachers. All of the secondary school teachers have qualifications such as their Ontario Teachers' Certificate. Fifteen of the elementary school teachers have this level of qualification, and of the remaining seven teachers, six are qualified with a Native Teacher Education Program (NTEP) and one is not.

The community and the school have a remarkable history of language retention. At school entry, Ojibwa language retention was reported approaching 100%. Instruction in English begins in grade one. The school provides instruction and retains Ojibwa, syllabic, cultural and elder teachers. The cultural teachers will take the students into the bush for one to two day excursions, and the elders teach the children about the history of Pikangikum, and First Nations beadwork and crafts. This is a genuine strength in the community.

The curriculum offered follows the Ontario curriculum. The school grants education credits, and is a Private School under the Education Act. Its credits are equivalent to provincial secondary schools and are transferable. The school offers a program from junior kindergarten to grade 12.

---

<sup>96</sup> Personal conversation, Principal Mr. Phil Starnes, March 6, 2010.



The grade 12 level program offers applied, academic and workplace levels and graduates would be eligible for university. Of the eight children that graduated from high school the previous academic year, none went on to post high school education. The age/grade gap for the Pikangikum First Nation is approximately three years. This means that a grade 12 graduate from the Pikangikum School at the basic level is equivalent to a grade nine level in a typical Ontario school. The school anticipates graduating 9 students from grade 12 for the current year finishing in June 2011. In conversation with the principal in May 2011, just two children completed their studies.

In the past, children from Pikangikum who appeared to have academic abilities and who might transition to post secondary school education were provided with the opportunity to obtain a higher quality education at a Private School operated by the Northern Nishnawbe Education Council (NNEC).<sup>97</sup> The NNEC is directed by the Chiefs of 24 Sioux Lookout First Nations and was established in 1978, and incorporated in 1979. It provides a boarding program for students between the grades of 9 to 12. It is an education authority providing secondary level education services to First Nations youth away from home and its purpose is to increase the numbers of First Nations professionals through post secondary programs in order to advance First Nations self-government, self-determination and economic self-sufficiency and to assist Band Councils local control of education.<sup>98</sup>

The school which was previously accessible to youth from Pikangikum, Pelican Falls First Nations High School offered Pikangikum youth the opportunity to reside in the community while attending the school from grades 9-12 and receive their education. The school offers programs that provide the youth with an education so that they were prepared to go on to trades, colleges or university. However, this privilege is no longer available for the youth of Pikangikum. The Office of the Chief Coroner was told that a determination has been made that since the Pikangikum School offers programs to grade 12, students from Pikangikum must receive their educations entirely at the Pikangikum School. The quality of the education offered at Pelican Falls First Nations High School is considered more complete and more intensive and its graduates may be better prepared to face the challenges of college and university. Pikangikum youth who were bright and demonstrated both aptitude and interest were permitted to attend the Pelican Falls First Nation High School in the past. This privilege is now no longer available to them. The Pelican Falls First Nation High School also allowed the children and youth to begin to transition out of Pikangikum to the broader community, an opportunity that has been lost. Regrettably, e-learning is not an option at Pikangikum as there is no budget available. There has been a series of deaths reported in youth leaving the familiarity of their First Nation and living in homes while attending remote schools. Undoubtedly, transitioning from their home communities to large urban centres such as Thunder Bay presents many challenges.

## **Recommendations**

### **Pikangikum First Nation and the Pikangikum Education Authority (PEA)**

**60. The Pikangikum First Nation, Education Authority and educators from the school should convene a meeting to meaningfully discuss the fundamental role of education as delivered in the community. This might include a discussion of the mission, vision and values of the Pikangikum Education Authority. Central to this discussion is the creation of a statement of understanding about what outcomes are expected or anticipated for**

---

<sup>97</sup> <http://www.nnec.on.ca>.

<sup>98</sup> <http://www.nnec.on.ca/administration>.

**the children and youth attending the school that will assist them in creating viable futures for themselves. Consideration should be given to employing a facilitator for the meeting from outside the community, with expertise in the provision of First Nations education.**

The question that must be answered at the highest levels in Pikangikum is, “what is the purpose of the school?” None of the children in the previous graduating class went on to post-secondary education, where they would be educated to a level to provide themselves with marketable skills both on reserve and in the community of Ontario and beyond. Children might see hope for their futures if they understood that their potential to achieve is unlimited and should be encouraged.

- 61. The Pikangikum First Nation, Chief and Council should pass a Band Council Resolution requiring that an accurate census be taken of all the children in the community who are of school age.**
- 62. The Pikangikum First Nation, Chief and Council and the Pikangikum Education Authority should pass a Band Council Resolution requiring children to attend school until 18 years of age. This reflects the reality that children and youth with good school and social connectedness are more likely to have positive educational outcomes and less likely to be involved in health risk behaviours and experience subsequent mental health issues.<sup>99</sup> Examples of health risk behaviours and mental health issues include gasoline sniffing, depression and suicide.**

### **D3. Truancy**

Children are not required to attend school by their families. The First Nation’s education is not governed by the provincial Education Act. In the province, section 21(1) of the Education Act R.S.O. 1990 sets out that all children between the ages of six and 18 shall attend school. The requirement is that they attend school each day. Section 116 and 117 of the Indian Act sets ages between six and 16 years of age.

Recently, Grand Chief Stan Beardy attended at Eabametoong First Nation with federal dignitaries, including Governor General David Johnston’s wife, as was reported in the Toronto Sun, November 7, 2010:

*Grand Chief Stan Beardy, of the Nishnawbe Aski Nation, said the community is putting together an action plan, with programs aimed at reconnecting young people with the land and with traditional values. In the longer term, he says they need job training and marketable skills and the community needs an opportunity for wealth creation. “What is happening here in Fort Hope—Eabametoong—is happening in Ontario. It’s happening within Canada, one of the richest countries in the world. And it is not acceptable, where people commit suicide because they just don’t see hope for themselves,” he said.<sup>100</sup>*

His messaging is abundantly clear. The youth need to be anchored to the foundation of their past, but require “job training” and “marketable skills” for their futures. In contemporary society, the recognition for the need for education is unparalleled. It becomes difficult to understand what dreams might be fulfilled in the futures of First Nations youth without an education.

---

<sup>99</sup> Looking for Something to Look Forward to: A Five-Year Retrospective Review of Child and Youth Suicide in B.C. Child Death Review Unit, BC Coroners Service, 2008, p. 47.

<sup>100</sup> The Toronto Sun, November 7, 2010, p. 19.

When reviewing the age and educational levels of First Nations, the Regional Longitudinal Health Survey 2002/03 made it clear that the elderly and the young are least likely to have attained at least a high school education. In addition, there is a substantial difference between First Nations and the remainder of the Canadian population, intensified for those First Nations adults living on reserve. These tables are taken from the Regional Longitudinal Health Survey 2002/03.

**Table 1. Age and education of Adults in First Nations communities (n = 10,812)**

Age and education	Age group (years)		
	18-29	30-59	60+
< HS Grad	57.0%	46.1%	70.8%
Completion of post-secondary diplomas and degrees	15.4%	37.1%	19.3%

**Table 2. Education of adults in First Nations communities compared to those First Nations not living in communities and the Canadian population**

Highest level of formal schooling	RHS First Nations adults in First Nations communities, ages 18+ (n=10,812)	First Nations adults not living in First Nations communities, 2001, ages 15+ <sup>17</sup>	Canadian population, 2001, ages 15+ <sup>18</sup>
< high school	52.4	44.1	33.2
High school	19.6	25.0	23.0
Diploma	22.9	25.4	28.4
Bachelors	4.5	4.7	11.7
Masters or doctorate	0.6	0.8	3.7

The OCC was told that truancy usually begins at less than 10 years of age. The children's parents are not up in the morning to get them ready for school, and so the children simply do not go to school. They often come from homes where alcoholism is a problem. Their life situations are further compounded as their best opportunity for adequate nutrition comes from the school, which provides two meals a day. The OCC was told that these children often slip into the subculture of solvent sniffers which become their surrogate family as they become increasingly remote and alienated from the school.

*“Although drug and/or alcohol abuse is a risk factor for suicide that needs to be addressed, this is another “risk behaviour” that is most often studied from an individual perspective – yet it cannot be understood in a vacuum without the social context of history and its outcomes. It is argued that social factors are the most important determinants of such problems: when people*

*become dislocated from their families, and from their cultures, they often “give themselves over” to a substance or a thing (such as drugs, alcohol, gambling or the Internet) to survive the pain of their existence. Indeed, addiction becomes common when culture is destroyed within a people. Here, the results of the residential school experience fit well. In sum, although individual differences in vulnerability to addiction do exist, and it is known that substance abuse adds a layer of complexity and often violence to the problems inherent within a community, the focus of overall healing should not be on the individual. Thus, in addition to individual culturally-appropriate treatment and support, the focus of change should be on powerful social determinants – the social and political aspects that could work to reshape society to create meaning and reintegration with culture and family in everyday life.”<sup>101</sup>*

All of the children who committed suicide were of school age and most had been out of school for years in several cases. 520 children are enrolled in school in Pikangikum this calendar year and it is estimated that another 350-500 are eligible to be in school. The Office of the Chief Coroner’s Panel commented that children who are out of school do not engage in any programming, are prone to abusing solvents, and become disengaged and isolated. Lack of parental direction to encourage school attendance may also suggest challenging environments in their homes. These are risk factors for subsequent suicide. The Panel members opined that the children need programming and education to prepare them for the next steps in their lives. Also, effective suicide prevention programs are most effective when administered beginning at early ages through the school system. This is vital education to assist these children.

## **Recommendations**

### **Pikangikum First Nation and the Pikangikum Education Authority (PEA)**

- 63. Secondary school education at Pikangikum School should improve to a level so that its graduates will be capable and willing to face the challenges of post-secondary education at the trades, college or university level. The PEA should develop options so that children who might have the potential and interest to achieve higher levels of post-secondary education can do so comfortably in Pikangikum, or in First Nations’ operated schools off-reserve in areas such as Pelican Falls and Thunder Bay should this be in the best interests of the student.**
- 64. The Pikangikum Education Authority, retaining expertise available from the provincial Ministry of Education, should consider developing an e-learning program at the secondary school level. The community may also wish to utilize the expertise of the Keewatinook Internet High School in developing an e-learning program.**  
The leadership of the PEA, Chief and Council should aggressively pursue this option. The children of Pikangikum today, promise to be the leaders of tomorrow, and need all of the opportunities possible to develop their potential.

### **Pikangikum First Nation and the Pikangikum Education Authority (PEA)**

- 65. The Pikangikum Education Authority should liaise with the Pikangikum Health Authority for the purposes of providing a public health nurse in the school to assist with such issues as solvent abuse and sexual and reproductive health. The public health nurse should be readily available to the youth and deliver the services through offices in the school. Funding may be available for this via a community health nurse provided by the Health Canada, Primary Care services.**

---

<sup>101</sup> Finlay, J, and Nagy, A, Pikangikum – Root Causes of Youth Suicide Within a Remote First Nation, January 17, 2011, p.20, in publication.

- 66. The Pikangikum Education Authority should consider developing a Day Nursery attached to the school and complying with the requirements of the Day Nurseries Act, R.S.O 1990 in providing for child care services to the community and for students of the school.**
- 67. The Pikangikum Education Authority should consider developing and implementing a full-day kindergarten program.**
- 68. Given the extraordinary level of solvent abuse and its consequent neurocognitive damage and the probable high presence of Foetal Alcohol Spectrum Disorder (FASD) in the community, the Pikangikum Education Authority should aggressively pursue funding and the development of programs for special education needs. In particular, screening for FASD and testing for solvent abusing children and youth should be conducted for those “at risk”.**
- 69. Remuneration for teachers at the Pikangikum School should follow the provincial salary grids. A pension plan should also be made available to the teachers. If possible, this should occur through the Ontario Teacher’s Pension Plan. Professional development support should be identified and accessioned for the teachers, through the provincial Ministry of Education.**

Educators explained that formalized child care services do not exist in the community. The rate of teen pregnancy is high. Young women who leave the school system to bear children never return. Child care services would allow these women to attend school and maintain contact with their children. Also, the presence of poverty and social problems on-reserve necessitate early childhood education programs to ensure that children are receiving valuable nurturing; nutritionally, physically and emotionally, that they might not otherwise receive. “Health is not only experienced across physical, spiritual, emotional and mental dimensions, but it is also experienced over the life course....Early child development follows, in which the circumstances of the physical and emotional environment impact not only the child’s current health but sets the ground work for future vulnerabilities and resiliencies.”<sup>102</sup>

Given the extraordinary stressors of life in Pikangikum and the high birth rate, full-day kindergarten would improve education and likely, health outcomes for children. It is arguable that there is not a community in Canada where early childhood education and kindergarten could have a more beneficial effect on the lives of children.

The teachers’ pay was reported as not being comparable and not following provincial salary grids. There is no pension plan available to the teachers and they do not contribute to the Ontario Teacher’s Pension Plan. The teachers do not have access to professional development support. The effect is predictable; teachers stay in the community for a short period of time, generally 3-4 years.

### **Federal Government, Indian and Northern Affairs Canada (INAC)**

- 70. Funding for First Nations education should be provided by INAC at a level comparable to that provided to other children and youth being educated in the province of Ontario.**

#### ***Inadequate Funding***

One of the striking disparities that exists with education of First Nation children is the funding disparity between what the Province of Ontario provides per child, and what the federal government provides. The obligation for federal funding for education arises from the Indian Act section 114(2) Schools:

<sup>102</sup> Reading, CL., and Wien, F., Health Inequalities and Social Determinants of Aboriginal Health, National Collaborating Centre for Aboriginal Health, 2009, p.3.

*The Minister may, in accordance with this Act, establish, operate and maintain schools for Indian children.*

In 2008-09, the estimated per pupil average cost for a band-operated school was \$4,127, compared to projected per pupil provincial funding of \$9,976 for the same period.<sup>103</sup> There are some similarities between the variables used in the band-operated formula and the Ontario funding formula, but comparisons are not direct. Further analysis would be required for a completely accurate comparison, as the above band-operated funding formula per pupil amount does not include funding provided by INAC to First Nations through proposal-based initiatives. Many of these proposal-based initiatives include funding for components incorporated in the per-pupil funding.<sup>104</sup> As a result, the federal funds provided per-pupil may in fact be higher than the figure provided above. What the federal government actually pays for First Nation education on-reserve is not clear. There is however, broad consensus that it does not meet what is spent by the Province of Ontario for its students, and falls thousands of dollars short. Whether it is the Federal Auditor General Sheila Fraser, or the Parliamentary Budget Officer's report on capital spending on First Nations schools in 2009, or the concerns of the Assembly of First Nations, there are short falls with funding education of First Nations children and youth on reserve.

The Province of Ontario, through the Ministry of Education provides per-pupil funding projected to be \$10,730 for 2010-11. The amount has grown since 2002-2003 from \$7,201. This equals a 49% increase from the 2002-2003 year.<sup>105</sup> The current band-operated funding formula was developed in 1988. The formula has not been indexed to the cost of living since 1996, but rather is capped at 2% annual growth.<sup>106</sup>

The most compelling issue is the children themselves. The children and youth of Pikangikum are likely among the neediest in the province as well as the country. They live in an impoverished environment, with overcrowding, lack of basic necessities such as running water and indoor toilets and where domestic violence, alcohol abuse, loss, isolation, fears of abandonment and possibly sexual abuse are realities. Neglect, crime, physical assaults, solvent abuse and suicide are not uncommon. These are the very children who require the most educational resources. Even the successful children produced by the school suffer with an age/grade gap of three years. These children may be suffering with Foetal Alcohol Spectrum Disorder, and be developing cognitive impairments as a result of their solvent abuse. English is generally not their first language.

To prepare them for the contemporary world both in and outside of Pikangikum, they need intensive, organized, individualized education plans. It is difficult to support formula-based "head count" funding in this unique population. Funding should in fact, be student focused and predicated on student success. The funding for First Nations children has not kept pace with inflation, let alone educational needs, as it was frozen at 2% per year in 1996 by the federal government. This means that federal funding allocations for the education of First Nations children living on reserve rose 16% from 2002-2003 compared to a rise of 49% from the same

---

<sup>103</sup> This information was obtained through the Office of the Assistant Deputy Minister, Ministry of Education, Ministry of Training, Colleges and Universities, Province of Ontario, October 20, 2010.

<sup>104</sup> This information was obtained through the Office of the Assistant Deputy Minister, Ministry of Education, Ministry of Training, Colleges and Universities, Province of Ontario.

<sup>105</sup> Ibid.

<sup>106</sup> Ibid.

period for children receiving their education from the Province of Ontario. The gap in funding becomes larger each year, and likely, is equally reflected in the educational outcomes for the children. The First Nation children and youth will continue to be left further and further behind.

The provincial Ministry of Education provided a fall 2009 progress report on the implementation of the Ontario First Nation, Métis and Inuit Education Policy Framework called Sound Foundations for the Road Ahead. In that document, the Ministry stated:

*“Differences in funding approaches between the federal and provincial governments were identified as a consistent concern. Specifically, there is a significant gap between the provincial funding for school boards and the level of funding provided to First Nations by the federal government through the Band-Operated Funding Formula.”<sup>107</sup>*

**71. INAC should fulfill its commitment to build a new school in Pikangikum as soon as possible. The school should be built to;**

- **accommodate all children currently of school age and projected into the future,**
- **include children’s playgrounds, soccer fields, baseball diamonds, and basketball courts,**
- **include an auditorium where community members can gather for traditional and cultural community events, and**
- **include a daycare facility.**

**D4. Overcrowding and the Inadequate Physical Plant**

The current school is a series of 17 portable buildings. In March, visitors from the Office of the Chief Coroner were asked to remove their footwear to ensure cleanliness. The floors were so frigidly cold, that representatives from the OCC had to keep their feet off the floor to keep warm.

The old school, which burned down, was maximally utilized for a variety of social functions. Assemblies were held whereby students stayed connected and programs were delivered within the building. No sense of school community exists with the current structures. There is no gymnasium. Each child gets gym once per week, at the community centre. However, the community centre also houses the courts every second week, which take precedence over school activities. Soccer fields, baseball fields and basketball courts do not exist. As such, healthy athletic activity is minimal, making children and youth more susceptible to the lure of solvent abuse from boredom. Children who are feeling isolated and lonely are being educated in structures such as portables which may enhance that feeling.

The Pikangikum First Nation has identified the following problems in their current series of 17 portable buildings:

- Constant leaking, mould and moisture issues
- Poor or no insulation leading to drafts, cold floors, dangerous ice-damming on roofs, and freezing pipes
- Soil erosion and shifted buildings leading to animals and children crawling into the spaces under the buildings, and increased fire hazards due to lack of clear exits;
- No common areas or gathering spaces

---

<sup>107</sup> Sound Foundations for the Road Ahead, 2009. Ministry of Education, [www.edu.gov.on.ca](http://www.edu.gov.on.ca).

- No library
- No tech or trade facilities
- No gym
- No bathroom facilities in any of the portable classrooms
- No lockers
- No outdoor recreational equipment or playground facilities
- No proper computer rooms
- No science facilities
- No special education and support space or facilities
- No access for wheelchairs and disabled students
- No space for full-day kindergarten program despite a rapidly growing population
- Students and parents assert that the kids do not look forward to attending a “non school,” and
- Extreme over-crowding in classrooms leading to children having to sit in hallways during class (i.e. teachers had to accommodate 55 children in the 2010-2011 grade eight class).<sup>108</sup>

Indian and Northern Affairs has apparently committed to building a new school. The Pikangikum Education Authority was unable to provide even an approximate date as to when the construction of the new school might begin. According to the Parliamentary Budget Officer’s report in 2009 on capital spending in First Nations schools, only 49% of schools were listed in good condition, 77 schools were housed in temporary structures, 20% of schools had not been inspected, and 10 schools were closed due to their condition.<sup>109</sup>

Picture 6 (July 2009) below clearly characterizes the importance of schools and their ability to host community events. This was taken at Sandy Lake First Nation High School Gymnasium where children had gathered to meet Mr. James Bartleman, former Lt. Governor of Ontario and Mrs. Ruth Ann Onley, wife of the Honourable Lt. Governor of Ontario, Mr. David C. Onley. The school is a focal point for community activity. A stage can be seen at the far end, and recreational sports such as basketball can be played.



**Picture 6. This was taken at Sandy Lake First Nation High School Gymnasium.**

<sup>108</sup> See Appendix 5.

<sup>109</sup> [http://www2.parl.gc.ca/sites/pbo-dpd/documents/INAC\\_EN.pdf](http://www2.parl.gc.ca/sites/pbo-dpd/documents/INAC_EN.pdf).



The school becomes the community hub. It performs a vital social function and in a First Nations community with limited infrastructure, the importance of a school with all that a full physical plant can offer can not be overstated.

## **Recommendations**

### **72. INAC should fund:**

- **A public health nurse in the school at Pikangikum.**
- **A Day Nursery attached to the school to provide early childhood education.**
- **The special education needs of the children and youth of Pikangikum. This should include general screening for Foetal Alcohol Spectrum Disorder (FASD), with plans to support both these needy children and those suffering with solvent abuse in their educational pursuits. This presents a potential link with the Foetal Alcohol Spectrum Disorder Initiative offered by Health Canada, First Nations and Inuit Health Branch.**

Educators explained that formalized child care services do not exist in the community. The rate of teen pregnancy is high. Access to informed choices for birth control may be an issue. Young women who leave the school system to bear children never return. A Day Nursery would allow these women to attend school and maintain contact with their children.

Also, the presence of poverty and social problems on-reserve necessitate early childhood education programs to ensure that children are receiving valuable nurturing; nutritionally, physically and emotionally, that they might not otherwise receive.

“Health is not only experienced across physical, spiritual, emotional and mental dimensions, but it is also experienced over the life course...Early child development follows, in which the circumstances of the physical and emotional environment impact not only the child’s current health but sets the ground work for future vulnerabilities and resiliencies.”<sup>110</sup>

Given the extraordinary stressors of life in Pikangikum and the high birth rate, full-day kindergarten would improve education and likely, health outcomes for children. It is certainly a community where early childhood education and kindergarten would have a tremendous effect on the lives of children.

### **Federal Government, Province of Ontario, and the Chiefs of Ontario**

**73. The federal government, Indian and Northern Affairs Canada, the Chiefs of Ontario and political First Nations organizations such as the Nishnawbe Aski Nation, and the Province of Ontario, Ministry of Education, Aboriginal Education Office should convene a meeting to begin a dialogue about the transfer of the delivery of education to First Nations children and youth living on-reserve residing in Ontario from federal to provincial jurisdiction. This in no way should be construed as an effort to negate the constitutional and treaty obligations of the federal government with respect to funding First Nations education, but rather, using the established resources and expertise of the provincial government, redirects the focus on planning, execution, delivery and outcomes for First Nations youth residing in Ontario, in essence, the quality of education provided to First Nations children and youth in the province.**

---

<sup>110</sup> Reading, CL., and Wien, F., Health Inequalities and Social Determinants of Aboriginal Health, National Collaborating Centre for Aboriginal Health, 2009, p.3.

## D5. Federal and Provincial Involvement in Education Delivery

According to the 2006 census, there are approximately 1,200,000 Aboriginal people in Canada. Aboriginal people include First Nations, Inuit and Métis. The number in Ontario is approximately 250,000, or 21% of the total number of Aboriginals in Canada. There are approximately 160,000 First Nations people in Ontario.<sup>111</sup> There are 50,312 Aboriginal students who attend elementary and secondary schools in Ontario.<sup>112</sup> Of the First Nations children and youth, 18,300 live in jurisdictions of provincial school boards and attend provincial schools, 20,100 live in First Nations communities and attend federally funded elementary and secondary schools, and 5,212 who attend provincially funded schools under a tuition agreement, provided by federal funding.

Education is provided to First Nations children and youth in three ways:

1. First Nation students who live in First Nation communities (reserves) and attend federally funded elementary or secondary schools in First Nation communities.
  - The estimated number of students is 20,100.
  - Elementary and secondary education of these students is the responsibility of the local First Nation Education Authority, the band council, or the federal government.
  - Funding for the education of these students is provided by the federal government.
  - Secondary schools in First Nation communities register with the Ministry of Education as private schools in order to offer credit courses leading to the Ontario Secondary School Diploma. In 2005, there were 34 First Nation secondary schools.
  - The Ministry of Education provides professional development opportunities for teachers and principals in First Nation schools on a fee-for-service basis.<sup>113</sup>

This is the situation in the Pikangikum First Nation.

2. First Nation students who live in First Nation communities, but attend provincially funded elementary or secondary schools under a tuition agreement.
  - The number of students is 5,212.
  - Some First Nations provide education programming up to Grade 6, others up to Grade 8. Most students must leave their communities to continue their education in provincially funded schools.
  - A tuition agreement between a First Nation or the federal government and a school board covers the cost of education provided by the school board.<sup>114</sup>

In the past, some children in Pikangikum who had demonstrated both an interest and ability in academics were eligible to leave the community to attend high school in Pelican Falls. However, the OCC was told that this option is no longer available.

3. First Nation students who live in the jurisdiction of school boards and attend provincially funded elementary or secondary schools.
  - The estimated number of students is 18,300.
  - Education funding for these students is provided by the Ministry of Education under the Grants for Student Needs (GSN), and the students are treated like all other students of the board.<sup>115</sup>

---

<sup>111</sup> En.wikipedia.org/wiki/Aboriginal\_peoples\_in\_Canada.

<sup>112</sup> Ontario First Nation, Metis, and Inuit Education Policy and Framework, Aboriginal Education Office, Ministry of Education, 2007, www.edu.gov.on.ca., p.5.

<sup>113</sup> Ontario First Nation, Metis, and Inuit Education Policy and Framework, Aboriginal Education Office, Ministry of Education, 2007, www.edu.gov.on.ca, p. 23.

<sup>114</sup> Ibid., p. 24.

<sup>115</sup> Ontario First Nation, Metis, and Inuit Education Policy and Framework, Aboriginal Education Office, Ministry of Education, 2007, www.edu.gov.on.ca.

“According to 2001 Census data, there is a significant gap between the educational attainment of the Aboriginal population and that of the non-Aboriginal population. Many Aboriginal people have few employment skills and lack the academic/literacy skills needed to upgrade their qualifications in an increasingly knowledge-oriented labour market.”<sup>116</sup>

The Province of Ontario, through the Ministry of Education, Aboriginal Education Office produced a document entitled, *Ontario First Nation, Métis and Inuit Education Policy Framework*. This seminal document described the strategic directions for delivering quality education to Aboriginal students in Ontario’s provincially funded schools. The following are excerpts taken from this document, which provides a clear understanding of the provincial government’s priorities with respect to education of First Nations.

“The Ontario government is dedicated to excellence in public education for all students, including First Nation, Métis, and Inuit students. This position is reflected in Ontario’s New Approach to Aboriginal Affairs, released by the government in June 2005, which envisions prosperous and healthy Aboriginal communities that will create a better future for Aboriginal children and youth. Ontario and Aboriginal leaders recognize the importance of education in improving lifelong opportunities for First Nation, Métis, and Inuit children and youth. Ontario’s New Approach to Aboriginal Affairs commits the government to working with Aboriginal leaders and organizations to improve education outcomes among Aboriginal students. Acting on this commitment, the Ministry of Education has identified Aboriginal education as one of its key priorities, with a focus on meeting two primary challenges by the year 2016:

- to improve achievement among First Nation, Métis, and Inuit students; and,
- to close the gap between Aboriginal and non-Aboriginal students in the areas of literacy and numeracy, retention of students in school, graduation rates, and advancement to postsecondary studies.

The ministry recognizes that, to achieve these goals, effective strategies must be developed to meet the particular educational needs of First Nation, Métis, and Inuit students.”<sup>117</sup>

The same document sets out the vision, policy statement and framework principles to achieve the primary challenges it has set out.

...Vision

First Nation, Métis, and Inuit students in Ontario will have the knowledge, skills, and confidence they need to successfully complete their elementary and secondary education in order to pursue postsecondary education or training and/or to enter the workforce. They will have the traditional and contemporary knowledge, skills, and attitudes required to be socially contributive, politically active, and economically prosperous citizens of the world.

## **Policy Statement**

The Ministry of Education is committed to First Nation, Métis, and Inuit student success. Through cooperation and partnerships with First Nation, Métis, and Inuit families, communities, and organizations, First Nation governments and education authorities, school boards, other

---

<sup>116</sup> Ibid.

<sup>117</sup> Ontario First Nation, Metis, and Inuit Education Policy and Framework, Aboriginal Education Office, Ministry of Education, 2007, www.edu.gov.on.ca, p. 1.

Ontario ministries, the federal government, the Ontario College of Teachers, and faculties of education, the ministry is committed to developing strategies that will:

- increase the capacity of the education system to respond to the learning and cultural needs of First Nation, Métis, and Inuit students;
- provide quality programs, services, and resources to help create learning opportunities for First Nation, Métis, and Inuit students that support improved academic achievement and identity building;
- provide a curriculum that facilitates learning about contemporary and traditional First Nation, Métis, and Inuit cultures, histories, and perspectives among all students, and that also contributes to the education of school board staff, teachers, and elected trustees; and
- develop and implement strategies that facilitate increased participation by First Nation, Métis, and Inuit parents, students, communities, and organizations in working to support academic success.

### **Framework Principles**

The First Nation, Métis, and Inuit Education Policy Framework are guided by the following principles:

1. Excellence and Accountability

The Government of Ontario believes quality education is essential for the continuing development of both Aboriginal and non-Aboriginal communities.

The academic achievement of every First Nation, Métis, and Inuit student is supported through the delivery of quality education. The Ministry of Education provides support and resources adapted to the specific needs of First Nation, Métis, and Inuit students.

2. Equity and Respect for Diversity

The Government of Ontario creates and nurtures an academic environment for every First Nation, Métis, and Inuit student that promotes the development of a positive personal and cultural identity, as well as a sense of belonging to both Aboriginal and wider communities. The Government of Ontario creates and supports an academic environment that fosters First Nation, Métis, and Inuit languages and cultures. It acknowledges the diversity found in First Nation, Métis, and Inuit communities and endorses learning about First Nation, Métis, and Inuit cultures, histories, and perspectives in the public education system.

3. Inclusiveness, Cooperation, and Shared Responsibility

Cooperation among governments, ministries, educational institutions (including the Ontario College of Teachers and faculties of education), and First Nation, Métis, and Inuit families, communities, and organizations is essential for the implementation of education programs and services designed to meet the specific needs of First Nation, Métis, and Inuit students, regardless where they live.

4. Respect for Constitutional and Treaty Rights

The Government of Ontario respects Aboriginal and treaty rights protected by Section 35 of the Constitution Act, 1982.<sup>118</sup>

As detailed in the forgoing, the outcomes for the children of Pikangikum for education were poor. It becomes conceivable that without any possibility for prosperity in their futures, hopelessness may set in and the contemplation of suicide may become an option. Education is essential for the future of First Nations youth.

---

<sup>118</sup> Ontario First Nation, Metis, and Inuit Education Policy and Framework, Aboriginal Education Office, Ministry of Education, 2007, [www.edu.gov.on.ca](http://www.edu.gov.on.ca), p. 7-8.

There are a variety of reasons why the province is better suited to deliver education to First Nations:

- The Province of Ontario has significant expertise in the delivery of education. It delivers education for a population of 13,000,000 inhabitants. The federal government provides for education to a population of less than 1,200,000 spread over the expanse of Canada.
- The federal government's provision of funding for education to First Nations is less than that of the provincial government for its own students.
- Gaps in outcomes between First Nations and non-Aboriginal youth are likely to continue to grow without commitment of equivalent resources, at a minimum. Advocacy by the province partnering with First Nations political bodies may have the effect of prevailing upon the federal government to resolve the funding impasse.
- The province has a clear mandate to provide for improved educational outcomes by ensuring that First Nations youth have knowledge of "traditional and contemporary knowledge, skills, and attitudes required to be socially contributive, politically active, and economically prosperous citizens of the world."
- The province's position, as reflected in Ontario's New Approach to Aboriginal Affairs, 2005, ensures First Nations Education Authorities would retain control, autonomy and self-determination over their education systems, but would be able to partner, where desired and draw upon the vast resources available through the provincial Ministry of Education.
- The Ontario Ministry of Education, Ministry of Training, Colleges and Universities has submitted the following response to the ongoing issues with respect to the provincial-federal relationship in providing First Nation education in Ontario (Raymond Théberge, Assistant Deputy Minister, June 2011).

*The Ontario Aboriginal Education Strategy, launched in 2007 with the release of the Ontario First Nation, Métis and Inuit Education Policy Framework, has been designed to help improve opportunities for First Nation, Métis and Inuit students – whether they live in remote areas or in urban areas. This strategy sets the foundation for improving achievement among Aboriginal students in provincially funded schools and supports life long learning as students transition to postsecondary education, training or workplace opportunities.*

*Ontario continues to work with the federal government and our First Nation partners to improve the relationship between our provincially funded schools and schools on reserve.*

*To increase support for First Nation students, a tripartite steering committee has been formed with the purpose of developing a targeted First Nation Student Achievement Strategy. The steering committee includes representation from the Chiefs of Ontario, the Ontario ministries of Education and Aboriginal Affairs, and the federal Department of Aboriginal Affairs and Northern Development.*

Ultimately, First Nations children and youth growing up in the province, whether on-reserve or off-reserve, are collectively, all our children and youth. Ethically, morally and intellectually, why would the citizens of Ontario continue to permit its neediest children to go without the educational advantages afforded to all its other children? Ontario operates one of the best educational systems in the world...except for First Nations children on reserve, where it plays a limited, if any, role.

## **Recommendation**

### **Nishnawbe Aski Nation**

**74. The First Nations communities in the Nishnawbe Aski Nation should consider developing a First Nation School Board for the North. This might be created by liaising with NAN and other stakeholders such as Northern Nishnawbe Education Council (NNEC), the provincial Ministry of Education, and ensuring First Nation representation by inviting elected membership from each of the Tribal Councils. The Board might wish to set as some of its many goals, enhanced student achievement, models for the effective stewardship of resources, and delivery of education uniquely First Nations respecting culture and tradition.**

Currently, there is a lack of services available in Pikangikum that would be available to schools operating in the province under school boards. For example, school psychologists, speech pathologists, curriculum co-coordinators, student service workers and psychometric testing, to name a few. Pooling of collective resources under a First Nations Board may allow communities to make these services available.

The First Nations School Board could:

- Promote student achievement as well as physical and mental health.
- Provide for models of planning for effective stewardship of limited resources ensuring a student focus.
- Develop and maintain policies and organizational structures that encourage positive outcomes such as setting guidelines for truancy.
- Assist students with defining their educational goals and encourage them to pursue them.
- Monitor and evaluate student outcomes.
- Monitor and evaluate effectiveness of policies developed by the Board.
- Develop multi-year plans directed at enhancing student outcomes.

## **D6. Concluding Remarks**

There is no substitute for a quality education in preparing the youth of Pikangikum for the trials of life.

Many recommendations were generated around health care; these are presented to address access to care and promote suicide prevention, intervention, and postvention of the individual, family and community. In other words, the necessary health-mediated actions to prevent an “at risk” youth from committing suicide.

The greater issue is how to create resiliency in a child so that suicide is never a viable option or choice. The answer lies largely in education, which will promote hope and aspirations for the future. The greatest challenge facing Pikangikum is not in healthcare delivery, but rather, in creating an educational system that begins with early childhood education, and ends when the successful high school graduate goes onto post-secondary education in trades (vocation), colleges or a university. Upon graduation, that youth will have learned the skills that will make him or her competitive in any labour market.

When Pikangikum is capable of delivering and/or arranging the delivery of an education system of sufficient quality, their youth will be capable of moving readily onto higher education. At a future time, a critical mass of these skilled and knowledgeable young adults will return from their post-secondary education and become the future leaders of the First Nation. With best efforts, this may take about a half of a generation, or about 15 years. The Chief, Council,

Pikangikum Education Authority and the parents must be committed and accountable for ensuring their children go to school. The whole of Pikangikum society must embrace and understand that education is an integral component of the solution to their social ills. Currently, the facility is highly inadequate. The curriculum at the high school level is not producing youth prepared for the rigours of post-secondary education for enrolment in a college or university, or vocational training, such as trades. The teaching staff is not remunerated in a way which inspires enduring commitment to the program, and the Education Authority does not appear to have accountability for student focused outcomes. All this must change, and there must be an absolute commitment to this change.

