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Risk and Protective Factors for Suicide among Inuit in Canada

A Summary of Statistics Related to Suicide and Mental
Health

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Conflict of Interest

The author does not have any conflicts of interest to declare.



Executive Summary

Key Messages

- The risk of suicide is elevated among northern Inuit communities in Canada because of intergenerational trauma from colonization, marginalization and the loss of the traditional Inuit lifestyle. This trauma has created social and economic inequities among Inuit communities.
- Mental distress, including problematic substance use, mental health disorders and self-harm, are important risk factors for suicide among Inuit. These risk factors are often downstream symptoms of social, cultural and economic disruption.
- Statistics on substance use patterns, mental health and the social determinants of health among Inuit populations are important for informing suicide prevention activities. Collecting these data is part of the National Inuit Suicide Prevention Strategy developed and led by Inuit Tapiriit Kanatami.
- Given the high prevalence of non-medical cannabis use among Inuit, more research is needed on the impacts of cannabis use on mental health and other health-related outcomes.
- Improving research and data collection on factors related to suicide among Inuit is needed for suicide surveillance and prevention. These efforts are consistent with the Truth and Reconciliation Commission, which underscores the need for population health data for Inuit.
- Improving the social determinants of health, including housing, education and access to culturally safe health care, is integral for mental well-being and suicide prevention at the population level.

Introduction

Inuit have some of the highest suicide rates in Canada, ranging from five to 25 times higher than the general population, depending on the Inuit region. Suicide prevention is one of the highest priorities for Inuit Tapiriit Kanatami (ITK), the national organization representing Inuit across Canada. Intergenerational trauma from colonization, marginalization and the loss of the traditional Inuit lifestyle has created widespread social and economic inequities among Inuit and elevated risk for suicide in Inuit communities in Canada. Problematic substance use¹ is also a strong predictor of suicide risk (Canadian Centre on Substance Abuse, 2016) and one of the priorities of the Canadian Centre on Substance Use and Addiction (CCSA) is to address the harms related to substance use through meaningful collaboration with Indigenous organizations.

ITK developed the National Inuit Suicide Prevention Strategy (NISPS) in 2016. The strategy recognizes the root causes of what makes Inuit susceptible to suicide risk and provides a holistic approach to suicide prevention. It continues to be an essential tool in guiding community service providers, policy makers and governments to work together to reduce the rate of suicide among Inuit in Canada. The NISPS also promotes a shared understanding of underlying risk and protective factors for suicide among Inuit. One of the priorities in the NISPS is the acquisition and dissemination of accurate data that reflects the most up-to-date statistics about suicide and suicide risk (Inuit Tapiriit Kanatami,

¹ Problematic substance use is defined as a harmful pattern of alcohol or other substance use that negatively impacts one's health and life.



2016). This data is important for monitoring the health and well-being of Inuit populations in Canada, and for informing ITK's research agenda and ongoing suicide prevention activities.

This report synthesizes statistics on mental health, substance use and the social determinants of health that influence suicide risk among Inuit who live across Northern Canada. In line with CCSA's priority to address harms related to substance use, statistics for alcohol, cannabis and other substance use are captured among the factors related to suicide risk. The report is intended to be a resource for Inuit associations and affiliated organizations, including ITK, those working in suicide prevention, and researchers and policy makers who require the most recent statistics related to suicide risk and the broader mental well-being of Inuit in Canada.

Methods

Statistics are from the 2012 and 2017 [Aboriginal Peoples Survey](#) (APS), with estimates from the [Inuit Health Survey 2007–2008](#) (IHS) included for reference. Direct comparisons between the IHS and APS are not possible due to different survey methodologies and questionnaires. The APS is a national survey conducted by Statistics Canada on the social and economic conditions of First Nations people living off-reserve, Métis and Inuit. The APS survey design allows for the analysis of data specific to Inuit for all Inuit regions of Northern Canada. These surveys are limited in scope to providing statistics on the risk and protective factors related to suicide as outlined by the NISPS. The prevalence of risk and protective factors related to mental health and suicide among Inuit were broken down by regions of Inuit Nunangat,² as well as by age and sex, where possible. Statistical analyses were conducted using the 2017 APS data to assess the association between non-medical cannabis use and selected mental health outcomes, including suicide ideation and attempt.

Results

In accordance with the priorities laid out in the NISPS, this report presents data on the prevalence of indicators related to suicide, mental wellness and the social-determinants of health among Inuit who live in Inuit Nunangat. Substance use patterns are included among this suite of indicators.³ A total of 17 indicators related to suicide risk and five indicators related to suicide protection are presented, with prevalence estimates broken down by sex, age and region. The indicators include a wide range of factors, from individual risk factors such as previous suicidal thoughts or attempts, to community-level factors related to social and economic well-being, such as access to health care and food insecurity. The results highlight that Inuit in northern communities continue to experience a range of social and economic adversity that impacts mental health, including a lack of access to health care (17%), food insecurity (at least 30%), inadequate household income (50%) and dissatisfactory housing conditions (30%).

Most risk factors detailed in this report (10 out of 17) relate to mental health and substance use. Key findings about mental health and substance use among Inuit across Inuit Nunangat include:

- In 2017, 5.8% (age 18+) reported having suicidal thoughts in the past year and 2.1% reported attempting suicide. The lifetime prevalence of attempted suicide increased 3.5 times between 2012 and 2017, with the largest increases occurring among males (four times) and those aged 18 to 54 (four times).

² The majority of Inuits (73%) live in communities spread across Inuit Nunangat, which contains five regions: the Inuvialuit Settlement Region (Northwest Territories), Nunavut, Nunavik (Northern Quebec) and Nunatsiavut (Northern Labrador).

³ An indicator is a measure of a factor related to the health of a population.



- Heavy episodic drinking is associated with suicide risk.⁴ Almost one-third of Inuit (age 15+) reported heavy episodic drinking at least once a month in 2017.
- In 2017, 20% (age 15+) reported daily or almost daily cannabis use. Daily or near daily cannabis use was associated with increased odds of reporting suicide ideation or attempt in the past year.
- The use of other illegal substances in Inuit Nunangat is low. Approximately 1% reported monthly or more frequent use of other illegal substances such as cocaine or solvents.
- In 2017, 13% (age 18+) reported having a mental health condition, including anxiety, depression, bipolar disorder, substance use disorder or anorexia. 22% indicated they had consulted with someone about their mental health or substance use.⁵
- Statistical analyses showed that daily or near daily cannabis use was associated with increased odds of reporting suicide ideation or attempt in the past year among Inuit in Canada (aged 15+). Any past year cannabis use was associated with increased odds of self-reporting a mood disorder, such as depression, bipolar disorder, mania or dysthymia.

Conclusions

This report provides an overview of factors related to substance use, mental health and suicide among Inuit. The results underscore the importance of public education efforts about safe and responsible ways to drink alcohol and use cannabis. Such education includes understanding the risks associated with frequent alcohol and cannabis use, including impacts on mental health. Information about the link between cannabis use and mental health outcomes presented in this report can help inform suicide prevention activities and identify individuals who may be at risk for self-harm.

The report highlights the importance of having an Inuit health survey governed and led by Inuit to help ensure that data reflect Inuit health and wellness accurately. It will, however, still be helpful to integrate Inuit indicators into other population health datasets, and for these datasets to improve data quality, comprehensiveness and timeliness. These other data collection and reporting platforms need to ensure that data is collected in consultation with Inuit partners and accessible to Inuit partners and rights holders.

The report also highlights the need to collect information on the harms associated with substance use among Inuit, in addition to information on the prevalence and frequency of substance use. Research and data collection efforts also need to recognize the importance of strengths-based approaches to limit stigmatizing narratives and to inform the development of programs that build on individual and community resilience.

⁴ Heavy episodic drinking is defined for males as having five or more drinks and for females having four or more drinks on one occasion.

⁵ This figure includes consultation with a healthcare practitioner, family member, friend or member of the community.



Introduction

Background

One of CCSA's overarching priorities is to address the harms related to substance use through meaningful collaboration with Indigenous organizations. CCSA is therefore learning from and collaborating with Inuit Tapiriit Kanatami (ITK), the national organization representing Inuit across Canada. Inuit make up about 5% of Indigenous peoples in Canada, totalling over 65,000 people in 2016 (Inuit Tapiriit Kanatami, 2018). The majority (73%) live in communities spread across the Inuvialuit Settlement Region (Northwest Territories), Nunavut, Nunavik (Northern Quebec) and Nunatsiavut (Northern Labrador). Collectively, these regions are known as Inuit Nunangat, meaning the "lands, waters, and ices of the [Inuit] people" (Inuit Tapiriit Kanatami, 2019a).

Inuit Nunangat has the highest suicide rates in Canada, ranging from five to 25 times higher than the Canadian average, depending on the specific Inuit region. Suicide prevention is one of ITK's highest priorities and has been identified as "the most urgent challenge" (Inuit Tapiriit Kanatami, 2016). The high rates of suicide in Inuit Nunangat stem from the effects of colonization, marginalization, the transition to permanent settlements and the loss of the traditional Inuit lifestyle of harvesting and gathering food on the land (Inuit Tapiriit Kanatami, 2016). These effects led to intergenerational trauma and widespread social and economic inequities between Inuit Nunangat and most regions of Canada, creating an elevated risk for suicide in Inuit communities.

A focus on the social-determinants-of-health is fundamental in understanding the disproportionate health burden experienced by Inuit in Canada (Public Health Agency of Canada, 2018). Social and economic inequities in Inuit Nunangat continue to be barriers to health and well-being. Substance use harms, mental illness, suicide and family violence are examples of lasting intergenerational impacts of historical trauma, racism and loss of traditional institutions. Improving the social determinants of health, including housing, education and access to culturally safe health care, is integral for mental well-being and suicide prevention at the population level. ITK recognizes that Inuit have a leading role in suicide prevention and that Inuit must decide how to address the challenges in their communities (Inuit Tapiriit Kanatami, 2016).

The National Inuit Suicide Prevention Strategy

ITK released the National Inuit Suicide Prevention Strategy (NISPS) in July 2016 to provide a coordinated, evidence-based, national response to suicide prevention. The strategy recognizes the root causes of what makes Inuit susceptible to risk and provides a holistic approach to suicide prevention. It focuses on interventions and supports earlier in life so that individuals are less likely to reach a place in their lives where they might contemplate suicide. These interventions and supports are informed by evidence about suicide risk and protective factors among Inuit individuals, families and communities. The suicide prevention strategy aims to reduce the occurrence and prevalence of suicide risk factors while increasing the occurrence and prevalence of protective factors. The strategy is an essential tool in guiding community service providers, policy makers and governments in working together to reduce the rate of suicide in Inuit Nunangat. The NISPS promotes a shared understanding of underlying risk and protective factors for suicide among Inuit.



National Inuit Suicide Prevention Strategy Working Group

ITK coordinates the NISPS Working Group, which works to implement the NISPS at both national and regional levels. The Working Group consists of members from the Inuit Land Claim Organizations (or designates) with experience in suicide prevention in their respective regions. The group also includes representatives from Pauktuutit Inuit Women of Canada, the Inuit Circumpolar Council Canada, the National Inuit Youth Council and ITK. The NISPS Working Group performed an expert review of this report.

Suicide Risk and Protective Factors in Inuit Populations

Understanding risk and protective factors for suicide among Inuit populations is central to the NISPS (Inuit Tapiriit Kanatami, 2016). The most prevalent suicide risk and protective factors as defined by ITK in the NISPS are listed in Table 1.

