

BC CORONERS SERVICE
AND
FIRST NATIONS HEALTH AUTHORITY
DEATH REVIEW PANEL

A REVIEW OF
FIRST NATION
YOUTH AND
YOUNG ADULT
INJURY DEATHS:
2010-2015



Coroners Service



First Nations Health Authority
Health through wellness

NOVEMBER 2017

FRONT COVER: Painting by Prince George based Cree artist Carla Joseph

The painting to me represents a young person losing their life way too young – being gone but never forgotten.

The tree has tears that make an ocean to show that love that people feel for the lost ones who are gone.

The birds represent the lost finding peace and being one with the creator.

Carla Joseph, Cree



PREFACE

On December 8-9, 2016, the British Columbia Coroners Service (BCCS) in partnership with the First Nations Health Authority (FNHA) held a death review panel on injury deaths of First Nations youth and young adults. These deaths are a loss deeply felt by family, friends and their community. The review of the circumstances that resulted in these deaths provided panel members with valuable information to help determine what could be done to prevent similar deaths in the future.

We are sincerely grateful to the following members of this panel for sharing their expertise, bringing the support of their respective organizations and participating in a collaborative discussion. The participants' contributions have generated actionable recommendations that we are confident will contribute to reducing First Nations injuries in BC. BCCS Child Death Review Unit staff, Adele Lambert, Carla Springinotic, in partnership with FNHA staff, Kathryn Berry-Einarson and Krista Stelkia provided support, compiled the background research for panel discussions and prepared this report.

Evan Adams	First Nations Health Authority
Kathryn Berry-Einarson	First Nations Health Authority
Nicole Gibbons	First Nations Health Authority
Keva Glynn	Ministry of Health
Deepthi Jayatilaka	First Nations Health Authority
Perry Kendall	Provincial Medical Health Officer
Jackie Lee	Ministry of Children and Family Development
Shannon McDonald	First Nations Health Authority
Ian Pike	BC Injury Prevention Research Unit
Jennifer Miller	Representative for Children and Youth
Shelaina Posting	Ministry of Education
Laurence Rankin	Vancouver Police Department
Melanie Rivers	First Nations Health Authority
Elizabeth Saewyc	School of Nursing, University of British Columbia
Bob Saunders	BC Coroners Service
Alex Scheiber	Ministry of Children and Family Development
Kayla Serrato	First Nations Health Authority
Jewel Thomas	Musqueam Nation Elder

On behalf of the panel, we submit this report and recommendations to the Chief Coroner of BC and the Chief Executive Officer, First Nations Health Authority for consideration.

Michael Egilson
 Chair, Death Review Panel
 BC Coroners Service

Dr. Shannon McDonald
 Deputy Chief Medical Officer
 First Nations Health Authority



Everlasting

"This image represents those lives that were taken too early. These were busy people, participating in many events throughout their lives, represented by the various images around the outside area. Inside the main figure with arms outstretched symbolizes they are being encompassed by all the glory of the world around them, ready for the next stage of existence in the Universe. These people were from many walks of life and lived in the city, in the country, in the suburbs, in villages, and towns, they were from Tradition and Culture, education, creative, athletic, and energetic, modern and technology. They are in the past in our present, we look to the future with the rays of the sun rising to a new day and the darkness of night brightened by the stars which they now are, with the Ancestors in the heavens above, gone from this earth but not forgotten in our hearts. They are 'Everlasting'."

Les Louis, Lower Similkameen Indian Band

EXECUTIVE SUMMARY

Injuries are one of the leading causes of death among First Nations people. Although the reasons First Nations youth and young adults die are similar to their non-First Nations peers, there are continuing disparities in injury and mortality rates for First Nations young people.

To better understand the gap, the BC Coroners Service (BCCS) in partnership with the First Nations Health Authority (FNHA) convened a First Nations death review panel in December 2016 to review the circumstances of unexpected deaths¹ of 95 First Nations youth and young adults (age 15 to 24 years), who died between January 1, 2010, and December 31, 2015.

Previously the BCCS had completed a number of child death review panels for all children and youth, and specific reviews for youth and young adult deaths. Although these earlier panels included information about Aboriginal peoples, the recommendations applied to all young people and did not focus specifically on First Nations communities.

This review focuses specifically on First Nations peoples. It considers the historical legacy of colonization, the impact of the social determinants of health, and the First Nations perspective on health and wellness when analysing the facts and circumstances of deaths and to identify public safety opportunities, including those specific to First Nations peoples, and to prevent future similar deaths.

The First Nations review panel members were appointed under the *Coroners Act*. The review panel was comprised of professionals with expertise in Indigenous health, injury prevention, child welfare, public health, education, law enforcement and academia.

During the six-year review period (2010-2015), an average of 16 First Nations youth and young adults died each year from preventable injuries. The circumstances of the youth and young adults who died were reviewed in aggregate. Current research and statistics were reviewed and key themes identified.

1 Unexpected deaths are those deaths due to causes that were unintentional, undetermined or due to suicide, or homicide.

During this review the panel identified that:

- The reasons that First Nations young people die are similar to their non-First Nations peers; however, the mortality rate for First Nations youth and young adults is almost two times the rate of their non-First Nations peers.
- First Nations unexpected deaths are preventable. Prevention approaches must consider the unique cultural diversity, community strengths and protective factors, as well as factors that wear away at resilience.
- Many youth and young adults who died had previous contact with supporting systems (e.g. schools, health care, community supports and services) and experienced barriers to accessing support. These represent missed opportunities to support young First Nations people.

The review found that:

- **Accidental deaths (motor vehicle crashes, overdose, drowning and fire) accounted for 60% of all First Nations youth and young adult unexpected deaths;**
- **Suicides accounted for a third of all First Nations youth and young adult unexpected deaths; and**
- **Homicides accounted for 5% of all First Nations youth and young adult unexpected deaths.**

As well:

- **Almost one quarter of First Nations youth and young adults who died were parents of young children.**
 - **For many of the young people who died, there were missed opportunities for support. Many were engaged in school or had recent service involvement with Ministry programs or services.**
-

In relation to the deaths reviewed the panel identified three key areas to prevent future similar injury related deaths and support wellness and well-being:

- Connectedness to peers, family, community and culture
- Access to services
- Cultural safety and humility and trauma-informed care

These findings are the basis for the following recommendation put forward to the Chief Coroner, CEO of the First Nation Health Authority and the Chair of the First Nations Health Council:

RECOMMENDATION 1: Promote Connectedness to Peers, Family, Community and Culture

By December 31, 2018, the First Nations Health Authority will:

- Encourage communities applying for wellness grants to incorporate traditional healing and ensure that applicants consult and engage with First Nations youth as part of the community wellness grant process.
- Facilitate at First Nations gatherings such as 'Gathering Our Voices' and other community events eliciting youth views about how to increase connectedness, wellness and safety and resilience in their communities.
- Partner with BC Injury Research and Prevention Unit (BCIRPU) regarding a project whereby youth identify safe/unsafe places in their community.

RECOMMENDATION 2: Reduce Barriers and Increase Access to Services

By December 31, 2018, the First Nations Health Authority in partnership with relevant agencies will:

- Review alcohol education and further develop First Nations harm reduction activities specific for alcohol.
- Achieve the target for trauma informed care training for all FNHA staff.
- Work with partners to increase access to culturally safe treatment services.
- Continue to partner on overdose crises response.

By December 31, 2018, the Ministry of Children and Family Development (MCFD) will:

- Work with BC Housing to increase access to low barrier housing for First Nations young people.
- Increase earlier and easier access to prevention focused mental health services.

By March 31, 2018, the First Nations Education Steering Committee and the Ministry of Education will engage with First Nations youth on learning needs and what would improve connectedness to school.

By December 31, 2018, the Ministry of Advanced Education, Skills and Training (AEST) in collaboration with First Nations youth will identify and address barriers for First Nations young people entry to post-secondary education.

By December 31, 2018, the Ministry of Health, Ministry of Children and Family Development, and Ministry of Education in collaboration with FNHA will develop a plan to deliver trauma informed training to staff working/delivering services to First Nations young people.

RECOMMENDATION 3:

Promote Cultural Safety and Humility and Trauma-Informed Care

By December 31, 2018, the FNHA will collaborate with Ministry of Education and Ministry of Advanced Education, Skills and Training service partners to sign the Declaration of Commitment to advance cultural safety and humility within their organizations.

By December 31, 2018, the FNHA will develop an injury surveillance and monitoring strategy.

RECOMMENDATION 4:

Elicit Feedback through Community Engagement

By March 31, 2018, the FNHA will complete a community engagement process to elicit feedback on how the broad recommendations can further be adopted within local community actions. An addendum will be created and added to the report with the community responses.

CONTENTS

PREFACE	i
EXECUTIVE SUMMARY	iii
INTRODUCTION	1
DEATH REVIEW PANEL	2
DATA LIMITATIONS AND CONFIDENTIALITY	3
HISTORICAL CONTEXT	5
INJURY RELATED DEATHS & HISTORICAL CONTEXT	5
THE FIRST NATIONS PERSPECTIVE ON HEALTH AND WELLNESS	6
BC CORONERS SERVICE CASE REVIEW FINDINGS	9
CLASSIFICATION OF DEATH	10
Classification of Death: Accidental Deaths (N=57)	16
Classification of Death: Suicides (n=30)	18
COMMON RISK FACTORS	20
Substance Use	21
History of Trauma	21
Mental Health (n=23)	22
SPECIALIZED INVESTIGATIONS	26
RECOMMENDATIONS	27
CONNECTEDNESS	29
Promote Connectedness to Peers, Family, Community and Culture	
ACCESS TO SERVICES	30
Reduce Barriers and Increase Access to Services	
CULTURAL SAFETY	32
Promote Cultural Safety	
COMMUNITY ENGAGEMENT	33
Elicit Feedback through Community Engagement	
GLOSSARY & REFERENCES	35

PART 1

INTRODUCTION

Injuries are one of the leading causes of death among First Nations people. Although the reasons First Nations youth and young adults die are similar to their non-First Nations peers, there are continuing disparities in injury and mortality rates for First Nations young people.

Unexpected or injury-related deaths are preventable. To better understand these deaths and identify opportunities for prevention, a death review panel appointed under the *Coroners Act* was held in December 2016.

Previously, the BC Coroners Service (BCCS) had completed a number of child death review panels for all children and youth, and specific reviews for youth and young adult deaths. Although these earlier panels included information about Aboriginal peoples, the recommendations applied to all young people but did not focus specifically on First Nations communities.

This review focuses specifically on **First Nations** young people. The BCCS in partnership with the First Nations Health Authority (FNHA) convened a First Nations death review panel to review the circumstances related to the unexpected deaths of 95 First Nations youth and young adults (age 15 to 24 years), who died between January 1, 2010, and December 31, 2016.

Although this report compares the number and rates of First Nations deaths to their non-First Nations peers, simply achieving similar rates for injury or deaths is not the goal. First Nations organizations and communities must work collectively to identify how best to prevent future deaths.

This review incorporates the First Nations perspective on health and wellness, and the prevention of First Nations injury and mortality. This review considers the legacy of historical events, as well as the impact of the social determinants of health in analysing the facts and circumstances of deaths in order to identify public safety opportunities and prevent future similar deaths.

The panel identified three broad recommendations with a number of provincial actions that will meaningfully support the prevention of similar deaths in the future. The panel also recognized that the lives of the young people reviewed took place in individual communities that have unique needs and traditions and that the broad recommendations can be locally adapted to the needs of each community.

It was always the intention of this panel to include local expertise to expand on how the broad recommendations could unfold in a meaningful way within communities. One of the primary purposes of this report is that it be used as a supporting tool to further engage First Nations communities on local actions to promote connectedness, reduce barriers to services and ensure cultural safety and humility for young people. The results of that engagement and the wisdom learned will be electronically appended to this report once completed.

DEATH REVIEW PANEL

A death review panel is mandated² to review and analyse the facts and circumstances of deaths in order to provide the Chief Coroner with advice on medical, legal, social welfare and other matters concerning public health and safety, and the prevention of deaths. A death review panel may review one or more cases before, during or after a coroner's investigation or inquest.