Shkylinik wrote the following about the community of Grassy Narrows in 1985:

*“One can hardly conceive of a non-native community in Canada where almost half of the entire population of school-age children would be allowed to withdraw from school.*

*Poor attendance virtually guarantees that children will fall further and further behind in terms of grade progression. If a child never fully masters the basic concepts of language and the arithmetic skills that are normally learned in kindergarten and grades one through three, he or she becomes discouraged by the inevitable repetition of the lower grades and quits school permanently.”<sup>119</sup>*

In Pikangikum, the child that is out of school begins to fall victim to the lure of solvent abuse, develops neurocognitive damage, depression, and at times, commits suicide. The education system has a large part of the answer; it just needs to provide it.

---

<sup>119</sup> Shkilnyk, AM., A Poison Stronger Than Love; The Destruction of An Ojibwa Community, Yale University Press, 1985, p. 35-36.





## **PART E: POLICING SERVICES IN PIKANGIKUM**

### **E1. Introduction**

The Ontario Provincial Police (OPP) has a vested interest in the sustainability of First Nations policing in Ontario, in keeping with its public safety mandate and legislated responsibilities under the Police Services Act (PSA). The OPP is the only police service in Canada to retain a statutory obligation to provide policing service anywhere in the province where none exists. Since implementation of the federal First Nation Policing Policy (FNPP) in Ontario in 1991, the OPP has been directly involved in the administration and delivery of policing arrangements under the Ontario First Nations Policing Agreement (OFNPA). For approximately 20 years prior to that, with the departure of the Royal Canadian Mounted Police (RCMP), the OPP was responsible for policing all of Ontario's First Nation reserve communities.

Today, the OPP provides active administrative support to 19 First Nation communities under the OFNPA, and direct police service to another 19 across the province. Nine self-directed First Nations police services serve the balance of Ontario's 134 First Nations communities, with operational and specialty services support from the OPP.

### **E2. Pikangikum First Nation**

The OPP has a long history of providing policing to Pikangikum and in supporting the officers who have worked there. Pikangikum is currently policed under the OFNPA by First Nations constables employed by the community and supported by the OPP. Pikangikum is the busiest First Nations community in Ontario in terms of policing. There were approximately:

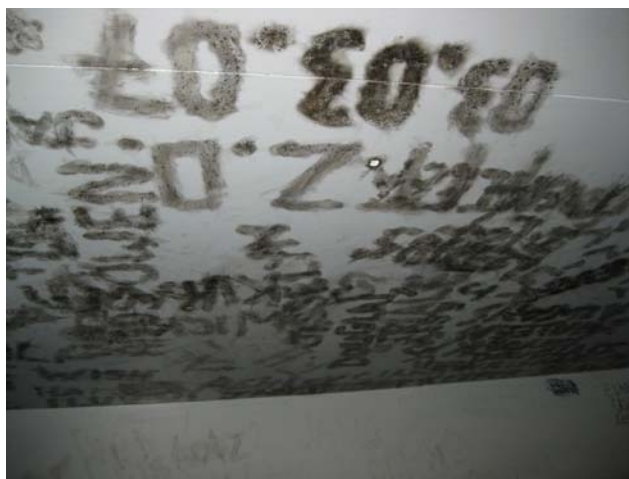
- 4,700 calls for service in 2009,
- 3,000 lock ups per year, and to have 60 persons in cells at one time is not uncommon.

Pikangikum has a complement of seven First Nations constables under the OFNPA and one position through the five-year Police Officer Recruitment Fund (PORF). The community is rarely able to maintain its full First Nation constable complement and even if the designated staffing level could be maintained, the community would be critically short of police officers.

The community wants to see its First Nations constable positions filled with qualified candidates and the OPP supports this position. Recruitment and retention of First Nations constables is difficult given significant challenges ranging from issues of workload, remoteness, housing, accommodation shortages and the challenges of the inherent stresses where these constables are having to police their neighbours, and at times, their families.



**Picture 7. Sitting area and toilet facilities in cells.**



**Picture 8. Graffiti on the ceiling of the cell.**

Note the graffiti on the ceiling of the cell. Persons in custody with lighters used their lighters to burn graffiti on the ceiling. In the past, Band constables would lodge prisoners in the cells without searching them. This practice stopped when the new police office opened.

Although the OFNPA is administered through the OPP Aboriginal Policing Bureau, delivery of policing service to Pikangikum is the responsibility of the OPP Red Lake Detachment, supported by OPP Northwest Region and Aboriginal Policing Bureau.

Since October 2007, OPP officers have been deployed from detachments around the province to Pikangikum, on two-week assignments, to assist with policing. The OPP continues to accrue significant overtime costs to cover vacancies and supplement officer strength to address community safety issues. The OPP costs associated with deployment of officers to Pikangikum, on a rotational basis, are currently estimated at \$1.3 million annually. Within the OFNPA, these costs are not recoverable.

The Chief and Council are not fully in favour of the current OPP deployment program, primarily citing concerns with a lack of officer continuity. However, there is recognition that without this program and given the high vacancy rate of Pikangikum First Nations constables, adequate police service to the community would be in serious jeopardy. The OPP and Pikangikum Police

focus is to stabilize the community in terms of public safety, with the safety of those who are most vulnerable in the community as the priority.

In Pikangikum, there are fewer pillars of stability. Other communities (First Nation and non-First Nation) in the province may have several. Policing in Pikangikum is, along with the Nursing Station, one of the pillars. In most communities, if one pillar falters, others may step in and accept the burden of increased responsibility. Unfortunately, this is not the case in Pikangikum. The demands on policing as an institution and individual officers on the ground are wide ranging, significant and unrelenting. While this is an opportunity for policing to intersect and interact with the community, it can be overwhelming given the number of calls for service and demand for essential police work.

The Chief and Council largely see the OPP as a support to their own police service, and have indicated on numerous occasions a desire to establish their own stand-alone police service controlled by a Pikangikum police governing authority operating on its First Nation territory.

Pikangikum is not dissimilar from other small, isolated First Nations communities in terms of governance stability. There is a high turn-over of elected officials and the authority of elected Band Chiefs and Councils over policing matters can be ambiguous and not clearly delineated.

Pikangikum does differ significantly in terms of community safety issues as evidenced by the number of calls for police service in the community.

### **E3. Community Expectation of Policing**

Numerous challenges confound efforts to adequately and appropriately address the policing needs of First Nations communities. Given the absence of non-aboriginal comparators as to structure and governance, an understanding of community expectation is essential to build and maintain the relationships and the trust needed to ensure the safety of the most vulnerable in the community.

Ambiguity can exist over the authority for the community's policing:

- The elected community leadership views the OPP as a support to what should be Pikangikum's own police service, and therefore subject to their authority.
- Absence of clarity in formal relationships has adversely affected delivery of policing services within the community.

As suggested, the potential for local First Nation political involvement with police authority can occur and does not serve the interest of the community and public safety well.

The perceived role of the Chief and Council:

- Community members see their elected officials as the first point of contact in situations requiring the police, and call them directly with the expectation that they will dispatch the required assistance.
- Having the elected leadership as the first point of contact in community policing matters is radically different from municipal environments and by default, causes elected local First Nation officials to become directly involved in policing matters.
- There is potential for authorities to be misunderstood and/or misused.

- The OPP has recently established a supervisory function in the community, with Chief and Council's approval, to create a liaison to the community and provide an immediate point of contact on contentious issues. In addition to a police supervisor based in the community, an officer-in-charge is identified for each shift.
- Chief and Council have also identified a main point of contact for all policing matters.

Lack of community services increases the expectations of policing:

- Given its presence and authority, the police represent a level of stability in the community and are expected to be able to maintain essential elements of the community infrastructure.
- The police are an integral part of the community and the expectation is that where a pillar of community falters, the police will be ever present to provide the necessary support.
- This level of involvement, although essential given the circumstances in Pikangikum, creates a variety of challenges. At the same time, it is also proven to be an opportunity to develop strong and trusting relationships with the true leadership in the community.
- Police officers are called to fulfill a wide range of non-traditional policing functions, including: providing guidance, counselling, crisis intervention, medical transport, emergency services (i.e. fire, medical), transportation, towing service, truancy officer, and transportation for visiting court officials, lawyers, and government officials.

#### **E4. Governance Structures**

The existing governance structure of First Nations policing is problematic. While civilian oversight of policing is considered essential to build public trust, governance of First Nations policing, under the FNPP, is mostly left to elected band councils and chiefs. The authority of elected band chiefs and councils over policing matters needs to be clearly delineated. The potential for local First Nation political involvement with police authority can hold grave consequences, as has been demonstrated on more than one occasion in Pikangikum.

#### **E5. Pikangikum Policing Statistics**

##### **Calls for Service Comparison:**

Community	2008	2009	2010*
Big Trout Lake First Nation	1,313	1,383	639
Weagamow Lake First Nation	1,378	839	588
Pikangikum First Nation	4,971	4,765	3,715

##### **Pikangikum First Nation Summary:**

Alcohol-related Arrests:

(Main Categories: Disturb the peace; Federal statutes; Indian Act)

2007	2,849
2008	2,987
2009	1,972
2010	1,226*

Investigations in relation to Violent Crime:

2007:	500
2008:	454
2009:	576
2010:	426*

Breakdown by major category 2010\*:

Sexual assault:	36
Assault:	232
Assault with weapon or causing bodily harm:	102
Assault peace officer:	9
Assault peace officer with weapon:	1

Mental Health Act – Attempt Suicide:

2007:	98
2008:	78
2009:	96
2010:	78*

Sudden Death (includes accidental, natural, suicide and other):

2007:	15 (10 suicide, all ages)
2008:	9 (7 suicide, all ages)
2009:	14 (8 suicide, all ages)
2010:	4 (3 suicide, all ages)*

\*As of October 3, 2010

(Source: Ontario Provincial Police, Policing Services in Pikangikum, OPP Red Lake Detachment, October 22, 1010)



Picture 9. Special knife provided to police in Pikangikum to assist with cutting down hanging victims.

## **Recommendations**

### **Pikangikum First Nation, Chief and Council**

- 75. The Pikangikum First Nation should consider developing a Pikangikum Police Board, to interface between the police service and the community. The Board should be comprised of elders and community appointees, with the Chief as Chair.**
- 76. When developing its terms of reference, the Board should ensure that the elected members of the local First Nation, such as the Council have representation on the Board through the Chief, and:**
- **Do not attempt to influence or interfere with the expertise of the police in carrying out their day-to-day policing duties.**
  - **Develop a process whereby community members can voice their concerns to the Board, who would then investigate and attempt to resolve the matter.**

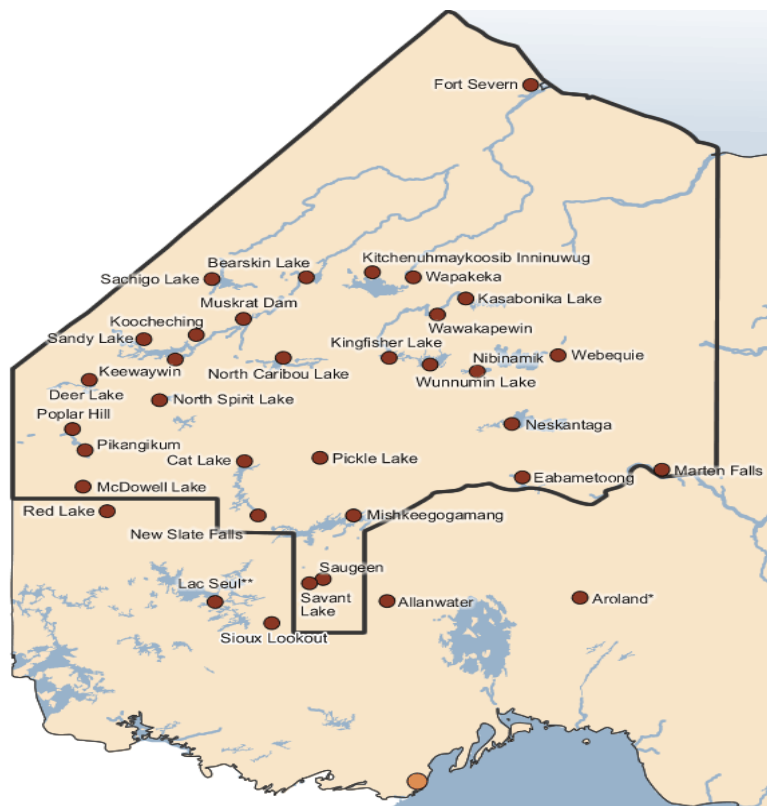
## **E6. Concluding Remarks**

The community has a high crime rate compared with other First Nations communities. The OPP and Pikangikum Police have a stabilizing effect and diminishing their capacity to respond has the potential to lead to an escalation of chaos and significant harm, particularly to those who are most vulnerable, such as children, youth and the elderly. Police need to be allowed to exercise their expertise in the absence of political interference. The presence of a Board will allow the community to have a voice which is heard with respect to policing matters, but ensure non-interference. An extremely positive event has been the successful recruitment from the community of five officers who began attending the Ontario Police College in January 2011. In addition, a new police office has opened and ensures that the most modern of police facilities now serves the people of Pikangikum. In May of 2011, three Pikangikum officers graduated and will begin working in the community.

## PART F: THE PROVISION OF CHILD WELFARE IN THE NORTH AND TO PIKANGIKUM

### F1. Tikinagan Child and Family Services

Tikinagan Child and Family Services is the provincial child welfare agency that provides service to 30 First Nations communities in remote North West Ontario, including Pikangikum. The communities range in size up to 2,500 people, with the total area's population being serviced by Tikinagan of approximately 17,000. Most of these communities are only accessible by air. The agency's head office is located in Sandy Lake First Nation and the administrative office is in Sioux Lookout. There are about 30 offices located in the communities serviced by the organization.



Picture 10. Communities serviced by Tikinagan Child and Family Services.

In addition to the area of jurisdiction designated by the Ontario Ministry of Children and Youth Services, Tikinagan also has agreements with Kenora-Patricia Child and Family Services to provide child protection services to the First Nations populations in Sioux Lookout, Lac Seul, and Red Lake, and with Thunder Bay CAS to provide child protection services to Aroland. The agency also serves Pickle Lake, Allanwater and Savant Lake.

### Mandate

Tikinagan Child and Family Services is one of 53 Children's Aid Societies in Ontario mandated under the Child and Family Services Act to protect children from harm. The organization is also mandated by its Chiefs to provide services that are culturally sensitive to the needs of Aboriginal children, families and First Nations. The organization is accountable to the Chiefs and to the communities for this responsibility. Tikinagan was not a member of the Ontario Association of

Children's Aid Societies (OACAS), through which training for Ontario's child protection workers is delivered, but recently rejoined on approximately November 1, 2010.

Tikinagan's model of service, Mamow Obiki-ahwahsoowin, means "everyone working together to raise our children." This vision of working with families is meant to ensure that parents, extended family members, Elders, community resource workers and First Nation leaders are all involved in decisions about protecting the children.

The Tikinagan Vision is: "The Creator entrusted First Nations with the sacred responsibility of protecting our children and developing strong families and healthy communities. The Chiefs created Tikinagan to support and strengthen our children, our families, and our communities. The future of our communities is our children. They need to be nurtured within their families and communities. As such, community responsibility for child protection is an essential aspect of Native self-government." (*Tikinagan.org*)

### **Services 2009-2010**

In 2009-2010, Tikinagan conducted 926 investigations, provided ongoing service to 413 families and had 570 children in care at year end. There are 381 approved foster homes and 60 specialized foster homes under its jurisdiction.

### **Challenges**

One of the challenges facing Tikinagan in meeting its mandates is staffing shortages. The recruitment and retention of trained and qualified staff is a priority for the organization as such gaps impact on the service provision to families and communities. Other issues are transportation and weather challenges; the agency expends significant resources on flying workers in and out of communities to conduct protection investigations and to provide ongoing service. Workers and managers experience difficulty in the completion of paperwork and meeting administrative timelines due to work load pressures and limited access to technology and computers. Pikangikum provides unique challenges for the provision of child welfare services.

### **Pikangikum**

Pikangikum is a community of about 2,400 people. On paper, Tikinagan has a Service Manager, a Direct Supervisor and approximately 18 workers assigned to provide child welfare services in Pikangikum. A full staffing complement is rarely, if ever, a reality. There are about 200 open protection files in the community and approximately 80 children in care. A great deal of energy is expended developing and maintaining relationships with the Chief, Band and Council members in addition to the families within the community. Efforts are made to include them in case conferences and service planning in order keep the children safe in the community, whenever possible.

Some of the difficulties experienced by staff include threats, vandalism, and lack of cooperation from community members. Staff members share a small office space and there is no cell phone service in Pikangikum which can be, at minimum inconvenient, at worst, a safety issue. Attempts have been made to recruit staff from the community, however it is difficult to locate and retain interested or qualified applicants. For staff not residing in the community, the remoteness and related weather and transportation conditions pose barriers to completing tasks.



Common issues experienced by the children and families in Pikangikum:

- Concerns about supervision, security and safety
- Lack of attachment
- Vandalism
- Chronic substance abuse (alcohol and solvents)
- Domestic violence
- Sibling violence
- Neglect and poverty
- Abandonment
- Abuse
- Substandard housing
- Foetal Alcohol Spectrum Disorder/Effects
- Boredom and lack of activities
- Poor school attendance
- Suicide
- Adolescent pregnancy

A recent Society Internal Review on one youth's death by suicide found the following:

“Dozens of children in Pikangikum First Nation have committed suicide. The majority of those children, like this child, came from families in which the following factors were present:

1. both parents are chronic alcoholics;
2. chronic spousal violence between the parents is present;
3. children are frequently not adequately supervised and neglect is apparent;
4. another family member or close friend has committed suicide;
5. the child who is at risk to suicide attends school sporadically or not at all; and
6. the child who is at risk to suicide is known to be a chronic solvent abuser.”

Society's reviewers have noted that:

*“the community is remote; its approximately 2,500 full time residents are largely unemployed; housing is substandard; 95% of the homes are without sewer or water; alcohol and solvent abuse, and gasoline sniffing in particular, is epidemic throughout the community; spousal violence is a common occurrence in many families; school attendance is poor across all age groups; and outside of school there is no programming-formal or otherwise- to distract children from sniffing solvents, committing petty crimes, and committing arson out of anger or boredom. It is important to note that only 400 of the 800 children who are eligible to attend school in Pikangikum can in fact attend school; the school has room for only 400 children.*

*The Society is chronically understaffed at Pikangikum and staff turnover is extremely high owing to the extreme working conditions that exist in the community. Gas sniffing, other solvent abuse and excessive alcohol consumption provide relief from an ever-present climate of hopelessness and despair that characterize Pikangikum First Nation. It should therefore come as no surprise to professionals from outside this community that many of the professionals who dare to work in Pikangikum are at continuous risk of being overwhelmed by a malaise that comes from limited community-based resources and a profound sense of helplessness in facilitating change for children and their families”.*

*(Source: Office of the Chief Coroner, Paediatric Death Review Committee, June, 2010.)*

## **Demographics and Challenges**

There are 70-90 babies born each year in Pikangikum (44 from January-July 2010). Most of the children and the adults speak the Ojibwa language; not all staff can communicate with them. While there is a high school in the community, a large number of children do not attend and there are very few youths who go on to post secondary education. Many of the community members live their entire lives in Pikangikum and never leave the community. In the recent past, the elected leadership in the community has been fraught with turnover relative to other First Nations in the north and this instability has interfered in relationships and agreements that require consistency.

Youth who are known to be “sniffers” congregate in groups and roam the community; their sometimes violent and unpredictable behaviours while high contribute to safety concerns for others. Small children have been seen with bags over their faces and professionals and other community members feel powerless to intervene. After-hours duty can be dangerous.

Some of the issues facing residents are not openly acknowledged or discussed within the community. For example, at least one youth who committed suicide was believed to have been struggling with issues of sexual identity. It is believed that sexual abuse, incest and teenage pregnancy are not uncommon. However, sex education was removed from the school’s curriculum many years ago. The perception is that sexuality or sexual matters are “taboo” subjects for discussion.

## **Youth Suicide**

The number of youth suicides is a growing and recognized concern for staff and others, however, the topic is not one that is discussed openly and solutions are difficult to reach or agree upon. There are limits to the mental health services available to the youth of Pikangikum and Nodin is the only mental health agency providing services to the families and youth in Pikangikum and it cannot keep up with the demand for its services due to its own resource limitations. At times, Tikinagan finds itself as the default recipient of referrals for children and families requiring mental health services. Tikinagan receives referrals that are more appropriately suited for mental health interventions rather than child protection interventions, particularly suicide attempts by children and youth. The organization does not have the resources, training or expertise to manage some of these very complex cases, nor should it be asked to do so. Suicide attempts brought to the attention of staff should be directed to health care professionals immediately, and managed under their care accordingly. Tikinagan’s role should be directed toward identification of children at risk for suicide, and appropriate and prompt referral. However, at times they are identified as the only resource in the community to assist, and become the defacto apriori default provider.

Some parents turn to the Society to place children in care under a Customary Care Agreement in order to access solvent abuse treatment programs outside of the community. With the child out of their care, the parents do not receive the Child Tax Credit, a financial hardship for most families and may pressure the Society to return the child to the family before the treatment is completed. If parents are not involved with the Society for protection concerns, they can access treatment through the band-operated Pikangikum Solvent Abuse Program and continue to receive the Child Tax Credit. To date, the effectiveness of the Pikangikum Solvent Abuse Program is considered limited.

This is an untenable situation for both the children and youth and Tikinagan. A comprehensive community-based solution must be developed.

### **Provincial Child Welfare Standards**

Issues related to the remoteness of the communities, staffing, resources and the extent of the social problems impacting the families and the community provide many challenges. While there are approved kinship and foster homes within the community, at times, the supply cannot keep up with the demand. For example, in 2009 approximately 50 children, deemed to be in need of protection, were removed from their homes. Many, if not most, had to be relocated to foster homes in other northern communities such as Kenora. This large influx of children into care set off a series of events which resulted in community reaction and exacerbated the already chronic staff shortages and need for additional resources. As a result, Tikinagan issued an urgent call for assistance from the other child welfare agencies in the province for experienced child protection staff to help handle the backlog of cases. Unfortunately, this request met with very limited success as recruitment of even temporary staff members proved problematic.

Compliance with provincial child protection standards is problematic. With staffing levels as they are, the Society frequently does not have front line staff to manage cases; files are assigned as “sitting” cases to the Unit Supervisor who attempts to visit the higher risk cases on an irregular basis. In the fall of 2010, there were 131 “sitting” cases in Pikangikum, 60 of them considered to be high risk.

### **A State of Perpetual Mourning**

Pikangikum has been described as a community “in a state of perpetual mourning.” Death halts the community; when a member dies, there is no school, no business, and no activities. Funerals are often held at the school and the deceased are frequently buried on the family property. Tikinagan reported 38 Serious Occurrences to the Ministry of Children and Youth Services involving youth suicide occurring from 2000-2009; 16/38 were from Pikangikum. Most children or youth growing up experience the suicide of a close family member or friend at least once. Tikinagan has committed its staff to training that will assist in the identification of children-at-risk for suicide within the context of Pikangikum First Nation. In Pikangikum, perhaps more than anywhere, the child welfare balancing act of “least intrusive action,” while keeping children safe from harm, is a difficult challenge.

A Society Internal Child Death Review recommended the following: “Tikinagan should engage the extended family system and community leaders in the development of an intervention plan that not only mitigates the risk of harm to the children but as well reduces their risk of suicide.”

### **Recommendations**

#### **Tikinagan Child and Family Services**

- 77. The Tikinagan Child and Family Services should establish, as one of its priorities, the recruitment, training and retention of qualified staff (frontline, administrative and management) to assist in the provision of services, compliance with provincial standards and the protection of children within its catchment area, particularly in Pikangikum.**
- 78. The Tikinagan Child and Family Services should be supported by the Ministry of Children and Youth Services (MCYS) in its attempts to recruit, train and retain qualified staff to perform child protection duties.**

- 79. The child welfare capacities of staff should be enhanced through orientation, ongoing training and supervision. Benchmarks should be established for caseloads, required documentation and timelines, and audited for compliance.**
- 80. Staff of Tikinagan Child and Family Services in Pikangikum should have access to an office, telephones and computers, including the software and capabilities required to complete standardized child protection documentation when working in Pikangikum and like remote communities.**
- 81. In addition to basic child protection training, staff members should be offered specific training in topics such as Foetal Alcohol Spectrum Disorder, Suicide Prevention, Solvent Abuse and Engaging Families and Communities.**
- 82. Tikinagan and Nodin Child and Family Intervention Services should be stakeholders in the development of Pikangikum's Community Suicide Prevention Program.**
- 83. Tikinagan has identified that in some cases, more intrusive action is required and its own recommendation is supported: "... Pikangikum First Nation Chief and Council should pledge to support Tikinagan's protection mandate by recognizing that removing children from their families and community may save children's lives." Ways and means of addressing the financial hardship arising from the loss of the Child Tax Credit for children no longer in the care of the family should be considered and addressed to ensure that the best interests of the child are being met.**
- 84. Tikinagan should endeavour to maximally utilize its membership in the Ontario Association of Children's Aid Societies (OACAS) to allow its staff access to the resources and training provided by the OACAS.**

Sections F2-F7 were written by Dr. Donald Auger and edited by Dr. B. Lauwers

## **F2. Pikangikum: A community in crisis**

Pikangikum is a community in crisis. First Nations people living in northern Ontario communities such as Pikangikum are the poorest of the poor in Ontario. Most of them are on welfare and almost all families live well below the established poverty line for families in Canada as defined by the standards set by the federal government. Most studies indicate that the majority of Aboriginal people live in extreme poverty. For this and a myriad of other reasons, there is a high level of despair among community members. This was noted by the consultants who completed the Northern Remoteness Study, which included Pikangikum:

*“Meetings with the Chiefs and Councils revealed a general level of despair over the lives of their children and grandchildren. Community services to support their children, in most communities, are practically non-existent. Many children and adults suffer from solvent abuse, and alcoholism, with little opportunity for treatment. The rate of suicide is far above the provincial average. When children are not able to remain in their own homes, there are few alternatives for them. It is very difficult to recruit foster homes when housing shortages are so severe and the rates paid to foster parents do not adequately cover the costs involved in caring for the children. The result is that many children are moved far away from their families and communities. The pain and despair in the voices of the Elders when they tell stories of their grandchildren, who have either died through suicide or have been removed by the CAS, are heartbreaking. The despair is so great and the feeling of hopelessness so overwhelming that there is little energy to even attempt minimal steps to improve conditions, even if the resources were available to do so.”<sup>120</sup>*

There are a disproportionate number of children in the care of Tikinagan Child and Family Services. The number of children in care in relation to the total population of 0 to 18 year olds is so high that it represents the largest disproportion of children in care in Ontario. There is effectively no school. Classes are held in portables (mobiles), and it is believed that there is not enough space to hold all of the children of school age and that a number of children do not attend classes. Children and youth are often out late at night and truancy is high. Substance abuse is very high. The major addictive substances used by community members, from young children to older adults, include solvents and alcohol. Many members use these substances to excess and the experience of Tikinagan workers is that solvents and alcohol are involved in the majority of instances where children are taken into care and may also be involved in many of the deaths. The community continuously experiences the deaths of its members. There have been a large number of infants and young children who have died while in care. There are many accidental and unnatural deaths. There is a disproportionate number of youth who have committed suicide in the community. The number is so high that it too, represents the largest disproportion of youth suicide in the Province. Suicide ideation permeates normal conversations among youth.

## **F3. The Development of Child Welfare in Ontario**

The first Children’s Aid Society (CAS) in the province was established in Toronto:

---

<sup>120</sup> Ontario Association of Children’s Aid Societies (OACAS). Barnes Management Group Inc. Northern Remoteness: Study and Analysis of Child Welfare Funding Model Implications on Two First Nations Agencies. Tikinagan Child and Family Services and Payukotayno James Bay and Hudson Bay Family Services. December 2006, p. 4.

*“On May 17, 1892, the CAS opened the doors of its first temporary shelter at 18 Centre Street. It accepted children who had been abandoned, or whose parents needed temporary relief from their responsibilities; neglected or deserted children; juveniles awaiting trial or those who had been convicted of crimes. The society’s first president: John Joseph Kelso.”<sup>121</sup>*

After the creation of the Toronto Children’s Aid Society, there were two periods of development – the first period occurred during the period from 1891 to 1912 when sixty (60) CAS’s were created throughout the Province. The second period occurred during the 1980s and 90s when five new societies were established to provide services to northern Aboriginal communities, with a sixth being created in 2004 in downtown Toronto.<sup>122</sup>

Provincial child welfare services were extended to Indian Reserves following major changes to the Indian Act in 1951. The changes included a section (now Section 88) that provided for the application of provincial laws of a general nature to “Indians on reserve.” This change allowed Children’s Aid Societies to apprehend children from Indian Reserves. As a result of this change there were exceedingly large numbers of Indian children who were taken into the care of a CAS. Many of these children were eventually placed for adoption with non-aboriginal parents around the world. This is generally known as the “60s scoop” even though it occurred throughout the period from 1951 to about 1980. For example, in 1980 there were just over one thousand Aboriginal children in the care of CAS’s, with more than half of them in the care of Kenora-Patricia Children’s Aid Society.<sup>123</sup>

Aboriginal leaders thought it important to stop this process and take control of child welfare themselves. They wanted to stop the loss of children, and the destruction of the family, the community social fabric and culture that occurred through this process. In 1981, the Chiefs of Ontario Indians passed a Resolution denouncing these laws and calling for a means for Indian communities to look after their own children. In 1984, the Child and Family Services Act was amended and the new Part X of the Act allowed for the creation of child welfare authorities and societies. Not long after, several incorporated groups were recognized under Part X as “child welfare authorities” and later, as societies.

#### **F4. Cultural Tension**

The “Anishinabek” nation is comprised of The Ojibwa, Cree and Oji-Cree people. There is a certain amount of cultural tension that arises from the fact that the Anishnabek have always had methods of dealing with child welfare matters within their communities, but the provincial Child and Family Services Act displaces the long-existing Anishnabek system. Many Anishnabek say that the child welfare rules that have been imposed on them are not culturally relevant, that they have their own rules, and that they have a right to establish and control their own child welfare system. They believe that their rules need only be recognized within Ontario as a culturally valid, legal alternative method of caring for children.

The Ojibwa, Cree and Oji-Cree people, the Anishinabek, have lived in northern Ontario and other places since time immemorial. Each group has its own separate and distinct culture. Like

---

<sup>121</sup> Kieran, Sheila. *The Family Matters, Two centuries of family law and life in Ontario*. Key Porter Books, Toronto, 1986, p. 73.

<sup>122</sup> Ontario Association of Children’s Aid Societies (OACAS). *Your Children’s Aid, Child Welfare Report 2009/10*. Toronto, April, 2010. Appendix A. pp. 49-51.

<sup>123</sup> Brubacher, Maurice. *Coming Home, The Story of Tikinagan Child and Family Services*. Sioux Lookout, Tikinagan Child and Family Services, 2006.

people in other cultures, the Anishinabek have traditional practices, customs and rules related to the family, including marital relations, adoption and child care. One of the major components of the Anishnabek rules for child welfare is that the members of a child's extended family unit must take responsibility for ensuring that children are looked after and kept safe under a complex set of "kinship-obligations." These methods are rooted in the culture and are inseparable from it. The Anishnabek believe that their system is as valid as child welfare practice under the Child and Family Services Act because it has existed in the community since as long as they can remember. They believe that many of the problems that occur within the community are merely local problems and can be handled by members of the extended family and other community. They believe that this system is more relevant because it is grounded within the culture and everyone knows the rules.

In most reserve communities, these traditional or customary child care practices are still in place and still operate. This is so, even in areas where the child welfare system is well established and operates within the community. These traditional practices, customs and rules are followed and understood by everyone in the family and community, and each person plays a role and carries a responsibility for upholding these cultural practices. They say that these traditional practices, customs and rules are Aboriginal rights which are protected under Section 35 of the Canadian Constitution.

Through the process of colonization, Aboriginal cultures have undergone great changes resulting in a loss and reduction in the traditional practices and customs. This has resulted in a huge number of problems for families and individuals, including the deterioration of the family unit, and a feeling by individuals that they have lost their identity and sense of belonging to the community. In order to ensure a strong sense of identity and belonging, individuals must regain and retain healthy links to family and community. The Aboriginal child and family services agencies across the province are committed to providing services to families and children that will ensure the safety of the child; assist the family to regain their traditional practices, customs and rules, especially those related to the family, child care and adoption; and assist individuals to regain a physical, psychological (mental), emotional, and spiritual balance. This will strengthen the culture, the communities, families and children and their connectedness.

Community members believe that having workers from outside the community coming in to deal with child welfare matters is a poor way to deal with things. They see this as a means of shifting the responsibility for the care of children to people from outside their community and their culture. The leaders say it is time for them and their community members to take back their responsibilities. They say this is an essential part of having control over the child welfare system. Once people assume their responsibilities, they will regain control and be able to deal with problems in a culturally relevant manner using traditional methods. Currently, the Government of Ontario has no plans to create a separate system of care for Aboriginal children and youth. The MCYS has engaged the Association of Native Child and Family Service Agencies of Ontario regarding funding to support the harmonization of child welfare tools so that they are more culturally relevant.

## **Recommendation**

### **Ministry of Children and Youth Services**

**85. It is recommended that the Ministry of Children and Youth Services establish a fund for the documentation, development and implementation of Anishnabek child welfare laws, similar to the fund established by a previous Minister in 2007, and that the fund be made available through the office of the Chiefs of Ontario.**

## **F5. The Functions of a CAS**

Section 15 of the Child and Family Services Act allows the Minister of Children and Youth Services to designate an approved agency as a children's aid society for a specified territorial jurisdiction and for certain functions. The functions of a CAS are set out in Section 15. (3) of the Act:

- Investigate allegations or evidence that children who are under the age of sixteen years or are in the society's care or under its supervision may be in need of protection;
- Protect, where necessary, children who are under the age of sixteen years or are in the society's care or under its supervision;
- Provide guidance, counselling and other services to families for protecting children or for the prevention of circumstances requiring the protection of children;
- Provide care for children assigned or committed to its care under this Act;
- Supervise children assigned to its supervision under this Act;
- Place children for adoption under Part VII; and
- Perform any other duties given to it by this or any other Act.<sup>124</sup>

The "duty to report":

Section 72 of the Child and Family Services Act requires anyone who has reasonable grounds to suspect that a child is or may be in need of protection must promptly report the suspicion and the information upon which it is based to a children's aid society.<sup>125</sup> The definition of a "child in need of protection" includes physical, sexual and emotional abuse, neglect and risk of harm. This section of the Act applies to all members of the public, particularly professionals who work with children. When anyone makes a report or referral to a children's aid society, an investigation of the report is carried out, with follow up where necessary. There are a large number of referrals that come to Tikinagan during each fiscal year. It is noted that about forty percent (40%) of these referrals relate to children living in Pikangikum.<sup>126</sup>

## **F6. Children in Care (CIC)**

When parents drink they sometimes abandon, neglect, and abuse their children. When this occurs, CAS workers step in to care for the children. The result of this involvement is that the number of Aboriginal children across the north who are in care is much higher than the provincial average. There are a disproportionate number of Aboriginal children in care (CIC's) in all areas of Ontario. Seventeen per cent (17%) of all children in care in the province are of Aboriginal descent. The rate per hundred thousand of Aboriginal children in care in Ontario is 2,875, while the rate for all children in Ontario is 640. Thus, the rate for Aboriginal children is about four and a half (4.5) times the provincial rate (see Table below).

<sup>124</sup> Ontario. Child and Family Services Act. R.S.O. 1990, as amended. Section 15.

<sup>125</sup> Ontario. Ministry of Children and Youth Services. Reporting Child Abuse & Neglect, It's Your Duty. Toronto, 2005.

<sup>126</sup> Ibid., Section 72.