Table 1. Risk and protective factors for suicide among Inuit in Inuit Nunangat (Inuit Tapiriit Kanatami, 2016)

Risk factors	Protective factors
Historical trauma (e.g., impacts of colonialism)	Cultural continuity (e.g., connection to Inuit language, culture, and history)
Community distress (e.g., social inequities such as crowded housing, food insecurity, lack of access to services)	Social equity (e.g., adequate access to economic, educational, health and other resources)
Wounded family (e.g., intergenerational trauma, family violence, family history of suicide)	Family strength (e.g., safe, supportive and nurturing homes)
Traumatic stress and early adversity (e.g., prenatal stress, witnessing or experiencing physical or sexual assault)	Healthy development (e.g., providing safe and nurturing environments for children)
Mental distress (e.g., depression, substance use and mental health disorders, self-harm)	Mental wellness (e.g., access to Inuit-specific mental health services and supports)
Acute stress (e.g., intoxication, access to lethal means)	Ability to regulate and cope with acute stress

Suicide risk factors are characteristics or circumstances that increase the likelihood that someone will consider, attempt or die from suicide. Many of the risk factors Inuit face today were set in motion by colonial processes and have been transmitted across generations, creating conditions that compound multiple risk factors. Some of these risk factors occur at the community level (e.g., exposure to suicide, historical and intergenerational trauma) and some occur at the individual level (e.g., mental health and substance use disorders). Risk factors can accumulate throughout life. Many Inuit face individual risk factors in addition to being exposed to risk factors in the community. Decreasing the prevalence and impacts of these risk factors can ultimately reduce suicide rates (Inuit Tapiriit Kanatami, 2016; Saxena, Krug, & Chestnov, 2014).

Similarly, increasing the prevalence and impacts of protective factors can also reduce suicide rates (Saxena et al., 2014). Protective factors decrease the likelihood that someone will consider, attempt or die from suicide, and can help mitigate the negative effects of risk factors. Risk and protective factors provide target areas on which to focus suicide interventions in both individuals and communities. Under the guidance of the NISPS, communities across regions of Inuit Nunangat are implementing programs and interventions to reduce risk factors and increase protective factors.



Substance Use and Suicide among Inuit

Harms associated with substance use are a primary health and social concern in Inuit communities (Cameron, 2011; Fortin, Bélanger, Boucher, & Muckle, 2015; NVision Insight Group, 2018). Issues around substance use in Inuit Nunangat are determined by unique geographical, historical and cultural contexts, which need to be understood when evaluating the association between substance use and suicide. Substance use is considered to be a downstream symptom of social, cultural and economic disruption. Negative impacts can occur when substances are used to cope with adverse living conditions or mental distress. Not all substance use presents health and social concerns, and negative impacts from substance use, including risk for suicide, are generally linked to weekly or more frequent patterns of use over a period of months or years.

The NISPS discusses substance use and suicide among the Inuit as follows (emphasis added):

The social challenges that emerged in settlements under these stressful conditions included increased **substance misuse** and violence. Many Inuit encountered **alcohol** for the first time in settlements during a period when people were struggling to cope with trauma symptoms linked to the loss of loved ones to disease, residential school experiences, and the immense stress placed on our culture and way of life. (p. 16)

... a significant number of Inuit who die by suicide have experienced child maltreatment or present symptoms that are associated with maltreatment and trauma, such as high levels of impulsiveness, aggression, **substance misuse** and depression. (p. 21)

The *Nunavut Suicide Follow-Back Study* found greater rates of depression, personality disorder, **substance misuse**, and also characteristics of impulsivity and aggression (which may be underlying aspects of a mental disorder) in Inuit who died by suicide between 2003 and 2006, compared with people of a similar gender and age who did not die by suicide. (p. 23)

Alcohol, tobacco and cannabis are the most frequently used substances among Inuit. Alcohol and cannabis have both been linked to suicide among Inuit (Chachamovich et al., 2015). Patterns of alcohol and cannabis consumption in Inuit Nunangat are generally different compared to other regions of Canada. Consumption of alcohol overall is less frequent than the national average, but rates of heavy episodic drinking are much higher (Decaluwe, Fortin, Moisan, Muckle, & Belanger, 2019; Fortin et al., 2015). Heavy episodic drinking, also known as “binge” drinking, is defined for males as having five or more drinks and for females having four or more drinks on one occasion. It is more likely to be associated with violence, different kinds of abuse, self-inflicted injury and death, and other negative outcomes (Nunavut Liquor Act Review Task Force, 2012). Cannabis is also commonly used by Inuit in Canada, but there is less research examining the prevalence and impact of cannabis use among Inuit (Wolfson et al., 2020).

Monitoring the prevalence and patterns of substance use is important for mitigating the suicide risk associated with it; however, the availability of this data for Inuit is currently limited compared to the general Canadian population. There is also a lack of data on substance-related harms, including the role of the acute use of substances on suicidal risk among Inuit. ITK and the NISPS Working Group are working to improve data collection and reporting efforts to improve surveillance of factors related to suicide, including substance use.



Report Objectives

This report was developed by the Canadian Centre on Substance Use and Addiction (CCSA) in collaboration with ITK and the NISPS Working Group. Its purpose is to share statistics related to substance use, mental health and the social determinants of health among Inuit and is informed by the NISPS. ITK continues to gather and communicate data related to suicide and suicide attempts among Inuit, and the data summarized in this report is meant to support this work. The summary is intended to be a resource for Inuit associations and affiliated organizations, including ITK, those working in suicide prevention, and researchers who are interested in information about suicide risk and protective factors among Inuit, as well as the broader mental well-being of Inuit.

CCSA is a national leader in its field, and is able to reach a diverse audience of partners, stakeholders, healthcare professionals, researchers and the Canadian public. This report is also intended to increase awareness about the NISPS and the research and data collection needs for substance use and other factors related to suicide and mental well-being among Inuit in Canada.

Tracking data on risk and protective factors for suicide among Inuit is important for monitoring the progress of the NISPS, and quantitative data related to these factors will help inform ongoing suicide prevention initiatives and future research agendas. The data summarized in this report include a comprehensive list of statistics on the prevalence of risk and protective factors related to suicide among Inuit, broken down by the regions of Inuit Nunangat, as well as by age and sex, where possible. These statistics are from the [Inuit Health Survey 2007–2008 \(IHS\)](#), and the 2012 and 2017 [Aboriginal Peoples Survey \(APS\)](#).

In line with CCSA's priority to address harms related to substance use, prevalence statistics for alcohol, cannabis and other substance use are captured in the suite of risk factors related to suicide among Inuit. A lack of quantitative data on substance use trends over time among Inuit is an information gap. While this report offers some discussion on these statistics, conclusions about the causes, trends or meaning of the data are beyond the scope of this report. Any comparison of Inuit statistics from the Aboriginal Peoples Survey with other Canadian and Indigenous populations is also out of scope.

Cannabis use was identified as an important focus given the recent legalization of non-medical cannabis use and that research into the mental health outcomes of cannabis use among Inuit was identified as a knowledge gap during an Inuit Forum on Cannabis and Mental Health. The forum, held in Happy Valley-Goose Bay, Newfoundland and Labrador, in October 2019, recommended monitoring the use of cannabis and its health impacts among Inuit as a research priority (Mental Health Commission of Canada, Canadian Centre on Substance Use and Addiction, and Inuit Tapiriit Kanatami, 2019). A recent scoping review on cannabis prevalence and interventions among Inuit communities also concluded there is limited evidence about cannabis use among Inuit (Wolfson et al., 2020). Therefore, in addition to prevalence statistics for cannabis use, this report also presents the results of an analysis to better understand the linkage between cannabis use and mental health and suicide among Inuit. This analysis can help inform key messages and Inuit-led research on cannabis and suicide prevention. Overall, the report demonstrates a need for an improved framework of data collection related to health and well-being among Inuit, including data related to substance use and substance-related harms.



Methods

Surveys

The statistics in this report are from the following sources:

- The [Inuit Health Survey 2007–2008](#) (IHS), led by the Centre for Indigenous Peoples' Nutrition and Environment at McGill University, is the first comprehensive survey examining the health of Inuit in Nunavut, Nunatsiavut and the Inuvialuit Settlement Region across 33 coastal communities and three inland communities. The survey was participative in nature, involving a combination of self-administered questionnaires, interviewer-completed questions and a clinical component collecting physiological data. A total of 2,796 Inuit households were approached in late summer and fall of both 2007 and 2008, with 1,901 households (68%) participating for a total sample size of 2,595 adults. To facilitate comparison with the previous [Nunavik Inuit Health Survey 2004](#), the questionnaire used many of the same items and wording. The Nunavik survey, conducted by the Institut national de santé publique du Québec, collected data across all 14 Nunavik communities in late summer and fall of 2004 and included an individual questionnaire administered in face-to-face interviews with subjects aged 15 and over. Among eligible households, 521 agreed to participate in the Nunavik survey and 1,006 individuals answered the questionnaire.
- The 2012 and 2017 [Aboriginal Peoples Survey](#) (APS) conducted by Statistics Canada is a national survey on the social and economic conditions of First Nations people living off-reserve, Métis and Inuit. The 2012 survey is the fourth cycle of the survey and the 2017 APS is the fifth; both follow the same thematic approach. The APS is a sample survey, drawn from the 2016 Census of Population, with a cross-sectional design. The 2017 APS was conducted from January to August 2017 and the 2012 APS from February to July 2012. The survey design allows for the analysis of each Indigenous group and reliable data for each of the four Inuit regions across three targeted age groups: 18 to 24, 25 to 54, and 55 and over. Those aged 15 to 17 were also sampled, and data is included for this age group for some indicators where available. The total sample size for Inuit Nunangat was 4,639 with an 84.5% response rate.

The IHS and APS are the only two surveys that provide population-level data on all Inuit who live in Inuit Nunangat. Both surveys are limited in their ability to provide statistics on all risk and protective factors for suicide outlined in the NISPS and both questionnaires lack a balanced representation of protective factors. In addition, the APS captures a broad range of health and socioeconomic information across all Indigenous populations in Canada, and may not fully capture the most relevant statistics related to the health and wellbeing of Inuit living in Inuit Nunangat.

Analysis

Prevalence estimates for each indicator⁶ in the 2012 and 2017 APS are presented in this report as a proportion (%) of all survey respondents with accompanying 95% confidence intervals (CIs). Missing values, including “don't know,” “not stated” and “refusal,” were excluded from the denominator when calculating percentages. Weights were applied to each case so that the sample and the proportions within the sample reflected the total population being estimated. Significant differences were determined by assessing whether 95% CIs overlapped. If there was no overlap, estimates were

⁶ An indicator is a measure of a factor related to the health of a population.



considered significantly different at $p < 0.05$. Where data variability and sample size permit, estimates by sex at birth (male, female), age group and region are reported. Prevalence estimates from the IHS and the Nunavik Inuit Health Survey 2004 were obtained from primary reports.

The results section of this report presents the most recent prevalence estimates from the 2017 APS, with results from 2012 APS discussed in the text for reference. Operational definitions from the 2017 APS questionnaire are provided in Appendix A for all survey questions included in the summary. Estimates for each indicator are further described in detail in Appendix B, including results from the IHS. Comparisons between the IHS and APS should be interpreted with caution given different survey methodologies and questions. Additional indicators from the IHS relevant to suicide risk and protective factors are included in Appendix C.

Multivariate logistic regression analyses were conducted using the 2017 APS data to assess the association between non-medical cannabis use and selected mental health indicators. The analysis included the entire Inuit population of Canada, both inside and outside of Inuit Nunangat. Regression models using past-year non-medical cannabis use as the independent focal variable were conducted for each of the following five outcomes, all self-reported in response to the APS question cited: (1) ever contemplated suicide in the past year (SU_Q10); (2) ever attempted suicide in the past year (SU_Q20); (3) poor general mental health (GMH_Q05); (4) mood disorder (CC_Q80); and (5) anxiety disorder (CC_Q85) (see Appendix A for survey questions). Past-year cannabis use was separated into three predicting values: daily or near-daily use, less than daily use and no use. Each model controlled for the following factors: age, sex, region, median income, past-year alcohol use and past-year use of other illegal drugs (referred to as “street drug use” in the APS questionnaire). Age and income variables are included as categorical variables for ease of interpretation.



Results

Overview

Prevalence statistics from the 2017 APS are presented by sex, age and region for indicators related to risk and protective factors for suicide among Inuit. All figures are derived from data from the 2017 APS. Comparison between 2012 and 2017 are summarized in the text when possible. Due to the lack of comparability across different survey methodologies, statistics from the Inuit Health Survey 2007–2008 and the Nunavik Inuit Health Survey 2004 are summarized in appendices B and C. Most indicators from the 2017 APS relate to a select number of risk or protective factors. Specifically, indicators related to mental distress, substance use and community distress are heavily represented in the results, while there were no indicators from the 2017 APS that aligned closely with acute stress or loss, traumatic stress and early adversity, wounded family, family strength, healthy development and coping with acute stress.