Panel members were appointed by the Chief Coroner of BC under Section 49 of the *Coroners Act*, including persons and professionals with expertise in Aboriginal health, public health, law enforcement, injury prevention, education, child welfare, and academia, and a First Nations Elder.

Regardless of their employment or other affiliations, individual panel members were asked to exercise their mandate under the *Coroners Act* and express their own opinions and conclusions. The findings and recommendations contained in this report need not reflect or be consistent with the policies or official position of any other organization.

In the course of reviewing deaths that occurred between 2010 and 2015, the panel reviewed:

- BCCS investigative findings;
- Academic and research literature;
- Information provided by panel members;
- Environmental, social and medical factors associated with the deaths;
- Possible trends or themes;
- The current state of related public policy and strategies; and,
- Existing challenges.

Each panel member shared their professional perspective and collectively identified actions towards preventing future injury deaths.

2 Under the *Coroners Act*

DATA LIMITATIONS AND CONFIDENTIALITY

The number of victims who died as a result of injury presents challenges in accurately analysing and reporting information while protecting privacy and data accuracy. Provisions under the *Coroners Act* and *Freedom of Information and Protection of Privacy Act* allow for the BCCS to disclose information to meet its legislative mandate and support the findings and recommendations generated by the review process. For the purposes of this report, information is presented in **aggregate**³. Details that could identify the people have been omitted to respect the privacy of the person who died, as well as their families. The BCCS is sensitive to the privacy of individuals and families that we serve and proceeds with caution when reporting case review findings.

Prior to June 2016 there was the potential to under-report deaths based on Aboriginal identity. Past BCCS data collection resulted in limited or absent information about Aboriginal identity and whether an individual lived on a reserve. As of June 1, 2016, the BCCS implemented the Aboriginal Administrative Data Standard (AADS); this will improve the data quality and completeness of Aboriginal identity on BCCS case files.

For this review, First Nations identity was based on information gathered during the coroner's investigation from family and friends, or service agencies. Vital Statistics Certificate of Death forms and BCCS case files of all decedents were reviewed for First Nations identifiers. Specifically, the following process was used to identify decedents as First Nations people:

- The Aboriginal identifier on the Vital Statistics Certificate of Death was yes; and,
- Includes any one of the following:
 - The decedent was a resident of First Nations reserve;
 - Case file documentation indicated First Nations identity;
 - or,
 - The decedent was interred on reserve.

Metis and Inuit youth and young adults were not included in this review.

3 Bolded terms are defined in the glossary.

“Not recognizing the cultural diversity of Aboriginal Peoples in Canada is one of the most common mistakes non-Aboriginal people make when engaging with Aboriginal communities.”

Bob Joseph, Gwa'waenuk Nation

PART 2

HISTORICAL CONTEXT

INJURY RELATED DEATHS & HISTORICAL CONTEXT

The impact of colonization on First Nations and Aboriginal health and well-being is highlighted in studies and reports which indicate that:

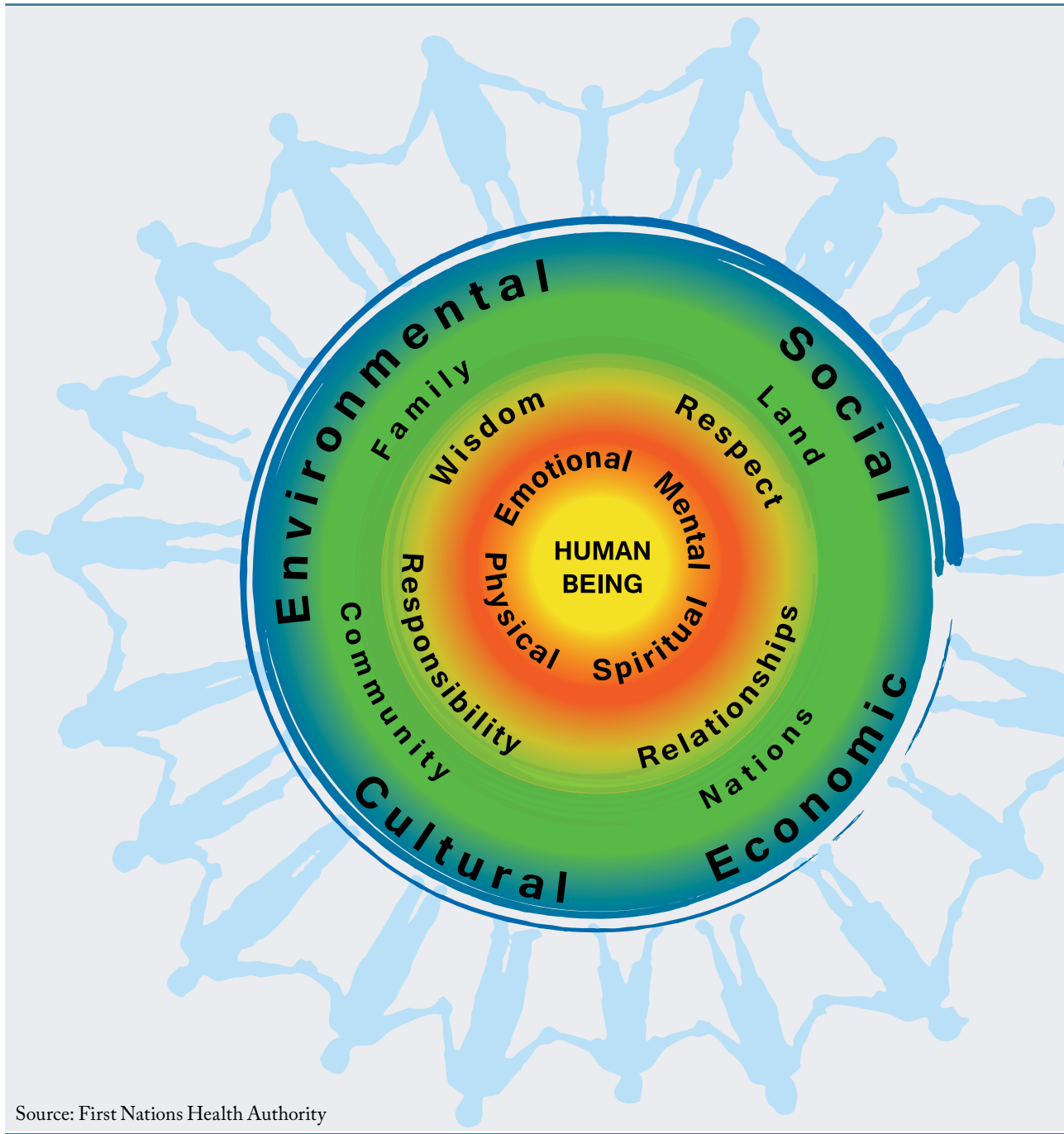
- “Aboriginal peoples’ experiences are rooted in multigenerational, cumulative, and chronic trauma, injustices, and oppression. The effects of trauma can reverberate through individuals, families, communities and entire populations, resulting in a legacy of physical, psychological, and economic disparities that persist across generations.” (National Collaborating Centre for Aboriginal Health, 2016)
- “The impacts of historical trauma (colonization, residential schools, racism, and isolation) are experienced in many ways, including high rates of injury from violence and other health risk behaviours.” (Nutton, J., and Fast, E., 2014)

5

To address preventable deaths due to injuries in First Nations populations, the legacy of historical events and traditional beliefs, values and cultures of First Nations peoples must be recognized. To achieve health and wellness, one must appreciate the “holistic nature of health in First Nations culture and the inter-connectedness of individuals, families, communities and Nations; and the importance of the surrounding social, economic and cultural milieu.” (Campbell, A. 2013)

British Columbia has the greatest diversity of Indigenous cultures in Canada, with over 200 First Nation communities, each possessing its own unique culture and traditions. In fact, seven of Canada’s 11 First Nations language families are located exclusively in BC – representing more than 60% of the country’s First Nations languages. Further, each Nation has a distinct cultural history that shapes their identity, needs and goals.

As with culture, First Nations communities in BC are also geographically diverse. As a result of the geographical diversity, there are major differences in each Nation's local economy, food security, educational opportunities, capacity and challenges. Therefore, each community's youth population face a unique set of challenges related to these differences. In all cases, we have found that involvement in community cultural activities can save lives by restoring pride, self-worth, a sense of purpose and overall health and wellness (mental, spiritual, emotional, and physical).



Source: First Nations Health Authority

UNDERSTANDING THE FIRST NATIONS PERSPECTIVE ON HEALTH AND WELLNESS

The First Nations Perspective on Health and Wellness, as illustrated on p. 6, provides a holistic framework and visual aid for understanding how the health of individuals, families, communities, and nations are related and interconnected. This interpretation is based upon traditional concepts of wellness that have been passed down from Elders and traditional healers, as well as feedback and input gathered at community engagement forums such as Gathering Wisdom events over the last several years.

The centre circle represents the individual human being. Health and wellness begins with the individual taking responsibility for their own health and well-being to the best of their ability. Moving outwards from the centre are the mental, spiritual, emotional, and physical aspects of health. When these four domains are balanced, they contribute to a life that is lived healthy and well.

The third circle contains the core values that are the foundation of wellness. Respect, wisdom, responsibility, and relationships are all central to achieving balance, wellness, and right relations within Creation. When these values are brought into everyday life, they can support a healthy and balanced life.

The fourth circle represents the peoples and things with whom relationships are formed. The individual human being is part of a complex set of relationships as a member of a family. Individuals are from a particular place and have a relationship with the land upon which they were born. Communities may be composed of a collective of knowledge, interests, experiences, or values. Nations include an extended community of families and kinships. All of these relationships are central to good health and well-being.

The fifth circle signifies the social, cultural, economic, and environmental conditions in which First Nations peoples attempt to achieve and maintain health and wellness. These ‘determinants’ are largely external to the mainstream health care system, but they play a large role in creating environments that can support health and well-being. Social determinants include necessities such as food, housing, education, health promotion and safety. Environmental determinants include basics like access to clean and safe water, healthy land and other resources that are required to ensure good health. Economic determinants are essential to many First Nations’ self-determination; the ability to make decisions over how to best manage resources on traditional territories is a fundamental determinant of health.

The outermost circle represents the FNHA vision of “healthy, self-determining and vibrant BC First Nations Children, Families, and Communities.” Within this circle are people holding hands to demonstrate togetherness, respect and relationships. Children, as the heart of communities, are included in the circle along with adults and Elders. There are gaps in the circle to signify that the circle is constantly changing; people may enter and leave, and the circle can grow and shrink over time, much like the cycles of life.

Injuries are one of the leading causes of death in First Nations people. (NAHO, 2006)

Although the reasons First Nations youth and young adults die are similar to their non-First Nations peers, there are continuing disparities in injury and mortality rates for First Nations young people.

In Canada, these disparities exist at national and regional levels. (George, et al., 2015)

Although the rates of injury-related deaths have decreased over the past decades, First Nations young people continue to experience a higher rate of death due to injury than their non-First Nations peers.

PART 3

BC CORONERS SERVICE
CASE REVIEW FINDINGS

This report summarizes the deaths of 95 First Nations youth and young adults, aged 15-24 years, who died between January 1, 2010, and December 31, 2015.⁴ Wherever possible, data for non-First Nations youth and young adults has been provided for comparison purposes.

For this review, First Nations identity was based on information gathered from family and friends during the coroner's investigation or Aboriginal identifiers on the Vital Statistics Registration of Death.

This document uses the term 'unexpected deaths' to describe deaths due to accidental or undetermined causes or by an act of suicide or homicide. This analysis does not include any death due to natural causes.