### All Children and Youth in out-of-home care 2007 (children in care of CIC's)<sup>127</sup>

Area	CIC	0 - 18 population	Rate per 100,000
Canada	67,706	7,378,376	920
Ontario	18,763	2,931,745	640

Within Tikinagan's catchment area, the rate per hundred thousand is 6,345, or about ten (10) times the rate for the province; at Pikangikum, the rate per hundred thousand is 9,497, or about fifteen (15) times the provincial rate and just over ten (10) times the rate for all of Canada (see next table). During the summer of 2009, about sixty (60) children were taken into care at Pikangikum. This represented 6.7 % of all of the children 18 and under in the community.

### Aboriginal Children and Youth in out-of-home care 2007 (children in care of CIC's)

Area	CIC	0 - 18 population	Rate per 100,000
Ontario	3,209	111,615 <sup>128</sup>	2,875
Tikinagan	585	9,220	6,345
Pikangikum	85	895	9,497
Northern Superior	215	4,057	5,300

Source: Ontario Association of Children's Aid Societies. Your Children's Aid, Child Welfare Report 2009/10. Toronto, 2010.

The rates per hundred thousand for Aboriginal children in care in Ontario are higher than for any other province or territory in Canada (see table below).

### Aboriginal Children in Care in other parts of Canada 2007

Area	CIC	0 - 18 population	Rate per 100,000
Northwest Territories	395	12,810	3,080
Yukon Territory	178	7,212	2,470
Manitoba	7,241	297,004	2,440

Source: Ontario Association of Children's Aid Societies. Your Children's Aid, Child Welfare Report 2009/10. Toronto, 2010.

Currently, Tikinagan has approximately six hundred children in care, with between eighty-five (85) and ninety (90) children in care at Pikangikum. The majority of the reasons children are brought into care relate to Section 5 of the Eligibility Spectrum – "caregiver capacity." The reasons would include situations where the caregiver has a history of abusing or neglecting children, demonstrates an inability to protect children, has a problem, or lacks the skills to

<sup>127</sup> Ontario Association of Children's Aid Societies. Your Children's Aid, Child Welfare Report 2009/10. Toronto, 2010.

<sup>128</sup> Health Canada, First Nations and Inuit Health, Ontario Region. *Drug Utilization Reports, 2007-08*. Ottawa. May, 2009.

provide the necessary care. In most of these situations, the use of solvents, alcohol or drugs is evident, which only serves to exacerbate or accentuate any difficulties a parent may have in caring for his or her children.

The recent report of the Commission to Promote Sustainable Child Welfare made the following observations:

*Aboriginal children are overrepresented in the in care population. Although Aboriginal children comprise just 2.5% of the total Ontario child population, they represent approximately 14% of children in care. Whereas the population of children in Ontario has been relatively unchanged in recent years, Aboriginal communities are experiencing very high rates of growth of their child populations. Between the 2001 and 2006 census periods, the number of Aboriginal children reported increased by 20%. The combination of population growth and difficult socioeconomic conditions has resulted in a very different trend for Aboriginal children in care than the trend discussed earlier for Ontario as a whole....*

*The majority of Aboriginal children in care are placed outside of their communities, often with non-Aboriginal families and often hundreds of kilometres from home. Aboriginal leaders cite housing as a major barrier in many communities to the availability of foster placements for children. SAFE and PRIDE are also seen as presenting significant barriers to enabling more of their children to remain in their communities and with aboriginal families. Many aspects of these tools are seen as inappropriate and even offensive to Aboriginal communities. Several standards are viewed as being impractical standards for foster homes in Aboriginal communities. As examples, the requirement that a foster child have his/her own bedroom is impractical in most communities. Similarly, the use of a woodstove, the primary source of heat for many remote Aboriginal communities can be a disqualifying factor for a foster home. Of fundamental concern among Aboriginal leaders is the continuing cultural and community impact arising from the sheer number of Aboriginal children who are in care in homes outside their own communities. **These concerns are shared by the Commission.**<sup>129</sup>*

*There are significant and unique considerations that will need to be addressed to ensure that Aboriginal children who need to be in care for periods of time receive the support they need while remaining connected to their families, communities and culture.<sup>130</sup>*

## **F7. Funding**

### **Federal and Provincial Legislative Jurisdiction**

The Province has the legislative authority, or jurisdiction, under Section 92 and other sections of the Constitution Act, 1982 to establish laws of general application in relation to social services. The main clauses of Section 92 include Sec. 92 (13) Property and Civil Rights; 92 (16) Matters of a Merely Local or Private Nature in the Province; and, 92 (7) Establishment of Charities. Over the years, the Province has passed a host of social service legislation relating to general welfare, mental health, and child welfare.

---

<sup>129</sup> Emphasis added.

<sup>130</sup> Future Directions for the In-Care Services in a Sustainable Child Welfare System, Working Paper No. 3, December 2010. p. 12.

The first provincial child welfare law, An Act for the Protection and Reformation of Neglected Children, was passed in 1888. This law was the precursor to the present-day Child and Family Services Act (CFSA). The CFSA, like most other provincial laws, contains clauses allowing for the passage of Regulations for the administration and operation of the Act. All provincial laws and the programs set up under these laws, including the Child and Family Services Act, are applicable to all residents of the province regardless of their age, gender, race, or ethnicity. The right to receive services under these programs is guaranteed by Section 15 of the Canadian Charter of Rights (equality rights).

Provincial laws may be superseded in instances where the federal government has the legislative authority under Section 91 and other sections of the Constitution Act, 1982 to pass a law on the same, or similar, topic. An example of this is found in relation to “Indians.” Canada has the legislative authority to pass laws related to “Indians and lands reserved for Indians” under Section 91(24) of the Constitution Act. Canada exercised its legislative authority under this head of power and passed the Indian Act in 1876. The Constitution Act prevents the provinces from passing laws directly in relation to Indians and lands reserved for Indians. Section 88 of the federal Indian Act, allows for the incorporation of a provincial law as federal legislation if it does not target First Nation members and does not undermine some fundamental aspect of First Nations culture or life (“Indianness”). Provincial law is also applicable if there is no competing federal legislation under Section 91(24) that supersedes it, which would include By-Laws passed by First Nations under Section 81 of the Indian Act. Any general provincial law is also subject to the impact of Section 35 of the Constitution Act, the “inherent right to self-government,” and to the ways in which the courts, particularly the Supreme Court of Canada, have interpreted Section 35 to include the concepts of “accommodation” and “consultation.”

The status Indian population is entitled to a variety of services and programs provided by the federal government as a result of fiduciary obligations arising from the Indian Act and the Treaties. (The Treaties signed in the Tikinagan catchment area are Treaty # 9 in 1905 and Treaty # 5 in 1910). Some of these programs and services are only provided to status Indians resident on reserve, while others are provided regardless of their residence. Canada has not made any provisions to directly provide child welfare services to Status Indians.

The Indian population, whether Métis, Status, Non-status, On-reserve, or Off-reserve is also entitled to a variety of services and programs provided by the provincial government as a result of the operation of Section 15 of the Canadian Charter of Rights and Freedoms (equality rights). This would include child welfare services under the Child and Family Services Act.

In Ontario, the status Indian population obtains child welfare and other social services indirectly through a federal-provincial Agreement concluded in 1965.

### **The 1965 Welfare Agreement for Indians<sup>131</sup>**

The 1965 Welfare Agreement for Indians is a bilateral agreement between Canada and Ontario. First Nations were not consulted in relation to any of the provisions of the agreement, nor were they a party to it. The Agreement arose out of the Federal-Provincial Conference held in 1963. One of the matters discussed was “charting desirable long-range objectives and policies applicable to the Indian people...”

---

<sup>131</sup> Canada. Memorandum of Agreement Respecting Welfare Programs for Indians. Ottawa, 1965, p. 1.

*and it was determined that the principal objective was the provision of provincial services and programs to Indians on the basis that needs in Indian Communities should be met according to standards applicable in other communities; AND WHEREAS Canada and Ontario in working towards this objective desire to make available to the Indians in the Province the full range of provincial welfare programs.”*

The intent of the Memorandum of Agreement Respecting Welfare Programs for Indians was to provide the full range of provincial welfare programs to Indians in the Province. Pursuant to this agreement Canada reimburses Ontario for a share of the costs of four major social welfare programs provided to Indians, including Ontario Works, Child and Family Services (CFS), Daycare and Homemakers services. The cost sharing is determined according to a formula contained in Section 3 of the Agreement. Under the formula, about 95% of the cost of the eligible program delivery is subject to reimbursement by Canada and the remainder of the direct cost is covered by Ontario. The province pays the indirect costs for administration, expertise and the provision of standards; the indirect costs total about 15% of the direct costs. The province pays for the services on an up-front basis and is then entitled to seek compensation from the federal government according to the formula.

The federal obligation under the Agreement to compensate the Province for eligible program costs has been open-ended for the past forty-five years. The costs associated with providing the four programs covered by the Agreement are limited to the services specifically noted for each program in the Schedules to the Agreement. While there is no cap on the annual federal contribution, the federal government has made attempts to limit the open-ended nature of the funding commitment. An example of this is seen in relation to child welfare where the funding for the Band Representative function under the Child and Family Services Act was terminated in 2003.

The definition in the Agreement of who is an Indian also limits the federal obligation. An “Indian” is defined in Clause 1. (1) (a) of the Agreement as “a person who, pursuant to the Indian Act, is registered as an Indian, or is entitled to be registered as an Indian;” and an “Indian with Reserve Status” is an “Indian who is, i) resident on an Indian reserve; ii) resident on Crown land, or in territory without municipal organization in the Province, or iii) designated as such by the Minister of [Indian Affairs and Northern Development];” (Clause 1. (1) (c). Clause 1. (2) provides:

*Where an Indian with Reserve Status moves to and commences to live in a municipality in Ontario, he shall continue to be deemed as an Indian with Reserve Status, for the purposes of this Agreement, until such time as he has actually lived for a period of twelve consecutive months in that municipality.*

Clause 2. (1) provides that,

*“Ontario undertakes during the term of this Agreement, . . . to extend the Aggregate Ontario Welfare Program [which includes child welfare] to Indians with Reserve Status in the Province.” The effect of these clauses is to limit the federal obligation to pay eligible program costs only for those Indians who are eligible, or, those “Indians with Reserve Status”, who have not lived more than twelve consecutive months in a municipality.*

## **Northern Remoteness Study, 2006**

In 2006, a study of the child welfare funding model implications for Tikinagan Child and Family Services (Tikinagan) and Payukotayno: James Bay and Hudson Bay Family Services (Payukotayno) was funded through the Ontario Association of Children's Aid Societies (OACAS) and conducted by the Barnes Management Group (the Northern Remoteness Study).<sup>132</sup> Part I of the study focused on service gaps in providing child welfare services, including foster care, child in care services, protection, human resources, transportation, translation and interpretive services, emergency measures, physical property and technology. The information was gathered during site visits to the communities of Pikangikum, North Spirit Lake, Sandy Lake, Webequie and Marten Falls First Nations in the Tikinagan catchment area, and to the communities of Moosonee, Moose Factory and Fort Albany First Nations in the Payukotayno catchment areas. The second part of the study made a number of recommendations which were developed in conjunction with the Remote Funding Sub-Committee of the OACAS Funding Advisory Committee.

The major recommendation of the study was to establish a Remoteness Funding Model with the objectives of:

- Allocating resources based on differences in the costs of providing child welfare services and addressing inequities.
- Enabling the agencies to meet extraordinary costs.
- Investing in activities which would contribute to reducing/removing the root causes.<sup>133</sup>

It was also recommended that the following actions be implemented:

- Compute and apply a "Remoteness Factor" to ramp up baseline funding at the agencies.
- Create an "Extraordinary Cost Fund" for each agency.
- Invest in activities that would contribute to reducing/removing the root causes of the high costs of operations.<sup>134</sup>

A computation for each agency was prepared using the proposed Remoteness Funding Model. The calculation used a "weighted average Remoteness Factor" as a multiplier to the provincial average funding factors linked to service volumes to determine a "target funding factor." The difference between the target funding factors and the current funding factors was then applied to the 2006-07 Submission Estimate Volumes to arrive at a revised baseline funding for each agency. The results of this calculation suggested substantial increases to the funding allocated for each agency due to remoteness and child population. The MCYS identified what they felt were methodological concerns about the report including that it had been written prior to the implementation of the Child Welfare Multi-year Funding Model.

Each of these agencies continues to struggle with the high costs in the north and the transport of personnel, equipment and supplies and files. In 2010/11, Aboriginal CAS's received \$8.5 million in new dedicated funding to assist with meeting their unique needs.

---

<sup>132</sup> Ontario Association of Children's Aid Societies (OACAS). Barnes Management Group Inc. Northern Remoteness: Study and Analysis of Child Welfare funding Model Implications on Two First Nations Agencies. Tikinagan Child and Family Services and Payukotayno James Bay and Hudson Bay Family Services. December, 2006.

<sup>133</sup> Ibid. Part II, p.8.

<sup>134</sup> Ibid. Part II, p.9.

## **Recommendations**

### **Ministry of Children and Youth Services**

- 86. The Ministry of Children and Youth Services should implement the recommendations contained in the Northern Remoteness Study on behalf of Tikinagan, Payukotayno and other northern agencies. In the alternative, if the MCYS can not endorse and comply with the recommendations of the Northern Remoteness Study, it should undertake its own review of the costs associated with the provision of child welfare services in the north of Ontario. This review could be undertaken as a component of the current Commission to Promote Sustainable Child Welfare. It should accurately reflect upon the cost of providing service to remote and fly-in First Nations communities, and the significant and substantive challenges that providing child welfare services to First Nations encompasses. It should ensure that children's aid societies providing service to First Nations communities have unique and adequate funding to provide that service to provincial standards, or as closely approximating the level of service provided in other jurisdictions in Ontario as is reasonably possible.**
- 87. The Ministry of Children and Youth Services should establish for each region an extraordinary cost fund and guidelines for distribution of those funds.**

An even greater burden is created in child welfare by extraordinary spikes in service volume within a community. A good example of this occurred at Pikangikum in the summer of 2009 when about sixty-five (65) children were taken into care. This extraordinary spike more than doubled the number of children in care from the community. The child welfare staff members who provided service to the community were overwhelmed. In addition to already high work loads due to the shortage of staff, the existing staff members were required to provide services to the additional children and families. Spikes in service volume have occurred at different times in communities within the Tikinagan catchment area. Similar service spikes have also occurred at other aboriginal agencies. For example, between January and May 2008, Dilico Anishinabek Family Care experienced a spike in service volume of 70 children, and more recently in January and February, 50 additional children were taken into care.

An extraordinary cost fund would be of benefit to all Children's Aid Societies in northern Ontario, whether Aboriginal or non-Aboriginal. Emergencies, extraordinary events and huge rises in service volume frequently occur at all agencies, particularly the Aboriginal agencies. The current budget and allocation process does not provide immediate funding for spikes in service volume. Increases to a budget do not catch up to spikes in service volume for about two years. This places an agency with spikes in service volume in a predicament; does the agency try to cope with the increased volume using existing staff, thereby increasing their case loads, or does the agency hire additional staff, thereby placing the agency in a deficit position?

## **F8. Concluding Remarks**

Tikinagan Child and Family Services is required to provide service to extremely challenging clients in remote areas of the province. The clients themselves often do not have even the basic necessities of life such as adequate housing, running water and safe, affordable food sources. To this, is added the complexity of trying to administer child welfare services where the client may not speak English, in a community that can only be accessed by airplane, in poor weather conditions. The Society has encountered great difficulty in identifying and retaining adequately trained staff. Resources, both human and fiscal have been areas of great tension.

Pikangikum First Nation represents all these challenges in the extreme. As the Society is but one of a few service providers to the community, they find themselves in the unenviable position of trying to mitigate a series of compelling difficulties, such as domestic violence, parental substance abuse, or solvent abusing suicidal youth, with limited to no community resources or supports to assist them. They have become the default provider for many absent services, which are easily accessible and exist in southern Ontario.

Currently, there are approximately 200 open files with approximately 80 children in care from Pikangikum, a community of 2,400. Lack of adequate housing and overcrowding has created a situation whereby children in care must be sent out of the community to foster homes far away. This has been a source of ongoing tension between the First Nation, Chief and Council and the Society.

Tikinagan should continue its efforts on behalf of the Pikangikum First Nation. Without doubt, it provides stability and oversight for the well-being of the many “at risk” children in the community, in the most extreme and challenging circumstances.





## PART G. THE SOCIAL DETERMINANTS OF HEALTH

*“Indigenous peoples” connection to the land not only distinguishes them ecologically and geographically, but a connection to the land also makes them spiritually unique. Aboriginal peoples are tied to the land and it to them. These timeless and imbricated (overlapped) relationships with the land distinguish Indigenous peoples from others around the globe. These relationships are the essence of the individual and collective identities of Indigenous peoples.”<sup>135</sup>*

### G1. Introduction

*“The importance of recognizing the underlying “root causes” or “causes of causes” in any explanation of the situation or circumstances faced by First Nations in remote communities is fundamental. These underlying factors include first contact and colonialism, the experience of the residential schools and the subsequent demoralization of traditions, language, and culture. The forced erosion of culture and traditional lifestyle led to a psychological disconnection from family, community, and social networks. The predominant outcome as witnessed in Pikangikum is the deterioration of mental health and the high incidence of youth suicide.”<sup>136</sup>*

In 2007, an International Symposium on the Social Determinants of Indigenous Health occurred in Adelaide, Australia. Amongst the key drivers for the meeting was to provide a forum for international exchange on the topic of social determinants of health, as well as to derive “key lessons...to address the social determinants of Indigenous health globally in order to improve the health status of Indigenous Peoples.”<sup>137</sup> Canada participated in the Symposium, and was represented by the First Nations and Inuit Health Branch of Health Canada, as well as others.

Amongst those key lessons identified were:

- “The colonization of Indigenous Peoples was seen as a fundamental underlying health determinant.”<sup>138</sup> An identified requirement was to reverse colonization by restoring Indigenous Peoples’ control over their lives by ensuring self determination.
- A second was the “...disruption or severance of ties of Indigenous Peoples to their land, weakening or destroying closely associated cultural practices and participation in the traditional economy essential for health and well being.”<sup>139</sup>
- A third was “...the resolution of Indigenous poverty and economic inequality. Poor health was seen as the corollary of poverty and inequality. Economic redistribution was considered essential for moving towards equality in health outcomes.”<sup>140</sup>

---

<sup>135</sup> Social determinants and Indigenous health: The International experience and its policy implications. Report on the International Symposium on Social Determinants of Indigenous Health Adelaide, 29-30 April 2007 for the Commission on the Social Determinants of Health (CSDH), p. 25.

<sup>136</sup> Finlay, J, and Nagy, A, Pikangikum – Root Causes of Youth Suicide Within a Remote First Nation, January 17, 2011, p.3, in publication.

<sup>137</sup> Social determinants and Indigenous health: The International experience and its policy implications. Report on the International Symposium on Social Determinants of Indigenous Health Adelaide, 29-30 April 2007 for the Commission on the Social Determinants of Health (CSDH), p.5.

<sup>138</sup> Ibid., p. 2.

<sup>139</sup> Ibid.

<sup>140</sup> Ibid.

Colonization is the extension of political and economic control over an area by a state whose nationals have occupied the area and usually possess organizational or technological superiority over the native population.<sup>141</sup> This describes the migration of Europeans to the lands traditionally occupied by First Nations. Hans Werner, in writing a book review for the Toronto Star on *The Wild Ride: A History of the North West Mounted Police 1873-1904* by Charles Wilkins wrote, “One of the sadder aspects of the story is that the Mounties, having won the trust of Indians such as Crowfoot, then had to turn around and enforce Ottawa’s Indian relocation program to make way for the CPR [Canadian Pacific Railway]. Ethnic cleansing is never very pretty, even when we’re the ones doing it. The Wild Ride’s large double spread photo of a Blackfoot family, refugees in their own land, coming out of nowhere with nowhere to go, sears with haunting eloquence.”<sup>142</sup>

The view of the International Symposium on the Social Determinants of Indigenous Health was that rather than being an historical fact, colonization was a “contemporary actuality.”<sup>143</sup>

The Canadian contributions to the Symposium raised a number of observations:

- All Indigenous peoples have a common “...history of colonization and the associated subjugation...”<sup>144</sup>
- Colonization is a contemporary reality.
- Canadian Aboriginal Peoples have a holistic concept of health including physical, emotional, intellectual and spiritual components.
- An individual’s health can not be understood in the absence of considering the well-being of their community or nation.
- The poor health of Aboriginal Peoples is connected to economic and political marginalization.
- Factors reducing the health status of Aboriginal Peoples in Canada include poverty, violence, poor housing, and deficient physical environments.
- Three quarters of Aboriginal women have been victims of family violence, and they are three times as likely to die from that violence.

These key concepts are fundamental to understanding the illness and health, including mental health and substance abuse in the Pikangikum First Nation. Pikangikum has a fully staffed functioning nursing station open 24/7, access to a physician in the community 25 days of the month, a NNADAP worker, a part-time solvent abuse worker, full time mental health workers, a Health Authority with oversight for delivery of health services to the community, and a variety of other health-related services. Yet, the population could not be described as healthy, by any measure. With up to 300 children and youth abusing solvents, unknown numbers of alcohol and opioid abusers, and the persistent excess mortality associated with suicide, health could best be described as fragile. The question this elicits is, with this level of available service, why isn’t the population healthy?

The answer resides not in access to medical services, but rather, the **social determinants** which help people to stay healthy. This chapter will explore the social determinants of health as it relates to Pikangikum.

---

<sup>141</sup> See Glossary of Terms

<sup>142</sup> Werner, Hans, Canadian History, The Great March West, Toronto Star, p. E15, Sunday December 26, 2010.

<sup>143</sup> Ibid., p. 30.

<sup>144</sup> Ibid., p. 24.

## Coercion

“When I was older I learned that during “treaty days,” an official from the Department of Indian Affairs told my parents that I had to go to school “or else.” They said that if I didn’t go to school my parents would not be eligible to receive the family allowance money, or assistance of any source from the government. That was a big “or else” in those days because those kinds of social assistance payments were often the only money that came into the household. No wonder my parents insisted that I go to school. They really had no choice.”<sup>145</sup>

## G2. Definition

Simply stated, the social determinants of health are “...the economic and social conditions under which people live which determine their health.”<sup>146</sup> The Public Health Agency of Canada recognizes 12 social determinants of health including:

- Income and social status
- Social support networks
- Education
- Employment/working skills
- Social environments
- Physical environments
- Personal health practices and coping skills
- Health child development
- Biology and genetic endowment
- Health services
- Gender
- Culture<sup>147</sup>

A conference held in Toronto in 2002 expanded the number to 14 which included Aboriginal status, disability, early life, education, employment and working conditions, food insecurity, health services, gender, housing, income and income disparity, race, social exclusion, social safety network, and unemployment and job security.<sup>148</sup>

Perhaps the best understanding of Aboriginal social determinants of health arises from the National Collaborating Centre for Aboriginal Health which published in 2009, *Health Inequalities and Social Determinants of Aboriginal Peoples’ Health*. This document refers to:

- Proximal determinants of health including health behaviour, physical environments, employment and income, education and food security.
- Intermediate determinants of health including health care systems, educational systems, community infrastructure, resources and capacities, environmental stewardship and cultural continuity.
- Distal determinants of health including colonialism, racism and social exclusion, and self-determination.

<sup>145</sup> Auger, DJ., *Stories from the Residential School, Nishnawbe-Aski Nation and the Aboriginal Healing Foundation*, 2005, p.9.

<sup>146</sup> [http://en.wikipedia.org/wiki/Social\\_determinants\\_of\\_health](http://en.wikipedia.org/wiki/Social_determinants_of_health).

<sup>147</sup> <http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php>

<sup>148</sup> Raphael, D., *Social Determinants of Health: Canadian Perspectives*, 2<sup>nd</sup> edition, Canadian Scholars Press, 2009.

### **G3. First Nations Health**

#### **First Nations Regional Longitudinal Health Survey (RHS) 2002/03**

In attempting to understand how the social determinants of health affect health in Pikangikum, including its mental health, it is essential to begin by understanding what the health of First Nations looks like on a national level. This was achieved by the First Nations Regional Longitudinal Health Survey (RHS) (See Appendix 4) completed and published in March 2005. This survey was conducted by First Nations with the premise that the information arising from the survey will improve the lives of their "...children, adults and elders in our communities."<sup>149</sup> The reader is strongly encouraged to read the report, available at [www.rhs-ers.ca](http://www.rhs-ers.ca).

The RHS, based on data gathered in 2002/03 was completed in 2005. There were 52 geographical sub-regions involved, including 238 communities throughout Canada. This represented 5.9% of the First Nation's population. In Ontario, 5 territories participated involving 29 communities, including Eabametoong, Grassy Narrows, Lac Seul, Sachigo and Sandy Lake First Nations to name a few. The study sample involved 22,602 surveys, 10,902 adults (>18 years of age), 4,983 youth (12-17 years of age) and 6,657 children (0-11 years of age).

#### **RHS Cultural Framework and a Vision of Wellness**

This framework, from a First Nations perspective "...encompasses the total health of the total person within the total environment."<sup>150</sup> It involves physical, mental, emotional and spiritual well-being. First Nations view wellness as a "complex and multilayered philosophy."<sup>151</sup>

*"We pull out the cultural framework (like an accordion)...to demonstrate from this perspective of First Nations health, human beings are connected to the natural world, and thus to Creation through many different levels, or layers, of understanding. Each level represents only a small portion of the preceding one. All levels are interconnected.*

*This approach to health and wellness is based on BALANCE...of seeking balance, of achieving balance and of maintaining balance. To visualize this model of health, imagine each level as a wheel, with each of these wheels rotating on a common axis. If one wheel is out of balance, it will affect the balance of the other wheels and also the overall balance of the system. Thus, when we speak of First Nations health, we are referring to the BALANCE of this system. The RHS Cultural Framework encompasses the total health of the total person within the total environment. This is a holistic and rather complex understanding of First Nations Wellness."<sup>152</sup>*

For First Nations, entrenched in an examination of wellness and health, is the need to address "culture, language, worldview, and spirituality."<sup>153</sup>

#### **First Nations Education and the European Model**

FN utilized informal education which was integrated into their everyday life activities. Children learned when they participated with their parents, the boys with their fathers and the girls with their mothers. Children also spent time with their grandparents who taught them "...through the

---

<sup>149</sup> First Nations Regional Longitudinal Health Survey (RHS) 2002/03, Results for Adults, Youth and Children Living in First Nations Communities, Assembly of First Nations/First Nations Information Governance Committee, second edition, March 2007.

<sup>150</sup> Ibid. p. 1.

<sup>151</sup> Ibid. p. 2.

<sup>152</sup> Ibid. p. 3.

<sup>153</sup> Ibid. p. 5.

use of story-telling, myths and symbols used to represent groups of ideas.”<sup>154</sup> Education was the responsibility of the kinship group, which likely represented an extended family.

The European model for education was that it was provided by the state. The residential schools were established by the Canadian government and operated by religious groups, and their purpose was to “...civilize, educate, assimilate and Christianize Aboriginal people.”<sup>155</sup>

*“The changes to the ways in which Cree and Ojibwa people were educated in the residential schools, created a large group of Aboriginal men and women who had neither the education, skills and experience to survive in the bush in a traditional way, nor sufficient education to obtain a job in mainstream, non-Aboriginal society. This group of people got caught between two cultures. They often had a difficult time functioning in either culture, and became marginalized in both cultures. In addition, many of the people lost their pride and felt ashamed of who they were and what they had become. They had lost their identity. In an effort to cope with this situation some individuals resorted to alcohol. And when alcohol was not available, they resorted to drug and solvents to hide their shame and pain and also to forget their experiences.*

*Unfortunately, the children of these men and women grew up learning exactly what their parents knew, that is, their shame about who they were. They also grew up between two cultures without an identity and some could see no usefulness for their lives. The result of the marginalization is that many aboriginal people have become trapped in a cycle of poverty, neglect, abuse, shame, loss of pride, lack of identity and connectedness.”<sup>156</sup>*

#### My Poor Little Brother

“My brother and I went to residential school at the same time. I was a couple of years older than him. One day I had to take two trays to the dispensary. The trays only had a glass of water and two pieces of dried bread on them. When I got upstairs I brought one tray to a boy from my community, who was in a locked room and brought the other tray to another room. This room was also locked. When they opened the door, much to my surprise, I saw my brother lying on the bed. He did not have many clothes on and all I could see was his little body covered with bruises. There were bruises all over his body. I asked him what happened. He told me that he and some other boys had tried to run away and he got a real bad licking with a great big heavy black belt. That is how he got the bruises. My poor little brother looked so pitiful lying there in that bed all bruised up with nothing to eat except the dried bread I was bringing him. He was only twelve or thirteen at the time.”<sup>157</sup>

In Ontario, 16 residential schools were created, 14 were in the north, and 2 in the south. Of these, six were operated by Roman Catholic religious orders, five by the Church of England (Anglican), one each by the Presbyterian and United Church, and three by the Mennonites. The last schools in Ontario to close were the Poplar Hill (1989) and Stirland Lake (1990) schools, both Mennonite schools.

<sup>154</sup> Auger, DJ, Indian Residential Schools in Ontario, Nishnawbe Aski Nation, copyright 2005, p. 3.

<sup>155</sup> Ibid. p 3.

<sup>156</sup> Ibid. p 4.

<sup>157</sup> Auger, DJ., Stories from the Residential School, Nishnawbe Aski Nation and the Aboriginal Healing Foundation, 2005, p.57.

Pikangikum First Nations sent their children to Pelican Lake Indian Residential School in Sioux Lookout, as well as the Mennonite schools at Poplar Hill, Stirland Lake and Cristal Lake.

The Pelican Lake School was operated by the Anglican Church (Church of England) from 1926-1973. It was built on 287 acres of wooded land on Pelican Lake. It had a maximum capacity of 142 students, with a minimum entry age of six. Orphaned children were accepted at any age, even as young as 2.5 years of age. Junior students attended classes from 9 a.m. to 4 p.m. while senior students attended for one half-day, and spent the other half-day learning farming or home making. Organized activities included Girl Guides, Boy Scouts, and Air Cadets, a sewing club, hockey teams, hunting and fishing trips, baseball and soccer.

### **First Nations Regional Longitudinal Health Survey: The Impacts of Residential Schools on Health**

Up until 1980, 20-30% of the First Nations population attended residential schools. Of the adults surveyed, about 20% attended these schools. In 1991, a survey found that 39% of First Nation respondents over 45 years of age had attended a residential school and had stayed an average of six years.

47.3% of survivors of residential schools feel that their health was negatively affected. It appears that the influence of these schools has had enduring negative effects on the health of survivors. Troubling results demonstrate that 69.2% reported being physically abused, and 32.6% reported being sexually abused. The ensuing emotional, mental health and substance abuse issues that arise from these revelations for First Nations provide a contextual framework for understanding the significant impairments and disabilities that have become a prominent reality in certain First Nations.

*“Although direct causal links are difficult to demonstrate with quantitative methods, researchers strongly indicate that there is clear and compelling evidence suggesting that the long history of cultural oppression caused by residential schools has contributed to high levels of mental health problems and other negative health effects found in many First Nations communities.”<sup>158</sup>*

---

<sup>158</sup> DJ, Indian Residential Schools in Ontario, Nishnawbe Aski Nation, copyright 2005, p. 3.

<b>Negative outcome/impact on survivor due to:</b>	<b>Percent</b>
Isolation from family	81.3%
Verbal or emotional abuse	79.3%
Harsh discipline	78.0%
Loss of cultural identity	76.8%
Separation from First Nation or Inuit community	74.3%
Witnessing abuse	71.5%
Loss of language	71.1%
Physical abuse	69.2%
Loss of traditional religion or spirituality	67.4%
Bullying from other children	61.5%
Poor education	45.4%
Harsh living conditions**	43.7%
Lack of food	43.2%
Lack of proper clothing	40.5%
Sexual abuse	32.6%

Source: Regional Longitudinal Health Survey 2002/2003

Many survivors who attended did not attain academic skills beyond a basic level. This is ironic given the very nature of the premise under which education was to be provided to First Nations children.

There are many compelling results of residential schools that have negatively impacted the health of First Nations. These include:

- The negative impact of health and well-being due to isolation from their families, verbal and emotional abuse, harsh discipline and loss of cultural identity.
- The high incidence of suicide and deaths due to violence or alcohol-related causes.
- 19.4% attempted suicide in their lifetimes.
- 30.3 % of survivors could not speak their FN language fluently.
- The emotional anguish resulting from confused personal identities, alcoholism, and the inability to engage in productive activities.
- Attendees at residential schools were denied role models from whom to learn how to parent.
- Survivors do not appear to have been taught strategies for dealing with interpersonal conflict, leading to family breakdown.
- In addition to the mental health aspects, survivors also appear to suffer with excess incidence of a variety of physical illnesses.

<b>Diagnosis</b>	<b>Survivor</b>	<b>Non-survivor</b>
Arthritis	30.0%	15.6%
Diabetes	28.7%	10.8%
High blood pressure	23.0%	13.0%
Chronic back pain	20.3%	12.6%
Hearing impairment	15.8%	6.4%
Stomach or intest. problems	11.0%	6.8%
Cataracts	9.8%	2.9%
Tuberculosis	8.8%	1.5%
Heart disease	8.3%	4.0%
Thyroid problems	5.7%	3.5%
Rheumatism	5.4%	2.7%
Osteoporosis	5.4%	2.3%
Chronic bronchitis	5.2%	2.5%
Glaucoma	4.2%	1.1%
Effects of stroke	3.2%	1.0%
Liver disease**	2.4%	1.1%

\*Only significant results are reported p<.05  
\*\*Excludes Hepatitis

Source: Regional Longitudinal Health Survey 2002/2003

Some of these conditions existing in excess in survivors of residential schools make perfect sense, such as the prevalence of tuberculosis given the crowded sleeping conditions of the dormitory format. Others, such as cataracts are harder to explain.

*“In summary, residential schools have adversely affected the overall mental and physical well-being of survivors. The shame, pain and hopelessness resulting from abuses arising from residential schools have led to internalized oppression, lateral violence and post-traumatic stress disorder, among other things.”<sup>159</sup>*

#### A Foreign Experience

“With the assistance of a counsellor I came to understand about all the pain and anger I feel about residential school. When I attended the school, I was in a foreign land, at a foreign school, run by foreign people; that I was forced to speak, read and write a different language; and that I was forced to eat different foods. He taught me that when I was strapped for making a mistake; spanked for breaking the rules; teased by the other students because I spoke a different language; and humiliated when I was forced to participate in the sexual activity for the pleasure of someone else that it was not because I was a bad person. The counsellor showed me that these things caused my anger, my hatred for white people and my fear that I was becoming just like them. Once I acknowledged these things I was able to move on and find a way to put these things out of mind in a good way. Now, I seldom think of my residential school experiences. I spend most of my time learning new things and enjoying life.”<sup>160</sup>

<sup>159</sup> First Nations Regional Longitudinal Health Survey (RHS) 2002/03, Results for Adults, Youth and Children Living in First Nations Communities, Assembly of First Nations/First Nations Information Governance Committee, second edition, March 2007, p. 137.

<sup>160</sup> Auger, DJ, Indian Residential Schools in Ontario, Nishnawbe Aski Nation, copyright 2005, p. 71.



#### **G4. Colonization, Social Structure, Residential Schools and First Nations Health**

This is a complex topic which this report can not endeavour to adequately cover. What follows is largely obtained from *Suicide Among Aboriginal People in Canada*, by the Aboriginal Healing Foundation (2007). The interested reader is referred to this comprehensive document.

Change in Aboriginal society has been driven by a host of external influences at a pace dictated by these interests. Drivers of change have been economic, government, educational, medical and spiritual pressures. Traditional First Nations had unlimited mobility over large expanses of Canadian geography which was sparsely populated. By treaties, these nomadic hunters/trappers were forced onto reserves with overcrowded conditions, and disruption of traditional roles, social networks and identity with the imposition of new political realities as well as foreign bureaucratic institutions.