Regional Differences

The statistical summary of risk and protective factors related to suicide from the 2017 APS in this report show significant variations in prevalence of risk factors based on region of Inuit Nunangat (Figure 1).⁷ Key regional differences regarding mental health outcomes and substance use include:

- Among regions of Inuit Nunangat, the lifetime prevalence of suicidal thoughts and attempts were the lowest in Nunatsiavut and the highest in Nunavik.
- Inuit living outside Inuit Nunangat had a lower prevalence of reporting any past-year suicide attempts when compared to those living in Inuit Nunangat, but there were no differences in the prevalence of past-year suicidal thoughts.
- Self-reported mental health conditions, like mood disorder and anxiety disorder, were also consistently lowest in Nunatsiavut and highest in Nunavik.
- Nunavik had the highest levels of alcohol consumption, including past-year use and heavy episodic drinking. The prevalence of past-year alcohol use was also higher in the Inuvialuit Settlement Region and outside Inuit Nunangat, and lower in Nunavut. Rates of heavy episodic drinking were significantly lower in Nunatsiavut.
- Daily or almost daily cannabis use was significantly lower in Nunatsiavut, the Inuvialuit Settlement Region and outside Inuit Nunangat. The prevalence of daily or almost daily cannabis use was significantly higher in Nunavik.
- The prevalence of illegal substance use (excluding cannabis) was significantly lower in Inuit Nunangat compared to among Inuit outside Inuit Nunangat.

⁷ Significant variations are in comparison with the overall prevalence in Inuit Nunangat.



Figure 1. Regions of Inuit Nunangat

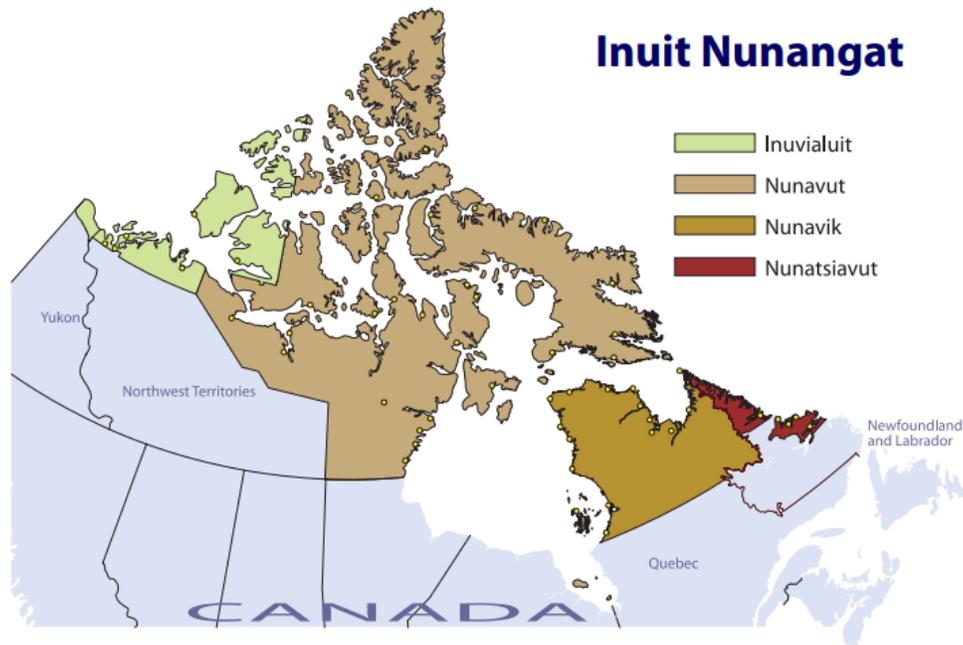


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Age and Sex Differences

Generally, factors rooted in the social determinants of health, such as healthcare access and food insecurity, varied by region, but were less likely to vary between males and females or by age. Key differences between males and females or between age groups for mental health outcomes and substance use include:

- Suicidal thoughts and attempts were most common among those aged 15 to 34.
- Self-reported mental health conditions, like mood disorder and anxiety disorder, were more prevalent among females.
- Males age 35 to 54 had the highest prevalence of past-year alcohol use, while males age 15 to 17 had the lowest.
- Cannabis use and daily or near daily cannabis use were significantly more common among males age 18 to 34 and 35 to 54 compared to females and other age groups.
- Females were more likely to report they had consulted with someone about their mental health or use of alcohol or drugs.

Differences between 2012 and 2017

This report largely focuses on comparing prevalence statistics between the 2012 and 2017 APS. (See Appendix B for alignment of indicators with the IHS 2007–2008.). Significant differences regarding mental health outcomes and substance use between 2012 and 2017 include:

- The lifetime prevalence of suicidal thoughts in Nunavik, particularly among males and those aged 18 to 34, increased 36%.



- The lifetime prevalence of suicidal thoughts among females overall in Nunatsiavut decreased 43%.
- The lifetime prevalence of attempting suicide in Inuit Nunangat increased 252%.
- Lifetime prevalence of attempting suicide increased 215% among females and 300% among males, but no differences in past-year prevalence of suicide attempts.
- The prevalence of self-reported mood disorder increased 143%, including an increase of 196% among females, an increase of 83% among males and an increase of 164% among those aged 18 to 34.
- The prevalence of self-reported anxiety disorder increased 159%, including an increase of 216% among females and an increase of 547% among those aged 18 to 34.
- The prevalence of past-year alcohol use in Inuit Nunangat increased 9%. Past-year alcohol use decreased 14% in Nunatsiavut and increased 20% in Nunavik.
- Weekly heavy episodic drinking in Inuit Nunangat increased 53%.
- Reported positive mental health (any of “good,” “very good” or “excellent” responses) increased 8% across all three age groups and both males and females.

Risk Factors

Mental Distress

The NISPS lists “depression, substance misuse, mental health disorder, and self-harm” as examples of mental distress. Key results on self-harm and mental health conditions from the 2012 and 2017 APS are as follows:

- In 2017, 5.8% (age 18+) reported having suicidal thoughts in the past year and 2.1% reported attempting suicide. The lifetime prevalence of attempted suicide increased 3.5 times between 2012 and 2017, with the largest increases occurring among males (four times) and those aged 18 to 54 (four times).
- In 2017, 11.2% of the population (aged 15+) in Inuit Nunangat reported having a mood disorder, including a significantly higher proportion of females (14.5%) compared to males (7.7%). There was a significant increase of 143% in the prevalence of self-reported mood disorder between 2012 and 2017 (from 4.6% to 11.2%).
- In 2017, 8.3% of the population (aged 15+) in Inuit Nunangat reported having an anxiety disorder, including a significantly higher proportion of females (12%) compared to males (4.4%). Between 2012 and 2017, there was a significant 159% increase in the prevalence of self-reported anxiety disorder in Inuit Nunangat, from 3.2% to 8.3%.
- In 2017, 13% of the population (age 15+) reported having a mental health condition, including anxiety, depression, bipolar disorder, substance use disorder or anorexia. Females were more likely to report having a mental health condition (16.5%) compared to males (11%).

1 Suicide ideation

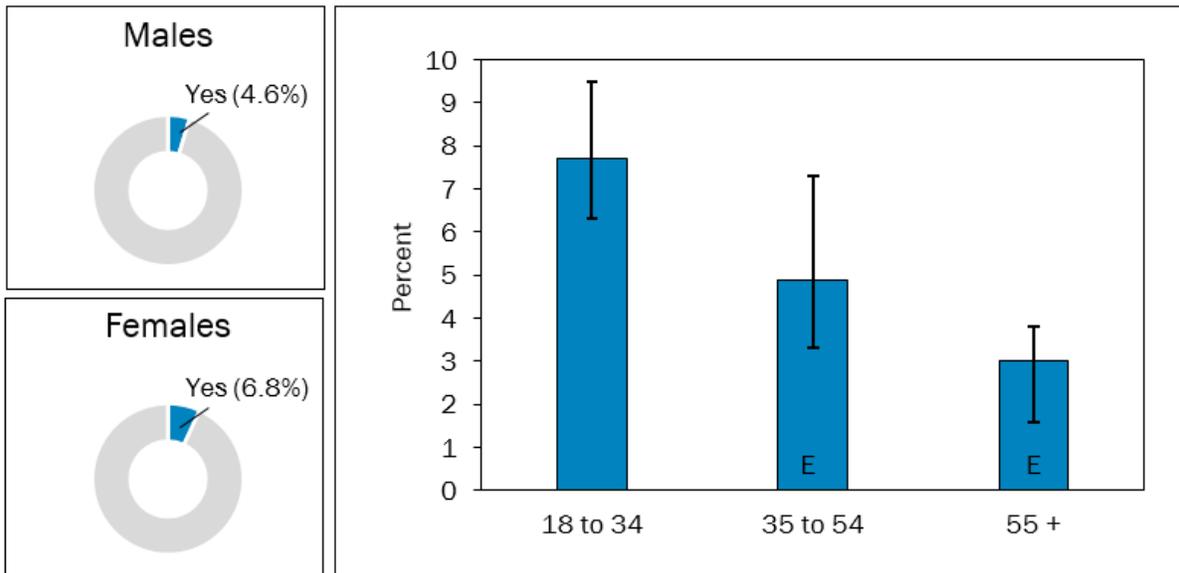
Suicide ideation is generally defined as thinking about, considering or planning suicide. It is usually a symptom of depression, mood disorders or other mental illness, or associated with adverse life



events. Most people who have suicidal thoughts do not attempt suicide, but suicide ideation is a risk factor for attempting suicide. In 2017, 22.5% of the population (age 18+) in Inuit Nunangat reported suicide ideation in their lifetime and 5.8% reported suicide ideation in the past year.

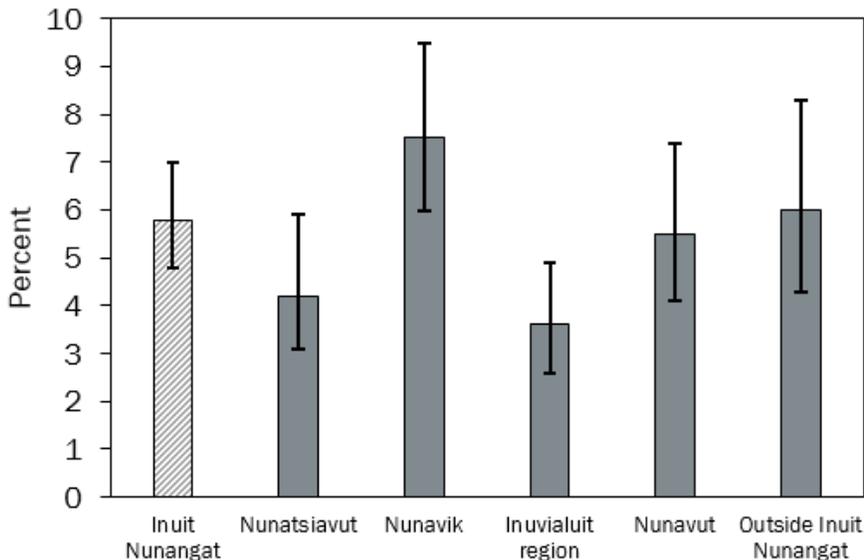
The prevalence of past-year suicide ideation among females (6.8%) was not significantly different than among males (4.6%) (Figure 2). Individuals aged 18 to 34 had a higher prevalence of past-year suicide ideation (7.7%) compared to those aged 55 and older (2.5%), but not compared to those aged 35 to 54 (4.9%) (Figure 2). The prevalence of past-year suicide ideation did not differ significantly in any region compared to Inuit Nunangat overall (Figure 3) and remained unchanged from 2012.

Figure 2. Past-year suicide ideation in Inuit Nunangat, by sex and age group



Note: "E" indicates high sampling variability; use with caution.