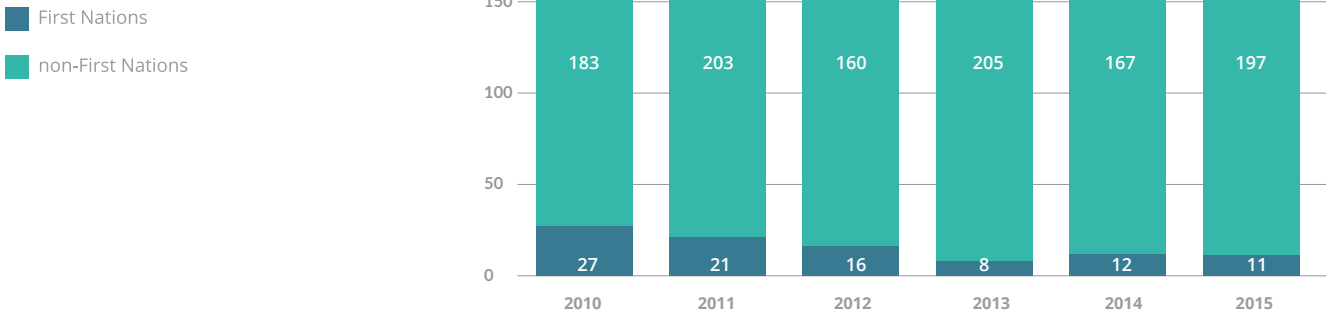
During the period of this review, 1,210 youth and young adults in BC aged 15 to 24 years died from causes classified as *accidental, suicide, undetermined or homicide*.

Of these unexpected deaths, 8% (n= 95) were deaths of First Nations youth and young adults (see Figure 1). Given census figures, First Nations deaths are higher than should be predicted based on the population size.

- The mortality rate for First Nations youth and young adults is almost two times higher (1.9) than the rate of their non-First Nations peers (64.0 per 100,000 compared to 32.7 per 100,000 respectively).

⁴ This review does not include overdose deaths occurring in 2016. In 2016, there were 115 illicit drug deaths among 15-24 year olds. Of these, six decedents were identified as First Nations young people.

FIGURE 1
Number of Injury Related Deaths, Age 15-24 Years, 2010-2015



Each year in BC, an average of 16 First Nations and 186 non-First Nations youth and young adults die as a result of injuries. There was no significant trend for the number of First Nations deaths per year during the review time period.

CLASSIFICATION OF DEATH

In this review, deaths classified as accidental accounted for more deaths in all age groups, followed by suicides and then homicides (see Figure 2).

- 60% of First Nations youth and young adult deaths were due to accidental causes.
- 32% of First Nations youth and young adults died due to suicide.
- 5% of First Nations youth and young adults died due to homicide.
- 3% of First Nations youth and young adult deaths were classified as undetermined.⁵

The reasons that First Nations youth and young adults die are similar to their non-First Nations peers, however there is a disproportionate number of deaths for First Nations based on population rates.

Accidental Deaths (n=57)

Accidental deaths accounted for 60% of all First Nations youth and young adult deaths. Accidental deaths were attributed primarily to motor vehicle crashes, poisonings, drowning, and fire (see Figure 3).

The rate of First Nations deaths due to MVC and residential fires was significantly higher ($p < 0.05$) than their non-First Nations peers.

⁵ An undetermined death is when the cause of death cannot be found after autopsy, toxicology and coroner investigation.

FIGURE 2

Classification of Death,
Age 15-24 Years, 2010-2015

■ First Nations
■ non-First Nations

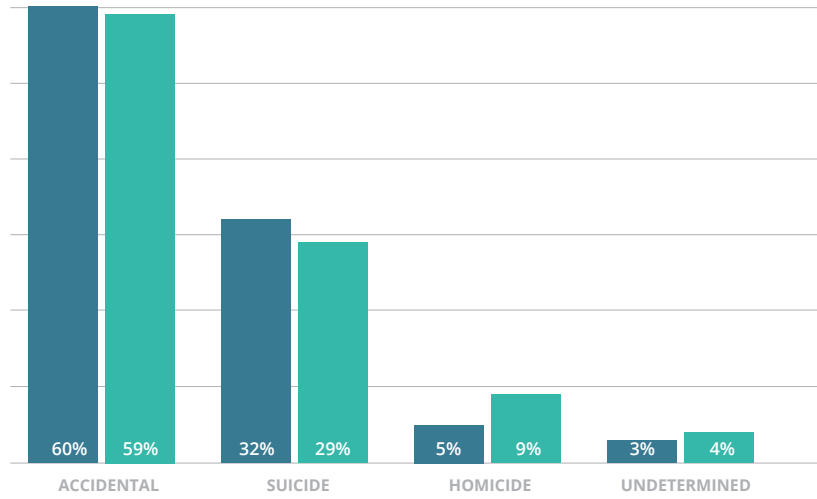
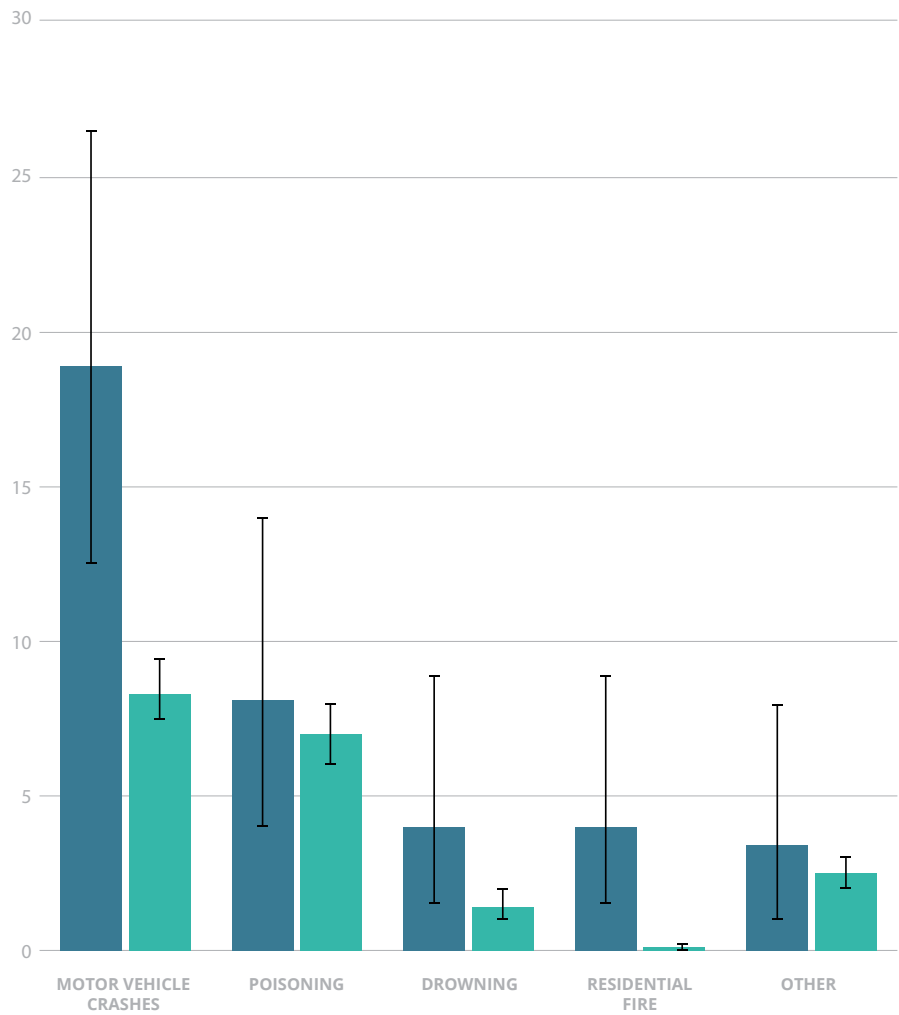


FIGURE 3

Rate of Accidental Deaths
per 100,000 person-years,
15-24 years, 2010-2015
with 95% confidence intervals

■ First Nations
■ non-First Nations



*OTHER includes: falls, environmental (avalanches, rock slides, exposure), air crashes, contact with machinery.

Some First Nations communities and individuals have collective and individual factors in their lives (e.g. historical trauma, colonization, poverty, powerlessness, or stressors) that may increase the risk of injury.

SOCIAL DETERMINANTS OF HEALTH

Evidence has established an association of certain social determinants with injury, and an influence on health and wellbeing.

The social-determinants for injury include: gender, socio-economic status, rural/urban living, and ethnicity and culture. (Asbridge, M., Azagba, S., Langille, D.B., Rasic, D., 2014)

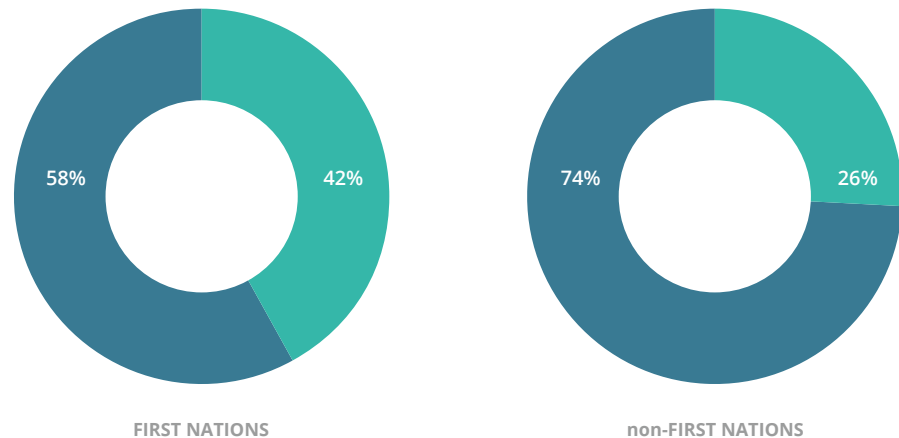
Indigenous specific social determinants of health include: colonization, colonialism, racism, marginalization, dislocation, social exclusion, self-reliance and self-determination. (Greenwood, M., 2015)

FIGURE 4

Unexpected Deaths,
Age 15-24 Years, 2010-2015

SOURCE: BC Coroners Service

■ Male
■ Female



SEX

In this review, overall, more males died than females (72% versus 28% respectively). Of the First Nations deaths, males represented more than half of all First Nations unexpected deaths (58% First Nations males as compared to 42% First Nations females) (see Figure 4).

- The number of First Nations females who died unexpectedly was greater than the number of non-First Nations females. The proportion of First Nations female deaths was 16 percent higher than non-First Nations females (42% as compared to 26% respectively) (see Figure 4).

Based on population estimates for First Nations youth and young adults, age 15-24 years (2010-2015 average):

- The mortality rate for First Nations males was **1.5 times** greater than their non-First Nations peers (70.7 compared to 46.8 per 100,000 person years respectively).
- The mortality rate for First Nations females was over **3 times** greater than their non-First Nations peers (56.6 compared to 17.6 per 100,000 person years respectively).

There is a different distribution of cases based on sex between First Nations and non-First Nations youth and young adults. Interventions may need to be tailored to address unique needs of each sex.

Evidence has established that males experience serious injury more often than females, suggesting a greater likelihood for male risk-taking and participation in contact sports. (Asbridge, M., et al., 2014)

The evidence also indicates that males view risk differently. Males were more likely than females to attribute injuries to bad luck rather than their own behavioural choices. (Morrongiello, B.A, Dawber, T., 2000)

Data for Aboriginal males showed higher crude rates of injury hospitalization than for Aboriginal females. (George, et al., 2015)

AGE

In this review:

- The mortality rate for First Nations youth age 15-19 years was over **2.6 times greater** than their non-First Nations peers (63.5 per 100,000 versus 24.3 per 100,000 respectively).
- The mortality rate for First Nations young adults age 20-24 years is over **1.6 times greater** than their non-First Nations peers (64.5 per 100,000 versus 40.3 per 100,000 respectively).

GEOGRAPHICAL CONTEXT – AREA OF RESIDENCE

In this review, more than half (57%) of First Nations youth and young adults who died lived in small population centres (1,000-29,000 residents), followed by rural areas (25%) (fewer than 1,000 population), and then medium to large population centres (18%) (more than 30,000 residents).

The literature indicates that rural communities risk being more isolated, lack access to support services, transportation, or experience longer emergency services response time.

Studies have reported differences in injury based on metropolitan and non-metropolitan areas. For example, a BC study found that Aboriginal populations living on-reserve in metropolitan areas had the lowest intentional injury rates compared to Aboriginal populations living on-reserve in non-metropolitan areas which had the highest rates of injury (18.6% as compared to 81.4% respectively). [Brussoni, et al., 2016]

In this review, the BCCS has identified whether a First Nations youth and young adult who died was living on reserve or off-reserve. Decedents who were identified as living on reserve may be from any First Nations Band.