Acculturation is “the modification of the culture of one group through the influence of the culture of another group.”<sup>161</sup> The response of the culture under stress can be integration, assimilation, separation and marginalization. For First Nations, loss of control over their lands, changes in their hunter/trapping subsistence economy, crowded living conditions, and weakening of belief systems, spirituality and social and political institutions resulted in acculturation stress. Highly traditional and highly assimilated cultures appear to be protected from excess suicide.<sup>162</sup>

John Berry (1980) has suggested that youth suicide in Northern Ontario is related to the youth being caught between two cultures, unable to find satisfaction in either. In essence, these youth lack linkages to the tradition of their elders and culture, and are removed from contemporary mainstream society by “poverty, isolation and educational barriers.”<sup>163</sup> The tragic path to excess mortality due to suicide is depicted below demonstrating the effect of colonization on the individual, family, community and society.

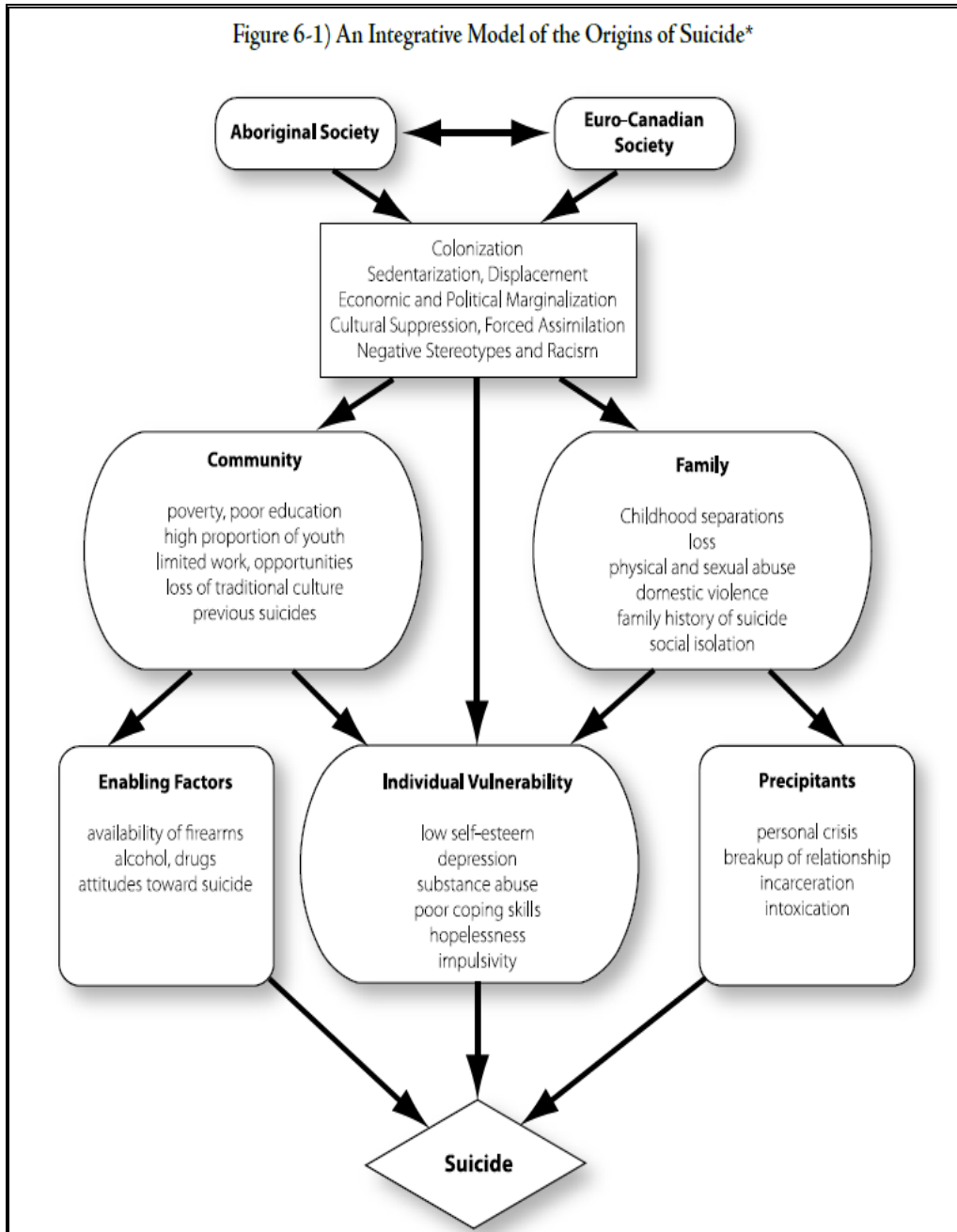
---

<sup>161</sup> Gage Canadian Dictionary.

<sup>162</sup> Kirmayer, LJ, *Suicide Among Aboriginal People in Canada*, The Aboriginal Healing Foundation, 2007. p 63.

<sup>163</sup> *Ibid.* p. 64.

Figure 6-1) An Integrative Model of the Origins of Suicide\*



Source: Kirmayer, LJ, Suicide Among Aboriginal People in Canada, The Aboriginal Healing Foundation, 2007. p 99

*“Thus colonization, and the resulting dislocation from traditional land, isolation, loss of language and culture, loss of identity, political marginalization, forced assimilation, and a severance from the land are all argued to be essential factors in understanding the gross inequities in the status and wellbeing between indigenous and non-indigenous people around the world – it is the underlying fundamental social determinant of health.”<sup>164</sup>*

The greatest effect of colonization was likely demonstrated by the residential school system. Children were taken from their parents at very young ages, as young as six and placed in environments which were foreign to them, resulting in emotional and cultural poverty. There, they were subjected to extreme cultural suppression, and tragically, emotional deprivation and physical and at times sexual abuse. The effect has been catastrophic and as depicted in the chart below, has effected successive generations of First Nations peoples.

#### Transgenerational Effects of Residential Schools

<ul style="list-style-type: none"> <li>• Enduring psychological, social, and economic effects on Survivors</li> <li>• Models of parenting and child rearing based on institutional experiences</li> <li>• Patterns of emotional responsiveness and expression</li> <li>• Repetition of physical and sexual abuse</li> <li>• Loss of cultural knowledge, language, and tradition</li> <li>• Undermining individual and collective identity and self-esteem</li> </ul>	<ul style="list-style-type: none"> <li>• Devaluing and essentializing Aboriginal identity</li> <li>• Individual and collective disempowerment, loss of control, and lack of efficacy</li> <li>• Disruption of family and kinship networks</li> <li>• Destruction of communities, nations, or peoples</li> <li>• Damage to relationship with larger society               <ul style="list-style-type: none"> <li>– popular images, racism, stereotypes, government tutelage and bureaucratic control, and judicial and corrections system</li> <li>– sense of living in a just society</li> </ul> </li> </ul>
--	--

Source: Transgenerational Effects of Residential Schools. Kirmayer, LJ, Suicide Among Aboriginal People in Canada, The Aboriginal Healing Foundation, 2007. p. 72

### G5. Social Determinants of Health and Pikangikum

The social determinants of health are “...the economic and social conditions under which people live which determine their health.”<sup>165</sup> The National Collaborating Centre for Aboriginal Health published in 2009, Health Inequalities and Social Determinants of Aboriginal Peoples’ Health. This recent publication referred to Aboriginal health in terms of proximal, intermediate and distal determinants.

### G6. Proximal Determinants of Health

#### Health Behaviours

Overuse of alcohol and smoking increases mortality and in addition, when used during pregnancy can lead to poor physical, emotional and intellectual development in children. Although exact figures for Pikangikum are unknown, concerns were expressed about the

<sup>164</sup> Finlay, J, and Nagy, A, Pikangikum – Root Causes of Youth Suicide Within a Remote First Nation, January 17, 2011, p.8, in publication.

<sup>165</sup> [http://en.wikipedia.org/wiki/Social\\_determinants\\_of\\_health](http://en.wikipedia.org/wiki/Social_determinants_of_health).

prevalence of alcoholism in adults, and the presence of Foetal Alcohol Spectrum Disorder in children.

Pikangikum is reported to be a dry reserve, but alcohol is obtained in Red Lake, which is two hours away in winter months by road. However, solvent sniffing in children and in youth is pervasive, with as many as 300 involved.

### **Physical Environments**

Levels of contaminants in air, water, food and soil can cause adverse health effects. For example, homes contaminated with mould may predispose to respiratory ailments, or contaminated water may cause gastrointestinal illness. This issue is related to First Nations through the dispossession of traditional lands, with dislocation to reserves. There are housing shortages on reserves, homes that exist are in need of major repair, and may be contaminated with mould. According to the RHS, 33.6% of houses on reserve need major repairs, and 31.7% need minor repairs.



**Picture 11. House in Pikangikum.<sup>166</sup>**

#### Acute housing shortages exist in most First Nations

- Overcrowded is defined as more than one person per room
- 17.2% of FN houses are overcrowded
- FN communities have a room density of .76 persons per room
- The national rate is 0.4 persons per room
- Occupant density for FN is increasing while in the general population it is decreasing

In 2003, the Auditor General reported that INAC estimated a shortage of 8,500 houses on reserve, with 44% of the existing housing requiring repairs. About 4,500 new households are being formed each year, yet the current federal funding supported the construction of just 2,600 houses per year.<sup>167</sup>

#### Basic Infrastructure and Amenities in Houses

Nearly all FN homes have the following amenities:

- Electricity 99.5%
- Hot running water 96.3%
- Cold running water 96.5%
- Flush toilet 96.5%
- Refrigerator 98.7%

<sup>166</sup> Provided by the Ministry of Aboriginal Affairs.

<sup>167</sup> Ibid., p. 45.

- Cooking stove 99.3%
- Telephone 81.7%
- Computer 40.8%
- Internet connection 29.8% (the more isolated the community, the less the connectivity)

Only 9 % of First Nations homes lack a septic tank or sewage service. Water delivery through a pipe is the source provided to 63.2% of the homes.

In Pikangikum, very few homes have either water or sewage service. The population is severely deprived, even when compared to other First Nations living on reserve.



**Picture 12. This house in Pikangikum is currently utilized. The owner raised a family with 14 children in this house (March, 2010).**

In Pikangikum, power is provided by a diesel fuel powered generator and is at capacity. There are plans to connect to the hydro grid. In 2000, a contractor had been retained to construct an electric power distribution grid from Red Lake with the intent and purpose being to provide electricity to both Pikangikum and Sandy Lake First Nations. On February 28, 2000, the First Nation informed the contractor for the project that funds were not available to pay him, and it was not completed. Of interest, power generated by the diesel generator is calculated to cost \$3,580,650 per year, and with the electric power grid, would be available at a cost of \$358,429 per year.<sup>168</sup> At the time the project was abandoned, it was 35% complete and 40 kilometres of hydro poles were up.

On November 17, 2000, INAC sent a letter to the Pikangikum First Nation informing them that they were placing them in third party management. This involved a “...third party being appointed by the Crown to administer funds otherwise payable to the Band and to execute the Band’s obligations under the funding arrangement in whole or in part.”<sup>169</sup> This was done allegedly because:

- A school fuel oil spill had resulted in clean up costs of \$1.6 million and the loss of the school for almost a year.
- Two floods at the water treatment plant resulting in costs of \$1 million and the absence of clean water putting the community in crisis.

<sup>168</sup> Pikangikum v. Nault, 2010 ONSC5122, p. 13.

<sup>169</sup> Ibid., p. 19.

- Substandard operation of the water treatment plant where plant operators were not monitoring the water quality and distributing unchlorinated water.
- The failed power grid project because the First Nation had not secured financing.

The First Nation refused. Subsequently, it brought an action suing for damages suffered by the FN as a result of alleged malfeasance of public office against Mr. Robert Nault, then Federal Minister of Indian and Northern Affairs (INAC) and the Attorney General of Canada. This appears to have had the effect of halting a long list of community-based projects.

“Thunder Bay staff indicates Minister was very blunt in terms of Pikangikum and holding position. As you know we have briefing note of proceeding with water and sewer project through a third party. I take his remarks to mean he wants no new initiatives or projects in Pikangikum until court action is completed.”<sup>170</sup>

As Mr. Justice John de Pencier Wright noted in his ruling of December 23, 2010:

*“To this day, the power grid has not been completed. Power that could have been supplied at a cost of several hundreds of thousands of dollars continue to be supplied to this Band at a cost of millions of dollars.*

*To this day, the effluent from the water treatment plant is still directed toward the lake.*

*To this day sewage facilities continue to be largely dependant upon holding tanks and pump trucks.*

*To this day potable water must largely be hauled to the consumer from the water treatment plant.”*<sup>171</sup>

There are 450 houses on reserve, 43 of which are connected to the sewage lagoon. 340 homes have no indoor plumbing or running water. The water treatment plant was constructed in 1995, and is not connected to the vast majority of homes. The water source for the water treatment plant is Lake Pikangikum. Water is provided by the existing water treatment system and it is delivered through underwater pipes to eight distribution centres that are not always functioning.<sup>172</sup> Water haulage trucks service some of the houses, where water is placed in 100 gallon holding tanks. Residents travel to the water distribution sites to obtain their water in drinking pails or containers.



**Picture 13. Residents of Pikangikum obtaining water.**<sup>173</sup>

<sup>170</sup> Ibid., p. 53.

<sup>171</sup> Ibid.

<sup>172</sup> Information based on North South Partnership for Children Participatory Assessment of Pikangikum, February 2008.

<sup>173</sup> Provided by the Ministry of Aboriginal Affairs.

A small number of the homes have holding tanks for their sewage. These are serviced by truck haulage. The vast majority rely on pit privies for their sewage disposal. These are generally in a state of poor repair and can be full and overflowing with sewage.



**Picture 14. Pikangikum home with outdoor pit privy, March 2010.**

Some facilities, such as the Nursing Station, have a piped sewage collection system that is pumped to an existing lagoon. The lagoon is located on the northwest edge of the community. It is reported that in the spring, the sewage lagoon overflows into the river upstream from the community and the water intake plant.

In September 2006, the Northwestern Health Unit provided a report of the Pikangikum water and sewage systems. It concluded that the provision of safe drinking and washing water at adequate volumes was necessary for a healthy community. It assessed Pikangikum's water and sewage disposal systems as "high-risk." It recommended that:

- The water treatment plant be connected to all the houses in the community by 2010.
- Residents of Pikangikum be provided with information regarding safe in-home water storage and consumption.
- Homes be repaired or replaced to ensure that they support bathroom facilities by 2010.
- All residences be connected to the sewage collection system by 2010.
- A research process be initiated to "...determine the extent of damage done by ongoing neglect of basic health-related infrastructures."<sup>174</sup>

In addition, it observed that the inadequate water supply and sewage disposal systems had placed Pikangikum residents at a high risk of illness, and it was probable that residents had suffered illnesses as a result of the unregulated water and sewage systems.<sup>175</sup> To this day, these recommendations have not been carried out.

*"In First Nations communities, social determinants of health include the direct and indirect effects of colonization as the underlying fundamental factor. Poverty, dislocation from family life and community, extreme stress, trauma, poor health and dependency on*

<sup>174</sup> Northwestern Health Unit, Inspection Report on the Pikangikum Water and Sewage Systems, September 2006, p. 15.

<sup>175</sup> Ibid., p. 16.

*government may all be seen as impacts of colonization. All of these factors, including the material deprivation resulting from poverty, have far-reaching effects on a community, on the family, and on children. Stress and trauma may also lead to coping behaviours that have problematic implications. These coping behaviours often include addictions to alcohol and drugs, which can have profound effects on the health of children and families within a community. However, instead of being viewed as a result of history and unbearable life circumstances, these behaviours are most often wrongly viewed as “unhealthy lifestyle choices.” The underlying reasons why people experience severe stress and perhaps engage in maladaptive ways of coping with severe stress are rarely addressed. These underlying reasons are the “causes of the causes.”<sup>176</sup>*

## **Recommendations**

### **Pikangikum First Nation**

- 88. The Pikangikum First Nation should develop a housing authority.**
- 89. The Pikangikum Housing Authority should conduct a study of existing homes and repair needs, as well as a completing a housing status strategic study to understand the community’s projected needs for the future, based on population growth. An external consultant to assist with the study should be retained.**

### **Indian and Northern Affairs Canada (INAC)**

- 90. INAC and the Pikangikum First Nation should complete its earlier project to connect the First Nation to the hydro grid. Funding for this initiative should be provided by INAC.**
- 91. INAC and the Pikangikum First Nation should review the current water treatment system and identify the need for any upgrades to ensure that Pikangikum has access to safe healthy potable water, immediately and in the future. Funding for the projected improvements to the water treatment system should be provided by INAC.**
- 92. INAC should be a stakeholder in the housing status strategic study (see recommendation #89) and plan for the building and upgrading of sufficient housing units to address the critical housing shortage and overcrowding that exists in the Pikangikum First Nation. It is the belief of the current Chief and Council that to effectively alleviate overcrowding, 50 new homes are required.**
- 93. INAC and the Pikangikum First Nation should review the sewage disposal system and identify the need for any upgrades to ensure that Pikangikum has a safe healthy sewage disposal system in the future; one which will not compromise the First Nations drinking water supply. Funding for the projected improvements to the sewage disposal system should be provided by INAC.**
- 94. INAC and the Pikangikum Housing Authority should ensure that all homes built in the future are connected to water for indoor plumbing, and the sewage disposal lagoon. In addition, the Pikangikum Housing Authority should study and determine which homes could be retrofitted to allow for indoor plumbing and sewage. Funding for the projected improvements to the homes which could be retrofitted for indoor plumbing and sewage disposal should be provided by INAC.**

---

<sup>176</sup> Finlay, J, and Nagy, A, Pikangikum – Root Causes of Youth Suicide Within a Remote First Nation, January 17, 2011, p.4-5, in publication.



## Employment and Income

Health improves with each increment in income. Low income Canadians die earlier and have more illness. With higher income comes better housing and better and sufficient food supply. There has been research that suggests that higher income allows a person discretion and some degree of control over stressful life situations.<sup>177</sup> 51% of First Nations are not employed across Canada. Women are more likely to be working part-time. Also, approximately 60% of young people aged 18 to 29 are unemployed. Education clearly shows a trend toward greater employment, with completion of a high school education, almost doubling the probability of employment.

The median personal income in 2001 of RHS adults in First Nations communities was \$15,667. The median household income was \$29,897. Men and women had essentially the same income levels.<sup>178</sup>

In Pikangikum, there are 170 jobs with 50 held by “outsiders” such as nurses and teachers. There are 542 heads of households receiving social assistance. Based on the North South Partnership for Children study, this translates into employment income of \$8 million (one third to outsiders) and \$8 million of social assistance annually.<sup>179</sup> Low-income Canadians are more likely to die earlier and to be sicker than high income Canadians, and this is regardless of age, sex, race or place of residence.<sup>180</sup> A family of four living in Pikangikum would receive about \$862/month, or about \$10,000/year. Each family can also receive a shelter allowance of \$400/month, which is paid directly to the Band, to cover power, water and firewood.<sup>181</sup>

There is no doubt that employment provides people with a sense of identity and purpose, socialization and opportunities for growth. This leads to an income and better health. However, in First Nations remote fly-in communities, the opportunities to create an economic base are limited.

## Federal Government

**95. The Federal Government, Indian and Northern Affairs Canada should develop an antipoverty strategy for Aboriginal people, particularly focusing on those living in remote and isolated First Nations reserves such as Pikangikum. This strategy could be modelled after provincial strategies such as Ontario’s Poverty Reduction Act, 2009 or Nova Scotia’s Poverty Reduction Strategy.**

Statistics Canada produces a figure called the Low Income Cut-off (LICO). It is the level at which an individual or family will struggle as it spends a large amount of its income on the necessities of life. The figure for 2006 was \$11,492 for an individual and \$24,742 for a family of five living in a rural area. Although not determined for individual families in Pikangikum, the figures provided above suggest a large number of the families residing in Pikangikum fall below the LICO.

The principles of Ontario’s Poverty Reduction plan resonate with the challenges of First Nations communities. It seeks to eliminate barriers to participate in the economy and society

---

<sup>177</sup> [www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php](http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php).

<sup>178</sup> First Nations Regional Longitudinal Health Survey (RHS) 2002/03, Results for Adults, Youth and Children Living in First Nations Communities, Assembly of First Nations/First Nations Information Governance Committee, second edition, March 2007, p. 28.

<sup>179</sup> Information based on North South Partnership for Children Participatory Assessment of Pikangikum, February 2008, p. 14.

<sup>180</sup> [www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php](http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php).

<sup>181</sup> Information based on North South Partnership for Children Participatory Assessment of Pikangikum, February 2008, p. 14.

based on race, ancestry, colour or ethnic origin. It recognizes the importance of healthy communities, the heightened risks of Aboriginal and racialized peoples, seeks to support families, and insists that those living in poverty are treated with dignity and respect. Importantly, it targets a 25% reduction in children living in poverty in 5 years.

The Nova Scotia Poverty Reduction Plan enables and rewards work by removing disincentives to work, improves support for those in need, focuses on children and families to break the cycle of poverty, and collaborates and coordinates to increase capacity and integration.

**96. The Government of Canada, Indian and Northern Affairs Canada should support the Pikangikum First Nation's Whitefeather Forestry Project.**

Pikangikum is currently limited in terms of economic development and there are limited employment opportunities. There is promise in the Whitefeather Forestry Project which is a project in the boreal forest involving Pikangikum's traditional lands. The provincial government has agreed, "subject to conditions" to grant Pikangikum a sustainable forestry license.<sup>182</sup>

The Whitefeather Forest Management Corp. is Pikangikum owned and has been working in close co-operation with the Ontario Ministry of Natural Resources (MNR) to meet the terms and conditions for acquiring the Sustainable Forest License (SFL). A conditional SFL based on the work that has been completed to date included an approval for an Environmental Assessment coverage for Forest Management Planning. The sole work to be completed is the Forest Management Plan (FMP), which is on schedule for completion in early 2012.

Pikangikum has also begun to deliver a major training program in support of this initiative, which has included construction of a training facility in Pikangikum consisting of three classrooms and an instructors' residence. These were scheduled to be completed by the spring of 2011. The Whitefeather Forest ASEP partnership includes Pikangikum, HRSDC, Confederation College, OMNR, and Goldcorp, amongst others. Training for a variety of careers including resource technicians, woodlands and heavy equipment operators amongst others are ongoing.

Once the Forest Management Plan (FMP) is completed, projected for the spring of 2012, Pikangikum will have management control over approximately 1.3 million hectares of crown lands (traditional ancestral lands of the people of Pikangikum known as the Whitefeather Forest), and will have approval to commence commercial forestry operations. It is estimated that approximately 350 jobs, on a sustainable, permanent basis, will be generated, both in the woodlands operations and in the opportunities that will be created in the sawmill and plants that will produce value-added products.

The Whitefeather Forest represents the hope and future for its current youth and future generations. The First Nation is requiring a concerted and co-ordinated commitment to provide financial resources to enable the work to be completed for securing and sustaining the SFL. This includes support for the purchase of LKGH, a market logging business in Red Lake. This interim opportunity includes putting to work Pikangikum's youth who are presently being trained for the numerous and varied jobs that will be filled once Pikangikum has secured the SFL for the Whitefeather Forest Project and has purchased LKGH.

---

<sup>182</sup> Information based on North South Partnership for Children Participatory Assessment of Pikangikum, February 2008, p. 13.

To position its youth to secure the Whitefeather Forest Project employment opportunities, Pikangikum has committed to the strategic purchasing of LKGH. This will provide immediate employment opportunities in the forest area adjacent to the projected Whitefeather Forest lands. In addition to the acquisition of an annual timber harvest, the purchase includes woodlands harvesting equipment and an option for a lease-to-purchase of the sawmill owned by LKGH in Red Lake.

In summary, the youth of Pikangikum need hope and promise for their future. Health is intimately linked to economic prosperity. If successful, the Whitefeather Forest Project has the potential to be transformative for the youth and future generations of Pikangikum. Significant and sustainable employment for the youth and community of Pikangikum is integral for the success of the many health-related recommendations to prevent youth suicide.

### **Education**

Education is tied to socioeconomic status and health. Persons with low literacy skills are less likely to be employed, more likely to be poor and die early. Education contributes to health and prosperity by providing people with the knowledge and skills to control their life circumstances and problem solve.<sup>183</sup>

As educational levels are related to income, prosperity and health, it is not surprising that First Nations suffer poorer health when compared with other Canadians.

The future of Pikangikum, including its health is largely contingent on the education of its children. Outcomes will need to vastly improve. There are 520 children enrolled in the school for 2010-2011, with estimates of 300-500 other children and youth eligible, but not attending school. None of the graduates from high school in the previous year attended post-secondary education. Ultimately, the health, well-being and hope for the children, youth, and community must rely upon its education system which should aggressively seek to educate a critical mass of youth above the high school level to the college or university level and to come back to the community and become its leadership. This singular issue, more than any other, is the driver to health and wellness and diminishing the suicide rate in Pikangikum (Refer to “Part D: Education” of this report).

### **Food Insecurity**

Food insecurity means that there will not be enough to eat because of lack of money. Food insecurity is related to health outcomes that include multiple chronic conditions including obesity, distress and depression (major depressive illness).<sup>184</sup> 58% of residents relying on social assistance experienced reported suffering from food insecurity in the previous 12 months.<sup>185</sup>

According to the North South Partnership’s Report, virtually all of Pikangikum’s resources come from the federal government. The community is heavily reliant on social assistance for income. Of interest is the association of food insecurity and depression, likewise linked to suicide.

---

<sup>183</sup> [www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php](http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php)

<sup>184</sup> Loppie, C and Wien, F, Health Inequalities and Social Determinants of Aboriginal Peoples’ Health, National Collaborating Centre for Aboriginal Health, 2009, p. 14.

<sup>185</sup> Ibid. p. 14.



**Picture 15. Food costs are extremely high in Pikangikum, particularly for fresh fruit, vegetables, and fuel (March 2010).**

## **G7. Intermediate Determinants of Health**

### **Health Care Systems**

Health care systems should ideally be designed to promote and maintain health, and prevent disease. Health care is delivered to First Nations on reserve by a collage of programs, at times fragmented, where jurisdictional ambiguity sometimes arises between federal and provincial responsibilities, and with limited accountability.<sup>186</sup>

In Pikangikum, physicians are in-community 25 days a month and access to primary care is not an issue. Access to mental health services, with four full time in-community counsellors is also present. Addiction and solvent abuse services are limited. Where the system of delivery fails is with respect to integration, jurisdictional boundaries and accountability. Access to tertiary care mental health professionals such as psychiatrists can be limited. Also, care for Pikangikum residents transferred out of the community can be difficult to arrange when trying to find a receiving physician. Lastly, some programs are deemed to be present, but their actual benefit to the community is unknown as accountability arrangements appear limited. (Refer to “Part C: Health In Pikangikum” of this report).

### **Educational Systems**

Well educated parents earn higher incomes, and pass the value of education and learning on to their children. Pre-school programs, such as early childhood education, have a maximal benefit. Importantly, culturally competent curricula can keep children engaged.

Pikangikum would greatly benefit from a day nursery which does not currently exist. The Eenchchokay Birchstick School is classified as an English as a Second Language School. There are cultural and language programs which include cultural teachers which consist of members of the community teaching traditional methods of living off the land such as hunting, trapping and ice fishing. Language retention upon school entry approaches 100%. Cultural teachers teach native art, language and music.

### **Community Infrastructure, Resources and Capacities**

The community in which an individual resides can influence their health. Where a community has limited infrastructure and economic development, the community may become marginalized

---

<sup>186</sup> Ibid., p. 15.

and its members deprived. Not surprisingly, a community requires a critical mass of qualified individuals to assist with the development of strategic direction and future planning.

With respect to qualified individuals, neither the Pikangikum Education Authority nor the Pikangikum Health Authority have the qualified expertise developed in the community and educated at the university level to assist them with executing their important portfolios.

Leadership has also been an issue in Pikangikum. The Indian Act provides that a Chief and Councillors hold office for two years under section 78. Sustainable traction on initiatives can be challenging in this environment. This is further compounded by the First Nations choice of control over elected officials. As noted by Mr. Justice John de Pencier Wright in describing the stability of the Pikangikum Band Council:

*“The political expertise and stability of the Band council has been a problem. The Pikangikum Band functions under a “customary system.” This means that the chief and members of council can be replaced summarily by what people in the south would call a “recall vote” at a general meeting of Band members. This makes it difficult to maintain continuity of policy and experience.”<sup>187</sup>*

### **Pikangikum First Nation**

**97. The Pikangikum First Nation should undertake a review of its electoral policy and practices and consider adopting an electoral process whereby elected officials retain office for a sustained period of time to allow for the growth of political expertise, stability, and to allow for momentum to be obtained with respect to projects directed toward enhancing community infrastructure. The First Nation might benefit from formalizing, in writing, and communicating its electoral process to its constituents. The First Nation could retain expertise for assistance from political organizations such as the Nishnawbe Aski Nation who would be aware of “best practices” with respect to First Nations’ governance. Consultation and assistance from the National Centre For First Nations Governance Institute should be obtained.**

### **Environmental Stewardship**

First Nations have enjoyed a healthy environment. Increasingly, their traditional lands have been subject to environmental stress.

Pikangikum has encountered difficulties in this regard. The useable land on the reserve is less than 2.5 square kilometres and can not adequately house the community.

**98. The Pikangikum Housing Authority should clearly identify its future land needs as a product of its study (see recommendation #89) and with the assistance of Indian and Northern Affairs Canada, obtain reserve lands to allow for sustained population growth in its membership.**

Pikangikum has approximately 70-90 infants born each year and has grown beyond its current useable reserve lands.

---

<sup>187</sup> Pikangikum v. Nault, 2010 ONSC5122, p. 10.

## **Cultural Continuity**

Chandler and Lalonde in 1998, as referenced in the below publication, described the notion of cultural continuity. It is the degree of “social and cultural cohesion within the community.”<sup>188</sup> In British Columbia, they found low rates of suicide amongst First Nations in which the reserve had control over such areas as land title, self-government (particularly where women were involved in government), control of education, policing, health and where cultural facilities were available. It is the “intergenerational connectedness...maintained through intact families and the engagement of elders, who pass traditions on to subsequent generations.”<sup>189</sup>

Pikangikum speaks Ojibwa, and most of the community can speak English. The North South Partnership found a “gap in knowledge transmission between the generations.” The Report states that elders talked about changes to lifestyle such as diet and technology, and the reluctance of the youth to learn traditional ways. Clearly, there was a reported lack of intergenerational connectedness, and proponents of cultural continuity theories would suggest that the excess mortality in Pikangikum has resulted from this.

## **G8. Distal Determinants of Health**

### **Colonialism, Racism and Social Exclusion and Self-Determination**

Colonialism impacted First Nations by dispossessing them of their traditional lands and displacing them onto reserves. The political agenda of 20<sup>th</sup> century Canada saw the creation of residential schools, which had the effect of destroying culture, language and family ties. The result was that children became disengaged from their ancestry, and did not learn for themselves how to parent.

Of First Nations peoples living on reserve, 37.9% stated that they had experienced racism in the prior 12 months.<sup>190</sup> Those that are perceived to be at the bottom of the social hierarchy may experience social exclusion and not experience the same opportunities with respect to education and income. The result may have a negative impact on their health. Self-determination ensures First Nations have “a say” in their futures. The work of Chandler and Lalonde, as referenced in the aforementioned referenced publication, suggested an inverse relationship between self-determination and suicide.

### **99. A Committee should be struck called the Pikangikum Steering Committee:**

- **Joint chairs should be named from a Provincial Ministry and the Federal Health Canada, First Nations and Inuit Health Branch.**
- **The Province of Ontario should have inter-ministerial representation at the Assistant Deputy Minister level from the Ministries of Health and Long-Term Care, Aboriginal Affairs, Children and Youth Services, Community Safety and Correctional Service, Health Promotion and Sport, and Education.**
- **The Pikangikum First Nation should be represented on the Committee by the Chief, Deputy Chief, a youth leader and an Elder.**

---

<sup>188</sup> Loppie, C and Wien, F, Health Inequalities and Social Determinants of Aboriginal Peoples' Health, National Collaborating Centre for Aboriginal Health, 2009, p. 18.

<sup>189</sup> Ibid., p.18.

<sup>190</sup> Ibid., p. 23.

- **Federal Government representatives on the Committee should include Indian and Northern Affairs Canada, and Health Canada, First Nations and Inuit Health Branch.**
- **Invited members might include the North West Local Health Integration Network, the Sioux Lookout and First Nations Health Authority, the Nishnawbe Aski Nation, the Sioux Lookout Meno-Ya-Win Health Centre, Nodin Child and Family Intervention Services, Tikinagan Child and Family Services, the Ontario Provincial Police, the Ontario Child and Youth Telepsychiatry Program, and a paediatric and adolescent psychiatrist providing services in the North West of Ontario.**
- **The purpose of the Pikangikum Steering Committee would be to advance the recommendations included in this report.**

The deaths under review at Pikangikum were those of youths who lost their lives due to suicide. This mental health issue is a Federal responsibility on-reserve. Provincially, the Ministry of Children and Youth Services has primacy over mental health of children and youth, with the Ministry of Health and Long-Term Care taking a smaller role.

**100. The context for change in Pikangikum should include:**

- **A dialogue with Elders, Chief and Band Council members, and selected community members about any recommendations stemming from the Report.**
- **Elders, Chief and Band Council members and selected community members should lead any initiative to encourage and facilitate change in Pikangikum First Nation.**
- **Mechanisms to support and bolster leadership in the change initiative need to be put in place.**
- **Given the historical and current context, the Pikangikum community, government, and all other involved parties should anticipate a long-standing change process. The duration of the intervention, in order to maximize outcomes, needs to span a decade.**

*“The strength of the community and its ability to make fundamental and incremental change rests with the leadership. In turn, the success of the leadership is dependent on the involvement of Elders and other community members to take ownership of the change process”.*<sup>191</sup>

There are many recommendations in this report. The causes of youth suicide are complex and traverse many boundaries locally, regionally, provincially and federally. To be successful, astute and skilled administrators are needed from a variety of stakeholder interests, who have sufficient knowledge of the intricacies of government and are experienced in collaboration and integration to generate a persistent and successful effort on behalf of the citizens of Pikangikum. This need is the genesis for the creation of the Pikangikum Steering Committee.

---

<sup>191</sup> Finlay, J and Nagy, A, Pikangikum – Root Causes of Youth Suicide Within a Remote First Nation, January, 2011, p. 26, in publication.

## G9. Concluding Remarks

The social determinants of health are the economic and social conditions under which people live which determine their health. A contemporary Aboriginal view of the social determinants of health considers proximal, intermediate and distal social determinants of health.

The most important social determinant of health is education. There is no greater barrier to improving the health, mental health and suicide rate in Pikangikum than through its education system. Many of the children do not go to school. Many of these children sniff solvents. Those that do go to school are not being given the quality of education which prepares them for the contemporary world outside of Pikangikum. Almost none of the students seek post-secondary education.

Pikangikum must educate a critical mass of its young children and youth and adequately prepare them to face the world and lead Pikangikum to a better and brighter future. As education increases, so does income and health. Education enables capacities and resiliencies to withstand life's stressors. Education will contribute to the health and prosperity of Pikangikum's people by giving them the knowledge and skills to control their life circumstances and problem solve. Education will lead to sustainable and rewarding employment, possibly in the Whitefeather Forestry Project. When this happens, the unfathomable deprivation they face through poverty, lack of running water, overcrowded inadequate housing, lack of a sewage system, and the death of their youth through suicide, will finally abate.