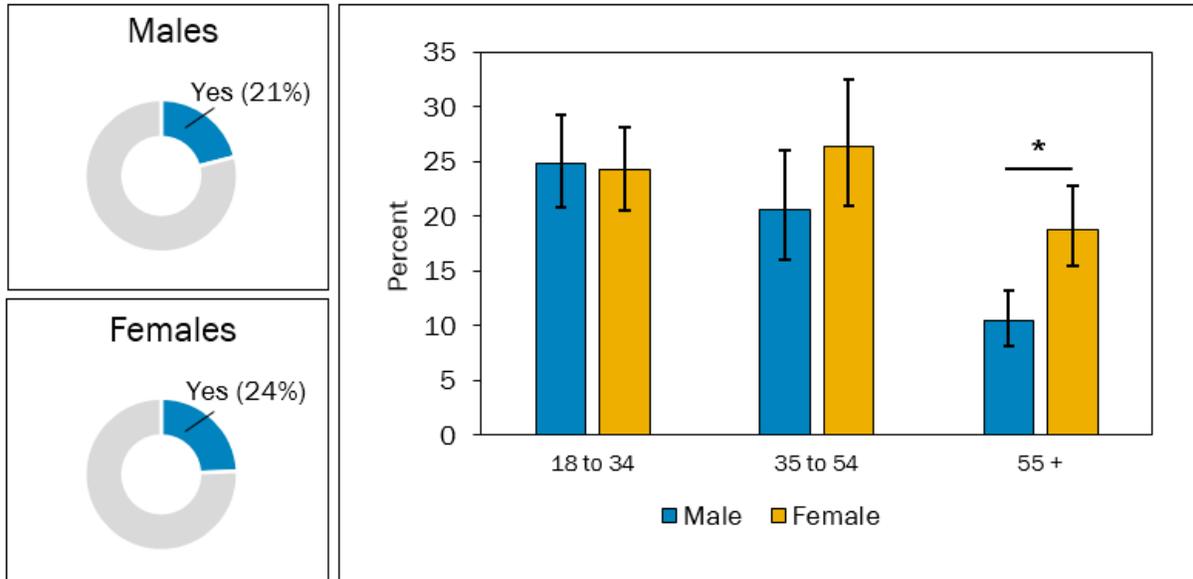
Figure 3. Past-year suicide ideation, by region





The prevalence of lifetime suicide ideation was also not significantly different between males (20.8%) and females (24%) (Figure 4). For lifetime suicide ideation, there was also no significant difference between the 18 to 34 age group (24.5%) and the 35 to 54 age group (Figure 4). Lifetime suicide ideation was significantly lower among the 55+ age group overall, and among this age group, females had a higher prevalence (18.8%) compared to males (10.4%) (Figure 4).

Figure 4. Lifetime suicide ideation, by sex and age group

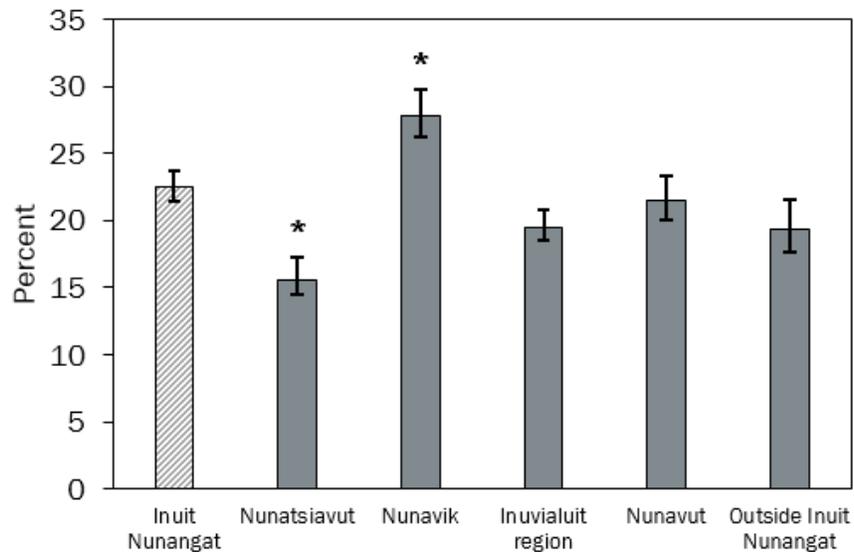


Note: “**” indicates significant difference between groups at the $p < 0.05$ level.

In 2017, the lifetime prevalence of suicide ideation was lower in Nunatsiavut (15.6%) and higher in Nunavik (27.8%) compared to Inuit Nunangat overall (22.5%) (Figure 5). Between 2012 and 2017, the prevalence of lifetime suicide ideation in Inuit Nunangat increased 165% among females aged 55+ (7.1% to 18.8%). Other notable differences between 2012 and 2017 include a 43% decrease among females overall in Nunatsiavut (27.2% to 15.5%), and a 36% increase overall in Nunavik (20.5% to 27.8%), particularly among males (19.6% to 28.8%) and among those aged 18 to 34 (21.6% to 32.2%).



Figure 5. Lifetime suicide ideation among Inuit, by region



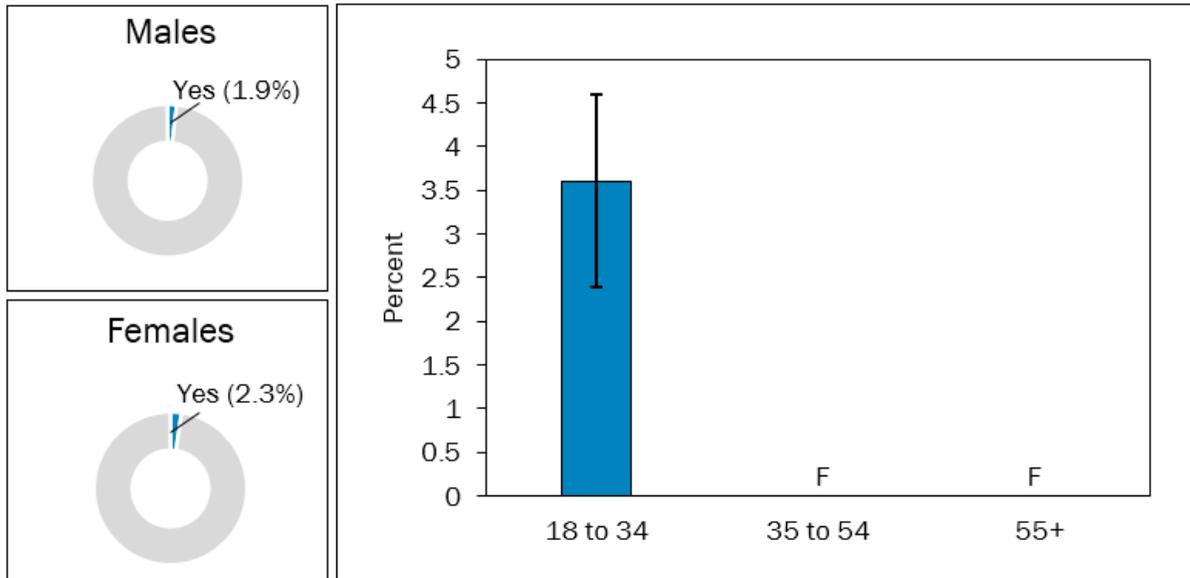
Note: “*” indicates a significant difference from Inuit Nunangat at the $p < 0.05$ level.

2 Suicide attempts

A suicide attempt is any non-fatal intent to take one’s own life. A suicide attempt is the strongest risk factor for suicide in the general population (World Health Organization, 2019). In 2017, 2.1% of the Inuit population (age 18+) in Inuit Nunangat reported attempting suicide in the past year, including 1.9% of males and 2.3% of females (Figure 6). The prevalence of past-year suicide attempts did not differ based on age group (Figure 6). The Inuit population outside Inuit Nunangat reported a lower prevalence of past-year suicide attempts (0.7%; interpret with caution) compared to Inuit Nunangat (Figure 7). There were no significant differences in past-year suicide attempts across sex, age groups or regions between 2012 and 2017.

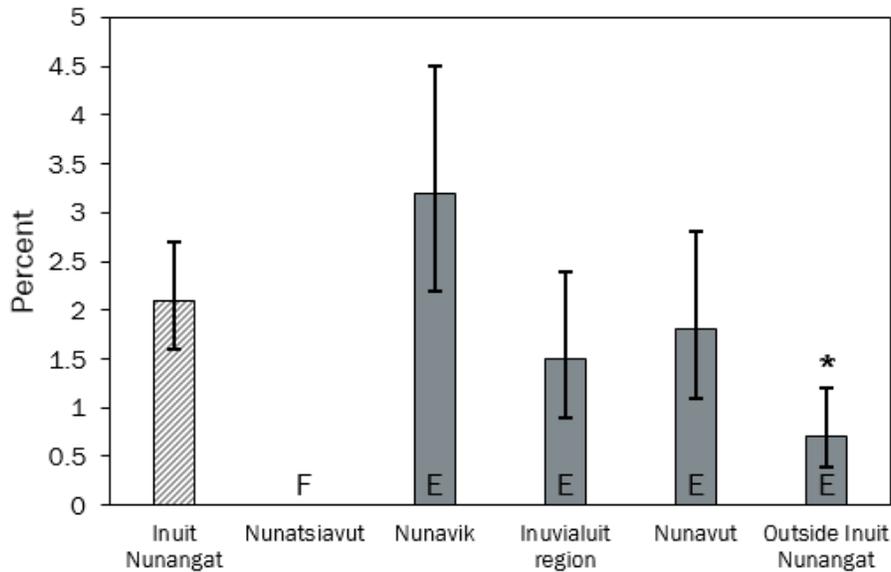


Figure 6. Past-year suicide attempt, by sex and age group



Note: "F" indicates data is suppressed for reasons of reliability.

Figure 7. Past-year suicide attempt, by region



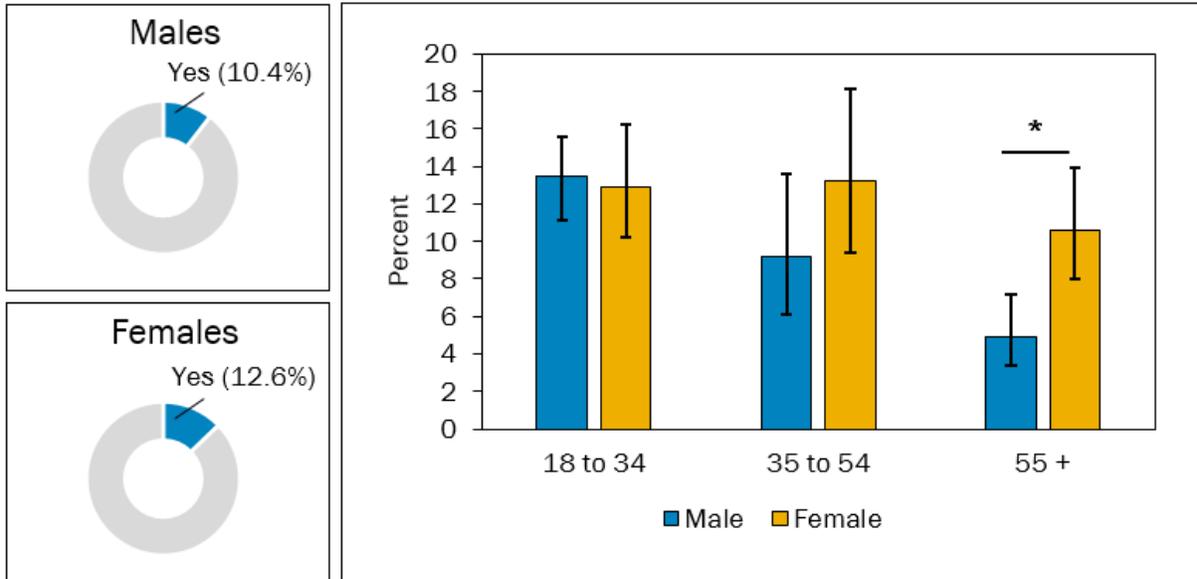
Note: "E" indicates high sampling variability; use with caution. "F" indicates data is suppressed for reasons of reliability. "**" indicates a significant difference from Inuit Nunangat at the p<0.05 level.