This review found that more First Nations decedents were living on reserve at the time of death. There was five times the number of suicides on reserve than off reserve (25 versus 5 respectively) (see Table 1).

TABLE 1

On Reserve and Off-Reserve

CLASSIFICATION OF DEATH	ON RESERVE	OFF-RESERVE	TOTAL
Accidental	37	20	57
Homicide	<5	<5	5
Suicide	25	5	30
Undetermined	<5	<5	<5
Total	67	28	95

A 2013 Brussoni study indicates that metropolitan versus non-metropolitan residence appears to be a more important predictor than on/off reserve residence for all injuries (intentional and non-intentional injuries). (Brussoni, et al., 2013)

The study indicates that geographic remoteness influences disparities in injury rates among Canadians. Injury-related deaths are up to 79% higher in rural areas compared to metropolitan areas and that rural residents may have higher tolerance for risky behaviours, work in hazardous occupations, and experience environmental hazards such as roads with fewer safety features. (Brussoni, et al., 2013)

EDUCATION AND EMPLOYMENT

In this six-year review, 36% of First Nations youth and young adult decedents were employed full-time or part-time, 28% were students, and 23% were unemployed. There were 12 decedents for whom employment or student status was unknown.

Most aggregate-level studies report a positive association between unemployment rates and rates of overall mortality and mortality due to suicide. (Svoboda, T.J., Shah, C.P., and Robert Jin, 1997)

First Nations adults with lower personal and household incomes more often reported experiencing injury than those with high personal and household incomes. (FNIGC, 2012)

While BC First Nations experience higher rates of unemployment compared to their non-First Nations counterparts for those who are employed the jobs are generally lower paying and more hazardous compared to the rest of the BC population. (PHO, 2008)

Education and training is associated with employment opportunities. The First Nations Regional Health Survey (2008/10) report indicated that over 50% of First Nation adults did not graduate from high school, compared to 33.2% in the Canadian population. Isolated communities had a higher proportion of First Nation adults who did not completed high school (65.6%), compared to non-isolated communities (47.8%). (FNIGC, 2016)

15

REGIONAL DIFFERENCES

A higher number of First Nations youth and young adults who died lived in the Northern Health Authority or the Island Health Authority (see Figure 5). Northern Health Authority and Island Health Authority have higher populations of First Nations youth and young adults; therefore it would not be unexpected to find a higher number of fatalities in these regions.

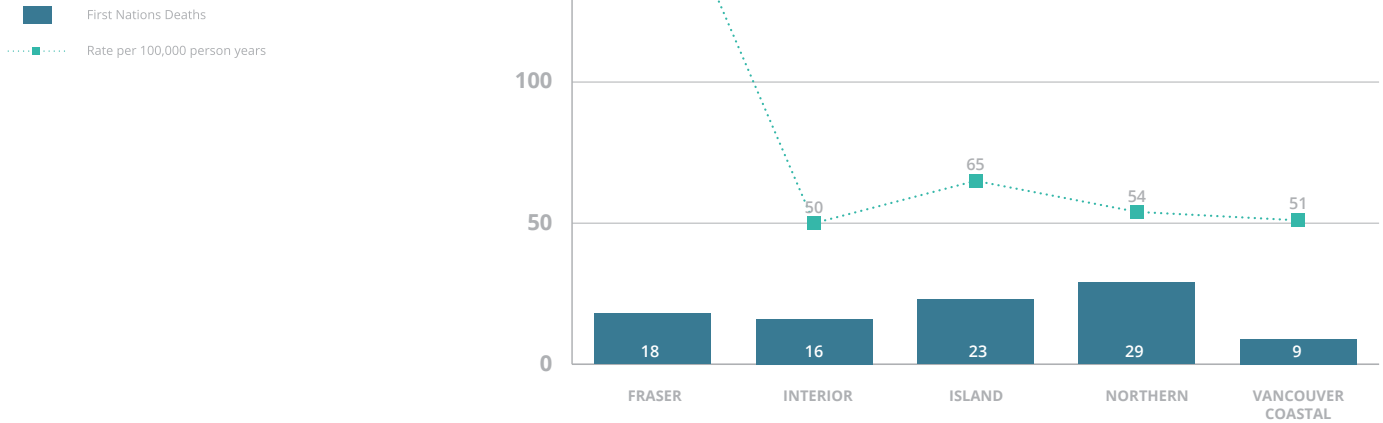
Fraser and Island Health Authorities demonstrated the highest rates of deaths per 100,000 population among First Nations youth and young adults (183/100,000 and 65/100,000, respectively) (see Figure 5).

Evidence indicates variations in injury based on region of residence. Although injuries are higher for all populations in rural areas, disparities exist between Aboriginal and non-Aboriginal populations.

Harsher physical environments in rural and remote areas, road conditions and inclement weather all contribute to risk of injury. A number of First Nations communities in BC are only accessible by boat, barge or float plane (weather permitting) or via secondary and gravel resource roads where the surface, environmental conditions and driveability vary considerably with the seasons. (Northern Health Authority, 2013)

FIGURE 5
Number of First Nations Deaths
and Rate per 100,000 person years

SOURCE: BC Coroners Service



Classification of Death: Accidental Deaths (N=57)

Motor vehicle crashes (MVC)⁶ were the leading cause accidental death for First Nations and non-First Nations youth and young adults (49%, n=28 versus 43%, n=284 respectively). Nine First Nations drivers and eight passengers died in MVCs. As well, 11 First Nations young people were struck by a motor vehicle while walking or standing on a roadway.

- Most MVCs fatalities (86%, n=24) involved single vehicle crashes.
- More MVCs fatalities occurred on highways (61%, n=17), followed by municipal streets (14%, n=4), rural roads (11%, n=3), and then logging road or trails (14%, n=4).
- Three quarters (75%) of fatal crashes occurred in low light conditions (n=21), whereas 25% (n= 7) occurred during daylight hours.

In this six year review Northern Health Authority had a higher number of MVC fatalities (n=11), followed by Interior HA (n=8). The difference between First Nations and non-First Nations MVC crashes in these two Health Authorities was not statistically significant.

A BC study reported that in general hospitalization for injuries were highest in the central and northern regions of British Columbia and on northern Vancouver Island for both Aboriginal and non-Aboriginal populations. (Brussoni, et al., 2013)

Roadways and road infrastructure differ throughout the province. Research has shown that fatalities can be eliminated and serious injuries reduced through safe road design, barriers, paved shoulders, sidewalks and speed control (Transport Canada, 2011).

6 Includes cars, trucks, ATVs, dirt bikes, trains.

Environmental conditions, driver or pedestrian actions or vehicle maintenance issues contributed to MVCs.

- In almost two-thirds (64%, n=18) of the MVCs, driver behaviours (e.g. intoxication, speed, distraction, inexperience, or unlicensed) were noted as contributing factors for the crash.
- In half (n=14) of the MVCs environmental conditions (e.g. visibility, slippery or wet roads, animals) were also noted as contributing factors.
- Of the 11 pedestrian fatalities, pedestrian related behaviours (e.g. impairment, sleeping on a roadway, running into a roadway, or distraction) were contributing factors (n=10, 91%).
- In three of these MVC events, pedestrian behaviour combined with driver behaviours (e.g. driver impaired, speed) were contributing factors to the cause of the crash.
- In 14% of crashes (n=4), vehicle maintenance issues (e.g. no brakes, mechanical failure, low tires) were identified as factors in the crash.

Research indicates that motor vehicle collisions cause the most injuries and fatalities in Aboriginal and First Nations children and youth, especially males.

Status Aboriginal Canadians were almost five times more likely than non-Aboriginal Canadians to be injured. Explanations for the difference include: environmental factors (e.g. road conditions on reserves), physical factors (e.g. vehicle maintenance, seatbelt use) and social factors (e.g. driving behaviour, number of car occupants), and lifestyle factors involving frequent highway driving. (Karmali, S., Laupland, K., Harrop, R., et al., 2006)

Seatbelts

Of the 17 MVCs involving deaths of First Nations youth and young adult drivers or passengers:

- 41% (n=7) were known to be wearing a shoulder and lap belt.
- For some MVCs (12%, n=2) a seatbelt was not applicable (e.g. ATV use, dirt bike)

A 2016 McCreary survey reported that 71% of Aboriginal youth reported always wearing a seatbelt, a 10% improvement since the 2008 survey.

Youth from rural communities or on-reserve were less likely to wear a seat belt. Youth from these areas indicated that seat belt laws were not enforced, and they did not see the need to wear seatbelts when driving short distances or on roads with less traffic. (McCreary Centre Society, 2016)

Impairment

Alcohol impairment was indicated in 64% (n=18) of all First Nations MVC fatal crashes. This is 26% higher than their non-First Nations peers.

Of the First Nations youth and young adults:

- 8 of 11 (73%) pedestrians were impaired by alcohol at the time of the crash.
 - Two drivers (ethnicity unknown) involved in pedestrian deaths were intoxicated.
- 3 of 9 (33%) First Nations youth or young adults drivers were impaired at the time of the crash.
- 5 of 8 (63%) of First Nations youth or young adult passengers who died were riding with a driver who was impaired at the time of the crash.

A recent Provincial Health Officer’s report on motor vehicle crashes found that “Insurance Corporation of BC (ICBC) data for 2003-2007 indicates that 39.3% of MVC fatalities that occurred on reserve in BC involved alcohol impairment, compared to 26.4% of related fatalities that occurred off reserve. For on reserve crashes, alcohol impairment contributed to more deaths, than speed (37.5%) or not using a seat belt restraint (21.4%)”. [PHO Report 2016]

Poisoning due to acute intoxication by drugs and/or alcohol was the second leading cause of accidental death for First Nations and non-First Nations youth and young adults (21%, n=12 compared to 36%, n=237 respectively). Accidental poisonings accounted for 13% of all First Nations youth and young adult deaths in this review.

- Almost all (92%, n=11) accidental poisoning deaths were due to ingestion of multiple substances (e.g. heroin, cocaine, methadone, alcohol, methamphetamines or fentanyl).
 - Two thirds (67%, n=8) of the First Nations youth and young adults who died by overdose had a history of chronic dependent substance use.
- In 63% of cases (n=7), the youth or young adult was with others at the time of use.
- In 45% of cases (n=5), medical intervention (CPR) was administered; one person received Naloxone.

This review preceded the 2016 opioid overdose crisis. In 2016, there were 115 illicit drug deaths among 15-24 year olds. Of these, six decedents were identified as First Nations young people. This is an emerging concern for all youth in British Columbia, and further review will be required to continue work on this issue.

Drowning (n=6) and **residential fires** (n=6) resulted in 12 First Nations youth and young adult deaths.

Classification of Death: Suicides (n=30)

Suicides accounted for 32% of all First Nations youth and young adult deaths.

In this review, slightly more First Nations youth or young adults who died by suicide were students (n=11), then unemployed (n=10) followed by those who were employed (n=9).

Of the First Nations youth and young adults who died by suicide:

- Almost three quarters (73%, n=22) were living with family.
- 60% (n= 18) had communicated distress to family, friends or a partner prior to their deaths, with 33% (n=10) expressing suicide intent.
- More than one quarter of the First Nations youth who died by suicide (27%, n=8) had a history of suicide attempt.

In this review, 20% of First Nations youth and young adults who died by suicide (n=6) had a psychiatric diagnosis indicated on file. As well, 20% (n=6) of First Nations youth and young adults were receiving support services for mental health concerns at the time of their deaths.

In this six-year review, Island Health had a higher number of suicides (n=12), followed by Fraser Health (n=8), Interior Health (n=4), Northern Health (n=3) and Vancouver Coastal Health Authority (n=3) (see Figure 6).

The difference in the rates of suicide in Fraser Health Authority and Island Health Authority was statistically significant (see Table 2).