*“Overall, it is argued that the social determinants of health or “causes of the causes” provide the context for understanding the collective well-being of Aboriginal peoples in remote Ontario First Nations. A layered approach to community healing is therefore necessary to achieve sustainable change, and the goals of intervention must include improving the material and social conditions within which people live, in addition to the provision of culturally appropriate mental health services. It is apparent that there is currently no equitable distribution of power and resources, as evidenced by the impoverished conditions in remote First Nations communities. Consideration of the social determinants of health described herein and their root causes are critical when developing interventions that will work to reduce or eliminate youth suicides in Pikangikum. This being understood, it is clear that youth suicide in Pikangikum is the outcome of an historical progression that began with colonialism and its demoralizing impact on the retention of culture and tradition. This was followed by the residential school experience and then the resulting intergenerational collective trauma and its effects on parenting and subsequent well-being. Running parallel to this pathway is dependency on government by means of a reserve system, which led to extreme poverty and an insecure economic base for families and community...*

*Like other northern communities, Pikangikum aspires to break this cycle and interrupt the damaging life trajectories. Self-governance is viewed as a potential vehicle for emancipation. In the process of exploring self-governance, it is necessary for the promotion of a graduated transition that allows for capacity-building in a measured way. A meaningful partnership that is dedicated to supporting this type of transition must exist between Aboriginal and non-Aboriginal peoples. This includes a movement towards economic security, the building of a solid community infrastructure, development of sustainable housing which is appropriate to culture and environment, the settlement of land claims and the provision of health and education services. The preservation of tradition and culture is fundamental to each. An extreme example of a dysfunctional partnership is the lack of resolution to unsafe drinking water in Pikangikum. For*



*over a decade, community outcry and government risk assessment each conclude that the water is dangerously unsafe...*

*Aboriginal peoples are reticent to collaborate with non-Aboriginal peoples, particularly when it relates to their own community well-being. This lack of trust is an outgrowth of the long history of government imposition and dependency and overt attempts at assimilation...Partnerships between First Nations and non-Aboriginal peoples require relationships that are meaningful, transparent, productive and enduring. As indicated earlier, agencies and institutions need to be reconfigured in order to embrace these types of partnerships, which are necessarily built on First Nations' values of mutual trust, respect, reciprocity and mutuality. These partnerships go beyond mere collaboration and compel the sharing of control over governance and management in order to equalize the power base. They may entail deference to traditional wisdom and approaches. Whereas outcomes are unpredictable and cannot be foreseen, new ways of working together emerge. Relationships are active, built over time, and are not abandoned when differences or difficulties arise. This type of partnership requires continual maintenance, the expenditure of personal and economic resources, and the ability to pursue new and innovative approaches that go beyond conventional boundaries. These partnerships are indeed the vehicle required to change perceptions and facilitate resolution.*

***History cannot be undone. However, strategies can be put in place to alleviate its impact. The circumstances and conditions in Pikangikum are widely known and are now legendary. The legend of Pikangikum focuses on tragedy and needs to be reframed to consider the potential for change. The immediate challenge is individual and collective healing. Simultaneously, a viable economic base to address the poverty and deprivation and their deleterious effects on the community needs to be established. However, how this takes place is the most critical question facing the Pikangikum community and its partners? Successful outcomes that interrupt the negative pathway can only occur through a meaningful partnership between members of Pikangikum First Nation and those who are genuinely interested in their well-being. Movement from a position of dependency to self-governance is required by way of a graduated transition period that allows for capacity-building in a measured way.***<sup>192</sup>

---

<sup>192</sup> Finlay, J, and Nagy, A, Pikangikum – Root Causes of Youth Suicide Within a Remote First Nation, January 17, 2011, p.23,24 & 27, in publication.



## PART H. ADVOCATE FOR CHILDREN AND YOUTH'S REPORT

The following report is printed in its original format as submitted to the Office of the Chief Coroner by the Office (OCC) for the Provincial Advocate for Children and Youth (OPACY) to provide their perspectives and contribution to the OCC's Death Review of the Youth Suicides at the Pikangikum First Nation 2006-2008 Report. The OPACY submission has been edited by the Chair for the purposes of publication only.

### H1. Introduction

The 2007 Standing Senate Committee on Human Rights report, "Children: The Silenced Citizens," observed that FN children are disproportionately:

- Living in poverty.
- Involved in the youth criminal justice and child protection systems.
- Facing significant health problems in comparison with other children in Canada, such as higher rates of malnutrition, disability, drug and alcohol abuse, and suicide.<sup>193</sup>

Informed by the voices of First Nations young people and their communities we met with over the last year, we enter the discussion of suicide from the bleak landscape noted by the Standing Senate Committee on Human Rights. The voices reflected in this work represent a cross-section of First Nations young people aged 15 – 18 from across the province of Ontario. These young people live on reserve, some attend schools in their communities, some leave their communities and fly to communities like Thunder Bay to attend high school and others attend colleges and universities in and beyond the north. These young people have taken the time to meet with us as part of group and individual discussions.

Almost uniformly, they express that they want to be a key part of identifying and participating in the development of resources and services needed to build and strengthen the capacity of their communities. They want to push back against what is often accepted as the common place reality of life on reserve. They want to be part of tackling the issues that drain hope and vitality and seem so insurmountable that many end their lives rather than live without the hope that is needed for their future. But this is not new, the same sentiments were expressed by young people in the 1995 report, "*Horizons of Hope: An Emerging Journey, Youth Forum Final Report*".<sup>194</sup> At that time, young people noted the time for talk was over and that it was time to put their ideas into action.

Four years later, in 1999, the inquest into the hanging death of Selena Sakanee drove home the impact of inaction and, once again, the importance of the recommendations made in the *Horizons of Hope Report*. In the subsequent Coroner's verdict explanation "the report was recognized and the jury endorsed its recommendations."<sup>195</sup>

---

<sup>193</sup> Canada, Standing Senate Committee on Human Rights, "Children: The Silenced Citizens: Effective Implementation of Canada's International Obligations with Respect to the Rights of Children" (2007), online: Standing Committee on Human Rights <[http://www.parl.gc.ca/39/1/parlbus/commbus/senate/Come/humae/repe/rep10apr07e.htm#\\_Toc164844427](http://www.parl.gc.ca/39/1/parlbus/commbus/senate/Come/humae/repe/rep10apr07e.htm#_Toc164844427)

<sup>194</sup> Nishnawbe Aski Nation, Youth Forum on Suicide. "Horizons of Hope: An Empowering Journey Final Report. (1995)

<sup>195</sup> Ontario, Ministry of the Solicitor General and Correctional Services, Office of the Regional Coroner, **Verdict Explanation: Selena Sakanee Inquest (1999)**

In 2000, an Intergovernmental Committee was formed. The Committee is currently comprised of representatives from Provincial and Federal levels of government and leadership and staff from Nishnawbe Aski Nation (NAN). The Committee has since evolved into the Intergovernmental Network (IGN) and retains central responsibility for implementing the recommendations of the jury from the inquest into the death of Selena Sakanee. The Advocate's Office, in its current form and in its former manifestation as the Office of Child and Family Advocacy, has long been part of the IGN.

This history highlights that young people have been here before. They have attended meetings, they have made recommendations and they have been part of recommending changes that involve them. It also reinforces the fact that more than 16 years after the NAN report was released, the same circular discussions are taking place. Young people still live in communities without resources or opportunity. Hope continues to be lost and young people continue to die from suicide. Young people die while adults continue to talk.

The content of this submission is based on notes taken over the last year as the Advocate's Office met with young people, community leadership and service providers in Ontario's northern on-reserve communities. The purpose of our discussions was to listen to young people and their communities as they identified the issues they are dealing with as part of their day to day lives across the spectrum of their social, economic and community lives.

Whether at the Regional Multi-Cultural Youth Centre, Dennis Franklin Cromarty High School [in Thunder Bay], provincial gatherings in Toronto or in fly-in communities, young people have had a great deal to say to our Office. They have talked to us about the need for resources, opportunities and schools in their own communities; the importance of recreation and leisure programs and having healthy active communities where parents and community members are engaged in activities and planning, and look out for them. They want the same educational and social opportunities as young people in the south without losing their connection to their communities, their language and their friends.

These articulate and passionate young people have a strong vision for their future and speak of the need for a greater role and voice in moving forward with actionable activities on the issues that they are facing in their day to day lives. As a result, we are focusing on the solutions young people desire and the role they want to play in creating real and lasting change in their communities.

This submission is organized around thematic highlights that emerged from discussions with First Nations young people and communities we have visited over the last year. Our discussions touched on the impact of history, colonization, the treaty system, residential schools, language, culture and the impact of isolation. These young people and their communities have spoken to us about the endless discussions of change that never seem to get traction and the ongoing patterns of substance abuse and physical and emotional abuse and neglect that dominates many communities.

Some of the young people we met with have spent up to 15 years of their lives listening and participating in engagement activities with funders and government. What they take away from these discussions is the sense that the funding associated with the limited programs they receive in their communities are unused revenues, time limited or in year funding, from across varying departments and ministries of government.

*“There is no money for youth activities, no real core funding we know programs come from excess revenues not any real interest in our needs.” ~ FN Youth ~*

Programs are short-lived and often under resourced. This leaves these seasoned youth leaders feeling that they are not a priority in the planning activities of the various levels of government or their communities. It is with this feeling that hope becomes lost and is replaced with frustration, apathy and distrust of all levels of government, including their own.

*“Everything we do we have to find everything, we have to try and find money for prizes and to buy stuff to advertise and that’s just the beginning. We have to hope they will let us use the space and that is hard because they all think we are going to break up everything. It’s hard trying to organize things when the adults don’t make it any easier for us to do it. After a while you just stop trying.” ~ FN Youth ~*

## **H2. Resources and Opportunity**

If young people are to begin seeing themselves as valued and important within their communities, they will need to see this value reflected in the resources and opportunities available to them on their reserves.

They want the opportunity to participate in, and benefit from, programs that invest and strengthen their skills and abilities and provide them with the chance to take on mentorship and leadership roles that are valued and resourced, supported and championed locally and provincially. They have told our Office they want to see an investment in training around program delivery that they can shape, influence and deliver locally. They want employment opportunities that support and provide opportunities for them to test their skills and abilities while contributing to the wellbeing of other young people in their communities. They believe strongly that with resources and opportunities they benefit in two ways. First, they are the leaders of today shaping leadership for those coming up behind them, and second, the leadership roles they have as young people are preparing them to be adult leaders of their communities in the future.

Young people in these communities are realistic about the opportunities they seek. They have told our Office they want access to the recreational resources of their local schools during the summer months when the teachers are not in the community. They want summer camp programs for children and youth that bring young people together in an organized way with the financial, physical and human resources that urban communities are able to provide. On a slightly larger scale, they have talked about linking communities. In one case, they went as far as calling for partnering opportunities across the most northern coastal communities and building on the connections that have been forged through the existing relationships of school sport activities. They want to find ways to come together to talk about issues and create programs, like the photo-voice project that our Office had the opportunity to view during our visit to Kashechewan and the passion for hockey that played out on Northern radio during our visit to Kitchenuhmaykoosib Inninuwug (KI).

During our discussions with young people in the fall of 2010 in Toronto and in Thunder Bay, they repeatedly reflected that they want to stop the endless cycle of discussion. They want to focus their efforts on developing actionable solutions that provide them with opportunities to lead, mentor and guide younger peers within their communities and demonstrate the power and ability of young people to build and strengthen their communities.

### Recommendations of Young People

- All levels of government linked to the funding of services for children and youth on and off reserve must make funding for services for First Nations children and youth a priority.
- Invest in training and employment opportunities that provide leadership and mentorship roles for young people on reserve. Link these young people provincially with peers to share and exchange ideas and the successes they have had within and across their communities.
- Ensure that at a provincial level First Nations young people are actively involved in the development and planning activities from the beginning.

### **H3. Schools and Education**

The education of FN youth and the condition of many of their schools are in a state of crisis across the north. They are also the source of the largest child and youth driven advocacy movement in Canada. Perhaps the most powerful voice on the status of First Nations education and schools is that of Shannen Koostachen, a 15 year-old young Cree woman from Attiwapiskat, Ontario. Shannen and her sister, have led the movement to have a permanent school built in her community. Shannen lived to see the promise that a school would be built but, unfortunately she died before construction of the school began. It still awaits building. Her comment below is an invitation to others to try and understand the impact not having a school has on the hopes and dreams of children and young people.

*“I would like to talk to you what it is like to be a child who grows up never seeing a real school. I want to tell you about the children who give up hope and start dropping out in grade 4 or 5. But I want to also tell you about the determination in our community to build a better world. School should be a time for hopes and dreams of the future. Every kid deserves this.” ~ Shannen Koostachen ~*

In its article “Still Waiting in Attiwapiskat”<sup>196</sup> Canadian Geographic asks if “Indian and Northern Affairs (INAC) will fail the next generation.” Based on Shannen’s account of her discussion with INAC Minister Strahl about funding for a permanent school in her community, the Advocate’s Office wonders if another generation of First Nations youth may suffer the pain of INAC’s failures. Rather than paraphrase Shannen’s reflections on her meeting with the INAC minister they are included here in their entirety:

*“When we met up with him, Chuck Strahl told me he didn’t have the money to build a school,” Shannen later told a gym full of high school students. “I looked at the rich room he sat in with all his staff. I told him I wished I had a classroom that was as nice as the office he sat in every day. He told me he couldn’t stay for more of the meeting because he had other things to do. We were very upset. The elders who were with us had tears in their eyes. But when he was about to*

---

<sup>196</sup> Linda Goyette, Canadian Geographic, (December 2010)  
<http://www.canadiangeographic.ca/magazine/dec10/attawapiskat.asp>

*leave, I looked him straight in the eye and said, 'Oh, we're not going to quit. We're not going to give up.'*" (Canadian Geographic, 2010)

Young people like Shannen have demonstrated their effectiveness as leaders. It is through her efforts that the importance of community schools and education were driven home. For the Advocate's Office, this heightens the importance of the role of youth as advocates for issues of importance to them.

Many on reserve communities struggle to provide basic education in buildings without heat, without proper classrooms or stable teaching staff; and as noted in the case of Attiwapiskat, any real school at all. Of grave concern to our Office, is the number of young people who each fall pack up their belongings and leave their families and communities to fly into urban centres like Kenora, Sioux Lookout, New Liskard and Thunder Bay to attend high school. These children live with host families and often lack the family support and guidance they require to adjust and adapt. The cultural overload and shift in academic expectations these young people face has significant impact on their coping abilities. Without the support of family these young people are often placed at increasing risk for depression, engagement in at-risk behaviour and suicide.

In our discussions with young people they have raised concerns about having to leave their communities to attend high school and the lack of employment opportunities they have in these new communities. They are concerned about the conditions in schools on reserve and limited employment opportunities resulting from their educational efforts. Finally, the lack of access they have to their schools after the schools close for the year leaves them with few recreational alternatives during the summer and holiday periods.

*"The schools don't work like our schools back home, it's completely different here. They are all used to it and we're expected to just slide in like we're like them."* ~ FN Youth ~

*"There is no real reason to go anyway, there are no jobs for us, and no one really cares if we are there or not. They just want us to show up, no one pays attention, and they know there is no work here for us, their just doing their jobs."* ~ FN Youth ~

*"It's hard in the winter because it so cold all the time. They shut it down a lot when it gets too cold. The wind blows under the doors and you're cold all the time. You end up staying at home and not going cause you're just going to freeze anyway"* ~ FN Youth ~

### **Recommendations of Young People**

- Train teachers in the south so they have a better understanding of our ways.
- Expand the resources, supports and orientation activities provided to young people leaving their communities to attend school off reserve.
- Provide more apprenticeship programs focused on teaching job training skills.

### **H4. Recreation and Leisure**

There is a need to create safe spaces and opportunities for First Nations children and youth to participate in recreation and pro-social activities that include sports, and other ways to develop their physical, social and communication skills. Poverty, poor facilities, and the absence of a provincial First Nations sport and recreation policy pose significant barriers for on-reserve children and youth to participate in activities that invest in their health, teamwork and social skills. While youth outreach worker positions exist in many communities, they are often single focused positions that are unable to respond to the wide range of interests of youth that exist in the community.

The role of recreation and leisure programming is in many ways as vital as education in that it provides a safe place for young people to come together and spend time.

*"We need equipment and training to teach and run skills training workshops. There is never enough of anything for us to do things." ~ FN Youth ~*

*"It's hard to do stuff because everything gets stolen, or we have to be careful because the dealers and trouble is everywhere. It's hard to be seen as a leader when these guys scare everyone. Right now they are the leaders in the community they are the ones all the little kids are turning into." ~ FN Youth ~*

### **Recommendations of Young People**

- Create positions for young people in communities to run summer, evening and weekend sports and recreation programs.
- Find leadership and program workshops that bring people together from local communities to develop and deliver new programs that can bring communities together around competitions, demonstrations or sharing of work.

## **H5. Culture and Language**

In almost every discussion our Office has had with First Nations young people and their communities, the importance of culture and language is brought forward. Young people do not separate language and cultural practices from their identity, but rather see them as central. What they want to be able to do is find a way of integrating the traditions and ways of their communities into an identity that also finds a place for friends and social behaviour that is a part of the mainstream communities they enter when they leave the reserve.

To do this they need the assistance of the elders and community members to guide and support them. But they need more than the traditional teachings if they are to survive as they live in what are two very different worlds on and off reserve. They see the elders as a key resource for guidance and they want to see the elders reach out more to understand the struggles they are managing on a day to day basis without judging them or negating the realities they are growing up with.

*"Preservation of Identity is one of the rights we are entitled to..... to be half native is still a native right? They say no." ~ FN Youth ~-*

*"Kids not knowing who they are really hurts me." ~ FN Youth ~*

### **Recommendations of Young People**

- Work with elders who want to really understand youth and their needs and find ways to bring language and traditional ways into their lives both on and off reserve
- Build linkages that support the integration of culture and language into resources and programs provided in communities.

## **H6. Family, Community and Leadership**

The most difficult part of our discussions with communities and young people were the ongoing impacts that the silence and pain associated with the ongoing legacy of being First Nations in Canada continue to hold for past and present generations of parents, elders and the leadership of



their communities. In our discussions, we have come to see the gaps in knowledge many young people have about the histories of their communities, their families and more broadly First Nations peoples in general. In turn, young people want to understand how the past influences their present circumstances.

They know the value of having healthy parents who are able to help and guide them in their development and learning. They have told us time and again they know their parents have had difficult lives and alcohol, drugs, depression and abuse are often their way of coping with their own history, but they need them to get healthy and protect them in their community. Many have told us they would rather be out with their friends than at home watching their parents self-destruct. In turn, many of them also reflect how hard it is to stay hopeful and look forward to the future when they see so many families in their communities dealing with the same issues. Young people note over and over that their parents are so caught in their own issues that they do not see their kids are falling apart, until it is too late.

*“Poor housing, low medical, high food costs, inadequate education, high suicide rates and drug and alcohol abuse; growing up on a northern isolated community with these conditions makes it difficult to grow up having a positive, healthy life style. If children are our future; then what is being done to invest in the future leaders of Ontario’s First Nations communities?” ~ FN Youth ~*

### **Recommendations of Young People**

- Provide parents with the counselling services needed to help them move forward.
- Like us, adults need to have a role in the community. They need to have jobs so they feel they are part of the community.
- Give adults the skills they need so they can be better parents.

### **H7. Final Reflections**

After more than a year travelling throughout the province, the Office of the Provincial Advocate for Children and Youth is only beginning to understand the tremendous social capital that exists in on-reserve communities across this province. Young people are saying they want to be part of creating change and opportunity for themselves and those who are growing up behind them. Council members and elders who time and time again have spoken passionately about the children of their communities have stated that they do not want this generation of children to experience the pain and despair they live with.

The youth of these First Nations communities have noted they do not see their communities and governments doing a great deal to prioritize and address the issues that impact their lives directly. They have expressed that promises are often made and yet nothing materializes. They feel little priority is given to their needs because “they are just kids.” They are tired of being invisible in their homes, invisible in a system that deems it acceptable that they receive their education in unheated, mould contaminated, soil contaminated classrooms while refusing to build schools where none now exist. They feel invisible in the decisions of the governments of broader society and of their own communities as they sit and watch year after year as more young people lose hope and are left unable to cope with the devastating conditions that exist in their communities.

The very things they have spoken to us about are the key to resilience for themselves and their communities. We, the OPACY, use the term resilience in the context of investing in the ability of young people to be part of change and knowing there will be setbacks as they move forward, but supporting them always to move forward. They need to have a “reason to live.” This point resonates eleven years after it was first made by Nodin Youth Services in, *Pikangikum First Nation Report on the Increase in Suicidal Behaviour*.<sup>197</sup>

First Nations youth are in the best position to articulate the many challenges in their lives, the challenges that lead some to suicide. Young people are mobilizing and are becoming increasingly politicized. They also continually face an adult culture that questions their ability, maturity and knowledge to bring about solutions. Our Office continues to work as closely as possible with communities and young people to challenge a mindset that continues to quietly hold that children and youth are to be seen and not heard when it comes to the forum of public and social policy discussions.

Young people from across this province have told our Office they want to be part of building partnerships that allow them to act as mentors and leaders for those growing up behind them. They do not see this as their work alone; they need their elders and community leadership to invest in their development. They want to find ways to tie the traditional with the new, provide programs and resources that are supported and attended by their communities and they want to be a priority of government tables across federal and provincial jurisdictions and within their own band, provincial and national First Nations leadership.

Sustainable long-term investments in young people are central to any strategy aimed at targeting suicide by investing in the social and mental health of First Nations youth. They have told us they know many of the resources directed to them are time limited, surplus revenue-generated and in the end, never last long. Investments need to be real, long-term, focused at the local-community level and flexible so as to be adaptable to the varying cultural, spiritual and religious orientations of communities.

There are challenges that lay ahead for all of those involved, this includes all levels of government, young people, their communities and their families, toward developing lasting solutions. As an independent voice for First Nations children and youth, the Advocate’s Office is aware that there is a long history of broken promises to previous generations of First Nations children and youth of this province. As I noted at the beginning of this submission, it has been sixteen years since the first report and the communities with the highest rates of suicide continue to struggle with the same issues that existed 16 years ago. Advocacy is about leveraging change. Long-term, stable programming and services that support young people and their communities are the keys to any solutions put in place.

*Mr. Irwin Elman, Provincial Advocate for Children and Youth*

---

<sup>197</sup> Pikangikum First Nation Report on the Increase in Suicidal Behaviour in 2000: Barbara Jo Fidler for Nodin Counselling Service, Sioux Lookout, Ontario

## H8. Bibliography

1. Canada, Canadian Council of Provincial Child and Youth Advocates, “Canada’s Aboriginal Children and Youth Must Do Better” (2010)
2. [http://provincialadvocate.on.ca/documents/en/Position%20Paper%20-Canadian Council of Provincial Child and Youth Advocates.pdf](http://provincialadvocate.on.ca/documents/en/Position%20Paper%20-Canadian%20Council%20of%20Provincial%20Child%20and%20Youth%20Advocates.pdf)
3. Canada, Standing Senate Committee on Human Rights, “Children: The Silenced Citizens: Effective Implementation of Canada’s International Obligations with Respect to the Rights of Children” (2007), online: Standing Committee on Human Rights <[http://www.parl.gc.ca/39/1/parlbus/commbus/senate/Come/humae/repe/rep10apr07e.htm#\\_Toc164844427](http://www.parl.gc.ca/39/1/parlbus/commbus/senate/Come/humae/repe/rep10apr07e.htm#_Toc164844427)>
4. Fidler , Barbara Joe, Pikangikum First Nation Report on the Increase in Suicidal Behaviour in 2000 Nodin Counselling Service, Sioux Lookout, Ontario
5. Goyette, Linda, Canadian Geographic, (December 2010)  
<http://www.canadiangeographic.ca/magazine/dec10/attawapiskat.asp>
6. Nishnawbe-Aski Nation Youth Forum on Suicide - Horizons of Hope: An Empowering Journey - Final Report 1995.



## **PART I: CONSOLIDATED RECOMMENDATIONS**

### **Theme: Health Care**

#### **Government of Canada, Health Canada**

1. The Government of Canada, working with the Provinces, Territories and Aboriginal Leadership groups such as the Assembly of First Nations, should create a National Suicide Prevention Strategy, as currently exists in other developed countries.
2. The Government of Canada, in developing its National Suicide Prevention Strategy, should liaise with Aboriginal Leadership to ensure that the Strategy considers, accepts and respects cultural diversity, and specifically acknowledges the extraordinary excess contribution of Aboriginal Peoples to the Canadian national suicide rate.
3. In developing its National Suicide Prevention Strategy, an exploration of the catastrophic contribution of First Nations mortality of adolescents and youth living on reserve should be considered, the reasons for the excess mortality clearly understood, and recommendations evolved which address this issue.
4. As a component of its National Suicide Prevention Strategy, the Government of Canada should consider the development of population level mental health indicators so that future decisions on mental health strategies will be data driven. An example would be to develop the capacity, through Health Canada, First Nations, and Inuit Health Branch of tracking, in real time, deaths due to suicide in Aboriginal communities. This would allow for the identification of those communities including First Nations reserves, where deaths due to suicide occur in excess and therefore, targeted strategies and enhanced resources may need to be provided to assist these communities in crisis.
5. The Government of Canada, through Health Canada, First Nations, and Inuit Health Branch should provide targeted funding to communities and reserves experiencing excess cases of child and adolescent suicides, including First Nations reserves to assist in developing solutions directed to the prevention of these deaths. The current National Aboriginal Youth Suicide Prevention Strategy is not apparently meeting the needs of these individual First Nations.
6. This funding should be appropriated to create comprehensive suicide prevention programs in these communities and reserves, led by the local health authority, in partnership with representatives from Health Canada, First Nations, and Inuit Health Branch, and the provincial Local Health Integration Network.
7. Qualified expertise to create and implement comprehensive suicide prevention programs in communities and reserves should be retained. Healthcare experts, such as nurses educated to a Masters Degree level in health science with an interest in project management would ensure that the components of the comprehensive suicide prevention programs were implemented, and that the children, youth, and families in these communities would benefit from the provision of enhanced resources. Data should be collected, and benchmarks and key performance indicators developed to track and measure outcomes, and accountability targets should be set. (Cross referenced to recommendations 24, 25 and 29.) Funding for these nurse manager experts could come from the newly created National Aboriginal Youth Suicide Prevention Strategy.
8. Health Canada, First Nations and Inuit Health Branch should develop an electronic medical record (EMR) which can link health systems to ensure proper transfer of information between all care providers operating in the “circle of care.” This system should be created in consultation with the provincial Local Health Integration Network and eHealth Ontario and is

vital to proper care of all Aboriginal peoples who receive components of their health care from both federal and provincial providers.

9. Health Canada, First Nations and Inuit Health Branch should provide funding to ensure that Pikangikum's Comprehensive Mental Health and Addictions Program, including the Community Suicide Prevention Program, can be created and function. (Cross referenced to recommendation 24.)

### **Government of Ontario, Ministry of Health and Long-Term Care**

10. The Province of Ontario, Ministry of Health and Long Term Care (MOHLTC) in collaboration with other ministries should create a Provincial Suicide Prevention Strategy.
11. The Province of Ontario, Ministry of Health and Long-Term Care (MOHLTC) in developing its Suicide Prevention Strategy, should liaise with Aboriginal Leadership groups to ensure that the strategy considers, accepts and respects cultural diversity, and specifically acknowledges the extraordinary excess contribution of Aboriginal peoples to the national suicide rate. The province should not allow jurisdictional tensions over First Nations between the federal government and the province to delay the creation of its Suicide Prevention Strategy.
12. The Province of Ontario, Ministry of Health and Long-Term Care (MOHLTC) in creating its Suicide Prevention Strategy, should liaise specifically with:
  - First Nations' Leadership, including the Chiefs of Ontario,
  - The First Nations political leadership for Northern Ontario, specifically the Nishnawbe Aski Nation, Grand Council Treaty #3
  - Health Canada, First Nations and Inuit Health Branch,
  - Local Health Integration Networks, specifically, those in the North West and North East of Ontario,
  - Aboriginal Children's Aid Societies to identify communities and reserves where the rate of suicide for children and youth is excessively high.
13. The Province of Ontario should cultivate its strategic direction with respect to enhancing mental health and addiction services over the next ten years to ensure that this includes the development of a provincial suicide prevention plan, and the reduction of suicides in children and youth. Components of this plan should consider promotion, prevention and early intervention in mental health for children and youth, with targeted efforts to reduce the stigma and discrimination associated with mental and substance abuse disorders.
14. As a component of its Suicide Prevention Strategy, the Province of Ontario should develop population-level mental health indicators so that future decisions on mental health strategies will be data driven. An example would be to develop the capacity of tracking, in real time, deaths due to suicides in Aboriginal communities including First Nations on reserves.
15. The Province of Ontario, Ministry of Health and Long-Term Care should create a telehealth consulting service for psychiatric care to remote First Nations communities. This service should allow for prompt (same day) access to child and adolescent psychiatrists for children in crisis. To ensure availability of psychiatrists to fulfill this role, the Ministry should provide a significant premium to physicians. The Ministry should partner with academic health science centres to create this service.
16. The Province of Ontario, Ministries of Children and Youth Services and Health and Long-Term Care should develop an integrated mental health service strategy stressing accessibility and program delivery for children and youth in northern Ontario (Northern Ontario Aboriginal Child and Adolescent Psychiatry Outreach Program). Some stakeholders identified to assist in the development of this strategy would be:
  - North West and North East Local Health Integration Networks

- Health Canada
  - Ministry of Children and Youth Services
  - A representative from the Sioux Lookout Regional Physicians' Services Inc. (SLRPSI)
  - Representatives from Meno-Ya-Win, Thunder Bay Regional Health Sciences Centre, Lake of the Woods District and Weeneebayko Hospitals
  - Representatives from the Sioux Lookout First Nations Health Authority and the Weeneebayko Area Health Authority
  - A representative from Nodin Child and Family Intervention Services
  - A paediatric psychiatrist who provides service to First Nations Youth in the North West
  - Health Canada, First Nations and Inuit Health Branch
  - Indian and Northern Affairs Canada
  - Non-Insured Health Benefits (NIHB)
  - Tikinagan Child and Family Services, Dilico Anishinabek Family Care, and other children's aid societies
  - A representative from the Ontario Child and Youth Telepsychiatry Program
  - A representative from the Nishnawbe Aski Nation
  - A representative from each of the Tribal Councils of the north
17. This Northern Ontario Aboriginal Child and Adolescent Psychiatry Outreach Program should be resourced jointly by the Ministry of Children and Youth Services, MOHLTC and Health Canada, First Nations and Inuit Health Branch and should endeavour to deliver culturally competent evidence-based child psychiatry incorporating flexible mixed models of service delivery, including:
- Triaging of direct referrals for children and youth in crisis
  - Indirect referrals including support to family physicians and therapists
  - Shared-care models
  - Telepsychiatry, available 24/7, including ready access for children and youth in acute crisis at risk for suicide
  - Mechanisms for communication between therapists, family physicians and psychiatrists

#### **North West and North East Local Health Integration Network (LHIN)**

18. The North West and North East LHIN, working with Health Canada, First Nations and Inuit Health Branch, the Nishnawbe Aski Nation and other political First Nations leadership, should create an integrated and seamless Mental Health and Substance Abuse Strategy. This program should identify all service providers, both federally and provincially, and create care paths for First Nations living on reserve, particularly for youth who require placement out of their home communities.
19. The North West and North East LHIN working with Health Canada, First Nations and Inuit Health Branch should endeavour to create a crisis telephone line and/or Internet service for the North West and East regions.

#### **Sioux Lookout First Nation Health Authority (SLFNHA), Nodin Child and Family Intervention Services**

20. The Sioux Lookout First Nations Health Authority, Nodin Child and Family Intervention Services should conduct a review of open and waiting list cases, for the purpose of benchmarking with other organizations providing these types of services, to determine an acceptable caseload for its counsellors.
21. Based on this benchmarking exercise, SLFNHA should create a business case to present to the Ministry of Children and Youth Services, the Ministry of Community and Social

Services, and Health Canada, First Nations and Inuit Health Branch, who fund Nodin, to ensure that adequate resourcing is provided to address the needs for the enormous backlog that currently exists. This will likely require additional full time equivalents for both counselling and supervising.

22. Nodin Child and Family Intervention Services should consider developing a model, (when adequately resourced), that is not limited to crisis intervention, as currently exists. Given their dedication to ensuring duly qualified staff, with accountability and supervision processes, consideration should be given to Nodin providing overall mental health case management to children and youth from the First Nations communities it currently services, including Pikangikum.

### **Pikangikum First Nation and the Pikangikum Health Authority (PHA)**

23. The Pikangikum Health Authority should develop a mission statement and clearly define its vision and values.
24. The Pikangikum Health Authority should develop a Comprehensive Mental Health and Addictions Program for children, youth and adults. This program should consider;
  - a Comprehensive Community Suicide Prevention Program,
  - developing plans to address the solvent and alcohol abuse crises, and
  - the need for integrated provision of mental health services including models which incorporate traditional practices, defined by the Pikangikum First Nation.
25. In developing its Comprehensive Mental Health and Addictions Program, the PHA should retain nursing expertise to assist in the development of the Program. Funding for this nurse manager expert could come from the newly created National Aboriginal Youth Suicide Prevention Strategy, the Health Canada, First Nations and Inuit Health Branch, and/or the Aboriginal Health and Wellness Strategy. Invited participants to ensure a truly integrated program might include:
  - Representatives from the Pikangikum Social Health, Education and Elders Committee
  - Representatives from the Pikangikum Nursing Station
  - Representatives from Pikangikum Mental Health and Addictions Programs including a mental health worker, youth patrol, solvent abuse worker, NNADAP, crisis team and community health nurse
  - A representative from AMDOCS
  - A representative from the Sioux Lookout Regional Physicians' Services Inc. (SLRPSI)
  - Representatives from Meno-Ya-Win Hospital
  - A representative from the Sioux Lookout First Nations Health Authority
  - A representative of the First Nation Family Physician Health Services branch of the Independent First Nations Alliance (IFNA)
  - A representative from Nodin Child and Family Intervention Services
  - A paediatric psychiatrist who provides service to First Nations youth in the North West
  - Health Canada, First Nations and Inuit Health Branch
  - Indian and Northern Affairs Canada
  - Non-Insured Health Benefits (NIHB)
  - The Ministry of Children and Youth Services
  - The Ministry of Aboriginal Affairs
  - The Ministry of Health and Long-Term Care
  - The North West Local Health Integration Network
  - Tikinagan Child and Family Services
  - Ontario Provincial Police



26. Until the Comprehensive Mental Health and Addictions Program is functional, the NNADAP, Solvent Worker and Youth Patrol programs should be examined and either augmented or reconstituted to provide meaningful assistance to the community. Job descriptions should be written so that targets and accountability expectations are clearly set out.
27. The Pikangikum First Nation, Chief, Council and the Pikangikum Health Authority should create a Community Suicide Prevention Program, to be delivered as a community program, under the Health Authority's current Chair and Directorship **funded by Health Canada, First Nations and Inuit Health Branch.**
28. The creation of the Community Suicide Prevention Program will require expertise in health care and project management that currently does not exist within the community. To achieve the necessary level of expertise, the Pikangikum Health Authority under its current Directorate, should partner with Health Canada, First Nations and Inuit Health Branch, and the North West Local Health Integration Network for the planning and delivery of the program.
29. The Pikangikum Health Authority should approach Health Canada, First Nations and Inuit Health Branch to provide funding to retain medical expertise, such as a nurse manager educated to a Masters Degree level in health science with expertise in project management to assist with creating and implementing the Community Suicide Prevention Program. The job specifications, qualifications, accountabilities and contract should be agreed upon by all three members of the tripartite partnership, that is, the Pikangikum Health Authority, Health Canada, First Nations and Inuit Health Branch, and the North West Local Health Integration Network.
30. The Community Suicide Prevention Program should be created by the Pikangikum Health Authority and their Nurse Manager Expert incorporating a steering committee model with invited participants and stakeholders including such interests as,
  - representatives from the Pikangikum Nursing Station,
  - representatives from Pikangikum Mental Health and Addictions Programs including a mental health worker, youth patrol, solvent abuse worker, NNADAP, crisis team and community health nurse,
  - a representative from the Pikangikum Education Authority,
  - a representative from AMDOCS,
  - a representative from the Sioux Lookout Regional Physicians' Services Inc. (SLRPSI),
  - representatives from Meno-Ya-Win Hospital,
  - a representative from the Sioux Lookout First Nations Health Authority,
  - a representative of the First Nation Family Physician Health Services branch of the Independent First Nations Alliance (IFNA),
  - a representative from Nodin Child and Family Intervention Services,
  - a paediatric psychiatrist who provides service to First Nations youth in the North West,
  - Health Canada, First Nations and Inuit Health Branch,
  - Indian and Northern Affairs Canada,
  - Non-Insured Health Benefits (NIHB),
  - the Ministry of Children and Youth Services,
  - the Ministry of Aboriginal Affairs,
  - the Ministry of Health and Long-Term Care,
  - the North West Local Health Integration Network,
  - Tikinagan Child and Family Services,
  - Ontario Provincial Police,

- Lachie Macfaddin land-based detoxification program.
31. The Community Suicide Prevention Program should seek methods to de-stigmatize the seeking of help by clients for mental health-related issues, and improve health privacy. Community members must be ensured of confidentiality in counselling sessions so that they will be more willing to seek out help and confide their concerns.