In 2017, 11.6% of the Inuit population (age 18+) in Inuit Nunangat reported attempting suicide in their lifetime. The prevalence of lifetime suicide attempts in Inuit Nunangat was not significantly different between males (10.4%) and females (12.6%) (Figure 8). Individuals in the 18 to 34 age group were more likely than those aged 55 and older to have attempted suicide in their life (13.2% versus 8.0% overall) (Figure 8). Between 2012 and 2017, there was an overall increase of 252% in the lifetime prevalence of attempting suicide, from 3.3% to 11.6%, including a 215% increase among



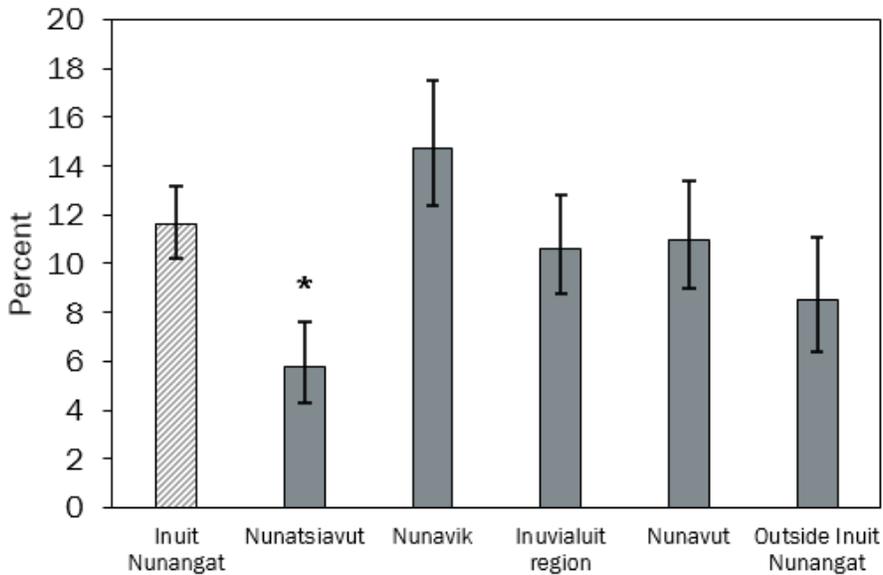
females (4.0% to 12.6%) and a 300% increase among males (2.6% to 10.4%). For regional differences, the lifetime prevalence of suicide attempts in Nunatsiavut was significantly lower compared to Inuit Nunangat overall (Figure 9). Between 2012 and 2017, the largest increases occurred among the 35 to 54 age group (438% increase), in Nunavik (297% increase), and in Nunavut (224% increase).

Figure 8. Lifetime suicide attempt in Inuit Nunangat, by sex and age group



Note: “**” indicates significant difference between groups at the $p < 0.05$ level.

Figure 9. Lifetime suicide attempt, by region



Note: “**” indicates a significant difference from Inuit Nunangat at the $p < 0.05$ level.

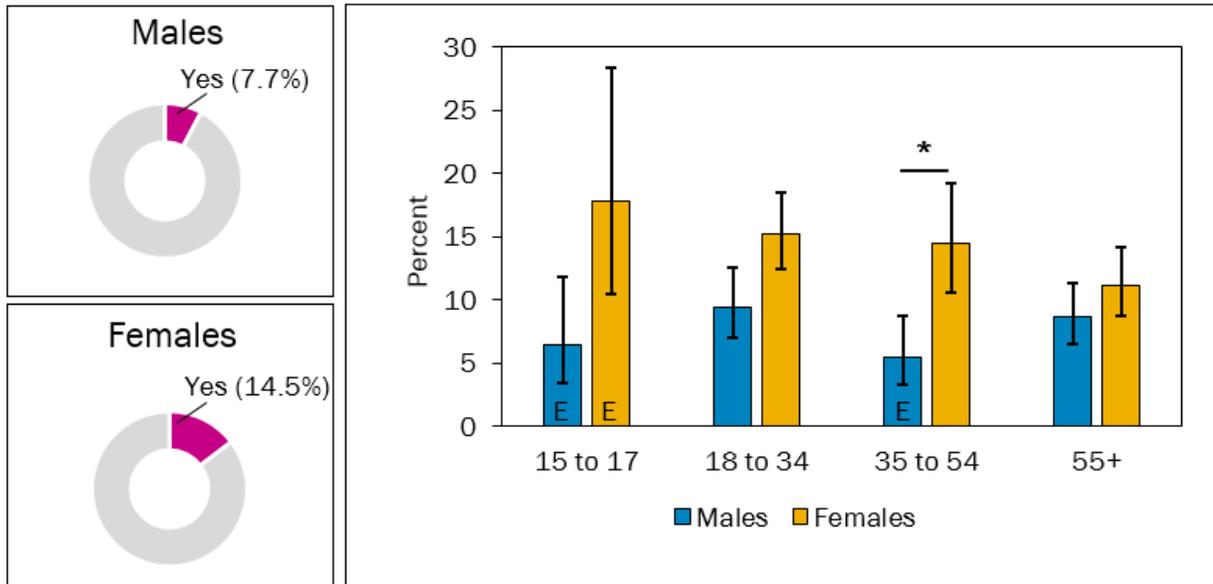


3 Self-reported mood disorder

A mood disorder is a mental health disorder affecting a person’s emotional state, causing significant impairment in daily life. Mood disorder statistics in the APS question are self-reported and may not reflect whether someone has had a clinical diagnosis of a mood disorder by a health professional. The APS question lists depression, bipolar disorder, mania and dysthymia as examples of mood disorders. In 2017, 11.2% of the population (aged 15+) in Inuit Nunangat reported having a mood disorder, including a significantly higher proportion of females (14.5%) compared to males (7.7%) (Figure 10). A larger proportion of females reported having a mood disorder within each age group, although the only significant difference between males (5.4%) and females (14.4%) occurred in the 35 to 54 age group (Figure 10).

Compared to all of Inuit Nunangat, the population in Nunatsiavut had a significantly lower prevalence of self-reported mood disorder (7.1%) and the Inuit population outside Inuit Nunangat had a significantly higher prevalence of self-reported mood disorder (17.4%) (Figure 11). When looking at changes in the prevalence of self-reported mood disorder over time, there was a significant increase of 143% in its prevalence between 2012 and 2017 (from 4.6% to 11.2%). This increase included a 196% increase among females and an 83% increase among males. The increase was largely driven by the 18 to 34 age group (164% increase) and a dramatic increase in Nunavik (213% among males and 307% among females).

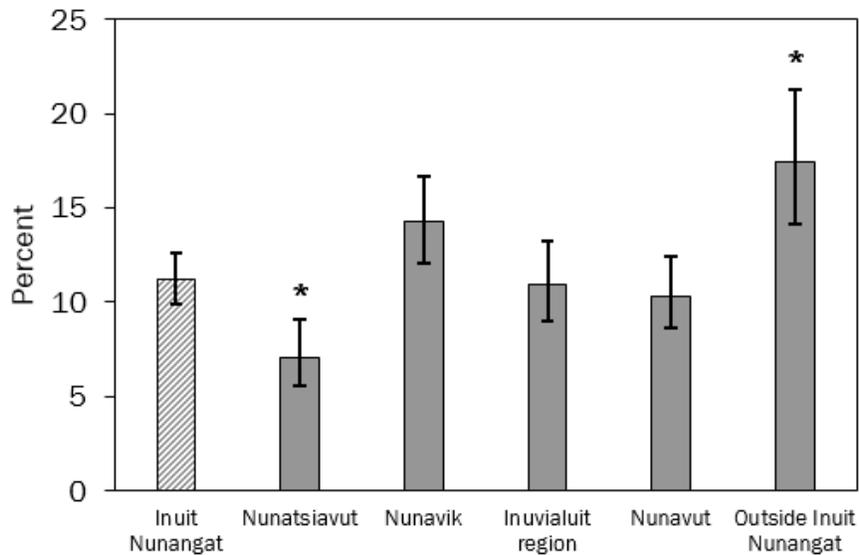
Figure 10. Self-reported mood disorder, by sex and age group



Note: “E” indicates high sampling variability; use with caution. “F” indicates data is suppressed for reasons of reliability. “**” indicates significant difference between groups at the p<0.05 level.



Figure 11. Self-reported mood disorder, by region



Note: “**” indicates a significant difference from Inuit Nunangat at the $p < 0.05$ level.

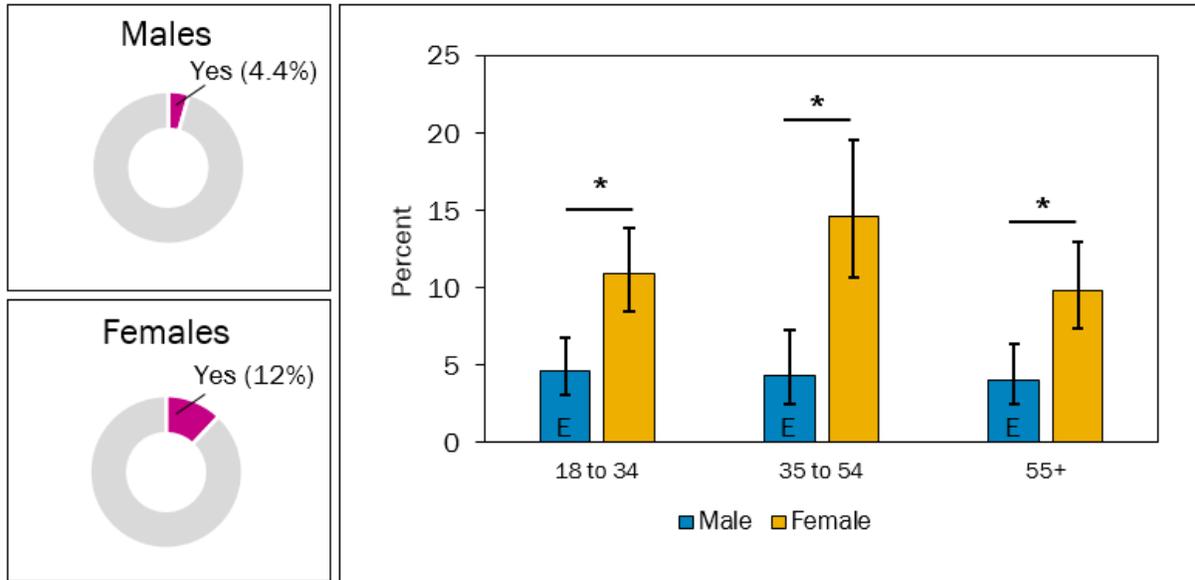
4 Self-reported anxiety disorder

An anxiety disorder is a mental health disorder characterized by feelings of worry, anxiety or fear that cause significant impairment in daily life. Anxiety disorder statistics in the APS are self-reported and may not reflect whether someone has had a clinical diagnosis of an anxiety disorder from a health professional. The APS question lists phobia, obsessive-compulsive disorder and panic disorder as examples of an anxiety disorder. In 2017, 8.3% of the population (aged 15+) in Inuit Nunangat reported having an anxiety disorder, including a significantly higher proportion of females (12%) compared to males (4.4%) (Figure 12). Females were more likely to self-report an anxiety disorder across all age groups (Figure 12). Between 2012 and 2017, there was a significant 159% increase in the prevalence of self-reported anxiety disorder in Inuit Nunangat, from 3.2% to 8.3%, including a 216% increase among females and a 547% increase among the 18 to 34 age group.

Similar to the results for self-reported mood disorder, the population in Nunatsiavut had a significantly lower prevalence of self-reported anxiety disorder (5.2%) and the Inuit population outside Inuit Nunangat had a significantly higher prevalence of self-reported anxiety disorder (16.7%) (Figure 13). Between 2012 and 2017, there was a significant 215% increase in the prevalence of self-reported anxiety disorder in Nunavik.