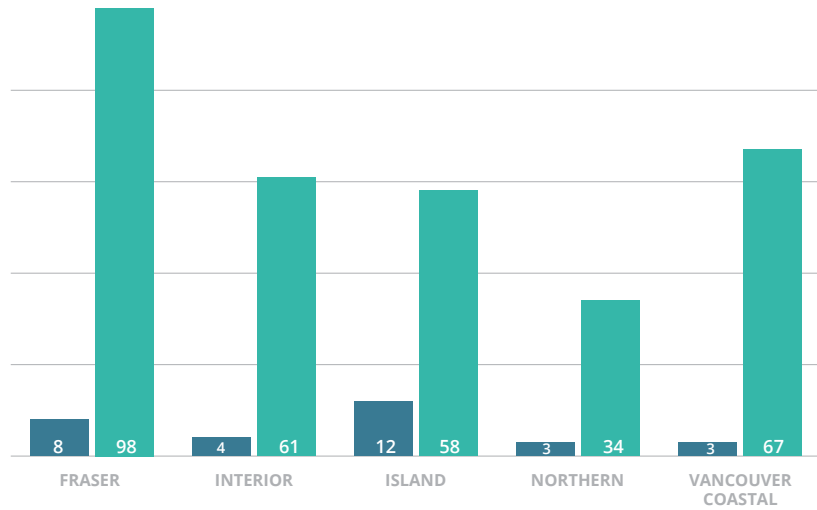
“While there is no single cause of suicide among Indigenous peoples, witnesses suggested a proper understanding of the conditions which cause mental distress and suicide is essential in preventing suicide from taking place. Specifically, factors identified by witnesses that can contribute to the incidence of suicide include historic and intergenerational trauma, the social determinants of health and mental illness.”

(House of Commons Report on the Standing Committee of Indigenous and Northern Affairs)

FIGURE 6

Number of Suicides, 15-24 years, by Health Authority, 2010-2015

■ First Nations
■ non-First Nations



First Nations male and female youth are respectively 5 to 7 times more likely to die by suicide than their non-First Nations peers. (Pike, I, et al., 2014)

This review was consistent with earlier findings. A 2006 BC study identified three leading causes of First Nations injury deaths:

- Motor Vehicle Crashes
- Unintentional Poisonings
- Suicide

(BCIRPU 2006)

COMMON RISK FACTORS

This review identified a set of common risk factors for First Nations youth and young adult deaths. These risk factors included substance use, history of significant personal trauma and mental health issues.

- Alcohol/Substance Use/Impairment was present in over 50% of the deaths.
- Recent trauma had touched the lives of one-third of the young people and most of those who died by suicide.
- Mental health concerns were identified in 25% of the young people’s lives, but only half of them appeared to be accessing or receiving any treatment.

TABLE 2

Rates of Suicide per 100,000 person years

HEALTH AUTHORITY	FIRST NATIONS RATE	NON- FIRST NATIONS RATE
Fraser	81.3	7.0
Interior	12.5	12.8
Island	33.9	11.6
Northern	5.6	18.6
Vancouver Coastal	17.1	7.8

TABLE 3

Alcohol or Drugs as Contributing Factors,
Age 15-24 years, 2010-2015

CLASSIFICATION OF DEATH	FIRST NATIONS (n = 95)	NON-FIRST NATIONS (n = 1,115)	TOTAL
Accidental	42	185	227
Homicide	2	2	4
Suicide	5	24	29
Undetermined	2	14	16
Total	51	225	276

In the BC Injury Research and Prevention Unit (BCIRPU) study, involvement of alcohol and drugs contributed to injury deaths. (BCIRPU 2006)

"Alcohol and drugs were involved in almost one-third of all injuries and more than two-thirds of injuries from assault. Heavy drinkers and cannabis users experienced higher incidence of injury." (FNIGC, 2012)

Approximately 1 in 10 First Nations youth (10%) were under the influence of alcohol, and 4.5% were under the influence of marijuana when their injury occurred. (FNIGC, 2012)

Young drivers indicated that the following factors contributed to drinking and driving: "normalization of the behaviour in the community; role modeling of risky drinking and driving behaviour in the home; poverty; unemployment; and poorly maintained rural roads. The study also identified factors that deterred First Nations youth from drinking and driving such as the trauma of seeing family and community members killed or injured". (PHO 2016)

Substance Use

Alcohol or drugs were identified as contributing factors in 276 injury deaths (23%) of BC youth and young adults. Alcohol and drugs were a contributing factor in over half (54%) of First Nations youth and young adult injury deaths.

For First Nations youth and young adults:

- Alcohol impairment was indicated in 18 (64%) of First Nations MVCs (n=28)
- Alcohol or substance impairment was indicated in all residential fire deaths (n=6)
- Alcohol or substance impairment was indicated in all poisoning deaths (n=12)
- Alcohol or substance impairment was indicated in four (66%) deaths by drowning (n=6)

Approximately one-third of the First Nations decedents in this review (35%, n=33) had a history of addiction to alcohol or illicit substances. Of the decedents who had substance issues, more young people (54%) were addicted to alcohol (n=18), followed by drugs and alcohol (24%, n=8), and drugs (21%, n=7).

Slightly more First Nations youth and young adult males had a history of addiction to alcohol or drugs than First Nations females (55% versus 45% respectively).

History of Trauma

In addition to a background of intergenerational trauma, 30 (32%) of all First Nations decedents had a history of significant, personal trauma. Significant personal trauma was defined as a history of neglect, abandonment, abuse, exposure to domestic violence or a recent death of a close friend or family member.

- Of those youth and young adults who died by suicide, 21 had case notes which indicated past significant personal trauma.
- Of those youth and young adults whose deaths were classified by accidental or undetermined, nine had case notes which indicated past significant personal trauma.

“The effects of trauma can reverberate through individuals, families, communities and entire populations, resulting in a legacy of physical, psychological, and economic disparities that persist across generations.”(National Collaborating Centre for Aboriginal Health, 2016)

One third of First Nation youth reported that one or more parents attended residential school. (FNIGC, 2012)

“The residential school system is a key contributor to historical trauma through forced relocation, spiritual, physical, emotional and sexual abuse, and intergenerational impacts on the descendants of survivors.” (FNHA, 2016)

To address preventable deaths due to injuries in First Nations populations the legacy of historical events and traditional beliefs, values and cultures of First Nations peoples must be recognized. (Campbell, A. 2013)

Mental Health (n=23)

In this review, 23 First Nations youth and young adults who died had a mental health history indicated on their case file. A mental health history includes a notation of: depressive disorders, anxiety disorders, phobias, psychosis or cognitive developmental delays.

Fewer than half (n=11, 48%) of First Nations youth and young adults who died and who had evidence of a mental health history had a record of receiving mental health supports and services either through a family doctor, social worker, school counsellor, community mental health team or psychiatrist.

Recognizing Resilience

Resilience, or the ability to succeed despite the trauma and hardship experienced by individuals and communities as a result of colonization, is a characteristic inherent in many First Nations communities, although the picture of what resilience looks like varies across communities. According to research by Chandler and Lalonde (1998), a central feature of the resiliency of First Nations communities is self-determination, which describes the extent to which a community as a whole has control over access to and use of resources such as land, education, self-government, police and fire services, health services, and cultural facilities.⁷

In Chandler and Lalonde’s work, it was demonstrated that in communities where levels of these resources were high, the number of youth suicides was lower. All of these factors are essential in promoting youth health and safety, and are considered in the recommendations that are put forward in this report.

7 Chandler, M.J. & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada’s First Nations. *Transcultural Psychiatry*, 35(2), 191–219.

PROTECTIVE FACTORS

Studies report a number of social and cultural protective factors for Aboriginal adolescent injury. These in addition to policy changes have shown evidence of preventing deaths and hospitalizations. For example:

- Aboriginal youth who felt they were part of their community, who ate traditional foods, and who had an Aboriginal Elder or Aboriginal education worker who they approached for support were more likely than youth who did not feel part of their community to report good or excellent mental health (87% versus 56%). (McCreary Centre Society, 2016)
- Aboriginal youth who had parents that ate an evening meal with them or knew what they were doing with their spare time were more likely to engage in injury prevention behaviours. (McCreary Centre Society, 2016)
- Studies and youth surveys have indicated how access to programs and engagement in community activities may affect risk taking behaviours.
- “Participation in at least one weekly recreational activity was associated with lower levels of heavy drinking and influenced the rate of change in the frequency of alcohol use over time.” (Rawana, et al., 2012)
- There is evidence that education completion is protective for health.
- “Youth who had supportive relationships at school and felt highly connected to school were more likely to plan to continue their education, less likely to skip class in the past month, or have attempted suicide or self-harmed in the past year compared to those with low school connectedness.” (McCreary Centre Society, 2016)

Higher levels of optimism were found to be protective of alcohol use and heavy drinking in early adolescence and emerging adulthood. (Rawana et al 2012)

These findings are consistent with earlier research that found that optimism was protective not only for substance use, but other mental health risks. (Carver, et al., 2010)

Chandler and Lalonde have examined suicide rates and their patterns among First Nations Bands in British Columbia. Suicide rates were lower for First Nations Bands that had made progress towards self-government and land claims, had cultural facilities to preserve and enrich their culture, and had control over local services such as health care, education, police and fire. (PHO 2007, Chandler and Lalonde, 2009)

Child and Youth Services

Youth services are primarily funded by government and developed or delivered by either government or contracted service agencies including:

- First Nations Health Authority⁸;
- Health Authorities⁹;
- Ministry of Children and Family Development;
- Fee-for-service health professionals;
- Ministry of Health;
- Ministry of Education and School Districts; and
- Local community agencies.

Access to services by children and youth varies across communities.

There is a need to increase the level of cultural humility and cultural safety when offering support, prevention programs and services for First Nations people. Practicing cultural humility is a core value of any work with First Nations peoples.

Being supported by service providers who are knowledgeable in **trauma-informed care** and provide a culturally safe environment will increase the likelihood that youth feel safe when accessing supports and services.

CULTURAL SAFETY is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care.

CULTURAL HUMILITY is a process of self-reflection to understand personal and systemic conditioned biases, and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a life-long learner when it comes to understanding another's experience. Cultural humility enables cultural safety. (First Nations Health Authority, 2016)

Opportunities for Support

Youth and young adults may have contact with multiple agencies (e.g. schools, health care, service providers, or community agencies). These points of contact provide opportunities for further involvement or support.

Parenting

BCCS investigative notes indicated that more than one-fifth (23%, n=22) of the First Nations youth and young adults who died were parents of young children. In this review, 55% were mothers.

- Seven of the decedents with children had contact with MCFD services within a year of their death. Three decedents had children in care of the Ministry.
- Eight (27%) of the youth and young adults who died by suicide were known to have young children.

8 The First Nations Health Authority services provided to First Nations communities through health centres, nursing stations or other agencies delegated to provide services to First Nations people.

9 There are five regional health authorities: Northern, Interior, Vancouver Island, Vancouver Coastal, Fraser and one Provincial Health Services Authority.

BCCS case notes indicated mental health concerns for five youth and young adult who were parenting young children. As well, 47% of youth and young adult decedents who were parenting had a history of alcohol and/or drug misuse.

Parenting families may have more contact with community services and agencies. This may provide opportunities for additional support.

Some examples of maternal child programs include:

- **Seabird Island connects parents with nurses and midwives, providing prenatal and parenting support and information.**
- **Sto:lo Health Agency partners with parents to reduce their stress and grow the essential parenting and life skills that will empower them to provide their children with a safe, loving home, and the inner strengths to reach their highest developmental potential.**

A study looking at adverse childhood experiences has found that there is a relationship of health risk behaviour and disease in adulthood based on childhood emotional, physical or sexual abuse and household dysfunction. (Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., et al., 1998)

The Adverse Childhood Experiences (ACE) study has documented how early childhood experiences are strongly related to development of risk factors for disease and well-being across the life course. (Centers for Disease Control and Prevention, 2016)

School Involvement

As mentioned in this review, 29% of decedents were students (n=28). Of these:

- 14 youth had a history of MCFD involvement within a year of their deaths.
- 11 youth had mental health concerns identified (e.g. depression, anxiety, developmental delay, ADHD).
- Five youth were receiving school supports (e.g. one-on-one support worker at school, modified school week, or a First Nations support worker) or were recommended to be assessed by a psychologist.

Ministry of Children and Family Development Service involvement

The Ministry of Children and Family Development provides a variety of supports and services to families with children. These may include: parenting and family support, child protection services, foster care, youth agreement, child and youth mental health services, and services and medical benefits for children and youth with special needs.