## **Theme: Suicide Prevention**

### **Primary Prevention Strategies**

#### *School-based Prevention: The Pikangikum Education and Health Authority*

32. The Pikangikum Education and Health Authority should cooperatively develop as a component of the Community Suicide Prevention Program, a school-based student health and suicide prevention program. This program should be a component of the health education curriculum, and should include a variety of health and social issues of which suicide would be one. The program should seek to enhance the capacities of the children in coping with stress, conflict resolution, problem-solving and communication. The fundamental purpose would be to build resiliency and self-esteem in the children, so that they would be better able to withstand the rigours of the crisis and conflict that may arise in their lives.
33. The school-based curriculum should incorporate traditional and cultural knowledge and should utilize the resource of incorporating elders when teaching the youth about such issues as cultural identity and self-pride. It should focus on mental, emotional, spiritual and physical well-being, and particularly discuss the dangers of solvent abuse and emphasize the recognition of suicidal behaviours.
34. The school-based health program should address such issues as alcohol and substance abuse, depression and suicide, domestic violence, sexual and/or physical abuse, and bullying. It must convey and communicate, in plain language to the children, strategies for help-seeking where these issues exist in their lives, and de-stigmatize and dispel attitudes and dispositions which portray the seeking of help in a negative light.
35. The school-based health program should seek to identify high risk youth for suicide by developing and utilizing a school-based screening program and refer high risk youth for intervention. Intervention for children who are identified as high risk for suicide might include one-to-one counselling, as well as small-group interventions based on skills building.

#### *Peer Support Programs*

36. The Pikangikum Education Authority and the Pikangikum Health Authority should develop a peer support program operated through the school by senior students called the Peer Support Youth Council. This program should seek to engage children who are identified as “at risk” for suicide and create bridges and ease for the “at risk” child to seek assistance appropriately. The peer counsellors should be trained in basic listening skills and identified as resource people for the youth in crisis. Oversight, management and debriefing for the Peer Support Youth Council could be provided by Nodin Child and Family Intervention Services.

#### *Community-Based Programs: The Pikangikum Health Authority*

37. The Pikangikum Health Authority should develop a community-based program to address suicide as a component to their suicide prevention strategy. The components could consist of:
- Education programs for youths and adults on topics including suicide, parenting and life skills. The educational programs directed toward suicide prevention should have mental health literacy tools for parents promoting the identification of undiagnosed or untreated mental health disorders so that professional assistance will be accessed.

- Creating peer counsellors to respond to young people in crisis, and bringing them to the attention of healthcare providers.
  - Outreach to families after a suicide or traumatic death.
  - Immediate response to a youth at risk.
  - Creating suicide risk screening programs in mental health, addiction and social service programs.
38. As a component of the community-based program, the Pikangikum Health Authority and Education Authority should develop and deliver workshops on life skills, parenting and problem solving, and communication with the children and youth, to parents and young adults in the community. These should be based on culturally sensitive models of roles and responsibilities.

#### Means Restriction

39. Given that means restriction, or eliminating access to specific lethal means of suicide has been proven to be effective in reducing suicide rates, and given that hanging was the method utilized in all the suicides examined, educational programs directed toward prevention should acknowledge the roles of limiting access to items that could be utilized as ligatures in children expressing suicidal ideation. It is acknowledged that given the ready availability of these items in a household environment, for example shirts, sheets, and shoelaces, it is likely to play a limited role.

#### Gatekeepers

40. The Pikangikum Health Authority should develop a role for community gatekeepers, such as elders, community leaders, police, social workers, counsellors, teachers and clergy to be taught to identify youth at risk for suicide, and refer them for treatment. The community-based gatekeeper training programs should seek to improve identification and recognition of suicidal behaviour to allow for prompt referral.

#### Communication and Media Handling of Suicides in Pikangikum: The Pikangikum First Nation, Chief and Council

41. The Pikangikum First Nation should convene a committee for the purposes of reviewing and developing policies on how it will communicate to the community the tragedy of suicides when they occur. Invited stakeholders might include the proprietors of the local radio station and newspaper, and representatives from the Pikangikum Nursing Station, the Pikangikum Mental Health and Addictions Programs, Nodin Child and Family Intervention Services, Tikinagan Child and Family Services, and the Ontario Provincial Police. The policy should be directed at diminishing the intense community focus on the death, and promoting mental health and coping strategies around suicide.

#### Programming for Children: The Pikangikum First Nation, Chief and Council

42. The Pikangikum First Nation should develop a project to create, with the assistance, support and aid from INAC, an athletic field, with a children's playground, including a basketball court and baseball and soccer fields to allow for children's programming.

### **Secondary Prevention: Early Intervention and Treatment**

#### Health Care Professionals and Mental Health Services: Health Canada, First Nations and Inuit Health Branch

43. The Pikangikum Nursing Station should develop an emergency room suicide response protocol. This protocol should contemplate identification of those who require emergent

hospitalization and how this will be achieved, and those that can be discharged from the Nursing Station. Where appropriate, discharge from the Nursing Station should consider;

- notification of the child or youth's parent and guardian,
  - creation of a safety plan,
  - immediate notification of the community mental health team, and Tikinagan Child and Family Services, where permitted by the Personal Health Information Protection Act,
  - provision of the discharge summary to the community mental health team, and Tikinagan Child and Family Services,
  - follow-up with the community mental health team within 24 hours.
44. Nurses working in the Pikangikum Nursing Station should receive specialized training and education with respect to assessing those at risk for suicide, including when patients should be referred for emergent psychiatric inpatient treatment in a Schedule 1 facility. This could be achieved by the nurses obtaining certification in mental health.
45. AMDOCS, the principal physician service provider to Pikangikum should develop an educational module for its physicians with regard to suicide prevention and treatment. This program should discuss:
- The high rate of mental health disorders in youth that kill themselves.
  - The utilization of treatment strategies in youth including the use of antidepressants such as selective serotonin re-uptake inhibitors.
  - The need to effectively treat children suffering with major psychiatric illnesses such as psychotic disorders.
  - The association of substance abuse disorders and suicide.
46. The Pikangikum Health Authority, the North West LHIN and the Pikangikum Nursing Station should develop an agreement with paediatric and adolescent psychiatric service providers whereby prompt consultation for youth presenting with suicidal ideation and/or risk factors can access this psychiatric expertise via telehealth video linkages.

#### *Crisis Telephone Line: North West and North East LHIN*

See recommendation 19.

#### *Mental Health Crisis Response Teams*

47. The Pikangikum Health Authority should develop a Mental Health Crisis Response Team through its Mental Health and Addictions Programs for those identified as suffering with parasuicidal ideation. This service should have the capacity to mobilize counsellors to respond to youth in crisis 24/7.

#### *Solvent and Substance Abuse Treatment*

48. The Pikangikum First Nation, and the Pikangikum Health and Pikangikum Education Authority should seek to identify all children and youth <19 years of age involved in solvent abuse. This could be facilitated through screening programs in the school, and with the assistance of the OPP and the Nursing Station. All youth and children identified as suffering with solvent abuse, who are age appropriate based on the criteria of the Child and Family Services Act, should be referred to Tikinagan Child and Family Services. All youth, regardless of age should also be referred to the Solvent Abuse Worker.
49. The Pikangikum Education Authority should augment the school's current curriculum on solvent abuse to ensure that education begins in kindergarten with developmentally appropriate modules throughout elementary school.
50. The Pikangikum Health Authority, with the assistance of Health Canada, Youth Solvent Abuse Program (YSAP), Tikinagan Child and Family Services, the Ministries of Children

and Youth Services and Health and Long-Term Care, and the Local Health Integration Network should develop a comprehensive in-community Solvent Abuse Program. Medical expertise on solvent abuse should be retained for this exercise. This program should incorporate support of the children before and after treatment in residential solvent abuse programs, adopting holistic approaches to treatment, including aftercare programs delivered in the community.

51. The Pikangikum Health Authority, Health Canada, First Nations and Inuit Health Branch, Youth Solvent Abuse Program (YSAP), Tikinagan Child and Family Services and Health and Long-Term Care and the Local Health Integration Network, in developing the comprehensive in-community Solvent Abuse Program, should liaise with residential solvent abuse providers such as White Buffalo Youth Inhalant Treatment Centre (WBYITC) to develop comprehensive after-care and follow-up to residential treatment programs. This should include outreach programs delivered at Pikangikum whereby a provider such as WBYITC delivers a community intervention including such items as identifying protective factors in the community such as the school system, community support groups, and connecting with elders.
52. Pikangikum First Nation should develop a Healing Treatment Centre with funding provided by Health Canada, Inuit and First Nations Health Branch. The Centre could house multiple providers of health services under one roof including Tikinagan Child and Family Services, the community mental health workers, NNADAP workers and the solvent abuse workers. In addition, children who are apprehended by police for solvent intoxication would not be lodged in police cells overnight, but rather, would be brought to a safe sheltered environment in the centre to be monitored by peace keepers until they are no longer intoxicated. The comprehensive in-community Solvent Abuse Program after-care program could be delivered in this location.
53. Social workers, mental health workers and solvent abuse workers will need to proactively reach out to involved families of solvent abusing children and youth, and should consider adopting models of home visits to ensure confidentiality and diminish the stigma attached to help-seeking which has emerged in the community.
54. The Pikangikum First Nation and Health Authority should liaise with Health Canada, First Nations and Inuit Health Branch and the Government of Canada to explore the feasibility of introducing Opal fuel in their community, a type of gasoline that will not make users intoxicated when sniffed.

### **Postvention: The Pikangikum First Nation Health Authority**

55. The Pikangikum First Nation Health Authority, as a component of its Community Suicide Prevention Program should develop a postvention program directed at the youth of the community.
56. The postvention program should be developed for delivery both in the school, and in the community. School engagement is a protective factor for preventing suicide and as such, the program should specifically consider addressing the isolated community of solvent abusers, who make up the largest percentage of suicide victims.
57. The components of the postvention program might include, but not be limited to, the following elements:
  - Mobilization of a Crisis Response Team.
  - The victim's family should be contacted, empathy and support provided, and an inventory of those who are most likely to be affected by the death developed.
  - A determination of what information is appropriate for release. This should ensure that the victim is neither glorified nor vilified.

- Identify those who are most likely affected by the death, including those who discovered the decedent.
  - The Crisis Response Team should seek to meet all those who have been identified individually, providing support and counselling.
  - Drop-in counselling centres following the suicide should be established to allow those who are experiencing distress to gain ready access to mental health services.
58. The Pikangikum First Nation should establish an appropriate and culturally sensitive approach to funereal and memorial activities. Of paramount importance, is that the activities do not "...romanticize or sensationalize the death." Youth "...should not view suicide as a way to obtain incredible amounts of attention".
59. The Pikangikum First Nation should consider developing a community cemetery. In this way, permanent physical memorials are placed in an appropriate locale, away from residential areas to avoid the constant recognition and reminder of suicidal deaths.

### **Theme: Education**

#### **Pikangikum First Nation and the Pikangikum Education Authority (PEA)**

60. The Pikangikum First Nation, Education Authority and educators from the school should convene a meeting to meaningfully discuss the fundamental role of education as delivered in the community. This might include a discussion of the mission, vision and values of the Pikangikum Education Authority. Central to this discussion is the creation of a statement of understanding about what outcomes are expected or anticipated for the children and youth attending the school that will assist them in creating viable futures for themselves. Consideration should be given to employing a facilitator for the meeting from outside the community, with expertise in the provision of First Nations education.
61. The Pikangikum First Nation, Chief and Council should pass a Band Council Resolution requiring that an accurate census be taken of all the children in the community who are of school age.
62. The Pikangikum First Nation, Chief and Council and the Pikangikum Education Authority should pass a Band Council Resolution requiring children to attend school until 18 years of age. This reflects the reality that children and youth with good school and social connectedness are more likely to have positive educational outcomes and less likely to be involved in health risk behaviours and experience subsequent mental health issues. Examples of health risk behaviours and mental health issues include gasoline sniffing, depression and suicide.
63. Secondary school education at Pikangikum School should improve to a level so that its graduates will be capable and willing to face the challenges of post-secondary education at the trades, college or university level. The PEA should develop options so that children who might have the potential and interest to achieve higher levels of post-secondary education can do so comfortably in Pikangikum or in First Nations' operated schools off-reserve in areas such as Pelican Falls and Thunder Bay should this be in the best interests of the student.
64. The Pikangikum Education Authority retaining expertise available from the provincial Ministry of Education, should consider developing an e-learning program at the secondary school level. The community may also wish to utilize the expertise of the Keewaytinook Internet High School in developing an e-learning program.
65. The Pikangikum Education Authority should liaise with the Pikangikum Health Authority for the purposes of providing a public health nurse in the school to assist with such issues as solvent abuse and sexual and reproductive health. The public health nurse should be readily available to the youth and deliver the services through offices in the school. Funding may be

available for this via a community health nurse provided by the Health Canada, Community Primary Care.

66. The Pikangikum Education Authority should consider developing a Day Nursery attached to the school and complying with the requirements of the Day Nurseries Act, R.S.O 1990 in providing for child care services to the community and for students of the school.
67. The Pikangikum Education Authority should consider developing and implementing a full-day kindergarten program.
68. Given the extraordinary level of solvent abuse and its consequent neurocognitive damage and the probable high presence of Foetal Alcohol Spectrum Disorder (FASD) in the community, the Pikangikum Education Authority should aggressively pursue funding and the development of programs for special education needs. In particular, screening for FASD and testing for solvent abusing children and youth should be conducted for those “at risk”.
69. Remuneration for teachers at the Pikangikum School should follow the provincial salary grids. A pension plan should also be made available to the teachers. If possible, this should occur through the Ontario Teacher’s Pension Plan. Professional development support should be identified and accessioned for the teachers, through the provincial Ministry of Education.

### **Federal Government, Indian and Northern Affairs Canada (INAC)**

70. Funding for First Nations education should be provided by INAC at a level comparable to that provided to other children and youth being educated in the province of Ontario.
71. INAC should fulfill its commitment to build a new school in Pikangikum as soon as possible. The school should be built to;
  - accommodate all children currently of school age and projected into the future,
  - include children’s playgrounds, soccer fields, baseball diamonds, and basketball courts,
  - include an auditorium where community members can gather for traditional and cultural community events, and
  - include a daycare facility.
72. INAC should fund:
  - A public health nurse in the school at Pikangikum.
  - A Day Nursery attached to the school to provide early childhood education.
  - The special education needs of the children and youth of Pikangikum. This should include general screening for Foetal Alcohol Spectrum Disorder (FASD), with plans to support both these needy children and those suffering with solvent abuse in their educational pursuits. This presents a potential link with the Foetal Alcohol Spectrum Disorder Initiative offered by Health Canada, First Nations and Inuit Health Branch.

### **Federal Government, Province of Ontario, and the Chiefs of Ontario**

73. The federal government, Indian and Northern Affairs Canada, the Chiefs of Ontario and political First Nations organizations such as the Nishnawbe Aski Nation, and the Province of Ontario, Ministry of Education, Aboriginal Education Office should convene a meeting to begin a dialogue about the transfer of the delivery of education to First Nations children and youth living on-reserve residing in Ontario from federal to provincial jurisdiction. This in no way should be construed as an effort to negate the constitutional and treaty obligations of the federal government with respect to funding First Nations education, but rather, using the established resources and expertise of the provincial government, redirects the focus on planning, execution, delivery and outcomes for First Nations youth residing in Ontario, in essence, the quality of education provided to First Nations children and youth in the province.

## **Nishnawbe Aski Nation**

74. The First Nations communities in the Nishnawbe Aski Nation should consider developing a First Nation School Board for the North. This might be created by liaising with NAN and other stakeholders such as Northern Nishnawbe Education Council (NNEC), the provincial Ministry of Education, and ensuring First Nation representation by inviting elected membership from each of the Tribal Councils. The Board might wish to set as some of its many goals, enhanced student achievement, models for the effective stewardship of resources, and delivery of education uniquely First Nations respecting culture and tradition.

### **Theme: Policing**

#### **Pikangikum First Nation, Chief and Council**

75. The Pikangikum First Nation should consider developing a Pikangikum Police Board, to interface between the police service and the community. The Board should be comprised of elders and community appointees, with the Chief as Chair.
76. When developing its terms of reference, the Board should ensure that the elected members of the local First Nation, such as the Council have representation on the Board through the Chief, and:
- Do not attempt to influence or interfere with the expertise of the police in carrying out their day-to-day policing duties,
  - Develop a process whereby community members can voice their concerns to the Board, who would then investigate and attempt to resolve the matter.

### **Theme: Child Welfare**

#### **Tikinagan Child and Family Services**

77. The Tikinagan Child and Family Services should establish, as one of its priorities, the recruitment, training and retention of qualified staff (frontline, administrative and management) to assist in the provision of services, compliance with provincial standards and the protection of children within its catchment area, particularly in Pikangikum.
78. The Tikinagan Child and Family Services should be supported by the Ministry of Children and Youth Services (MCYS) in its attempts to recruit, train and retain qualified staff to perform child protection duties.
79. The child welfare capacities of staff should be enhanced through orientation, ongoing training and supervision. Benchmarks should be established for caseloads, required documentation and timelines, and audited for compliance.
80. Staff of Tikinagan Child and Family Services in Pikangikum should have access to an office, telephones and computers, including the software and capabilities required to complete standardized child protection documentation when working in Pikangikum and like remote communities.
81. In addition to basic child protection training, staff members should be offered specific training in topics such as Foetal Alcohol Spectrum Disorder, Suicide Prevention, Solvent Abuse and Engaging Families and Communities.
82. Tikinagan and Nodin Child and Family Intervention Services should be stakeholders in the development of Pikangikum's Community Suicide Prevention Program.
83. Tikinagan has identified that in some cases, more intrusive action is required and its own recommendation is supported: "... Pikangikum First Nation Chief and Council should pledge to support Tikinagan's protection mandate by recognizing that removing children from their families and community may save children's lives." Ways and means of addressing the financial hardship arising from the loss of the Child Tax Credit for children no longer in the care of the family should be considered and addressed to ensure that the best interests of the child are being met.



84. Tikinagan should endeavour to maximally utilize its membership in the Ontario Association of Children's Aid Societies (OACAS) to allow its staff access to the resources and training provided by the OACAS.

### **Ministry of Children and Youth Services**

85. It is recommended that the Ministry of Children and Youth Services establish a fund for the documentation, development and implementation of Anishnabek child welfare laws, similar to the fund established by a previous Minister in 2007, and that the fund be made available through the office of the Chiefs of Ontario.
86. The Ministry of Children and Youth Services should implement the recommendations contained in the Northern Remoteness Study on behalf of Tikinagan, Payukotayno and other northern agencies. In the alternative, if the MCYS can not endorse and comply with the recommendations of the Northern Remoteness Study, it should undertake its own review of the costs associated with the provision of child welfare services in the north of Ontario. This review could be undertaken as a component of the current Commission to Promote Sustainable Child Welfare. It should accurately reflect upon the cost of providing service to remote and fly-in First Nations communities, and the significant and substantive challenges that providing child welfare services to First Nations encompasses. It should ensure that children's aid societies providing service to First Nations communities have unique and adequate funding to provide that service to provincial standards, or as closely approximating the level of service provided in other jurisdictions in Ontario as is reasonably possible.
87. The Ministry of Children and Youth Services should establish for each region an extraordinary cost fund and guidelines for distribution of those funds.

### **Theme: Social Determinants of Health**

#### **Pikangikum First Nation**

88. The Pikangikum First Nation should develop a housing authority.
89. The Pikangikum Housing Authority should conduct a study of existing homes and repair needs, as well as completing a housing status strategic study to understand the community's projected needs for the future, based on population growth. An external consultant to assist with the study should be retained.

#### **Indian and Northern Affairs Canada (INAC)**

90. INAC and the Pikangikum First Nation should complete its earlier project to connect the First Nation to the hydro grid. Funding for this initiative should be provided by INAC.
91. INAC and the Pikangikum First Nation should review the current water treatment system and identify the need for any upgrades to ensure that Pikangikum has access to safe healthy potable water, immediately and in the future. Funding for the projected improvements to the water treatment system should be provided by INAC.
92. INAC should be a stakeholder in the housing status strategic study (see recommendation #89) and plan for the building and upgrading of sufficient housing units to address the critical housing shortage and overcrowding that exists in the Pikangikum First Nation. It is the belief of the current Chief and Council that to effectively alleviate overcrowding, 50 new homes are required.
93. INAC and the Pikangikum First Nation should review the sewage disposal system and identify the needs for any upgrades to ensure that Pikangikum has a safe healthy sewage disposal system in the future; one which will not compromise the First Nations drinking water supply. Funding for the projected improvements to the sewage disposal system should be provided by INAC.

94. INAC and the Pikangikum Housing Authority should ensure that all homes built in the future are connected to water for indoor plumbing, and the sewage disposal lagoon. In addition, the Pikangikum Housing Authority should study and determine which homes could be retrofitted to allow for indoor plumbing and sewage. Funding for the projected improvements to the homes which could be retrofitted for indoor plumbing and sewage disposal should be provided by INAC.

### **Federal Government**

95. The Federal Government, Indian and Northern Affairs Canada should develop an antipoverty strategy for Aboriginal people, particularly focusing on those living in remote and isolated First Nations reserves such as Pikangikum. This strategy could be modelled after provincial strategies such as Ontario's Poverty Reduction Act, 2009 or Nova Scotia's Poverty Reduction Strategy.

96. The Government of Canada, Indian and Northern Affairs Canada should support the Pikangikum First Nation's Whitefeather Forestry Project.

### **Pikangikum First Nation**

97. The Pikangikum First Nation should undertake a review of its electoral policy and practices and consider adopting an electoral process whereby elected officials retain office for a sustained period of time to allow for the growth of political expertise, stability, and to allow for momentum to be obtained with respect to projects directed toward enhancing community infrastructure. The First Nation might benefit from formalizing, in writing, and communicating its electoral process to its constituents. The First Nation could retain expertise for assistance from political organizations such as the Nishnawbe Aski Nation who would be aware of "best practices" with respect to First Nations' governance. Consultation and assistance from the National Centre For First Nations Governance Institute should be obtained.

98. The Pikangikum Housing Authority should clearly identify its future land needs as a product of its study (see recommendation #89) and with the assistance of Indian and Northern Affairs Canada, obtain reserve lands to allow for sustained population growth in its membership.

### **Government of Ontario and Federal Government**

99. A Committee should be struck called the Pikangikum Steering Committee:

- Joint chairs should be named from a Provincial Ministry and the Federal Health Canada, First Nations and Inuit Health Branch.
- The Province of Ontario should have inter-ministerial representation at the Assistant Deputy Minister level from the Ministries of Health and Long-Term Care, Aboriginal Affairs, Children and Youth Services, Community Safety and Correctional Service, Health Promotion and Sport, and Education.
- The Pikangikum First Nation should be represented on the Committee by the Chief, Deputy Chief, a youth leader and an Elder.
- Federal Government representatives on the Committee should include Indian and Northern Affairs Canada, and Health Canada, First Nations and Inuit Health Branch.
- Invited members might include the North West Local Health Integration Network, the Sioux Lookout and First Nations Health Authority, the Nishnawbe Aski Nation the Sioux Lookout Meno-Ya-Win Health Centre, Nodin Child and Family Intervention Services, Tikinagan Child and Family Services, the Ontario Provincial Police; the Ontario Child and Youth Telepsychiatry Program, and a paediatric and adolescent psychiatrist providing services in the North West of Ontario.

- The purpose of the Pikangikum Steering Committee would be to advance the recommendations included in this report.

100. The context for change in Pikangikum should include:

- A dialogue with Elders, Chief and Band Council members, and selected community members about any recommendations stemming from the Report.
- Elders, Chief and Band Council members and selected community members should lead any initiative to encourage and facilitate change in Pikangikum First Nation.
- Mechanisms to support and bolster leadership in the change initiative need to be put in place.
- Given the historical and current context, the Pikangikum community, government, and all other involved parties should anticipate a long-standing change process. The duration of the intervention, in order to maximize outcomes, needs to span a decade.



## BIBLIOGRAPHY

1. Horizons of Hope: An Empowering Journey. Youth Forum, Final Report, Nishnawbe-Aski Nation Youth Forum on Suicide, 1996, p. 257.
2. MAA Strategic Course of Action: Desired Outcomes, June 2008.
3. Shkylnik, Anastasia, M., A Poison Greater than Love: The Destruction of an Ojibway Community, Yale University Press, 1985.
4. McRobert, David, Book Review, A Poison Greater than Love: The Destruction of an Ojibway Community, Akwekon Journal, 1985.
5. [http://en.wikipedia.org/wiki/Pikangikum\\_First\\_Nation](http://en.wikipedia.org/wiki/Pikangikum_First_Nation)
6. <http://www.nan.on.ca>.
7. <http://www.merriam-webster.com/dictionary/suicide>
8. <http://www40.statcan.gc.ca/101/cst01/perhth66a-eng.htm>
9. Ontario's New Approach to Aboriginal Affairs; Prosperous and Healthy Aboriginal Communities Create a Better Future for Aboriginal Children and Youth, Ontario Native Affairs Secretariat.
10. World Health Organization, Constitution of the World Health Organization, Geneva Switzerland: World Health Organization; 1978 Available from [www.searo.who.int/EN/Section898/Section1441.htm](http://www.searo.who.int/EN/Section898/Section1441.htm).
11. Macaulay, Ann. C., Improving Aboriginal Health. How can health professionals contribute? Canadian Family Physician, Vol. 55: April 2009.
12. Indian and Northern Affairs Canada [website] Ottawa, ON: Indian and Northern Affairs Canada; 2009. Available from: [www.ainc-ainc.gc.ca/index-eng.asp](http://www.ainc-ainc.gc.ca/index-eng.asp).
13. Dunning, R.W., Social and Economic Changes among the Northern Ojibwa, University of Toronto Press, 1959.
14. Kirmayer, J.K., et al, Suicide Among Aboriginal People in Canada, Aboriginal Healing Foundation, 2007.
15. <http://www.merriam-webster.com/dictionary/suicide>
16. [http://en.wikipedia.org/wiki/Pikangikum\\_First\\_Nation](http://en.wikipedia.org/wiki/Pikangikum_First_Nation)
17. Kostenuik, M., et al., Approach to adolescent suicide prevention, Canadian Family Physician, Vol. 56, August 2010.
18. Canadian Taskforce on Preventative Health Care. Prevention of Suicide. London, ON. Canadian Task Force of Preventative Health Care; 2003.
19. Gould MS., et al, Time-space clustering of teenage suicide. Am J Epidemiology 1990;131(1).
20. Friedman RA., Uncovering an epidemic-screening for mental illness in teens. N Engl J Med 2006;355(26).
21. <http://www40.statcan.gc.ca/101/cst01/perhth66a-eng.htm>.
22. Hettinga, P., et al, Acting on What We Know: Preventing Youth Suicide in First Nations, Health Canada, 2003.
23. Horizons of Hope: An Empowering Journey. Youth Forum, Final Report, Nishnawbe-Aski Nation Youth Forum on Suicide, 1996.
24. <http://www.fin.gov.on.ca/en/economy/ecupdates/factsheet.html>.
25. Chandler MJ., Lalonde, C., Cultural Continuity as a Hedge Against Suicide in Canada's First Nations.
26. Kirmayer, LJ., et al, Suicide Among Aboriginal People in Canada, The Aboriginal Healing Foundation, 2007.

27. Personal conversation, Police Chief Rick Angecone, Lac Seul First Nations, October 14, 2010.
28. Smylie, J. et al, Indigenous Children's Health Report: Health Assessment in Action, p. 35.
29. Sioux Lookout First Nations Health Authority, Annual Report, 2008-2009.
30. <http://www.tikinagan.org>
31. <http://www.oacas.org>
32. Tikinagan Child and Family Services Annual Report 2009-2010.
33. Notes from meetings with Tikinagan Staff members, March 2010.
34. A Society Internal Child Death Review 2010.
35. Sioux Lookout Meno-Ya-Win Health Centre; A backgrounder, First Nations Services, July 23, 2004.
36. Meno Ya Win Health Centre, Research Compilation, 2007-2009.
37. [www.google.ca/search?hl=en&source=hp&q=lake+of+the+woods+district+hospital&meta=&aq=1&aql=g10&aql=&oq=lake+of+the+w&gs\\_rfai=](http://www.google.ca/search?hl=en&source=hp&q=lake+of+the+woods+district+hospital&meta=&aq=1&aql=g10&aql=&oq=lake+of+the+w&gs_rfai=)
38. [www.tbrhsc.net/programs\\_&\\_services/mental\\_health.asp](http://www.tbrhsc.net/programs_&_services/mental_health.asp).
39. Ontario Provincial Police Policing in Remote First Nations Communities, OPP submission to the Paediatric Death Review Committee, Pikangikum Youth Suicide Review, October 2010.
40. Project Journey, A model Program for Developing and Engaging Aboriginal Youth, A proposal to reduce crime in Aboriginal Communities.
41. Sound Foundations for the Road Ahead, 2009. Ministry of Education, [www.edu.gov.on.ca](http://www.edu.gov.on.ca), p. 13.
42. Ontario First Nation, Metis, and Inuit Education Policy and Framework, Aboriginal Education Office, Ministry of Education, 2007, [www.edu.gov.on.ca](http://www.edu.gov.on.ca).
43. [En.wikipedia.org/wiki/Aboriginal\\_peoples\\_in\\_Canada](http://en.wikipedia.org/wiki/Aboriginal_peoples_in_Canada).
44. The Day Nurseries Act, R.S.O. 1990.
45. [www.peterballantyne.ca/health.html](http://www.peterballantyne.ca/health.html).
46. First Nations and Inuit Health Program Compendium, Health Canada, March 2007.
47. [www.wawataynews.ca/node/12374](http://www.wawataynews.ca/node/12374)
48. Macfadden, L., Pikangikum First Nation, Land Based Traditional Healing Program Proposal, 1997/98, submitted to Health Canada, Medical Services Branch, Ontario Region, December, 1997.
49. Macfadden, L., Letter to Chief Paddy Peters and Council Members, June 17, 1998.
50. Mental Health Act, R.S.O. 1990.
51. Brown, Ian. Main Problems in Aboriginal Mental Health, [www.niichro.com/mental%health/men\\_2.html](http://www.niichro.com/mental%health/men_2.html).
52. Integrated Health Services Plan, North West LHIN, 2010-2013.
53. Leading Health System Transformation in Our Communities, 2010-2013 North West LHIN Strategic Directions, June 2010, North West LHIN.
54. Aboriginal Health Programs and Services Inventory, North West LHIN, June 2010.
55. Kirmayer, L. et al, Suicide among Aboriginal People in Canada, The Aboriginal Healing Foundation, 2007.
56. Davidson L., Suicide clusters in youth. In: Pfeffer CR, ed. Suicide among youth; perspectives on risk and prevention. Washington DC: American Psychiatric Press, 1989:83-99.
57. Hazell, P., Adolescent suicide clusters: Evidence, mechanisms and prevention, Australian and New Zealand Journal of Psychiatry 1993;27: 653-665.
58. Macfadden, Lachie, Pikangikum Youth Conference 2008, April 6, p. 2.

59. Links, P. Ending the Darkness of suicide [editorial] *Can J Psychiatry* 2006; 51;(3):129-130.
60. Dervic, K, et al, Completed suicide in Childhood, *Psychiatr Clin North Am* (2008), p. 282.
61. McGarvey, E. et al, Adolescent inhalant abuser: environments of use. *Am J Drug Alcohol Abuse* 1999;25:731-41.
62. Howard, M. et al, Inhalant use among urban American Indian Youth. *Addiction* 1999;94:83-95.
63. Dinwiddie, S.H., Abuse of inhalants; a review. *Addiction* 1994; 89:925-39.
64. Weir, E., Public Health; Inhalation use and addiction in Canada, *CMAJ*, Feb. 6, 2001;164(3).
65. North West Local Health Integration Network, Integrated Health Services Plan, 2010-2013.
66. Acting On What We Know: Preventing Youth Suicide in First Nations. The Report of the Advisory Group on Suicide Prevention.
67. Youth volatile solvent abuse, Canadian Centre on Substance Abuse.
68. Dell, A.D. et al., Resiliency and Holistic Inhalant Abuse Treatment, *Journal of Aboriginal Health*, March 2005, p. 8.
69. Personal communication, Superintendent Brad Blair, OPP, October 2010.
70. Brock. S.E., Suicide postvention. May 2003 Paper presented at the DODEA Safe School Seminar.
71. Program Compendium, Health Canada, First Nations and Inuit Health, March 2007.
72. Balster, R.L., et al, Classification of abused inhalants, *Addiction*, 104, 878-882.
73. Inhalant abuse, First Nations and Inuit Health Committee, Canadian Paediatric Society, [www.cps.ca/english/statements/II/ii97-01.htm](http://www.cps.ca/english/statements/II/ii97-01.htm).
74. Inhalants. National Inhalant Prevention Coalition, [www.inhalants.org/guidelines.htm](http://www.inhalants.org/guidelines.htm).
75. Fidler, B.J., Pikangikum First Nation Report on the Increase in Suicidal Behaviour in 2000, Nodin Counselling Services, November 29, 2000.
76. Looking for Something to Look Forward to...: A Five-Year Retrospective Review of Child and Youth Suicide in B.C. Child Death Review Unit, BC Coroners Service, 2008.
77. Suicide and Prevention, An Overview, Dr. Paul Links, Arthur Sommer Rotenberg Chair in Suicide Studies, delivered October 28, 2010, Annual Educational Course for Coroners and Pathologists.
78. Ministry of Aboriginal Affairs.
79. The Constitution Act, 1867.
80. The James Bay Treaty No. 9, (made in 1905 and 1906) and adhesions made in 1929 and 1930.
81. [www.google.ca/search?hl=en&source=hp&q=acculturation+definition&meta=&aq=1&aqi=g10&aql=&oq=accult&gs\\_rfai=](http://www.google.ca/search?hl=en&source=hp&q=acculturation+definition&meta=&aq=1&aqi=g10&aql=&oq=accult&gs_rfai=).
82. <http://www.answers.com/topic/colonization>.
83. [http://en.wikipedia.org/wiki/Social\\_determinants\\_of\\_health](http://en.wikipedia.org/wiki/Social_determinants_of_health).
84. <http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php>.
85. Raphael, D., *Social Determinants of Health: Canadian Perspectives*, 2nd edition, Canadian Scholars' Press, 2009.
86. Mikkonen, J., and Raphael, D. (2010) *Social Determinants of Health: The Canadian Facts*. Toronto: York University School of Health Policy and Management, [www.thecanadianfacts.org](http://www.thecanadianfacts.org).
87. [www.cbc.ca/canada/story/2007/07/24/school-fire.html](http://www.cbc.ca/canada/story/2007/07/24/school-fire.html).
88. 2010 draft resolution, <http://www.cfuw.org/resolutions.aspx>.
89. [www.nnec.on.ca](http://www.nnec.on.ca).