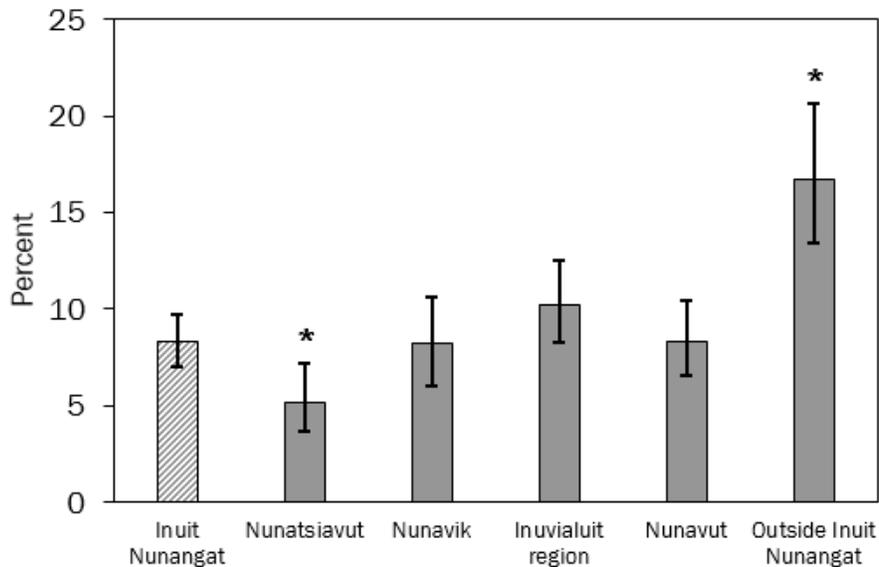


Figure 12. Self-reported anxiety disorder, by sex and age group



Note: "E" indicates high sampling variability; use with caution. "*" indicates significant difference between groups at the p<0.05 level.

Figure 13. Self-reported anxiety disorder, by region



Note: "*" indicates a significant difference from Inuit Nunangat at the p<0.05 level.

5 Mental health conditions

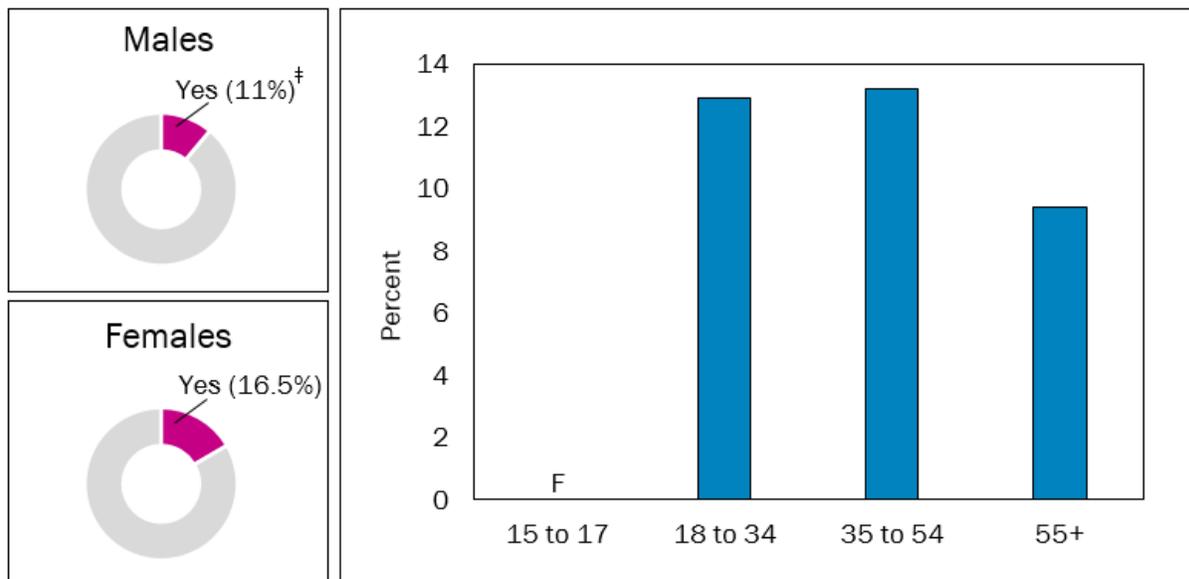
The APS asks participants about any emotional, psychological or mental health conditions they may have, including anxiety, depression, bipolar disorder, substance use disorder and anorexia (see Appendix A). In 2017, 13% of the population in Inuit Nunangat (age 15+) reported having a mental health condition, including 10% who reported "sometimes," 2.3% who reported "often" and 0.9%



who reported “always.” Females overall were more likely to report having a mental health condition (16.5%) compared to males (11%) (Figure 14).

The prevalence of reported mental health conditions is significantly higher outside Inuit Nunangat, with an overall prevalence of 27% (16% reporting “sometimes,” 4.8% reporting “often” and 6.3% reporting “always”). Females age 18 to 34 outside Inuit Nunangat had the highest prevalence of reporting any mental health conditions at 43%. Estimates for the overall prevalence of mental health conditions across regions of Inuit Nunangat are not reported because of the small sample size and variability for “often” and “always” responses. The 2012 APS does not ask this question about mental health conditions, so a comparison between 2012 and 2017 is also not reported.

Figure 14. Self-reported mental health condition, by sex and age group



Note: Estimates are combined responses for “sometimes,” “often” and “always” except for the 18 to 34 age group where the proportion of individuals responding “always” was suppressed for reasons of reliability. Confidence intervals are not shown as they were calculated for each response separately and not for combined estimates. “F” indicates data is suppressed for reasons of reliability. “[‡]” Indicates high sampling variability; use with caution.

Substance Use

Key results on substance use from the 2012 and 2017 APS are as follows:

- Almost one-third of Inuit (age 15+) in Inuit Nunangat reported heavy episodic drinking at least once a month in 2017, including half of those who reported any alcohol use in the past year. Between 2012 and 2017, there was a significant increase in monthly or more frequent heavy episodic drinking across Inuit Nunangat.
- In 2017, 40% of the population in Inuit Nunangat (age 18+) reported using cannabis in the past year. Half of those using cannabis reported daily or almost daily cannabis use (20% overall). Daily or almost daily cannabis use was significantly lower in Nunatsiavut (2.7%) and the Inuvialuit Settlement Region (15%).
- Daily or near daily cannabis use was associated with increased odds of reporting suicide ideation or attempt in the past year, and with increased odds of having a mood disorder.



- In 2017, 2.8% of all Inuit in Canada (including outside Inuit Nunangat) reported using any illegal drugs (excluding cannabis) in the past year, and of this percentage approximately 35% were among Inuit in Inuit Nunangat. Over 97% of the population (age 18+) overall and within each region reported no use of any illegal drugs in the past year. Across all Inuit in Canada, approximately 0.5% reported daily or almost daily use.
- In 2017, 1.2% of all Inuit in Canada (including outside Inuit Nunangat) reported non-medical use of prescription drugs in the past year, and of this percentage approximately 40% were among Inuit in Inuit Nunangat. Over 98% of the population (age 18+) in Inuit Nunangat and within each region reported no non-medical use of prescription drugs in the past year. Across all Inuit in Canada, approximately 0.3% reported daily or almost daily use.

1 Past year alcohol use

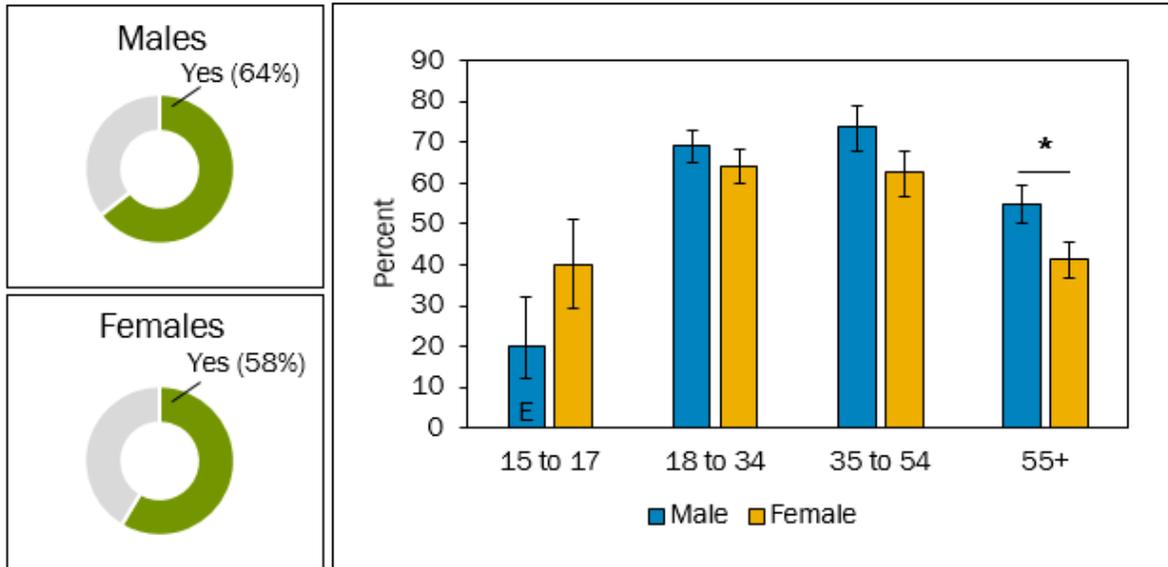
The amount and frequency of drinking alcohol are key determinants of the impacts of alcohol use. Consuming large amounts on the same occasion (see heavy episodic drinking, below) and consuming alcohol more frequently are more likely to be associated with health and social harms, including suicide risk (Nunavut Liquor Act Review Task Force, 2012). Many communities across Inuit Nunangat have alcohol regulatory frameworks that restrict access to and availability of alcohol. In 2017, only 61% of the population in Inuit Nunangat (age 15+) reported consuming alcohol in the past 12 months (compared to 75% among Inuit living outside Inuit Nunangat). This figure includes 2.5% who reported drinking more than four times a week, 13.6% who reported drinking one to three times a week, and 26% who reported drinking one to three times a month, according to the 2017 APS. Between 2012 and 2017, there was a significant increase of 9% in the prevalence of past-year alcohol use in Inuit Nunangat (56% to 61%).

Overall, 64% of males reported drinking alcohol in the past year (Figure 15), including 1.7% who reported drinking alcohol four to six times a week, 14.9% who reported drinking one to three times a week, and 29% who reported drinking one to three times a month. 58% of females reported drinking alcohol in the past year, including 2.6% who reported drinking more than four times a week, 12.5% who reported drinking one to three times a week, and 24% who reported drinking one to three times a month.

The highest prevalence of past-year alcohol consumption was among males age 35 to 54 (74%), and the lowest was among males age 15 to 17 (20%) (Figure 15). A significantly higher proportion of males aged 55 and older had used alcohol in the past year (55%) compared to females aged 55 and older (41%) (Figure 15). Any alcohol consumption in the past year was more common in Nunavik (71%), the Inuvialuit Settlement Region (67%) and outside Inuit Nunangat (75%), and less common in Nunavut (56%) (Figure 16). Between 2012 and 2017, past-year alcohol consumption decreased 14% in Nunatsiavut with a notable 20% decrease among the 18 to 34 age group. There was a 20% increase overall in Nunavik, mostly driven by a 23% increase among the 18 to 34 age group.

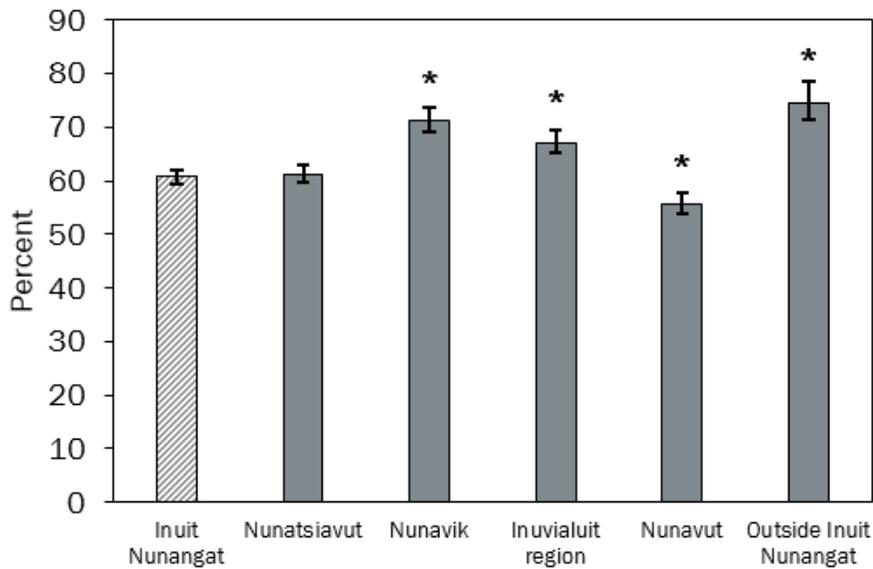


Figure 15. Past-year alcohol use, by sex and age group



Note: "E" indicates high sampling variability; use with caution. "*" indicates significant difference between groups at the p<0.05 level.