In October 2016, government expanded supports to youth transitioning out of care. The Agreements with Young Adults (AYAs) program covers costs such as living expenses, child care, tuition and health care while a former foster youth attends school or rehabilitation programs. Specifically the expanded support increases the amount of time a youth can receive AYA supports, extends the eligible age of enrollment to 26 years, adds life skills programming, and offers improved access to lower barrier housing for at risk youth.

- In this review, 59% (n = 20) of First Nations youth (15-19 years) had MCFD involvement within 12 months prior to their death with 26% (n = 9) being children in care. As well, 76% (n = 26) of First Nations youth decedents, had received MCFD services at some time in their life (greater than 12 months prior to their death) with 21% (n = 7) being children in care. Youth may have been receiving more than one service.

OTHER EXAMPLES OF COLLABORATIVE APPROACHES WERE IDENTIFIED BY PANEL MEMBERS

- **Ask Auntie.**
- **Indigenous Youth Wellness.**
- **National Collaborating Centre for Aboriginal Health.**
- **McCreary Centre First Nations youth engagement projects.**
- **Healthy Schools BC Committee.**

TABLE 4
Barriers to Service and Care

INDIVIDUAL BARRIERS	COMMUNITY BARRIERS	SYSTEMIC BARRIERS
Lack of knowledge about risks	Remote locations	Impact of the historical legacy of colonization
Lack of transportation to access services	Lack of funding to support community programs	Lack of cultural safety and cultural humility in programs and services available
Anxiety or fear of services	Lack of human resources to support on-reserve programs	Differences in health models (a Western-based biomedical model versus a holistic model of health and wellness)
Fear of stigmatization and discrimination	Jurisdictional barriers between service providers	Jurisdictional barriers such as lack of communication or transition planning between providers and service agencies
Behaviours that do not support health and wellbeing	Perceived lack of community capacity to facilitate change	
Low income or education		

BARRIERS TO SERVICE AND CARE

Some First Nations people may face barriers to accessing health care, social service programs and services. Barriers may exist at the individual level, at the community level and at the broader systemic level (see Table 4).

Case reports indicated the following barriers to accessing supports and services for mental health:

- Decedents declined services, or did not attend services offered;
- Waitlists for Aboriginal Child & Youth Mental Health;
- No Child & Youth Mental Health service provider in the community;
- No referral made to psychiatric assessment services; or
- Stopped taking prescribed medications.

There is a need for greater cultural humility and cultural safety when offering support, prevention programs and services for First Nations people.

SPECIALIZED INVESTIGATIONS

Following a coroner's investigation, recommendations may be put forward to the Chief Coroner for consideration. These recommendations address systemic issues with policies and practices and are intended to prevent future deaths in similar circumstances. Of the cases reviewed there were five cases with Coroners recommendations and one case that went to an Inquest.

Recommendations were directed to the Ministry of Transportation and Infrastructure, the Kamloops Indian Band, the Representative for Children and Youth, Local School District, the Interior Health Authority, Ministry of Children and Family Development, and the BC Injury Research and Prevention Unit.

PART 4

RECOMMENDATIONS

This death review panel has developed a set of recommendations considering the current research and applying this knowledge to First Nations youth and young adult case findings. The recommendations arising from the death review panel were developed in a manner that was:

- Collaborative;
- Attributable to the deaths being reviewed;
- Focused on identifying opportunities for improving public safety and prevention of future deaths;
- Targeted to specific parties;
- Realistically and reasonably implementable; and
- Measurable.

27

The overall findings of this review indicate that injury deaths are preventable.

During this review the panel identified key risk factors in many of the deaths:

- Significant personal trauma touched the lives of a third of the young people who died and most of those who died by suicide.
- Alcohol was a contributing factor in over half (54%) of First Nations youth and young adult injury deaths.

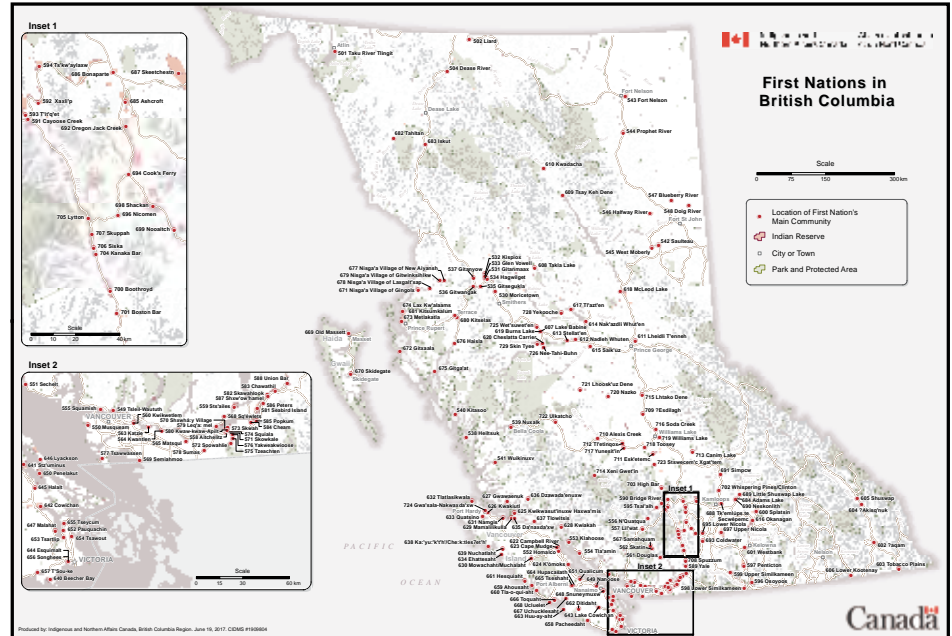
The review also found that there were missed opportunities to provide support for some of the young people who died. This review found that many First Nations young people were engaged in school (29%), or had recent involvement with child welfare or health care programs or services (60%). As well, almost one-quarter of these First Nations young people were parents of young children; bringing them into contact with health programs and services.

The panel identified three key areas to reduce injury deaths and support wellness and wellbeing:

- Connectedness to peers, family, community and culture
- Access to services
- Cultural safety and humility and trauma-informed care

FIGURE 7

First Nations in British Columbia
 SOURCE: Indigenous and Northern Affairs Canada, July 2017
 See Appendix 1 for larger version



28

In developing the recommendations, the Panel recognizes the important role of First Nations communities and culture in responding to injuries and deaths and supporting the wellness and wellbeing of young peoples. It is imperative to have an integrated approach, with services and programs designed by local communities with youth involvement in the development and planning. In BC, there are 203 First Nations communities, spanning vast geography, and many isolated by distance and infrastructure.

These 203 communities are spread across five regional health areas (see Figure 7). They are culturally diverse and unique, representing 34 different languages, 26 cultural groups, with distinct histories, strengths and capacity.

FIGURE 8

Partnerships in Health and Wellness
 SOURCE: First Nations Health Authority



CONNECTEDNESS

For First Nations people, culture and the inter-connectedness of individuals, families, communities and First Nations play an integral role in health and wellness. Studies report a number of social and cultural protective factors for Aboriginal adolescent injury. These, in addition to policy changes, have shown evidence of preventing deaths and hospitalizations.

Aboriginal youth who felt they were part of their community, who ate traditional foods, and who had an Aboriginal Elder or Aboriginal education worker who they approached for support were more likely than youth who did not feel part of their community to report good or excellent mental health. [McCreary Centre Society, 2016]

Geographic remoteness influences disparities in injury rates among Canadians. Although injuries are higher for all populations in rural areas, these rates are higher for First Nations peoples. In this review, more than half (57%) of First Nations youth and young adults who died lived in small population centres (1,000-29,000 residents), or rural areas (25%) (fewer than 1,000 population). Exposure to a harsher physical climate, particularly in remote, northern communities, poor housing conditions, increased use of certain vehicles, such as ATVs and increased use of licit and illicit substances, including alcohol, all contribute to higher levels of unintentional injuries resulting in mortality within First Nations populations.

Many of the young people who died were living on reserve; suicides in particular were five times higher for First Nations youth and young adults living on reserve than off reserve.

A study by Lalonde showed that from 1992-2006, more than 60% of First Nations Bands reported no youth (age 15-24) suicides. The Provincial Health Officer recommended “looking at what works in these communities may help more vulnerable communities to address these issues.” (PHO 2007)

29

Recommendation 1: Promote Connectedness to Peers, Family, Community and Culture

By December 31, 2018, the First Nations Health Authority commits to:

- Encourage communities applying for wellness grants to incorporate traditional healing and ensure that applicants consult and engage with First Nations youth as part of the community wellness grant process.
 - Facilitate at First Nations gatherings such as ‘Gathering Our Voices’ and other community events eliciting youth views about how to increase connectedness, wellness and safety and resilience in their communities.
 - Partner with BC Injury Research and Prevention Unit (BCIRPU) regarding a project whereby youth identify safe/unsafe places in their community.
-

ACCESS TO SERVICES

Youth and young adults may have contact with multiple agencies (e.g. schools, health care, service providers, or community agencies). These points of contact may provide opportunities for further involvement or support. Evidence shows the most effective prevention and intervention programs for Indigenous people are grounded in the wisdom of traditional Inuit, Metis, and First Nation teaching about a holistic approach to a healthy life.” (Chansonneuve D., 2007)

Studies and youth surveys have indicated how access to programs and engagement in community activities may reduce risk taking behaviours. Study findings indicate that engagement in community practices, good school performance, regular church attendance, preserved ties to cultural past and local control, high community social networks and enhanced adult-youth relations and communications appear to protect individuals, families and communities from experiencing suicide. (Isaak, CA., et al, 2010)

Participation in at least one weekly recreational activity was associated with lower levels of heavy drinking and influenced the rate of change in the frequency of alcohol use over time (Rawana et., al, 2012)

As well, data shows that education completion is protective for health. “First Nations adults who reported having graduated from high school reported moderately higher percentages of physical, emotional, mental, and spiritual balance than those that did not graduate from high school, with the largest difference occurring for mental balance.”

This review found that First Nations young people may experience barriers to service.

In this review, 23 First Nations youth and young adults who died had a history of mental health concerns indicated on their case file. However, fewer than half (n=11, 48%) of First Nations youth and young adults who died and who had evidence of a history of mental health concerns had a record of receiving mental health supports and services. For those receiving services, some declined services offered, or did not attend services offered. For others there was a waiting list or a lack of service providers in the community. Fear or mistrust of services, lack of culturally relevant services, or lack of trauma informed practice may prevent young people from accessing care.

**Recommendation 2:
Reduce Barriers and Increase Access to Services**

By December 31, 2018, the First Nations Health Authority in partnership with relevant agencies will:

- Review alcohol education and further develop First Nations harm reduction activities specific for alcohol.
- Achieve the target for trauma informed care training for all FNHA staff.
- Work with partners to increase access to culturally safe treatment services.
- Continue to partner on overdose crises response.

By December 31, 2018, the Ministry of Children and Family Development will:

- Work with BC Housing to increase access to low barrier access to housing for First Nations young people.
- Increase earlier and easier access to prevention focused mental health services.

By March 31, 2018, the First Nations Education Steering Committee and Ministry of Education will engage with First Nations youth on learning needs and what would improve connectedness to school.

By December 31, 2018, the Ministry of Advanced Education, Skills and Training (AEST) in collaboration with First Nations youth will identify and address barriers for First Nations young people entry to post-secondary education.

By December 31, 2018, the Ministry of Health, Ministry of Children and Family Development, and Ministry of Education in collaboration with FNHA will develop a plan to deliver trauma informed training to staff working/delivering services to First Nations young people.

CULTURAL SAFETY

Practicing cultural humility is a core value of any work with First Nations peoples. This approach combined with trauma-informed practice will increase the likelihood that First Nations young people feel safe accessing supports and services. Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances. It results in an environment free of racism and discrimination, where people feel safe when receiving support or services.

Recommendation 3: Promote Cultural Safety

By December 31, 2018, the First Nations Health Authority will collaborate with Ministry of Education and Ministry of Advanced Education, Skills and Training service partners to sign the Declaration of Commitment to advance cultural safety and humility within their organizations.

By December 31, 2018, the First Nations Health Authority will develop an injury surveillance and monitoring strategy.