90. [www.nnec.on.ca/adminstration](http://www.nnec.on.ca/adminstration).
91. The Toronto Sun, November 7, 2010.
92. Goyette, Linda, Still Waiting, Canadian Geographic, December 2010, p. 48.
93. Berens, William as told to A Irving Hollowell. Memories and Dreams of an Ojibwe Leader. Edited introduction by Jennifer S.H. Brown and Susan Elaine Gray. Rupert's land Society, 10 McGill-Queen's University Press, Montreal and Kingston, 2009.
94. Brubacher, Maurice. Coming Home, The Story of Tikinagan Child and Family Services. Sioux Lookout, Tikinagan Child and Family Services, 2006.
95. Canada. Health Canada, First Nations and Inuit Health Branch, Ontario Region. Drug Utilization Reports, 2007-08. Ottawa.
96. Canada. Memorandum of Agreement Respecting Welfare Programs for Indians. Ottawa, 1965.
97. Dunning, R.W., Social and Economic Change Among the Northern Ojibwa. University of Toronto Press, Toronto, 1959.
98. Frideres, James with Lilianne Ernestine Krosenbrink-Gelissen. Native Peoples in Canada, Contemporary Conflicts, 4th edition, Scarborough, Ont. Prentice Hall Canada Inc., 1993.
99. Hollowell, A.I., Culture and Experience, Waveland Press Inc., Prospect Heights, Illinois, 1955.
100. Hollowell, A.I. Selected Papers of A. Irving Hollowell, 1892-1974, Contributions to Anthropology, University of Chicago Press, 1976.
101. Kieran, Sheila, The Family Matters, two centuries of family law and life in Ontario. Key Porter Books, Toronto, 1986, p. 73.
102. Ontario, Ministry of Children and Youth Services. Reporting Child Abuse and Neglect, It's Your Duty. Toronto, 2005.
103. Ontario, Ministry of Children and Youth Services. 2009/10 Q2 YTD Summary, Northwestern Ontario Region.
104. Ontario. Report of the Ontario Legal Aid Review, Volume 2, A Blueprint for Publicly Funded Legal Services. Auger, D., Legal Aid, Aboriginal People, and the Legal Problems faced by Persons of Aboriginal Descent in Northern Ontario. Toronto, 1997, at pp. 397-438.
105. Ontario Association of Children's Aid Societies (OACAS). Barnes Management Group Inc. Northern Remoteness: Study and Analysis of Child Welfare Funding Model Implications on Two First Nations Agencies. Tikinagan Child and Family Services and Payukotayno James Bay and Hudson Bay Family Services. December, 2006.
106. Ontario Association of Children's Aid Societies (OACAS). Child in Care Fact Sheets. Toronto. August, 2009.
107. Ontario Association of Children's Aid Societies (OACAS). Your Children's Aid, Child Welfare Report 2009/10. Toronto. April, 2010.
108. Social determinants and Indigenous health: The International experience and its policy implications. Report on the International Symposium on Social Determinants of Indigenous Health Adelaide, 29-30 April 2007 for the Commission on the Social Determinants of Health (CSDH).
109. [http://en.wikipedia.org/wiki/Social\\_determinants\\_of\\_health](http://en.wikipedia.org/wiki/Social_determinants_of_health).
110. <http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php>.
111. Raphael, D., Social Determinants of Health: Canadian Perspectives, 2nd edition, Canadian Scholars' Press, 2009.
112. Mikkonen, J and Raphael, D., Social Determinants of Health The Canadian Facts. Toronto: York University School of Health Policy and Management, copyright 2010, p. 5. [www.thecanadianfacts.org](http://www.thecanadianfacts.org).



113. [www.rhs-ers.ca/english/ocap.asp](http://www.rhs-ers.ca/english/ocap.asp).
114. Auger, D.J., Stories from Residential School, Nishnawbe Aski Nation and the Aboriginal Healing Foundation, copyright 2005, Nishnawbe Aski Nation.
115. Auger, D.J., Indian Residential Schools in Ontario, Nishnawbe Aski Nation, copyright 2005.
116. [www.nrsss.ca/Resource\\_Centre/PelicanLakeIRS/index.htm](http://www.nrsss.ca/Resource_Centre/PelicanLakeIRS/index.htm).
117. Gage Canadian Dictionary.
118. North South Partnership for Children and the Pikangikum Community, Members and the Pikangikum community Members Participatory Assessment of Pikangikum, February 2008.
119. Loppie, C and Wien, F, Health Inequalities and Social Determinants of Aboriginal Peoples' Health, National Collaborating Centre for Aboriginal Health, 2009.
120. Future Directions for the In-Care Services in a Sustainable Child Welfare System, Working Paper No. 3, December 2010. p.12.
121. Finlay, J. F. and Nagy, A., Pikangikum – Root Causes of Youth Suicide Within a Remote First Nation, (in publication).



## GLOSSARY OF TERMS

**Aboriginal.** The term refers to First Nations (status and non-status), Métis and Inuit people in Canada.

**Aboriginal peoples.** The descendants of the original inhabitants of North America. Section 35(2) of the Constitution Act, 1982, states: "In this Act, Aboriginal peoples of Canada includes the Indian, Inuit, and Metis peoples of Canada." These separate groups have unique heritages, languages, cultural practices, and spiritual beliefs. Their common link is their indigenous ancestry.

**Aboriginal rights.** Rights held by some Aboriginal peoples as a result of their ancestors' use and occupancy of traditional territories before contact with Europeans or before British sovereignty in Canada. Aboriginal rights vary from group to group, depending on what customs, practices, and traditions were integral to the distinctive culture of the group.

**Acculturation.** The modification of the culture of a group or individual as a result of contact with a different culture.

**AFN.** Assembly of First Nations, a national organization representing approximately 700,000 First Nations citizens in Canada. It advocates and supports the diverse goals, rights, aspirations, traditional and spiritual values of First Nations citizens for all generations.

**Band.** Defined by the Indian Act, in part, as "a body of Indians ... for whose use and benefit in common, lands ... have been set apart." Each band has its own governing band council, usually consisting of a chief and several councillors. The members of the band usually share common values, traditions, and practices rooted in their language and ancestral heritage. Today, many bands prefer to be known as First Nations.

**Band council or First Nation council.** The band's governing body. Community members choose the chief and councillors by election, or through traditional custom. The band council's powers vary with each band.

**BFI.** Brighter Futures Initiative of Health Canada, one of four federal funding streams for mental health-related services. BFI supports community-based activities within a community development framework that fosters the well-being of First Nations children, their families and communities.

**BHC.** Building Healthy Communities, another Health Canada initiative which supports the development of specialized, community-based mental health crisis intervention training and services and solvent abuse programming.

**Bullying.** A pattern of repeated aggressive behaviour, with negative intent, directed from one person to another, where there is a power imbalance (Olweus et al., 1999).

**Child.** For the purposes of this report, refers to individuals up to, but not including 19 years of age.

**CICH.** Canadian Institute of Child Health, a national organization dedicated to improving the health status of Canadian children and youth.

**Closed case.** A case in which the coroner has completed the investigation into a death.

**Colonization.** Extension of political and economic control over an area by a state whose nationals have occupied the area and usually possess organizational or technological superiority over the native population. It may consist simply in a migration of nationals to the territory, or it may be the formal assumption of control over the territory by military or civil representatives of the dominant power.

**Deliberate self-harm.** The deliberate damage of one's own body without suicidal intent.

**Elder.** A man or woman whose wisdom about spirituality, culture, and life is recognized and affirmed by the community. Not all Elders are "old." Sometimes the spirit of the Creator chooses to imbue a young Aboriginal person. The Aboriginal community and individuals will normally seek the advice and assistance of Elders in various areas of traditional, as well as contemporary issues.

**Family dysfunction.** The consequence of a social practice or behaviour pattern (such as abuse or neglect) that undermines the stability of the family unit.

**First Nation.** Entities formerly referred to and legally recognized in the federal Indian Act as "bands." Section 35 of the Canadian Constitution (1982) protects the existing Aboriginal and treaty rights of First Nations and two other distinct groups of Aboriginal peoples, Inuit and Metis.

**First Nation Education Authority.** A First Nation Education Authority is comparable to a board of education. Most First Nations have an Education Authority, which is responsible for administering education for the community. It is responsible for hiring teachers and principals working in the community school(s), determines the curriculum to be used in the school(s), and negotiates tuition agreements with local provincially funded school boards when students have to leave the First Nation community to continue their elementary and/or secondary education.

**First Nation governance.** Refers to negotiated arrangements that enable First Nations to exercise greater decision- and law-making authority than is currently possible under the Indian Act. (The Canadian government refers to this process as "self-government.") In Ontario, the governance arrangements that are being negotiated by Canada with First Nations will not be treaties; will not create new rights, such as hunting and fishing rights; and will not expand the reserve land bases of First Nations.

**FNIHB.** First Nations and Inuit Health Branch of Health Canada (formerly Medical Services Branch), which works with First Nations and Inuit people to improve and maintain the health of First Nations and Inuit peoples.

**IAPH.** Institute for Aboriginal Peoples' Health, a branch of the Canadian Institutes of Health Research (CIHR), a federal agency responsible for funding health research in Canada.

**Indian.** A term that may have different meanings depending on context. Under the Indian Act, it means "a person who pursuant to this Act is registered as an Indian or is entitled to be registered

as an Indian.” A number of terms include the word "Indian,” such as "Status Indian,” "Non-status Indian,” and "Treaty Indian." Status Indians are those who are registered as Indians under the Indian Act, although some would include those who, although not registered, are entitled to be registered. Non-status Indians are those who lost their status or whose ancestors were never registered or lost their status under former or current provisions of the Indian Act. Treaty Indians are those members of a community whose ancestors signed a treaty with the Crown and as a result are entitled to treaty benefits. The term "Indian" was first used by Christopher Columbus in 1492, believing he had reached India.

**Indian Act.** Federal legislation that regulates Indians and reserves and sets out certain federal government powers and responsibilities towards First Nations and their reserved lands. The first Indian Act was passed in 1876, although there were a number of pre- and post-Confederation enactments with respect to Indians and reserves prior to 1876. Since then, the act has undergone numerous amendments, revisions, and re-enactments. The Department of Indian Affairs and Northern Development administers the act.

**Inuit.** Aboriginal people in northern Canada, living mainly in Nunavut, the Northwest Territories, northern Quebec, and Labrador. Ontario has a very small Inuit population. The Inuit are not covered by the Indian Act. The federal government has entered into several major land claim settlements with the Inuit.

**Marginalization.** To relegate or confine to a lower or outer limit or edge, as of social standing.

**Mental health problems.** A significant impairment of an individual's cognitive, affective and/or relational abilities that may be recognized as a medically diagnosable disorder.

**Mental health promotion.** Focuses on enabling and achieving positive mental health at the population level, by building competencies, resources and strengths and addressing the broader determinants of mental health. (Mental health promotion is not the same as the prevention of mental illness, which aims to reduce the incidence, prevalence or seriousness of specific disorders and problems) (Balfour, 2007).

**Métis people.** People of mixed First Nation and European ancestry. The Métis history and culture draws on diverse ancestral origins, such as Scottish, Irish, French, Ojibwa, and Cree.

**Modifiable risk factors.** Risk factors that can potentially be removed or alleviated through intervention, thereby reducing the probability of injury, disease or death.

**NANO.** National Aboriginal Health Organization, a national Aboriginal designed and controlled organization dedicated to improving the physical, social, mental, emotional, and spiritual health of Aboriginal Peoples.

**NIHB.** Non-insured Health Benefits, a third mental-health related program provided to First Nations through Health Canada. In addition to pharmaceuticals, medical supplies and equipment, dental and vision care and medical transportation, NIHB funding covers some professional mental health treatment and crisis intervention counselling.

**NNADAP.** The National Native Alcohol and Drug Abuse Program, a fourth mental health related program of Health Canada which supports community-based workers and First Nations-managed culturally appropriate treatment for alcohol and other substance abuse.

**Non-modifiable risk factors:** Risk factors that cannot be changed, including age, biological sex, Aboriginal ancestry and sexual orientation.

**Open case.** A case in which the coroner is still investigating a death.

**Parasuicide.** An act of nonfatal outcome, in which an individual initiates a nonhabitual behaviour that, without intervention by others, will cause self-harm, or ingests a substance in excess of the prescribed or generally recognized therapeutic dosage, and which is aimed at realizing changes which he/she desired via the actual or expected physical consequences.

**Postvention.** A range of activities following a youth suicide, designed to provide support for survivors and prevent suicide contagion and imitative suicidal behaviour (Dafoe & Monk, 2005).

**RCAP.** The Royal Commission on Aboriginal Peoples, which conducted an extensive commission of inquiry on Aboriginal issues across Canada and produced several volumes of research, culminating in a final, five-volume report in 1996.

**Reserve.** Lands set aside by the federal government for the use and benefit of a specific band or First Nation. The Indian Act provides that this land cannot be owned by individual band or First Nation members.

**SPAG.** The Suicide Prevention Advisory Group, a panel of eight Aboriginal and non-Aboriginal researchers and health practitioners appointed in 2001 by the National Chief of the Assembly of First Nations and the Hon. Allan Rock, former Minister of Health, to make recommendations regarding the prevention of suicide among First Nations youth.

**Substance use/abuse.** The use or misuse of substances such as alcohol and drugs (both legal and illegal).

**Suicide.** The Office of the Chief Coroner classifies a death as suicide if it results from an intentional act of a person knowing the probable consequence of what he/she is about to do, that is, the commission or omission of an act that results in his/her own death. A dictionary definition is: The act or an instance of taking one's own life voluntarily and intentionally especially by a person of years of discretion and of sound mind.

**Suicide attempt.** A self-inflicted, non-accidental injury that does not result in death.

**Suicidal behaviour.** Suicidal ideation, threats and/or suicide attempts.

**Suicidal ideation.** Thoughts of suicidal acts involving oneself.

**Traditional lands.** Lands used and occupied by First Nations before European contact or the assertion of British sovereignty.

**Treaty.** A formal agreement between the Crown and Aboriginal peoples.

**Treaty rights.** Rights specified in a treaty. Rights to hunt and fish in traditional territory and to use and occupy reserves are typical treaty rights. This concept can have different meanings depending on the context and perspective of the user.

**Tribal council.** A body that typically represents a group of First Nations to facilitate the administration and delivery of local services to their members.

**Youth.** For the purposes of this report, refers to individuals over 12, but less than 19 years of age.





## APPENDIX 1. Project Charter



### Youth Suicides in Pikangikum 2006 – 2008 Project Charter

#### Mission

To review the 16 cases of death by suicide in adolescents on the Pikangikum First Nation from 2006 to 2008 and develop recommendations to prevent deaths in similar circumstances in the future. This project seeks to address, in part, recommendation #1 from the Paediatric Death Review Committee Annual Report June 2009 arising from the review of 9 deaths, “It is recommended that some form of community inquiry focusing on Pikangikum be called to examine:

1. The understanding and response of the Chief and Council to conditions in the community, which has led to the high rate of suicide.
2. The role that education, health and other community services could play in preventing the hopelessness, desperation and ultimately, suicide of these young children.
3. The contributions of community members and natural leaders to the development of strategies to prevent youth suicide.
4. The community-wide suicide prevention strategies.
5. The development or results since the Sakanee Inquest into aboriginal youth suicide in 1999.”

#### Scope

1. This review will include all youth who died by suicide.
2. It is anticipated that the youth will be First Nations or Métis youth, but will include any and all youth, irrespective of race.
3. Only deaths occurring in the years 2006-2008 will be included, but deaths occurring in other years may be referenced.
4. The deaths examined will be restricted to those youth no younger than 10 years of age, up to, but not including 19 years of age.
5. The death review will be restricted to deaths occurring in the Pikangikum First Nations Community.
6. The final report of the deaths will be publicly released.

#### Early Consultation

The following individuals provided guidance and/or discussed the development of the overarching approach with the Chair:

1. Grand Chief Stan Beardy, Nishnawbe Aski Nation.
2. Pikangikum First Nation Council and Band, during a meeting with Dr. David Eden, February 2009.
3. Dr. David Eden, former Regional Supervising Coroner, North West Region.
4. Mr. Micheal Hardy, Executive Director, Tikinagan Child and Family Services.
5. Dr. Richard Meen, Child and First Nations psychiatrist, Kinark Child and Family Services.

6. Dr. Paul Links, Arthur Sommer Rotenberg Chair in Suicide Studies, Keenan Research Centre, St. Michael's Hospital, University of Toronto.
7. Ms. Sabrina Squire, RN, providing primary care to First Nation's Communities.
8. Ms. Susan Abell, Child Welfare Consultant and member of the Paediatric Death Review Committee.
9. Dr. Judy Finlay, Associate Professor, School of Child and Youth Care, Ryerson University; Co-Chair, North-South Partnership for Children and former Provincial Advocate for Children and Youth.
10. Mr. Irwin Elman, Provincial Advocate for Children and Youth.
11. Ms. Jeanette Lewis, Executive Director, Ontario Association of Children's Aid Societies.
12. Inspector Brad Blair, Ontario Provincial Police (OPP).
13. Ms. Cathy Paul, Director, Child Welfare Secretariat, Ministry of Children and Youth Services (MCYS).
14. Ms. Catherine Beamish, Sioux Lookout Law Firm – Native Peoples Law.
15. Ms. Lori Sterling, Deputy Minister, Ministry of Aboriginal Affairs.
16. British Columbia Coroners Service, Child Death Review Unit.
17. Chief Jonah Strang and members of Council in meetings that took place March 6 and 7, 2010.

## **Objectives**

### *Phase 1*

Five distinctive review panels each consisting of members with knowledge, experience and/or expertise in a particular field associated with the focus of their respective review panel will be created.

#### Part 1: Trip to Pikangikum First Nations/Sioux Lookout: The Chief, Band, Council and Elder's Panel

1. A meeting with Chief Jonah Strang, Band, Council and Elders was agreed to by Chief Strang on January 18, 2010. The purpose of the meeting is to determine:
  - Their willingness to participate in the review.
  - Their views on why the deaths are occurring.
  - Their recommendations for solutions to prevent deaths in the future.
2. Meet with the principal and teachers providing child and youth education from the primary to the high school level to determine:
  - The health education that is provided to the children and youth with respect to suicide from the vantage of prevention, intervention, and post-intervention.
  - Their views on why the deaths are occurring.
  - Their recommendations for solutions to prevent deaths in the future.
3. Meet with the primary health care team including Mr. Shawn Dookie and Ms. Melanie Turpin, RN's at Pikangikum Health Centre to discuss:
  - The available resources for the provision of mental health services and addiction services for the youth.
  - The role of Health Canada versus MOHLTC in the provision of these services.
  - Strategies utilized from the health care perspective for prevention, intervention, and post-intervention of youth suicide.
  - Their views on why the deaths are occurring.
  - Their recommendations for the solutions to prevent deaths in the future.
4. Meet with Tikinagan Child and Family Services Executive Director Mr. Micheal Hardy to discuss:

- The available resources for the provision of child welfare services including mental health services and addiction services for the children.
  - Strategies utilized from the child welfare perspective for prevention, intervention, and post-intervention of suicide.
  - Their views on why the deaths are occurring.
  - Their recommendations for solutions to prevent deaths in the future.
5. Meet with the North-South Partnership for Children to determine:
- Their willingness to utilize their expertise to assist the project.
  - Their recently completed review of the Pikangikum First Nations Community.
  - Their views on why the deaths are occurring.
  - Their recommendations for solutions to prevent deaths in the future.

The current vision for this portion of the project is a three-day trip to the north, including a one-day stay in Sioux Lookout and two days at Pikangikum. It will include Dr. Bert Lauwers, members of the OPP, Ms. Susan Abell, Ms. Karen Bridgman-Acker, a representative from NAN (appointed by Grand Chief Stan Beardy) and a representative from the North-South Partnership, possibly Ms. Linda Nothing-Chaplin.

#### Part 2: Interview of the Children of Pikangikum by the Child and Youth Advocate's Team:

##### The Children's Panel

The views of the youth of Pikangikum are considered an integral and necessary part of the project and must be properly considered in the final report. For this reason, the Child and Youth Advocate (CYA), whose mandate is to represent the views of youth and advocate of their behalf, was contacted. Utilizing their expertise with respect to youth advocacy, the CYA was asked to investigate the following with respect to a representative group of children from Pikangikum:

- Their views on why the deaths are occurring.
- Their recommendations for the solutions to prevent deaths in the future.
- Any other germane and important representations they wish to make.

The current vision of this portion of the project is that the Child Advocate, Mr. Irwin Elman and/or Ms. Laura Arndt would lead this team.

#### Part 3: Psychiatry, Child Welfare and Coroner's Death Review Panel

1. The Office of the Chief Coroner would utilize its normal investigative tools to acquire the following items for review, where they are available:
  - The Coroner's Investigation Statement.
  - The Post Mortem Examination Report.
  - The Serious Occurrence Report from the Children's Aid Society.
  - The Child Fatality Case Summary Report from the Children's Aid Society.
  - The Internal Review from the Children's Aid Society.
  - The Paediatric Death Review Committee's Report(s) of the death.
  - The medical records of the youth.
  - The educational records of the youth.
  - Police Report of the death.
2. An audit tool will be developed which will capture the demographic characteristics of the youth, their risk factors both modifiable and non-modifiable, and the services which were being provided for the youth. The audit tool will be applied to the documentation

obtained for each file, as in 3.1 above, by the members of the Office of the Chief Coroner:

- Dr. Bert Lauwers,
  - Ms. Karen Bridgman-Acker,
  - Ms. Doris Hildebrandt, and
  - Child Welfare Consultant, Ms. Susan Abell.
3. A summary will be developed for each of the deaths, and this will be appended to the completed audit tool for presentation to the panel.
  
  4. The Psychiatry, Child Welfare and Death Review Panel will consist of the following members:
    - a. Dr. A. E. Lauwers, Deputy Chief Coroner - Investigations, Chair Paediatric Death Review Committee and Chair, Deaths Under Five Committee, Office of the Chief Coroner
    - b. Ms. Doris Hildebrandt, Executive Officer – Investigations, Office of the Chief Coroner
    - c. Ms. Karen Bridgman-Acker, Child Welfare Consultant, Office of the Chief Coroner
    - d. Ms. Susan Abell, Child Welfare Consultant, member of the Paediatric Death Review Committee
    - e. Dr. Paul Links, Arthur Sommer Rotenberg Chair in Suicide Studies, Keenan Research Centre, St. Michael's Hospital
    - f. Dr. Richard Meen, Paediatric Psychiatrist, Kinark Child and Family Services
    - g. Dr. Peter Menzies, Centre for Addiction and Mental Health, Aboriginal Services
    - h. Ms. Sabrina Squire, RN
    - i. Dr. Cornelia Wieman, Department of Public Health Sciences, University of Toronto
  5. The Panel will meet at the Office of the Chief Coroner in Toronto and review each of the deaths, and where appropriate, develop recommendations directed to the avoidance of death in similar circumstances in the future.

#### Part 4: Social Determinants of Adolescent Mental Health: The Social Determinants Panel

1. The Office of the Chief Coroner will engage a consultant to generate a paper dedicated to this topic for inclusion in its report. This report will address the following topics:
  - a. An overview of the understanding of social determinants of health
  - b. A discussion of how this relates to mental health
  - c. What social challenges exist in Pikangikum that reflect on adolescent mental health.
  - d. Recommendations
2. Dr. Judy Finlay, School of Child and Youth Care, Ryerson University, and former Provincial Advocate for Children and Youth has agreed to provide this research paper.
3. The final report will be reviewed and edited by a panel consisting of Dr. Judy Finlay, Dr. Janet Smylie, Dr. Bert Lauwers and Dr. Richard Meen.

#### Part 5: Providing Child Welfare to First Nations: The Child Welfare Panel

1. The Office of the Chief Coroner will engage a consultant to generate a paper dedicated to this topic for inclusion in its report. This report will address the following topics:
  - a. The challenges of providing child welfare service in the north
  - b. The human resource challenges
  - c. The fiscal resource challenges

- d. The approach to providing mental health services to the youth of First Nation's communities from the child welfare perspective
  - e. The integration of child welfare and health care in the provision of service to First Nation Youth around issues of addiction and mental health. Non-existent or seamless?
  - f. Federal and Provincial responsibilities. Who does what?
  - g. Recommendations
2. Dr. Donald Auger, Executive Director of Anishnabek Family Care, will be asked to generate a paper dedicated to this topic for inclusion in the report.
  3. The final report will be reviewed and edited by a panel consisting of Dr. Donald Auger, Dr. Bert Lauwers, Mr. Micheal Hardy, Ms. Jeanette Lewis, Ms. Karen Bridgman-Acker, Ms. Sabrina Squire and Dr. Cornelia Wieman.

### Phase 2

A draft report of the collaborative findings, conclusions and recommendations of each of the 5 review panels will be produced and distributed to Stakeholders for their comments and feedback. Revisions based on the feedback and comments will be distributed and the report will be finalized when a consensus on content is reached by the Stakeholders and review panel members.

The following Stakeholders have been identified:

1. Association of Native Child and Family Service Agencies of Ontario (ANCFSAO)
2. Catherine Beamish, Sioux Lookout Law Firm – Native Peoples Law
3. Dr. Tom Dignan
4. Health Canada
5. Indian and Northern Affairs Canada (INAC)
6. Local Health Integration Network
7. Ministry of Aboriginal Affairs (MAA)
8. Ministry of Children and Youth Services (MCYS)
9. Ministry of Community Safety and Correctional Services (MCSCS)
10. Ministry of Health and Long-Term Care (MOHLTC)
11. Nishnawbe Aski Nation (NAN)
12. Ontario Association of Children's Aid Societies (OACAS)
13. Ontario Provincial Police (OPP)
14. Pikangikum First Nation Band
15. Tikinagan Child and Family Services

### Phase 3

The Chair is responsible for the final report. The final report will be released by the Office of the Chief Coroner to the public and available electronically. It is anticipated that a press conference will take place.

### Project Participants

1. Dr. A. E. Lauwers, Deputy Chief Coroner
2. Ms. Karen Bridgman-Acker, Office of the Chief Coroner
3. Ms. Doris Hildebrandt, Office of the Chief Coroner
4. Ms. Susan Abell, Child Welfare Consultant, Member, Paediatric Death Review Committee
5. Dr. Donald Auger, Anishnabek Family Care
6. Ms. Rowena Cruz, Office of the Chief Coroner
7. Mr. Irwin Elman, Office of the Provincial Advocate for Children and Youth

8. Dr. Judy Finlay, School of Child and Youth Care, Ryerson University
9. Mr. Micheal Hardy, Tikinagan Child and Family Services
10. Ms. Jeanette Lewis, Ontario Association of Children's Aid Societies
11. Dr. Paul Links, Keenan Research Centre, St. Michaels Hospital
12. Dr. Richard Meen, Kinark Child and Family Services
13. Dr. Peter Menzies, Centre for Addiction and Mental Health, Aboriginal Services
14. Ms. Linda Nothing-Chaplin, North-South Partnership for Children
15. Dr. Janet Smylie, Keenan Research Centre, St. Michael's Hospital
16. Ms. Sabrina Squire, RN
17. Dr. Cornelia Wieman, Department of Public Health Sciences, University of Toronto

#### Assumptions

1. All participants will accept direction from the Chair.
2. All participants understand the process and reasoning for the "review panel" approach as opposed to a Coroner's Inquest into the Pikangikum suicide deaths.
3. All participants will provide their individual professional expertise and be willing to compromise where necessary to develop a consensus on recommendations regarding adolescent suicide in the Pikangikum First Nation.
4. The Stakeholders, as listed below, will be receptive to receiving the report and understand its intention.
5. The report will be of value to all First Nation Communities and Public Health agencies across Ontario in providing mental health care to children and youth.
6. The Chair will review and edit all aspects of the final report.

## Benefits

1. The “review panel” process negates the lengthy time scheduling delays (years) and significantly increased cost of a Coroner’s Inquest, which would likely be months in duration.
2. The “review panel” process is not performed in a public forum, therefore, ongoing media scrutiny, public and/or political response would not be divergent factors and would allow participants to remain focused and free to exercise the mandate of the review.
3. The Stakeholders will have a concrete “third party” report to reference when developing Pikangikum First Nation children and youth programs, and specifically, directing resources focused on youth mental health.
4. The report will be a reference source not only for the Stakeholders, but all health providers across Ontario as well as other professional organizations and associations in creating, developing and implementing programs directed at child and adolescent mental health and suicide prevention.
5. The findings and recommendations of the report, if acted upon, may prevent deaths of adolescents and youths in both the Pikangikum First Nation and in similar circumstances in the future.





## APPENDIX 2. Audit Tool

Youth Suicides in Pikangikum 2006 – 2008

Reviewer's Name: \_\_\_\_\_

Date Completed (yyyy\mm\dd): \_\_\_\_\_

### A. Demographic Data

1. OCC File # \_\_\_\_\_

2. Sex: M \_\_\_\_\_ F \_\_\_\_\_ (Circle)

3. Date of Death (yyyy\mm\dd): \_\_\_\_\_

4. Place of Death: (Circle)

a. Indoors I) Home II) Kinship home III) Friend's home

IV) Other \_\_\_\_\_

b. Outdoors(describe): \_\_\_\_\_

5. Age at death: Years \_\_\_\_\_ Months \_\_\_\_\_

6. Medical Cause of Death: \_\_\_\_\_

7. Manner of Death: \_\_\_\_\_

### B. Risk Factor Identification

#### Individual Risk Factors

8. Mental health history: \_\_\_\_\_ (circle) Y N

Depression Eating disorder Anxiety disorder

Psychotic disorder Other: \_\_\_\_\_

9. Previous hospitalization, short-stay, or visit to a health care practitioner or social worker in the month prior to death? Y N

When? \_\_\_\_\_ Reason? \_\_\_\_\_

10. History of threatening self-harm: Y N

When? \_\_\_\_\_ Nature of threat: \_\_\_\_\_

11. History of deliberate self-harming injuries Y N UN

When? \_\_\_\_\_ Nature of harm: \_\_\_\_\_

12. Previous suicide attempts? Y N UN

How many? \_\_\_\_\_ When? \_\_\_\_\_ Nature of attempt: \_\_\_\_\_

13. Substance Abuse: Y N UN

Alcohol Solvent Abuse Marijuana Others: \_\_\_\_\_

14. Substance Abuse at the time of death?

Alcohol Solvent Abuse Marijuana Others: \_\_\_\_\_

15. Current treatment with psychotropic medications? Y N UN

Type \_\_\_\_\_

16. Was there a history of medical problems? Y N UN

List: \_\_\_\_\_

17. Sexual orientation: (circle) hetero bisexual gay/lesbian

#### Familial Risk Factors

18. Family history of suicide completion: (circle)



37. Was the decedent homeless? Y N UN  
Y N UN

Psychological Risk Factors

38. Had there been a recent death of a boyfriend, girlfriend, family member or friend in the month prior to death? Y N UN  
Relationship: \_\_\_\_\_

39. Was the death of this boyfriend, girlfriend, family member or friend due to suicide? Y N NA

40. Had the decedent had a recent romantic break-up? Y N UN

41. Did the decedent have an ongoing conflict within a romantic relationship? Y N UN

C. Child Welfare Involvement

42. Was the file of the decedent or family open to CAS or had the file been open to CAS in the preceding 12 months? Y N

43. Had the file ever been open to CAS? Y N

44. Reasons the file was opened:

\_\_\_\_\_

45. Was the youth's mental health being monitored by the CAS? Y N

Nature of concern being monitored:

\_\_\_\_\_

\_\_\_\_\_

46. Had efforts been made to accession mental health services for the deceased by the CAS? Y N

Describe: \_\_\_\_\_

\_\_\_\_\_

Provide a summary of the death. Include a description of:

The circumstances of the death.

The 5 facts related to death.

The involvement of CAS at the time of death.

Any mental health services which had been provided in the months prior to death.

Any recommendations which arise from your review that may prevent deaths in similar circumstances in the future.

Narrative: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Bibliography

1. Bursztein, C et al, Adolescent Suicide, *Current Opinion in Psychiatry*, 2008, 22:1-6.
2. Waldvogel, JL, Adolescent Suicide: Risk Factors and Prevention Strategies, *Current Problems in Paediatric and Adolescent Health Care*, Volume 38, Issue 4, April 2008.
3. Chandler, MJ and Lalonde, CE. (2008) Cultural Continuity as a Protective Factor against Suicide in First Nations Youth. *Horizons—A Special Issue on Aboriginal Youth, Hope or Heartbreak: Aboriginal Youth and Canada's Future*. 10(1), 68-72.
4. Links, P, Dealing with Risk of Suicide and Depression in Adolescents and Youth, Power Point presentation, May 2009.
5. Acting On What We Know: Preventing Youth Suicide in First Nations, The Report of the Advisory Group on Suicide Prevention, 2003.
6. "Looking for Something to Look Forward To..." A Five-Year Retrospective Review of Child and Youth Suicide in BC, Child Death Review Unit, BC Coroners Service, 2008.

## APPENDIX 3. The Psychiatry, Child Welfare and Death Review Panel Members and Contributing Authors

### *The Psychiatry, Child Welfare and Death Review Panel*



**Dr. Bert Lauwers**

Deputy Chief Coroner – Investigations  
Chair, Paediatric Death Review Committee

Dr. Bert Lauwers is currently the Deputy Chief Coroner-Investigations and Chair of the Paediatric Death Review Committee. Dr. Lauwers is a graduate of the University of Toronto Medical School and has a Fellowship in the College of Family Physicians. He is appointed as an Assistant Clinical Professor in the Faculty of Family Medicine at McMaster University. He is a former president of the Ontario Coroners Association.

In 2006, he became the Regional Supervising Coroner for Toronto-West. In January 2008, he was named the Associate Deputy Chief Coroner. He was appointed Deputy Chief Coroner - Investigations in September 2008 and led the Office of the Chief Coroner's project to develop recommendations to the Inquiry into Paediatric Forensic Pathology (Goudge Inquiry). Dr. Lauwers produces annually, with an executive team, the Report of the Paediatric Death Review Committee and Deaths Under Five Committee. He has conducted dozens of inquests, most recently the Sara Carlin Inquest examining the use of selective serotonin reuptake inhibitors in youths, and the Jeffrey James Inquest, which reviewed the utilization of physical restraints in psychiatric patients.



**Ms. Doris Hildebrandt**

Office of the Chief Coroner

Doris is a graduate of the University of Toronto having majored in Commerce and Finance. She joined the Office of the Chief Coroner in 2002 following an 18-year career in the financial and investment industry. Doris was initiated at the Office of the Chief Coroner in the Pathology Department where she assisted in various administrative and post mortem operations, and ultimately became the first official Forensic Exhibit Technician. Doris was seconded to the Coroner's Office in January of 2006 as the

Administrative Coordinator to the Regional Supervising Coroner, Toronto West. She subsequently held the position of Executive Officer – Investigations from 2007 to 2010, where she was responsible for coordinating the Deaths Under Five Committee as well as performing the executive and medical coordinator duties for the Paediatric Death Review Committee. Doris currently holds the position of Executive Officer – Inquests and Special Projects.



**Ms. Karen Bridgman-Acker, MSW, RSW**  
Child Welfare Specialist  
Office of the Chief Coroner

Karen is a social worker and Child Welfare Specialist at the Office of Chief Coroner for Ontario. She has worked in the child welfare field in various roles for the past 20 years. Karen joined the coroner's office in 2006 where she co-coordinates the child welfare case reviews for the Paediatric Death Review Committee. She is a member of the Deaths Under Five Committee and the Domestic Violence Death Review Committee and is the liaison between child welfare agencies and the Coroners' Offices. She is a co-author of the Paediatric Death Review Committee's Annual Report which is produced, presented and distributed publicly in June of each year.



**Ms. Susan Abell**  
Child Welfare Consultant  
Member of the Paediatric Death Review Committee

Susan has had a private practice providing management expertise and resources to a variety of organizations including a Children's Mental Health Centre, a Community Living Agency, Children's Aid Societies, and other child welfare programs. She has 17 years experience as an Executive Director of organizations serving families and children:

- 1999-2003: Executive Director of the Children's Aid Society of Ottawa
- 1993-99: Executive Director of YOUTHLINK, a Toronto, Ontario, community-based youth serving agency providing mental health, residential and street based services.
- 1986-93: Executive Director of Frontenac Children's Aid Society, Kingston

Since 2003, Susan has been a member of the Ontario Coroner's Office Paediatric Death Review Committee, which reviews child deaths, and in 2005, she served on the Coroner's Domestic Violence Death Review Committee.

Previously, Susan assumed other leadership roles and front line social work positions in child welfare and education.

- 1982-86: Department Head of the Hamilton Children's Aid Society.
- 1973-1982: Co-Coordinator of the Social Service Worker Program, Mohawk College, Hamilton.
- 1966-73: Protection worker, foster care worker and protection supervisor for the Children's Aid of Toronto.

Susan has had experience in serving on community Boards for many years. This has included; St. Lawrence College's Child and Youth Worker Advisory Committee, the United Way/Centraide Canada, United Way Kingston and Ottawa. Currently she is involved with Northumberland County United Way and the Board of Port Hope Community Health Centre. Previously she was chair of the Port Hope Library Board and a Board member at Northumberland Services for Women.