Figure 16. Past-year alcohol use, by region



Note: "*" indicates a significant difference from Inuit Nunangat at the p<0.05 level.

2 Heavy episodic drinking

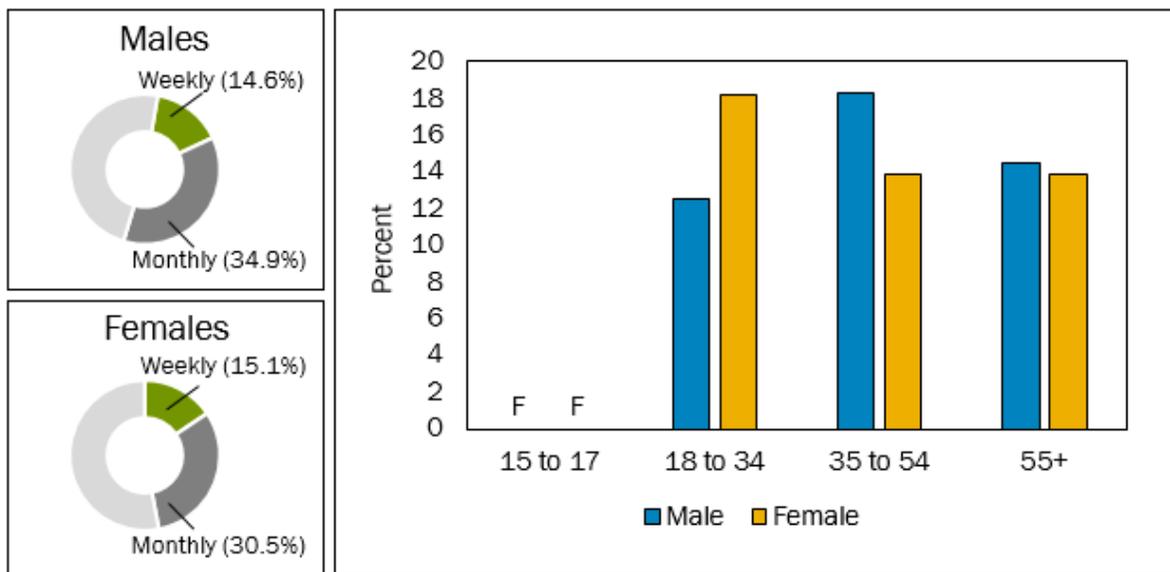
Heavy episodic drinking is defined for males as having five or more drinks and for females as having four or more drinks on one occasion. Figure 17 and Figure 18 show the prevalence of weekly or more frequent heavy episodic drinking among those who reported any past-year alcohol use by sex, age and region. Overall, almost one-third of the population (age 15+) in Inuit Nunangat report heavy episodic drinking at least once a month in the past year. Of those in Inuit Nunangat (age 15+) who



reported alcohol use in the past year, 47.5% reported heavy episodic drinking, including about 15% who reported doing so on a weekly or more frequent basis. There were no significant differences between males and females overall or for weekly or more frequent heavy episodic drinking (Figure 17). Those aged 15 to 17 were least likely to report any heavy episodic drinking (37%) compared to the 18 to 34 (20%) and 35 to 54 (19%) age groups. For frequency of heavy episodic drinking, there were no significant differences between age groups overall (Figure 17).

Between 2012 and 2017, there was a significant increase in frequent heavy episodic drinking across Inuit Nunangat, including a 53% increase in the proportion reporting heavy episodic drinking more than once a week (from 4.7% to 7.2%). A larger shift to more frequent heavy episodic drinking occurred among females, including a 44% increase in doing so once a week and a 74% increase in doing so more than once a week. This increase among females compares to a respective 21% increase and 36% increase among males.

Figure 17. Weekly or more frequent heavy episodic drinking, by sex and age group

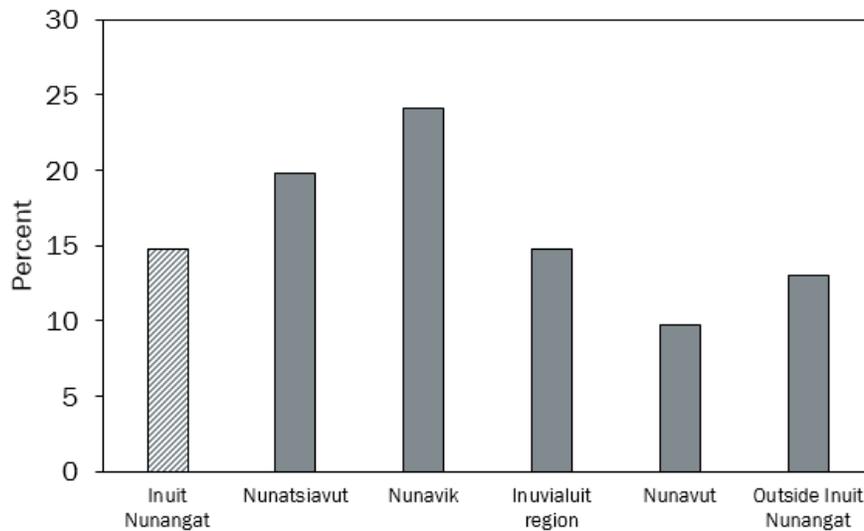


Note: Proportions are among those that reported any past year alcohol use only. Estimates are combined responses for “once a month,” “2 to 3 times a month,” “once a week” and “more than once a week.” Confidence intervals are not shown as they were calculated for each response separately and not for combined estimates. “F” indicates data is suppressed for reasons of reliability.

For regional differences, the prevalence of weekly or more frequent heavy episodic drinking was higher in Nunatsiavut (19.8%) and Nunavik (24.1%) compared to Inuit Nunangat overall (14.8%, Figure 18). In addition, a significantly smaller proportion of the population in Nunatsiavut (13%) and Nunavik (15%) reported no heavy episodic drinking compared to 22% in all of Inuit Nunangat. Between 2012 and 2017, the largest increase in frequent heavy episodic drinking occurred in Nunavik with a 103% increase for heavy episodic drinking once a week (6.4% to 13%) and a 109% increase in heavy episodic drinking more than once a week (5.3% to 11%). Note that this increase in frequent heavy episodic drinking in Nunavik may be partly explained by an overall increase in past-year alcohol use in general (see above).



Figure 18. Weekly or more frequent heavy episodic drinking, by region



Note: Proportions are among those that reported any past year alcohol use only. Estimates are combined responses for “once a week” and “more than once a week.” Confidence intervals are not shown as they were calculated for each response separately and not for combined estimates.

3 Illegal drug use (excluding cannabis)

Non-medical use of prescription drugs and use of illegal substances is associated with suicidal thoughts (Kumar, 2016). Frequent substance use over periods of months or years or the presence of a substance use disorder are more likely to lead to adverse effects related to mental health and suicide (Conner, Bridge, Davidson, Pilcher, & Brent, 2019; Esang & Ahmed, 2018; Poorolajal, Haghtalab, Farhadi, & Darvishi, 2016). The 2017 APS asks participants about use of illegal substances in the past year and lists cocaine, speed, solvents and steroids as examples (see Appendix A). Comparing estimates to 2012 is not possible as the 2012 APS asks only about lifetime use of illegal substances and not past-year use. In 2012, 9.5% of those in Inuit Nunangat reported lifetime use of illegal substances including a significantly higher proportion of males (13.8%) compared to females (6.0%). Use of illegal substances was reported the least frequently in Nunatsiavut (5.4%) and Nunavut (8.1%) and the most frequently in Nunavik (14.3%) and outside Inuit Nunangat (19.4%).

In 2017, 2.8% of all Inuit in Canada (including outside Inuit Nunangat) reported using any illegal substances in the past year, and of this percentage approximately 65% were among Inuit outside Inuit Nunangat. Over 97% of the population (age 18+) overall and within each region reported not using any illegal substances in the past year. Estimates for more frequent use across regions of Inuit Nunangat are very low and too unreliable to publish. Across all Inuit who live in Canada, 0.5% reported daily or almost daily use (high sampling variability, use with caution), 0.3% reported weekly use, 0.8% reported monthly use and 1.2% reported less than monthly use. The prevalence of illegal substance use is significantly higher among Inuit living outside Inuit Nunangat, where only 94% reported no past-year use, with 89% of those in the 18 to 34 age group reporting no past-year use.

4 Non-medical use of prescription drugs

The 2017 APS also asks participants about the non-medical use of prescription drugs in the past year. The 2012 APS asks about lifetime non-medical use of prescription drugs, so comparisons over



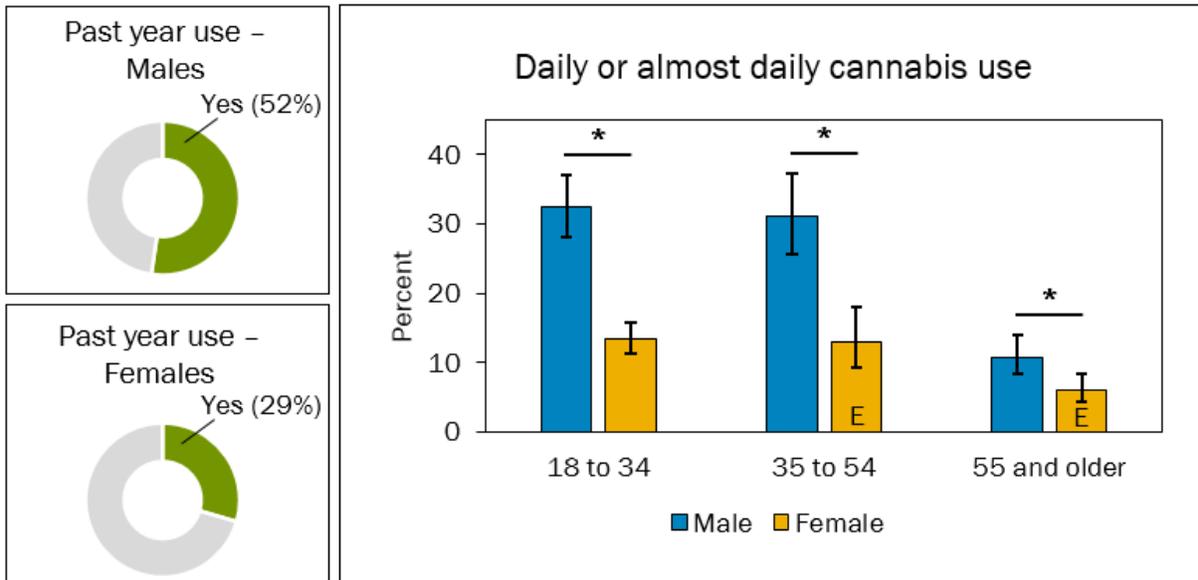
time are not available. In 2012, 2.8% of those in Inuit Nunangat reported non-medical use of prescription drugs in their lifetime, including a significantly higher proportion of males (4.0%) compared to females (1.8%). Lifetime prevalence was the highest among those aged 18 to 34 (4.1% compared to 1.7% among those aged 35 to 54; estimates for ages 55+ suppressed). Similar to patterns for other illegal drug use, non-medical use of prescription drugs was reported the least frequently in Nunavut (2.3%) and Nunatsiavut (2.6%), and was reported the most frequently in Nunavik (4.1%) and outside Inuit Nunangat (4.8%).

In 2017, 1.2% of all Inuit in Canada (including outside Inuit Nunangat) reported non-medical use of prescription drugs in the past year, and of this percentage, approximately 59% were among Inuit outside Inuit Nunangat. Over 98% of the population (age 18+) in Inuit Nunangat and within each region reported no non-medical use of prescription drugs in the past year, compared to 94% of the population outside Inuit Nunangat. Estimates for more frequent use across regions of Inuit Nunangat are low and too unreliable to publish. However, across all Inuit in Canada, 0.3% reported daily or almost daily use, 0.4% reported monthly use and 0.4% reported less than monthly use (estimates for weekly use suppressed).