COMMUNITY ENGAGEMENT

The panel recognized that the lives of the young people reviewed took place in individual communities that have unique needs and traditions and that the broad recommendations could be adopted quite differently based on local needs. It was always the intention of this panel to include local expertise to expand on how the broad recommendations could unfold in a meaningful way within communities. One of the primary purposes of this report is that it be used as a supporting tool to further engage communities on local actions to promote connectedness, reduce barriers to services and ensure cultural safety and humility for young people.

Recommendation 4: Elicit Feedback through Community Engagement

By March 31, 2018, the First Nations Health Authority will complete a community engagement process to elicit feedback on how the broad recommendations can further be adopted within local community actions. An addendum will be created and added to the report with the community responses.

PART 5

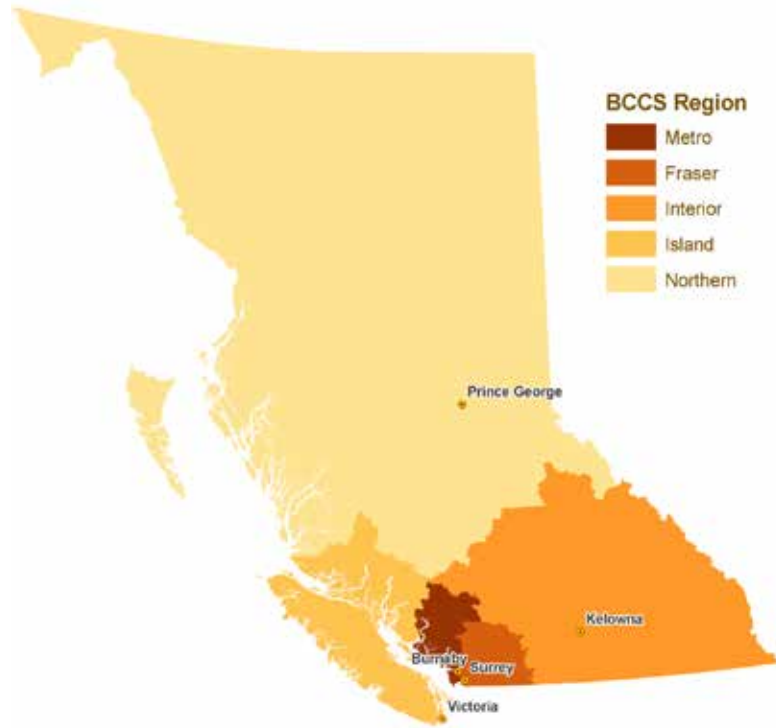
GLOSSARY & REFERENCES

Aboriginal	A collective term used to describe the three constitutionally recognized Indigenous populations in Canada – First Nations ('Status Indians'), Métis and Inuit. While the term Aboriginal is commonly accepted, identifying each of these populations specifically by name is preferable where appropriate.
Aggregate	Presentation of individual findings as a collective sum.
Cultural humility	A process of self-reflection to understand personal and systemic conditioned biases, and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a life-long learner when it comes to understanding another's experience. Cultural humility enables cultural safety.
Cultural safety	An outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care.
First Peoples	Refers to First Nations, Métis, and Inuit Peoples in Canada, as well as Indigenous peoples around the world. The plural 'peoples' recognizes that more than one distinct group comprises the Aboriginal population of Canada compared to singular 'people' which might refer to individuals.
First Nations	The term 'First Nations' has largely become the preferred terminology for Indigenous peoples of North America in what is now Canada, and their descendants, who are neither Métis or Inuit. First Nations people may be 'Status' (registered) or 'non-Status' as defined under the <i>Indian Act</i> .
Indian	Refers to the legal identity of a First Nations person who is registered under the <i>Indian Act</i> . The term 'Indian' should be used only when referring to a First Nations person with status under the ' <i>Indian Act</i> ', and only within its legal context. Aside from this specific legal context, the term 'Indian' in Canada is considered outdated and may be considered offensive due to its complex and colonial use in governing identity through this legislation and other distinctions of 'Treaty, non-Treaty, Status, non-Status'.
Indian Act	The Canadian federal legislation, first passed in 1876, that sets out certain federal government obligations, determines the relationship between Aboriginal peoples and the Canadian government, and regulates the management of reserve lands. It is considered a paternalistic document that determines who is and who is not recognized with constitutionally enshrined rights as an 'Indian' or not. The act has had a largely negative impact on First Nations and Aboriginal peoples and communities, especially women in relation to marriage status transfer, and has led to the division of families and communities.
Indigenous	Is most frequently used in an international or global context and is referred to by the United Nations broadly as 'peoples of long settlement and connection to specific lands who have been adversely affected by incursions by industrial economies, displacement, and settlement of their traditional territories by others'. Similarly the term can also refer to groups of peoples or ethnic groups with historical ties a territory prior to colonization or formation of a nation state. Typically, Indigenous peoples have preserved a degree of cultural and political separation from the mainstream culture and political system of the nation state within the border of which the Indigenous group is located.
Inuit	The Inuit are the Indigenous inhabitants of the Arctic circle. They are a distinct population of Indigenous peoples who are registered as such under the <i>Indian Act</i> . They are united by a common cultural heritage and a common language. 'Inuit' means simply "the people" in Inuktitut.

Métis	Refers to a person who is of mixed First Nation and European ancestry. The Métis Nation Governing Members have formalized a national citizenship definition that is defined as a person who self-identifies as Métis, is of historic Métis ancestry, is distinct from other Aboriginal peoples and is accepted by the Métis Nation. Métis people identify themselves, and are recognized, as distinct from First Nations, Inuit or European descendants. The distinct Métis culture arose after contact with the first European explorer/settlers but prior to colonialism. The term Métis does not simply mean someone of mixed Aboriginal ancestry.
Non-Status Indian	An Aboriginal person who is not registered under the <i>Indian Act</i> . This may be because his or her ancestors were never registered, or because he or she lost status under paternal provisions of the <i>Indian Act</i> .
Sex and Gender	Sex refers to the anatomy of an individual's reproductive system and secondary sex characteristics, whereas gender refers to social roles based on the sex of the person or personal identification based on an internal awareness.
Status Indian	This term, while outdated and inappropriate, is still used in the Canadian government to mean an Aboriginal person who is registered under the <i>Indian Act</i> .
Trauma-Informed	Recognizes and acknowledges the impact of trauma and the need for awareness and sensitivity to its dynamics in all aspects of service delivery.
Trauma-Informed Practice	An approach that both practitioners and organizations can take; the former in terms of clinical practice with individual patients, and the latter in terms of trauma-informed organizational policies which recognize the potential that trauma has occurred and strives to mitigate re-traumatization. <ul style="list-style-type: none"> ▪ Trauma-informed principles include: avoiding re-traumatization, empowering the victim, working collaboratively with flexibility, understanding cycles of trauma and intergenerational trauma and recognizing trauma symptoms as adaptations).

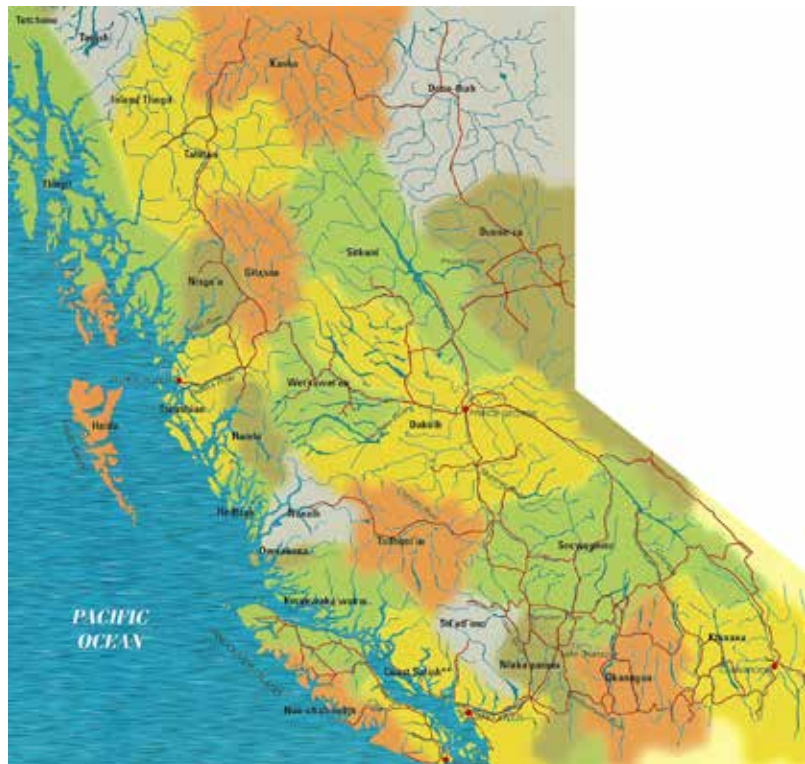
APPENDIX 1:

BC Coroners Service Regions

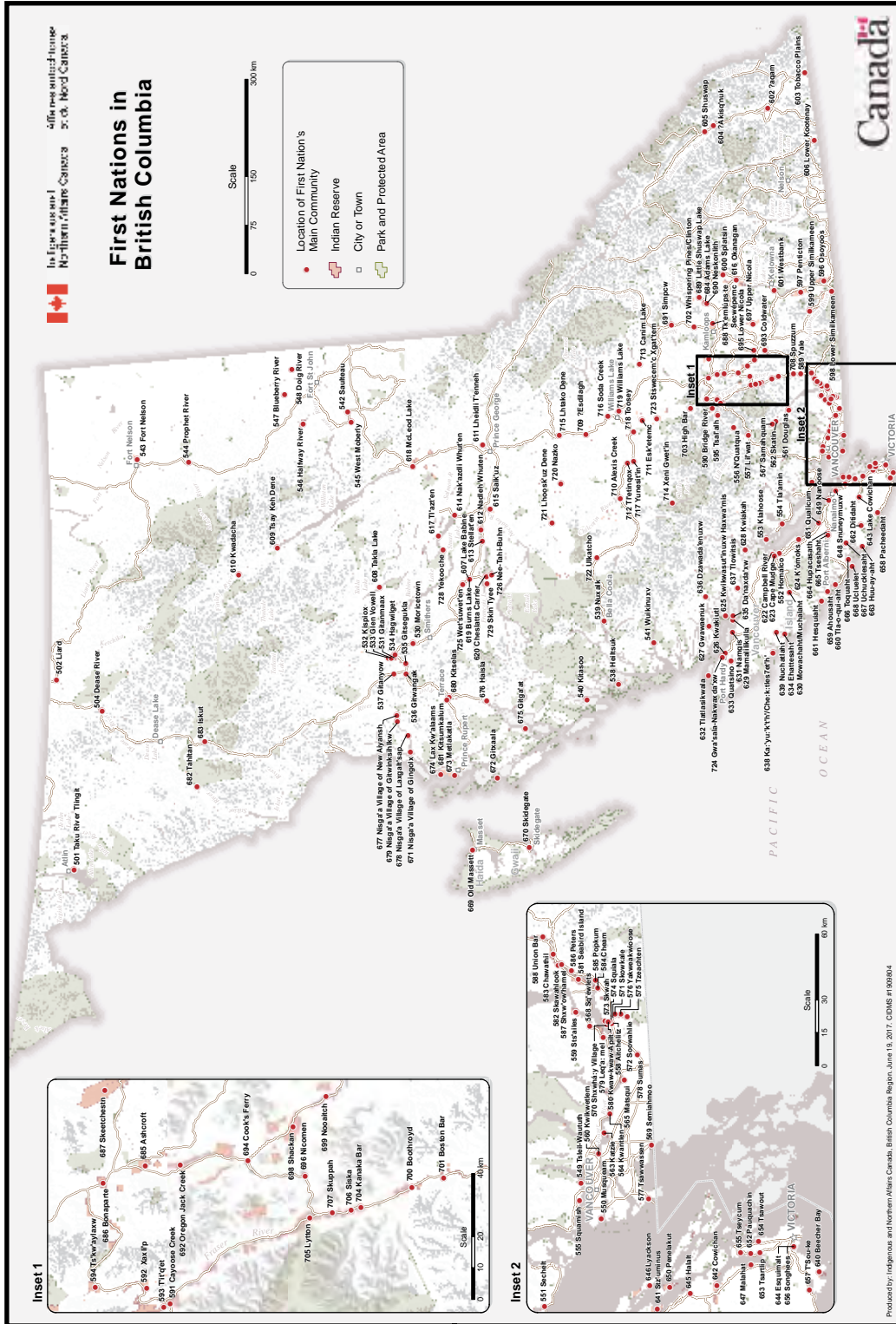


38

First Nations Peoples of BC



First Nations in BC



REFERENCES

- Adams, E., <http://www.fnha.ca/about/news-and-events/news/drug-use-is-a-health-issue-not-a-moral-issue> Accessed August 31, 2016.
- Allard, Y.E., Wilkins, R., and Berthelot, J.M., (2004), Premature mortality in health regions with high Aboriginal populations. *Health Reports*, Volume 15, No. 1, January 2004, Statistics Canada.
- Ames, M.E., Rawana, J.S., Pentile, P., and Morgan, A.S., (2015), The Protective Role of Optimism and Self-esteem on Depressive Symptom Pathways Among Canadian Aboriginal Youth, *Journal of Youth Adolescence* (2015), 44:142-154.
- Asbridge, M., Azagba, S., Langille, D.B., and Rasic, D., (2014) Elevated depressive symptoms and adolescent injury: examining associations by injury frequency, injury type and gender. *BioMed Central, Public Health* 2014, 12:190 doi:10.1186/1471-2458-14-190.
- BC Coroners Service Child Death Review Panel: A Review of Fire-Related Deaths in Children and Youth 2005-2014.
- BC Coroners Service, Preventing Death After Overdose: BC Coroners Service Child death Review Panel, A Review of Overdose Deaths in Youth and Young Adults 2009-2013, January 2016.
- BC Injury Research and Prevention Unit (BCIRPU), (2006), *Injuries Among First Nations People within British Columbia*. Vancouver: BCIRPU. 2006.
- Brussoni, M., George, M.A., Jin, A., Lalonde, C., and McCormick, R., (2016), Injuries to Aboriginal Populations living on- and off-reserve in metropolitan and non-metropolitan areas in British Columbia, Canada: Incident and trends, 1986-2010. *BioMed Central, Public Health*, (2016).
- Campbell, A., (2013), *Aboriginal Unintentional Injury Evidence Review: Epidemiology, Surveillance, Prevention and Frameworks*. March 2013.
- Centers for Disease Control and Prevention, US Department of Health and Human Services <http://www.cdc.gov/violenceprevention/acestudy/index.html> Accessed September 27, 2016.
- Chansonneuve, D., (2007), extracted from *A Compendium of Aboriginal Healing Foundation Research*, 2010) \ <http://www.ahf.ca/downloads/research-compedium.pdf>
- Chen, Y.A., Bridgman-Acker, K., Edwards, J., and Lauwers, A.E., (May 2011). Pediatric fire deaths in Ontario. *Canadian Family Physician*, Vol, 57.
- Drowning Prevention Research Centre Canada, *Canadian Drowning Report 2016 Edition*. http://www.lifesavingsociety.com/media/241812/canadiandrowningreport_english_web.pdf
- Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P., and Marks, J.S., (1998) Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, 1998; 14 (4).
- Fines, P., Bougie, E., Oliver, L.N., and Kohen, D.E., (2013), Hospitalization for unintentional injuries among Canadian adults in areas with a high percentage of Aboriginal-identity residents. *Chronic Diseases and Injuries in Canada* Volume 33, No4, September 2013.
- First Nations Regional Longitudinal Health Survey <http://fnigc.ca/our-work/regional-health-survey/about-rhs.html>
- First Nations Information Governance Centre (FNIGC), (2016), *First Nations Regional Longitudinal Health Survey (RHS) 2002/03, Results for Adults, Youth and Children Living in First Nations Communities* (FNIGC, 2005).
- First Nations Information Governance Centre (FNIGC), (2016), *First Nations Regional Longitudinal Health Survey* <http://fnigc.ca/our-work/regional-health-survey/quick-facts-rhs-200203.html>
- First Nations Information Governance Centre (FNIGC), (2012), *First Nations Regional Health Survey (RHS) 2008/10: National Report on adults, youth and children living in First Nations communities*. Ottawa: FNIGC. 2012 http://fnigc.ca/sites/default/files/docs/first_nations_regional_health_survey_rhs_2008-10_-_national_report_adult_2.pdf
- First Nations Information Governance Centre (FNIGC), (2012), *First Nations Regional Health Survey (RHS) 2008/10: National Report on Youth Living in first Nations Communities* Ottawa: FNIGC. 2012 http://fnigc.ca/sites/default/files/docs/first_nations_regional_health_survey_rhs_2008-10_-_national_report_youth.pdf
- First Nations Health Authority <http://www.fnha.ca/wellness/wellness-and-the-first-nations-health-authority/first-nations-perspective-on-wellness> Accessed August 31, 2016.

- First Nations Health Authority http://www.fnha.ca/newsContent/Documents/FNHA_OverdoseDataAndFirstNationsInBC_PreliminaryFindings_FinalWeb_July2017.pdf
- George, M.A., McCormick, R., Lalonde, C., Jin, A., and Brussoni, M., (2013), The RISC research project: injury in First Nations communities in British Columbia, Canada, *International Journal Circumpolar Health*, 2013 72:21182 – <http://dx.doi.org/10.3402/ijch.v72i0.21182>
- George, M.A., Jin A., Brussoni, M., and Lalonde, C., (January 2015), Is the injury gap closing between the Aboriginal and general populations of British Columbia? Statistics Canada.
- Government of BC, (2016), <https://www.bced.gov.bc.ca/abed/perf2015.pdf> (accessed August 29, 2016).
- Government of BC, (2016), <http://www2.gov.bc.ca/assets/gov/education/kindergarten-to-grade-12/teach/pdfs/curriculum/englishlanguagearts/2010efp1011.pdf> (accessed August 29, 2016).
- House of Commons Report on the Standing Committee of Indigenous and Northern Affairs, (2017), <http://www.ourcommons.ca/Content/Committee/421/INAN/Reports/RP8977643/inanrp09/inanrp09-e.pdf> Accessed August 29, 2017.
- Indigenous and Northern Affairs Canada. <https://www.aadnc-aandc.gc.ca/eng/1100100014265/1369225120949> Accessed August 22, 2016.
- Indigenous and Northern Affairs Canada, 2016 https://www.aadnc-aandc.gc.ca/DAM/DAM-INTER-BC/STAGING/texte-text/inacmp_1100100021016_eng.pdf
- Indigenous and Northern Affairs Canada, First Nations Profiles <http://fnp-ppn.aandc-aadnc.gc.ca/fnp/Main/index.aspx?lang=eng>
- Injury Prevention Intervention Strategies Among Aboriginal Peoples: A systematic Review of Literature and Preliminary Report of Aboriginal Injury Preventions Programs in BC (2007).
- Isaak, C.A., Campeau, M., Katz, L.Y., Enns, M.W., Elias, B., and Sareen, J., (2010), Community-based Suicide Prevention Research in Remote On-Reserve First Nations Communities (2009) *International Journal Mental Health and Addiction* (2010) 8:258-270.
- Kann, L., McManus, T., Harris, W.A., et al. (2016), Youth Risk Behavior Surveillance — United States, 2015. *MMWR SurveillSumm* 2016; 65(No. SS-6):1–174. DOI:<http://dx.doi.org/10.15585/mmwr.ss6506a1>
- Karmali, S., Laupland, K., Harrop, R., Findlay, C., Kirkpatrick, A.W., Winston, B., Kortbeek, J., Crowshoe, L., and Hameed, M., (2005), Epidemiology of severe trauma among status Aboriginal Canadians: a population-based study (2005) *CMAJ* 2005;172(8): 1007-11.
- McCreary Centre Society (2016), *Raven's Children IV, Aboriginal youth health in BC*, Vancouver, 2016. Accessed from www.mcs.bc.ca
- McCreary Centre Society (2012), *Raven's Children III, Aboriginal youth health in BC*, Vancouver, 2012. Accessed from www.mcs.bc.ca
- Morrongiello, B.A., and Dawber, T., (2000), Mothers' responses to sons and daughters engaging in injury-risk behaviors on a playground: Implications for sex differences in injury rates. *J Exp Child Psychol* 2000; 76(2):89-103.
- National Aboriginal Health Organization (NAHO) (2006), *Resources for First Nations on Injury Prevention: Annotated Bibliography* http://www.naho.ca/documents/fnc/english/FNC_InjuryPreventionAnnotatedBibliography.pdf
- Nutton, J., and Fast, E., (2015), *Historical Trauma, Substance Use, and Indigenous Peoples: Seven Generations of Harm From a "Big Event"*, Centre for Research on Children and Families, McGill University, June 2015, DOI: 10.3109/10826084.2015.1018755
- Pike, I., McDonald, R.J., Piedt, S., and Macpherson, A.K., (2014) *Developing injury indicators for First Nations and Inuit children and youth in Canada; a modified Delphi approach*, *Chronic Diseases and Injuries in Canada*, Volume 34, No 4, November 2014.
- Olsen, L., Smith, D., Turkotte, K., and Pike, I., (2007), *Injury Prevention Intervention Strategies Among Aboriginal Peoples: A systematic Review of Literature and Preliminary Report of Aboriginal Injury Preventions Programs in BC, Preliminary Report*, BC Injury Research Prevention Unit, Vancouver, BC 2007).
- Provincial Health Officer Annual Report (2007): *Pathways to Health and Healing, 2nd Report on the Health and Well-being of Aboriginal People in British Columbia*, Office of the Provincial Health Officer, BC Ministry of Health, 2016.

- Provincial Health Officer Annual Report (2011): Where the Rubber Meets the Road: Reducing the impact of Motor Vehicle Crashes on Health and Well-being in BC, Office of the Provincial Health Officer, BC Ministry of Health, 2016.
- Public Health Agency of Canada, (2009), Child and Youth Injury in Review. Retrieved from https://northernhealth.ca/Portals/0/Your_Health/Programs/Injury%20Prevention/Child%20and%20Youth%20Injury%20in%20Review%202009%20Edition.pdf August 31, 2016.
- Public Health Agency of Canada, (2013), Injury Section analysis of mortality data from Statistics Canada. <http://www.phac-aspc.gc.ca/publicat/lcd-pcd97/pdf/lcd-pcd-t1-eng.pdf>
- Rawana, J.S., and Ames, M.E., (2012), Protective Predictors of Alcohol Use Trajectories Among Canadian Aboriginal Youth, *Journal of Youth Adolescence* (2012) 41L229-243.
- Statistics Canada, CANSIM. Leading causes of death, total population, by age group and sex, Canada, annual, 2000 to 2012 (102-0561) <http://www5.statcan.gc.ca/cansim/a33?RT=TABLE&themeID=2979&spMode=tables&lang=eng>
- Svoboda, T.J., Shah, C.P., and Robert J., (1997), The Impact of Unemployment on Health: A review of the Evidence, *Journal of Public Health Policy*. 1997, Vol. 18 Issue 3, p275-301.
- Tommyr, L., and Blackstock, C., (2010), Commentary: Indigenous Health Special Issue. *International Journal Mental Health and Addiction*, 2010, 8:135-144.
- Transport Canada, Road Safety in Canada, 2011 <https://www.tc.gc.ca/media/documents/roadsafety/tp15145e.pdf> Accessed April 3, 2017.
- Walls, M.L., Hautala, D., and Hurley J., (2014), Rebuilding our community: Hearing silenced voices on Aboriginal youth suicide. *Transcultural Psychiatry* (2014) Vol. 51(1) 47-72.
- Wesley-Esquimaux, C.C., and Smolewski, M., (2004), *Historic Trauma and Aboriginal Healing*. Ottawa: Aboriginal Healing Foundation. Retrieved from www.ahf.ca/downloads/research-compedium.pdf

FOR FURTHER INFORMATION CONTACT:



Coroners Service

BC Coroners Service

PO Box 9259, Stn Prov Govt
Victoria BC V8W 9J4

Phone: 604 660-7745
Fax: 604 660-7766



First Nations Health Authority
Health through wellness

First Nations Health Authority

501-100 Park Royal South
West Vancouver, BC V7T 1A2

Phone: 604.693.6553
Fax: 604.913.2081