**Dr. Paul Links**

Arthur Sommer Rotenberg Chair in Suicide Studies  
Keenan Research Centre  
St. Michael's Hospital

Dr. Paul Links is the incumbent of the Arthur Sommer Rotenberg Chair in Suicide Studies, University of Toronto, the first Chair in North America dedicated to suicide research, and is a Professor in the Department of Psychiatry, Faculty of Medicine, University of Toronto. Dr. Links is a former President for the Canadian Association for Suicide Prevention (CASP) and President of the Association for Research on Personality Disorders. He is also the Deputy Chief of Psychiatry of the St. Michael's Hospital's Mental Health Service.

Dr. Links is the Editor of the Journal of Personality Disorders. He has published over 100 articles in scientific journals and three books. As an investigator, he has received research grants from many agencies including Health and Welfare Canada, the Ontario Ministry of Health, the Ontario Mental Health Foundation, Canadian Institutes of Health Research and the Workplace Safety and Insurance Board of Ontario. In October 2009, Dr. Links was awarded the CASP Research Award for outstanding contributions to the field of suicide research in Canada.

Dr. Links' clinical experience and expertise developed from working with both acutely suicidal and persistently suicidal individuals (those who face a life-and-death struggle on a daily basis and are at high risk of taking their own lives). He leads an active interdisciplinary group of researchers at the Suicide Studies Unit as Arthur Sommer Rotenberg Chair at St. Michael's Hospital.



**Dr. Richard Meen**

Paediatric Psychiatrist  
Kinark Child and Family Services

Dick Meen, Clinical Director of Kinark Child and Family Services, is a child and adolescent psychiatrist. As Clinical Director, Dick is leading Kinark through Kinark's Clinical Transformation Process. Dick has had an extensive history working within the area of Youth Justice and has a deep commitment to working with First Nations communities.



**Dr. Peter Menzies**

Centre for Addiction and Mental Health, Aboriginal Services

Peter is member of Sagamok Anishnawbek First Nation, and has spent the past ten years building culturally congruent mental health and addiction programs in partnership with both urban, rural and First Nations communities through his work at the Centre for Addiction and Mental Health. He is the organization's first Aboriginal Clinic Head and is responsible for creating the organization's Aboriginal Services Program providing support to communities across Ontario and nationally. Prior to joining CAMH, Peter worked for more than 20 years in a variety of front line and management positions at both Native and mainstream agencies. A skilled therapist and community developer, Peter has experience working with individuals and families in child welfare, family counselling, and income support programs and is a member of the Ontario College of Social Workers and

Social Service Workers. Peter received his undergraduate degree in Social Work from the University of Manitoba. He completed his Master of Social Work studies at Laurentian University and received his PhD from the University of Toronto. His thesis work focused on trauma and intergenerational trauma among First Nations peoples. He is an Assistant Professor at the Psychiatry Department at the University of Toronto. He is also an Adjunct Professor, Faculty of Social Work at Laurentian University. Peter regularly travels throughout northern Ontario providing assessment, capacity building and training support to health care workers in remote communities. His research interests include Aboriginal homelessness, intergenerational trauma, child welfare, suicide prevention, addiction and mental health needs. He has published numerous articles related to Aboriginal health issues and sits on a number of Aboriginal community boards and committees both at the local and national level.



**Ms. Sabrina Squire, RN**

Sabrina Squire graduated from the University of Western Ontario in 2004 with a Bachelor of Science in Nursing with Distinction. She has worked as a Community Health Nurse throughout northern Ontario and Nunavut in First Nations and Inuit communities for three years. Sabrina is a member of the Labrador Métis Nation. As a former Crown Ward of the Department of Child Welfare, Sabrina has a particular affinity for working with and improving the health of at-risk aboriginal youth. Sabrina is currently a first year medical student at the University of Ottawa.



**Dr. Cornelia Wieman**

Department of Public Health Sciences  
University of Toronto

Dr. Cornelia Wieman is Canada's first female Aboriginal psychiatrist. From 1997-2005, she worked at a community mental health clinic based on the Six Nations of the Grand River Territory. She is both Co-Director of the Indigenous Health Research Development Program and Assistant Professor in the Dalla Lana School of Public Health, Faculty of Medicine at the University of Toronto. She is a co-investigator on several initiatives funded through the Canadian Institutes of Health Research (CIHR) – Institute of Aboriginal Peoples Health including the National Network of Aboriginal Mental Health Research (NNAMHR) which she co-directs with Dr. Laurence Kirmayer. In 2007, she was appointed to CIHR's Governing Council. She was a member of the Advisory Group on Suicide Prevention (2002-2003) that developed a framework document for the Assembly of First Nations and First Nations & Inuit Health Branch to address the issue of First Nations youth suicide. From 2002-2005, she served as Deputy Chair of Health Canada's Research Ethics Board and currently serves as Chair of the Drug Utilization Evaluation Advisory Committee, First Nations & Inuit Health Branch. In 2006, she was appointed as a Member of the National Aboriginal Achievement Foundation's Board of Directors. In 2007, she was appointed to the First Nations, Inuit and Métis Advisory Committee, part of the Mental Health Commission of Canada. She was a 1998 recipient of a National Aboriginal Achievement Award, recognizing career achievement in the category of medicine.



## Contributing Authors



**Donald J. Auger**  
Executive Director  
Dilico Anishinabek Family Care

Donald J. Auger is an Anishinabek (Ojibwe) from the Pays Plat First Nation on the north shore of Lake Superior. He was raised in Geraldton and has lived in northern Ontario all of his life. He worked in various health care facilities as an x-ray technician and taught in the x-ray technology at

Cambrian College in Sudbury for ten years. He returned to school on a part time basis and acquired a Bachelor of Arts (B.A.) degree from Laurentian University at Sudbury. Retiring from Cambrian College, he attended at Queen's University, Kingston, where he received a Bachelor of Laws degree (LL.B.). After his call to the Bar of Ontario, Mr. Auger practised law in Thunder Bay, restricting his practice primarily to Aboriginal issues with individuals, corporate entities and First Nations of the Robinson Superior, Treaty # 3, and Nishnawbe Aski (Treaty # 9) areas in northwestern Ontario. Mr. Auger later assisted in the implementation of the Nishnawbe Aski Legal Services Corporation, an innovative, "one-stop shopping centre for legal services," which provided legal, paralegal and legal aid services to the members of the Nishnawbe Aski Nation across northern Ontario. During this period Mr. Auger completed a Master's degree (M.A.) in History at Lakehead University. Leaving the Legal Services Corporation after six years, he returned to full time studies at Osgoode Hall, York University (Faculty of Law) from which he graduated with the degree of Doctor of Jurisprudence (D. Jur.) in 2001. Dr. Auger worked for Nishnawbe Aski Nation in various capacities for about ten years. For the past five years, Dr. Auger has been the Executive Director of Dilico Anishinabek Family Care, a multi-service social services corporation which provides child welfare (Children's Aid Society), mental health, health and addictions programs for Anishinabek people in the City and District of Thunder Bay.



**Judy Finlay, PhD**  
Associate Professor  
School of Child and Youth Care  
Ryerson University  
Co-Chair  
Mamow Sha-way-gi-kay-win:  
North-South Partnership for Children

Judy Finlay, PhD is an Associate Professor, School of Child and Youth Care at Ryerson University. She is also Co-chair and founding member of Mamow Sha-way-gi-kay-win: North-South Partnership for Children and former Liaison for First Nations, Inuit and Métis at the Provincial Centre of Excellence for Child and Youth Mental Health at CHEO.

She is the former Child Advocate for the Province of Ontario (1991 – 2007).



**Irwin Elman**

Provincial Advocate

Office of the Provincial Advocate for Children and Youth

Irwin Elman holds an extensive background as an educator, counsellor, youth worker, program manager, policy developer and child and youth advocate. In working with young people in our ‘systems’, he has carried out these roles with respect – borrowing from the courage and hope of the young people he served to create innovative approaches for youth in Ontario, Jamaica, Hungary, and Japan. For over 20 years, Irwin was the Manager of the Pape Adolescent Resource Centre in Toronto: a program of the Children’s Aid Society of Toronto and the Catholic Children’s Aid

Society of Toronto. Later, he was the Director of Client Service at Central Toronto Youth Services: an innovative children’s mental health centre. As Ontario’s first independent Provincial Advocate for Children and Youth Irwin works to partner with children and the youth in elevating their voices to create positive change. He is building an Office that is built upon a foundation rooted in the strength and wisdom of the children and youth it serves; an Office driven by the efforts of talented and passionate staff who, every day, strive to improve the lives of children and youth in Ontario.



**Deborah Richardson**

Assistant Deputy Minister

Ministry of Aboriginal Affairs

Over the years, Deborah Richardson has been on the forefront of Aboriginal Affairs, spearheading many wide-ranging initiatives benefiting Aboriginal youth, addressing poverty in the Far North and improving social conditions in Aboriginal communities. She obtained her undergraduate degree in Sociology and Law from Carleton University. She completed her Bachelor of Laws at the University of Ottawa and was called to the Bar in 1996. Her

distinguished career began in the finance industry where she worked in business banking before becoming Manager of Diversity for the Royal Bank of Canada.

Her foray into Aboriginal Affairs began as Executive Director of the Native Canadian Centre of Toronto in 1999. She used her financial and operational expertise to build the Centre into one of the strongest Aboriginal organizations in Toronto. Much sought after for her operational experience, she then served as Director of Operations and Aboriginal Business Development for the OI Group of Companies. By 2004, Ms. Richardson was recruited into the public service as Associate Regional Director General for Indian and Northern Affairs Canada. By 2007, she was appointed Regional Director General, leading the federal department's largest regional organization. In 2008, she was recognized as a Top Leader under 40 and selected for the Governor General in Leadership Program. In 2008, Deborah was appointed Assistant Deputy Minister for the Aboriginal Relationships and Ministerial Partnerships division of the new Ontario Ministry of Aboriginal Affairs. In 2011, Deborah and her team won a prestigious public service award for their work in a public-private partnership initiative benefiting Aboriginal youth in the north. Deborah is a proud Mi'kmaq woman with strong ties to her home community of Pabineau First Nation. She lives with her partner Bob, and her daughters Jasmine and Fiona.

## APPENDIX 4. First Nations Regional Longitudinal Health Survey (RHS) 2002/03 and Impact of Health of First Nations Adults and Youth

### Education, Employment and Income

#### Education

When reviewing the age and educational levels of First Nations, it is clear that the elderly and the young are least likely to have attained at least a high school education. In addition, there is a substantial difference between First Nations and the remainder of the Canadian population, intensified for those First Nation adults living on reserve. These tables are taken from the RHS.<sup>198</sup>

Age and education	Age group (years)		
	18-29	30-59	60+
< HS Grad	57.0%	46.1%	70.8%
Completion of post-secondary diplomas and degrees	15.4%	37.1%	19.3%

Picture 16. A table showing the age and education of Adults in First Nations communities (n=10,812)

#### Employment

51% of First Nations are not employed. First Nations employment rates lag behind the Canadian population by 8%. The following was obtained from the RHS.<sup>199</sup>

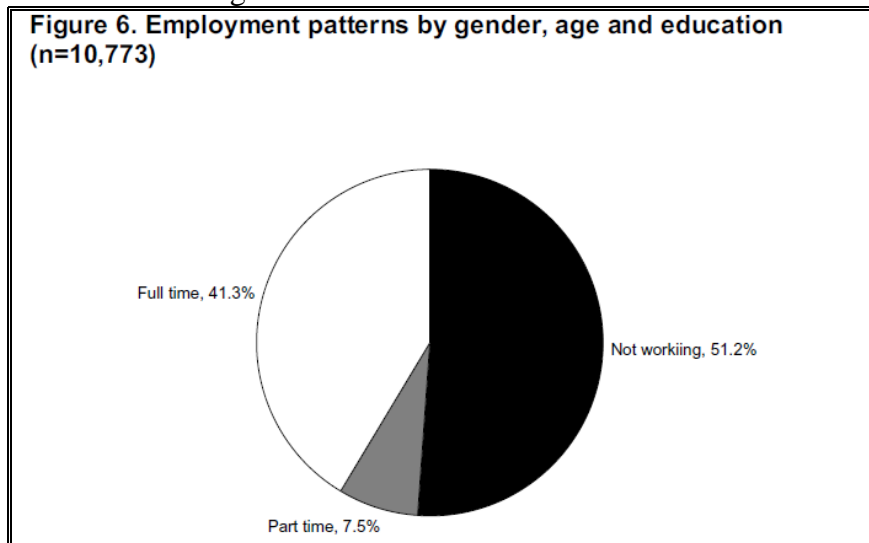


Figure 2. Employment patterns by gender, age and education (n=10,773)

<sup>198</sup> First Nations Regional Longitudinal Health Survey (RHS) 2002/03, Results for Adults, Youth and Children Living in First Nations Communities, Assembly of First Nations/First Nations Information Governance Committee, second edition, March 2007, p. 26.

<sup>199</sup> Ibid. pg. 27.

Telling trends emerge. Women are more likely to be working part time. Also, a significant number of young people aged 18-29 are unemployed, about 60%. Education clearly shows a trend toward greater employment, with completion of a high school education almost doubling the probability of employment.

Personal and Household Income

“The median personal income in 2001 of RHS adults in First Nations communities was \$15,667. The median household income = \$29,897. Men and women had essentially the same income levels.”<sup>200</sup>

Again, there is good evidence that those less than 29 and greater than 60 have the lowest median household income. The value of education indicates that as level of education increases, so does personal income. Also, income from government sources decreases with increasing education. 80% of women and 62% of First Nations men receive income from the government.

**First Nations (FN) Housing and Living Conditions**

Home Occupancy

- For Canadians generally, according to the 2001 Census, 65% own their own homes, almost all of the remainder rent their homes. Social housing plays a small role
- For First Nations living on reserve, 61.9% live in band-owned housing which is similar to social housing
- Drivers for this include; “extreme poverty; banks not giving on-reserve mortgages without a federal guarantee; and sometimes – prohibitive geography related to construction costs.”<sup>201</sup>

Condition of Housing

- 33.6% need major repairs
- 31.7% need minor repairs
- 48.5% living in band-owned houses report mould or mildew in their homes<sup>202</sup>

<b>Major repairs needed</b>	<b>Minor repairs needed</b>	<b>Only regular maintenance needed</b>	<b>No repairs needed</b>
33.6%	31.7%	24.0%	10.7%

<sup>200</sup> Ibid., p. 28.

<sup>201</sup> Ibid., p. 41

<sup>202</sup> Ibid., p. 44

### Drug and Alcohol Use

The use of alcohol by First Nations is associated with negative stereotypes of FN peoples. With the arrival of Europeans, came the greatly expanded use of alcohol in diplomatic engagements, and the far more ready availability to FN. Social and individual risk factors associated with substance abuse have been identified as:

- A history of sexual abuse
- A history of physical abuse
- A familial history of alcoholism
- Exposure to alcohol and drugs
- Childhood neglect
- Depression
- Attendance at residential/boarding schools
- Being a victim of violence<sup>203</sup>

First Nations are more likely to abstain from alcohol use than the Canadian population at large. For example, in the general population, about 80% reported alcohol use in the previous year, as opposed to only 66% of FN. After 60 years of age, the use of alcohol for FN drops to less than half the rate of Canadians on average.

Rates of alcohol use in remote isolated communities are more likely than non-isolated communities to report drinking. (75.7% vs. 64.6%)

The issue for FN is not the overall usage, but rather, the prevalence of higher rates of alcohol dependence, and heavy binge drinking; "...the proportion of heavy drinkers (those who have 5 or more drinks on one occasion) remains higher for Aboriginal people than that found in the general population. ...more than double the proportion of First Nations adults (16%) reported heavy drinking on a weekly basis than in the general population; (6.2%) appear to be at highest risk, with 20.9% of males reporting heavy drinking on a weekly basis, compared to 10.2% of females reporting weekly heavy drinking."<sup>204</sup>

With respect to others of drugs of abuse, 26.7% of FN had used marijuana in the past year, compared to only 14.1% in the general population. 29% of males between 18-29 years of age use marijuana on a daily basis. The illicit use of prescription drugs, namely opioids is a rising problem of concern for FN. Lastly, the RHS reported that the use of inhalants, such as gasoline sniffing was very low at 0.2%.<sup>205</sup> Treatment was sought for 16.3% of respondents for alcohol abuse, 7% for drug abuse, and 1.2% for solvent abuse.

## **The Health of First Nations Youth**

### School Education

According to the RHS, school performance can be measured by examining attendance and self-reporting at repeating grades.

Health factors related to school attendance include:

---

<sup>203</sup> Ibid., p. 115.

<sup>204</sup> First Nations Regional Longitudinal Health Survey (RHS) 2002/03, Results for Adults, Youth and Children Living in First Nations Communities, Assembly of First Nations/First Nations Information Governance Committee, second edition, March 2007, p. 116.

<sup>205</sup> Ibid., p. 116.

- Diet
- Alcohol consumption
- Smoking
- Sexual activity
- Health conditions
- Activity limitations
- Participation in physical activity and sport
- Art and music
- Drumming and dancing

Self-reporting of health was a good predictor of not attending school, experiencing learning problems at school, or disliking school.

	Fair/poor	Good	Very good/excellent
Not attending school	15.6%	9.8%	5.6%
Learning problems at school	62.5%	47.1%	37.3%
Dislikes school	22.3%	12.3%	7.8%
Never eating a nutritious diet	40.3%	27.8%	10.7%

The nutrition of youth at school was positively correlated with a number of different items. For example, as the level of nutrition improved, learning problems and having to repeat a grade decreased. School enjoyment increased.

A striking finding was the proportion of children of school age not attending school, as well as the high levels of self-reported learning problems at school. These figures for FN are not compared to the Canadian population, and would be more informative if they were. In a contemporary society, education to acquire skills and trades enhances the learner's ability to achieve gainful employment, which enhances income and likewise, health. These figures, with reference to FN in Canada provide a useful snapshot as to how skewed school attendance at Pikangikum is, where it is estimated that somewhere between 30-50% of school age children and youth do not attend school.

There were also positive correlations between school attendance, and participation in sports, art and music, singing, drumming and dancing; the very activities which were lost when the school burned down.

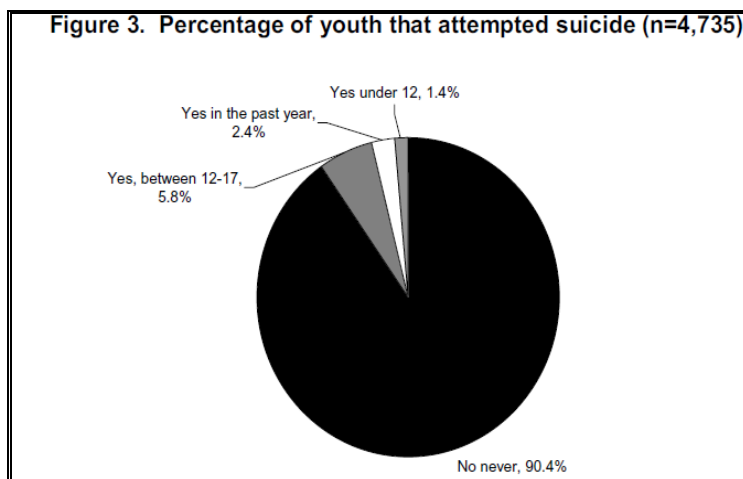
Increased alcohol consumption and smoking were negatively associated with school performance in that they were correlated with lower rates of school attendance and higher rates of repeating grades. 59% of youth between the ages of 15-19 smoke.

Of interest, only 1.5 % of respondents in the RHS 2002/03 Youth Survey reported that they had used inhalants (glue, gas, paint) in the previous year. In Pikangikum, gasoline sniffing is a major health issue in the youth.

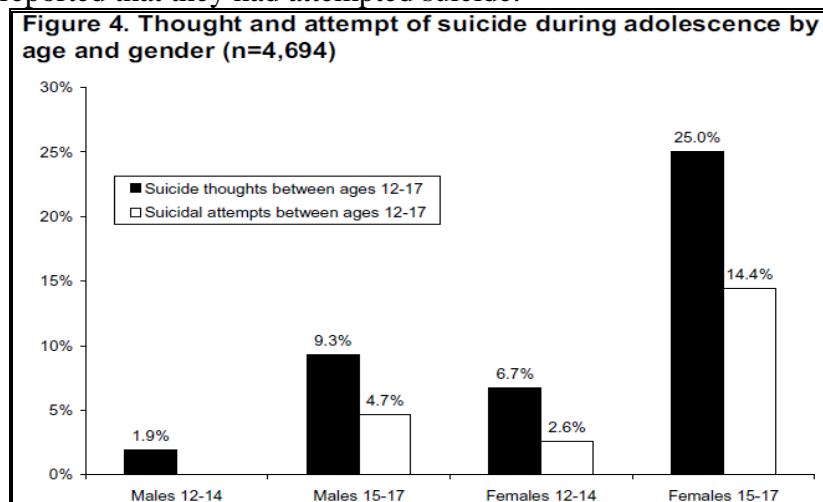
### Emotional and Social Wellbeing

The Canadian Community Health Survey of 2002 reported that 7.9% of Canadians aged 12 or older appear to have experienced at least one major depressive episode in the previous 12 months, versus 13.2% of the Aboriginal population.

Important figures here are that 27.2% of youth reported having suffered with depression in the previous year. For females between 15-17 years, 44% reported these feeling versus 22% of males. For females between 11-14 years of age, the rate was 28% versus 13.3% for males.<sup>206</sup>



The youth were reporting on lifetime suicide attempts. For First Nation youth between the ages of 12-17, 5.8% reported that they had attempted suicide.<sup>207</sup>



There is a striking difference between males and females in these reports. 25% of females reported thoughts of suicide, versus 9.3% of males between the ages of 15-17. For the Pikangikum youth suicides reviewed, the number of males and females were equally split.

When seeking help for problems, youth reported that for depression, 17.6% do not seek help from anyone. 21.9% go to a friend their own age, and 42.3% go to a parent or guardian. A concern here that merits addressing, is the large number of youth that do not seek help, and the lack of utilization of medical professionals for help, including doctor/nurse or health care aid.

<sup>206</sup> Ibid., p. 221.

<sup>207</sup> Ibid., p. 222.

This speaks to the need for community-based programs in parenting and family wellness and the role of support counsellors.



## **APPENDIX 5. Pikangikum’s Response to the OCC’s Death Review of Youth Suicides (The “Review”)**

We, the Council of Pikangikum, entirely acknowledge and appreciate the considerable time and thought of those that have prepared and drafted the 99 recommendations contained within the Review. We also respect and appreciate that contributors to this Review have acquired considerable knowledge and experience in their professional lives and are genuine in wanting to address these issues, not merely respecting Pikangikum but also with respect to other communities in Ontario and throughout Canada.

It should be pointed out that the recommendations are entirely silent regarding the significant role that our Elders play in any decision-making process in Pikangikum. Despite this glaring oversight, we at Pikangikum fully recognize that our Elders are of critical importance to the success of each and every process and strategy that seeks to address the issues inherent in this Review. As such, Chief and Council are ensuring that on-going engagement and consultation with our Elders occurs with respect to the recommendations and the First Nation’s suggested process for their implementation.

We convened meetings respecting the Review with Elders, Youth, Health Authority, Education Authority, and others including representatives of the OPP and staff at our school. These meetings were helpful in affirming immediate needs and priorities of the Pikangikum First Nation.

We note that several of the recommendations are not directed to Pikangikum specifically, but involve jurisdictional issues and policy recommendations that are inter-provincial. These are large issues that will be debated in the future amongst our fellow first Nations and by policy makers within the Government of Canada and Ontario. We have certain views respecting those “policy” recommendations. However we choose not to comment on them at this time as we do not want to deviate from what we believe is realistically obtainable from this important Review.

We have taken the time to consult with our people in order to identify the priorities that they see on the ground amongst the 99 recommendations. In our view, naming those priorities that appear in the recommendations avoids the risk that they will be lost in this sea of recommendations. We know from experience that if the recommendations are considered in their totality, this will happen over a very extended period of time, and will ultimately result in gridlock and a catatonic “do nothing because it’s too overwhelming.” We do not want these priorities or recommendations that speak to them to be “shelved.” This would not be helpful for our youth today nor would it honour those who are the subject of the Review.

As one of our priorities set out below, we propose a process going-forward to address the recommendations as a whole. To be clear, we support any, and all, recommendations that will contribute to addressing issues that may have contributed to the taking of a life of any of our youth. But we assert that it is essential that this Review becomes a purposeful instrument to implement what Pikangikum First Nation considers to be realistic and achievable key priorities within a short time-line.

It is for all of the above reasons that we wish to share the following response to this Review. We wish to emphasize that the following priority recommendations are not stated in any order of priority. Each is an essential priority.

## **Recommendations by Pikangikum Council that Require Immediate Implementation:**

### **1. New Pikangikum School (Referencing Recommendation #71)**

Our school burned to the ground in 2007. Prior to that, it had been “condemned” by health, engineering and environmental officials for several years. INAC had been promising to replace the school since its demise, but has yet to fulfill that promise.

When the school burned down, Council was informed by the INAC Minister and INAC’s Regional Director General that by agreeing to have a temporary school constructed, such a decision would not delay or impact INAC’s commitment to provide our children with a new school. We were told that the new school would be constructed by 2010. This has not come to pass, nor is there a firm commitment from INAC as to when the new school is to be built.

The reality of the temporary school as determined by our parents, principal, vice principal, teachers and students is generally bad construction and design resulting in:

- Constant leaking, mould and moisture issues;
- Poor or no insulation leading to drafts, cold floors, dangerous ice-damming on roofs, and freezing pipes;
- Soil erosion and shifted buildings leading to animals and children crawling into the spaces under the buildings, and increased fire hazards due to lack of clear exits;
- No common areas or gathering spaces;
- No library;
- No tech or trade facilities;
- No gym;
- No bathroom facilities in any of the portable classrooms;
- No lockers;
- No outdoor recreational equipment or playground facilities;
- No proper computer rooms;
- No science facilities;
- No special education and support space or facilities;
- No access for wheelchairs and disabled students;
- No space for full-day kindergarten program despite a rapidly growing population;
- Students and parents assert that the kids do not look forward to attending a “non school,” and
- Extreme over-crowding in classrooms leading to children having to sit in hallways during class (i.e. teachers had to accommodate 55 children in the 2010-2011 grade eight class).

#### **Action Required to Implement**

The Coroner and/or Deputy Chief Coroner convene a meeting, to be co-chaired with the Chief of Pikangikum. Invited to attend:

- Deputy Minister of Indian Affairs;
- Parliamentary Secretary to the Minister of Indian Affairs;
- Ontario Deputy Minister of Aboriginal Affairs; and
- Ontario Assistant Deputy Minister of Aboriginal Affairs.

The purpose of this meeting would be to obtain a commitment from the Minister of Indian Affairs that a new school, with a capacity of no fewer than 1,000 students, be constructed at Pikangikum within 12 months.

**2. Construction of 50 new homes, and water and sewer hook-up to all homes (Referencing Recommendations 92 and 94)**

Several homes in Pikangikum have as many as 18 people residing in them, and many have major structural deficiencies and moisture problems. Most of our homes have no access to running water or sewer facilities which negatively impacts on residents' ability to cook, clean, bathe and nourish themselves and their families in a healthy environment. It is well known that for our children and our Elders these conditions bring dire consequences.

We require a "special" injection of funds from Canada, and possibly Ontario, to construct 50 homes. This would not address our housing needs entirely but would ease some of the pressure resulting from the severe overcrowding and tragic consequences that invariably arise from such conditions.

Access to clean potable water is essential to ensure broad health and well-being in our community. The need for safe disposal and treatment of sewage has been at a critical stage for years in our community, and threatens to continue as a serious health hazard for our growing population. The health implications arising from a lack of access to clean water, and safe sewage management facilities are numerous and have been well-documented both inside and outside our community. The impacts are on-going in our community and cannot be understated. Our community requires all homes, new and old, be connected to water and sewer facilities. This means that a new water and sewer treatment plant that can service our homes, and the growing needs of our community, is absolutely necessary to safeguard the health of our people.

All homes, new and existing, must be connected to water and sewer.

**Action Required to Implement**

The Coroner and/or Deputy Chief Coroner convene a meeting, to be co-chaired with the Chief of Pikangikum. Invited to attend:

- Deputy Minister of Indian Affairs;
- Parliamentary Secretary to Minister of Indian Affairs;
- Deputy Minister responsible for CMHC;
- Ontario Deputy Minister of Aboriginal Affairs; and
- Ontario Minister of Housing.

**3. Gridline Connectivity (Referencing Recommendation #90)**

Chief and Council have been assured that the Gridline project approval and construction and a Treasury Board Submission is imminent. This needs to be confirmed and finalized.

**Action Required to Implement**

The Coroner and/or Deputy Chief Coroner convene a meeting to be co-chaired with the Chief of Pikangikum. Invited to attend:

- Deputy Minister of Indians Affairs
- Deputy Minister responsible for Treasury Board

The purpose of this meeting is to ensure that the gridline connectivity project proceeds forthwith, as promised.

#### **4. Whitefeather Forest Initiative: Sustainable employment and economic opportunity (Referencing Recommendation # 96)**

It is our respectful belief that any and all of the recommendations contained in this Report will provide few long-term solutions to improve the quality of life of our youth, unless there is a sustainable economy which will offer sustainable employment and career opportunities for our community. That is why our Whitefeather Forest Initiative should and must be financially supported at this critical juncture in its development.

Our Whitefeather Forest Management Corp. is Pikangikum-owned, and has been guided by the vision of our Elders. Please take the time to look at our Whitefeather website, [www.whitefeatherforest.com](http://www.whitefeatherforest.com), to see how far we have come since Elders commenced the process, working in close cooperation with the Ontario Ministry of Natural Resources (MNR) to meet the terms and conditions for acquiring the Sustainable Forest License (SFL).

It is of critical importance for all “stakeholders” involved in this Review to fully understand and appreciate the following: once the Forest Management Plan (FMP) is completed, projected to be in the Spring of 2012, Pikangikum will have management control over approximately 1.3 million hectares of crown lands (traditional ancestral lands of the people of Pikangikum known as the Whitefeather Forest), and will have approval to commence commercial forestry operations. It is estimated that approximately 350 jobs, on a sustainable, permanent basis, will be generated, both in the woodlands operations and in the value-added opportunities that have been planned to date.

The Whitefeather Forest represents the hope and future for our youth and for future generations. If the Government of Canada, Government of Ontario, and their respective agencies are to take the recommendations advanced in the Review seriously, there must be a concerted and coordinated commitment to provide financial resources to enable the work to be completed for securing and sustaining the SFL. This means that there must be support for the purchase of LKGH, the interim opportunity that would employ our youth who are currently undergoing training for the numerous and varied jobs that will need to be filled.

##### **Action Required To Implement**

The Coroner and/or Deputy Chief Coroner convene a meeting, to be co-chaired with the Chief of Pikangikum. Invited to attend:

- Whitefeather Forest Management Corp.;
- Deputy Minister of Indian Affairs;
- Deputy Minister responsible for FEDNOR;
- Parliamentary Secretary to Minister of Indian Affairs;
- Ontario Minister of Aboriginal Affairs;
- Ontario Deputy Minister of Aboriginal Affairs; and
- Ontario Minister of Natural Resources.

The purpose of this meeting is to acquire a commitment for \$4.5 million to secure the wood supply, the balance required to purchase LKGH; and the finalization of the requirements to secure the SFL.

## **5. Healing/Treatment Centre (Referencing Recommendation #52)**

Stormer Lake Resort is for sale. It is located within the traditional ancestral lands of Pikangikum and is in relative proximity to the Pikangikum community.

Funds should be identified to enable Pikangikum to purchase these lands and buildings for a Treatment Centre to address alcohol and substance abuse within our community (i.e. gas sniffing).

There are several treatment models that could be adapted specifically for Pikangikum's requirements. This must be studied carefully prior to operation and delivery of the services. However, the starting point is to secure the property and buildings.

### **Action Required to Implement**

The Coroner and/or Deputy Chief Coroner convene a meeting, to be co-chaired with the Chief of Pikangikum. Invited to attend:

- Federal Deputy Minister of Health Canada;
- Federal Parliamentary Secretary to Minister of Indian Affairs; and
- Ontario Deputy Minister of Health.

The purpose is to secure the funds to purchase the Stormer Lake property (approximately \$1.5 million and to identify annualized operation and maintenance costs.

## **6. Additional Reserve Lands for Pikangikum (Referencing Recommendation #98)**

The Pikangikum population presently exceeds 2,500, with the demographics projecting the on-reserve population being approximately 5,000 within a generation. There is presently no land on-reserve for the establishment of a new housing subdivision as all available land is not suitable for construction.

There is an immediate requirement for an expansion of the reserve.

There has been a long outstanding commitment by Canada to approve an additional 5 square miles for Pikangikum. Ontario has previously agreed to sell to Canada Crown lands for this purpose, which has not occurred.

### **Action Required To Implement**

The Coroner and/or Deputy Chief Coroner convene a meeting, to be co-chaired with the Chief of Pikangikum. Invited to attend:

- Canada Deputy Minister responsible for Lands & Trusts;
- Parliamentary Secretary to the Minister of INAC;
- Ontario Minister of Natural Resources;
- Ontario Deputy Minister of Aboriginal Affairs;
- Ontario Deputy Minister Responsible for Land Acquisition and Disposition.

The purpose is to secure the commitment from Canada for an addition to the reserve of a minimum of 5 square miles, the specific lands to be identified by Pikangikum; and for Ontario to agree to transfer those parcels of Crown lands to Canada for this purpose.

## **7. Mandate of Social Health Education Elders (SHEE) Committee to Implement the Balance of Recommendations (Referencing Recommendations 1 to 99)**

The SHEE Committee was established in March of 2010, to implement and coordinate certain programs and activities in Pikangikum and for the Pikangikum Health Authority to assume responsibility for implementation in Pikangikum.

Council believes that the SHEE Committee, under the direction of the Pikangikum Health Authority, is best positioned to advance strategies and work on securing the funding and supports required to implement the numerous recommendations contained within the Review. This includes those recommendations that fall within the 6 main themes in the report: health care (31 recommendations), suicide prevention (28 recommendations), education (15 recommendations), policing (2 recommendations), child welfare (11 recommendations), and social determinants of health (12 recommendations). Chief and Council are prepared to continue to support the SHEE Committee in its work throughout the next year. At that time, Chief and Council will review the Committee's progress to date, and will consider any necessary changes to its mandate and composition that may be required.

#### Action Required to Implement

The Coroner and/or Deputy Chief Coroner convene a meeting, to be co-chaired with the Chief of Pikangikum and Pikangikum Health Authority. Invited to attend:

- Deputy Minister of Indian Affairs;
- Federal Minister of Health Canada;
- Deputy Minister of Aboriginal Affairs;
- Ontario Deputy Minister of Aboriginal Affairs;
- Ontario Deputy Minister of Health; and
- Ontario Deputy Minister of Child and Youth Services.

It is recommended that the SHEE Committee, working in conjunction with the Pikangikum Health Authority, address the recommendations and prepare quarterly reports to Pikangikum Chief and Council on progress being made respecting implementation of the Review's recommendations. Subject to satisfactory progress being made within the first 12 months of its mandate, the Council of Pikangikum shall determine whether the SHEE Committee shall continue or whether appropriate amendments shall be made to its mandate and Terms of Reference.

#### **8. Semi Annual Meeting of Coroner, Pikangikum, Canada and Ontario**

Council have identified the need to ensure that officials from the governments of Canada and Ontario remain fully engaged in the implementation of the recommendations of the Coroner's Review.

#### Action Required to Implement

To ensure that there is no "passing the buck," miscommunications, or misunderstandings, it is recommended that a meeting be convened, to be chaired jointly by the Chief of Pikangikum and Chief Coroner for Ontario and/or Deputy Chief Coroner that would include the following:

- Minister of Indian Affairs;
- Deputy Minister of Indian Affairs;
- Parliamentary Secretary to INAC Minister;
- Minister of Health Canada;
- Ontario Minister of Aboriginal Affairs;
- Ontario Deputy Minister of Aboriginal Affairs; and

- Ontario Minister of Child and Youth Services.

A semi annual meeting of a minimum of an entire day shall ensure that there is a commitment to follow through to advance the recommendations.

Respectfully Submitted to the Coroner and Deputy Chief Coroner this 6<sup>th</sup> day of June, 2011.