5 Cannabis use

Cannabis use, particularly frequent use over periods of months or years, is linked to suicide and poor mental health (Konefal, Gabrys, & Porath, 2019), and cannabis dependence has also been linked to suicide among Inuit in Canada (Chachamovich et al., 2015). After alcohol and tobacco, cannabis is the most used substance in Inuit Nunangat (Figure 19). In 2017, 40% of the population in Inuit Nunangat (age 18+) reported using cannabis in the past year, including 52% of males and 29% of females (Figure 19). Daily or almost daily cannabis use was significantly more prevalent among males, between 1.8 to 2.4 times more common than for females depending on the age group.

Figure 19. Past year and daily cannabis use, by sex and age group



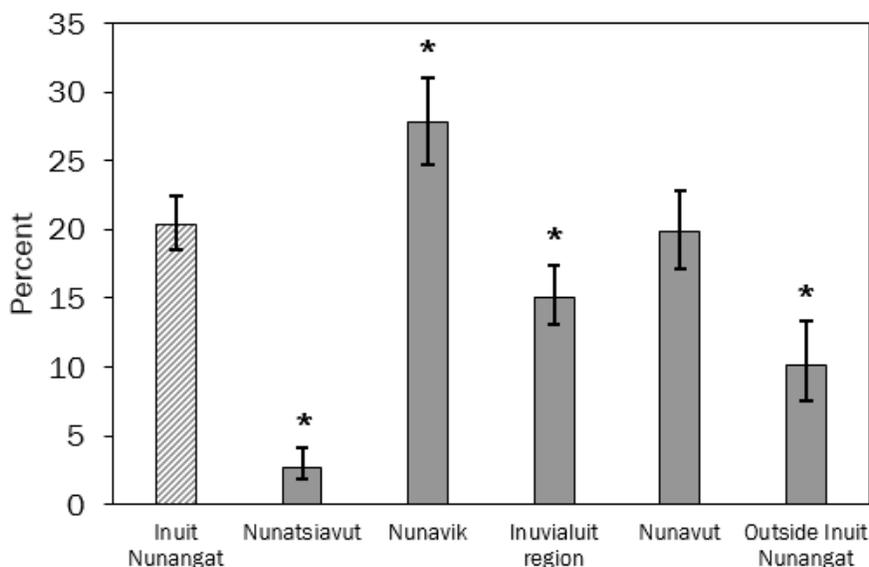
Note: "E" indicates high sampling variability; use with caution. "*" indicates significant difference between groups at the $p < 0.05$ level.

Overall, 20% of the population in Inuit Nunangat reported daily or almost daily cannabis use (Figure 20). Daily or almost daily cannabis use was significantly lower in Nunatsiavut (2.7%), the



Inuvialuit Settlement Region (15%) and outside Inuit Nunangat (10%), and significantly higher in Nunavik (28%). Across most regions, including outside Inuit Nunangat, approximately half of individuals who have used cannabis in the past year report daily or near daily use. The exceptions are Nunatsiavut, where approximately 20% of the population using cannabis report daily use, and the Inuvialuit Settlement Region, where 40% using cannabis report daily use. Comparisons for past-year or daily cannabis use between 2012 and 2017 are not possible as the 2012 APS only asks about lifetime cannabis use.

Figure 20. Daily or almost daily cannabis use, by region



Note: “*” indicates a significant difference from Inuit Nunangat at the $p < 0.05$ level.

There are few studies examining the link between cannabis use and suicide and cannabis use and mental health among Inuit. The results of logistic regression analyses from the 2017 APS are presented in Table 2 and Table 3, describing the relationship between cannabis use and mental health outcomes, including past-year suicide ideation, past-year suicide attempt, poor self-perceived mental health, self-reported mood disorder and self-reported anxiety disorder. The logistic regression models control for sex, age, region, median income, past-year alcohol use and past-year street drug use, so these variables do not underlie any significant differences. An odds ratio greater than one indicates that the mental health outcome is more likely among those reporting past-year cannabis use (less than daily) (Table 2) or among those reporting daily or almost daily cannabis use (Table 3).

The results show that while less than daily cannabis use only predicts increased risk of self-reported mood disorder (odds ratio [OR], 1.62; 95% confidence interval [CI], 1.15 to 2.29; $p < 0.05$) (Table 2), daily or near daily use predicts past year suicide ideation (OR, 1.94; 95% CI, 1.18 to 3.19; $p < 0.05$), past-year suicide attempt (OR, 3.60; 95% CI, 1.96 to 6.61; $p < 0.05$) and self-reported mood disorder (OR, 1.89; 95% CI, 1.25 to 2.85; $p < 0.05$) (Table 3). These findings support the existence of a link between daily or near daily cannabis use and risk for suicide ideation and attempts, and mood disorders among Inuit in Canada.



Table 2. Past year cannabis use (less than daily; independent variable) predicting past-year suicide ideation (n=4490), past-year suicide attempts (n= 4489), “poor” self-perceived mental health (n=4501), self-reported mood disorder (n=4504) and self-reported anxiety disorder (n=4507); (dependent variables)

Dependent variable	Odds ratio	95% Confidence Limits		Significance
		Lower	Upper	
Past-year suicide ideation	1.41	0.87	2.28	
Past-year suicide attempts	1.45	0.77	2.72	
“Poor” self-perceived mental health	1.49	0.85	2.64	
Self-reported mood disorder	1.62	1.15	2.29	*
Self-reported anxiety disorder	1.04	0.72	1.49	

Note: Ages 15 and older

* p<0.05

Table 3. Daily or almost daily cannabis use (less than daily; independent variable) predicting past-year suicide ideation (n=4490), past-year suicide attempts (n= 4489), “poor” self-perceived mental health (n=4501), self-reported mood disorder (n=4504) and self-reported anxiety disorder (n=4507); (dependent variables)

Dependent variable	Odds ratio	95% Confidence Limits		Significance
		Lower	Upper	
Past-year suicide ideation	1.94	1.18	3.19	*
Past-year suicide attempts	3.60	1.96	6.61	*
“Poor” self-perceived mental health	0.95	0.45	1.99	
Self-reported mood disorder	1.89	1.25	2.85	*
Self-reported anxiety disorder	1.51	0.95	2.41	

Note: Ages 15 and older

* p<0.05

Acute Stress or Loss

The NISPS lists recent loss, intoxication, access to lethal means, hopelessness and isolation as examples of acute stress or loss. No indicators from the 2017 APS aligned closely with this risk factor.

Traumatic Stress and Early Adversity

The NISPS lists experiencing acute or toxic stress in the womb and witnessing or experiencing physical or sexual abuse as examples of traumatic stress and early adversity. No indicators from the 2017 APS aligned closely with this risk factor.

Wounded Family

The NISPS lists intergenerational trauma, family violence and family history of suicide as examples of wounded family. No indicators from the 2017 APS aligned closely with this risk factor.



Historical Trauma

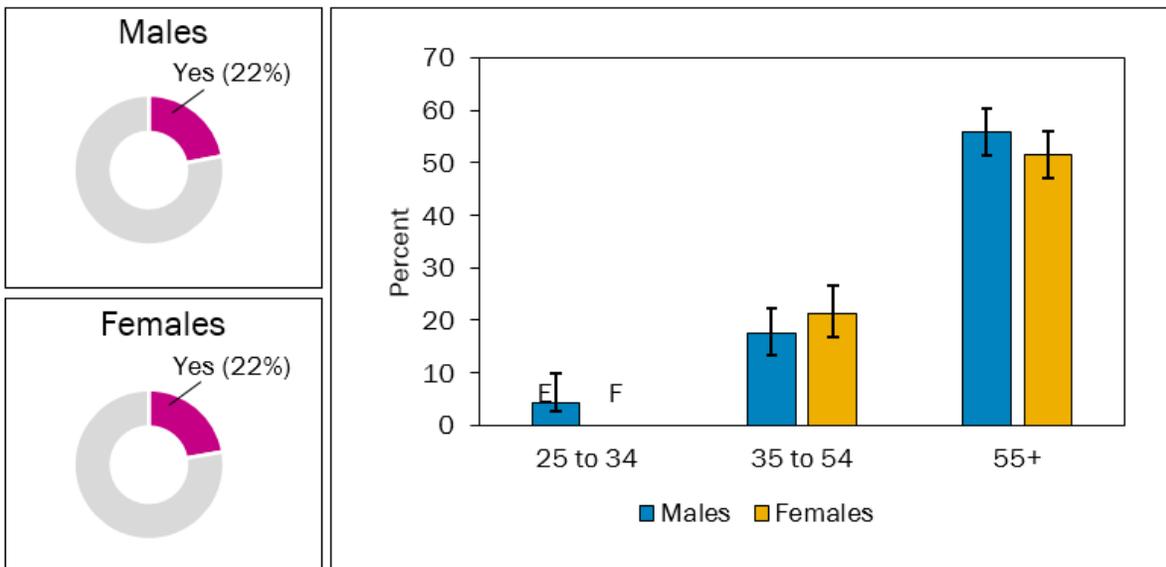
The NISPS lists impacts of colonialism, residential schools, relocations and dog slaughter as examples of historical trauma. Key results on historical trauma from the 2017 APS are as follows:

- In 2017, almost a quarter of the population in Inuit Nunangat (age 25+) had attended residential school.
- In 2017, 37% of the population in Inuit Nunangat (age 15+) had parents who attended residential school, including over a third of those aged 18 to 34 and half of those aged 35 to 54.
- Those living in the Inuvialuit Settlement Region were the most likely to have attended residential school (44%) and have parents who attended residential school (72%).
- In 2017, one in five individuals in Inuit Nunangat (age 15+) had grandparents who attended residential school, including over a third of those aged 15 to 17, and a quarter of those aged 18 to 34.

1 Attended residential school

Attendance at residential school as well as intergenerational exposure to residential schools have been associated with suicide risk among Inuit in Canada (Fraser, Geoffroy, Chachamovich, & Kirmayer, 2015; Kumar & Tjepkema, 2019). In 2017, 22% of the population age 25 and older in Inuit Nunangat had attended residential school in their lifetime, including 4% of those aged 25 to 34, 19% of those aged 35 to 54 and 54% of those aged 55 and older (Figure 21). The Inuvialuit Settlement Region had the highest prevalence of individuals who attended residential school across regions of Inuit Nunangat (44%) and Nunavik had the lowest prevalence (15%) (Figure 22). Inuit living outside Inuit Nunangat had the lowest prevalence of attendance at residential school (8.5%) (Figure 22).

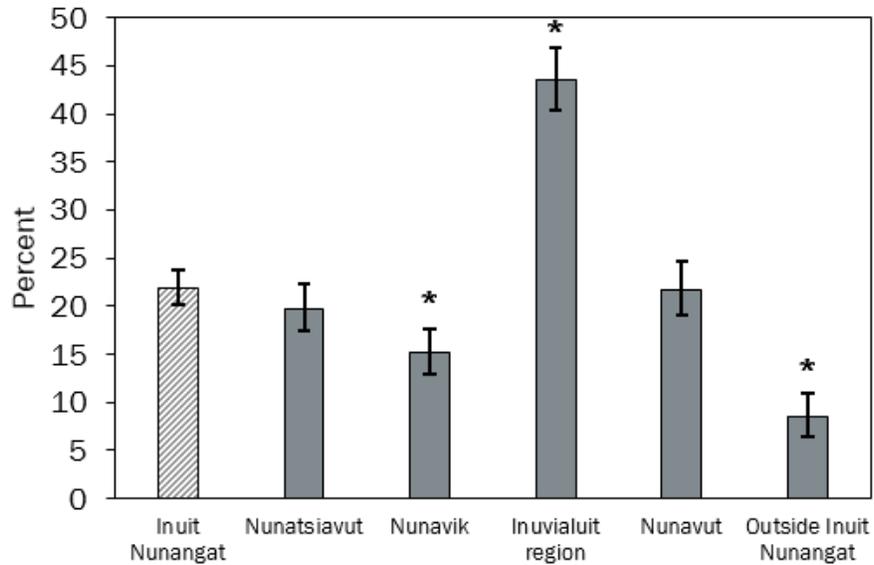
Figure 21. Lifetime residential school attendance, by sex and age group



Note: "E" indicates high sampling variability; use with caution. "F" indicates data is suppressed for reasons of reliability.



Figure 22. Lifetime residential school attendance, by region

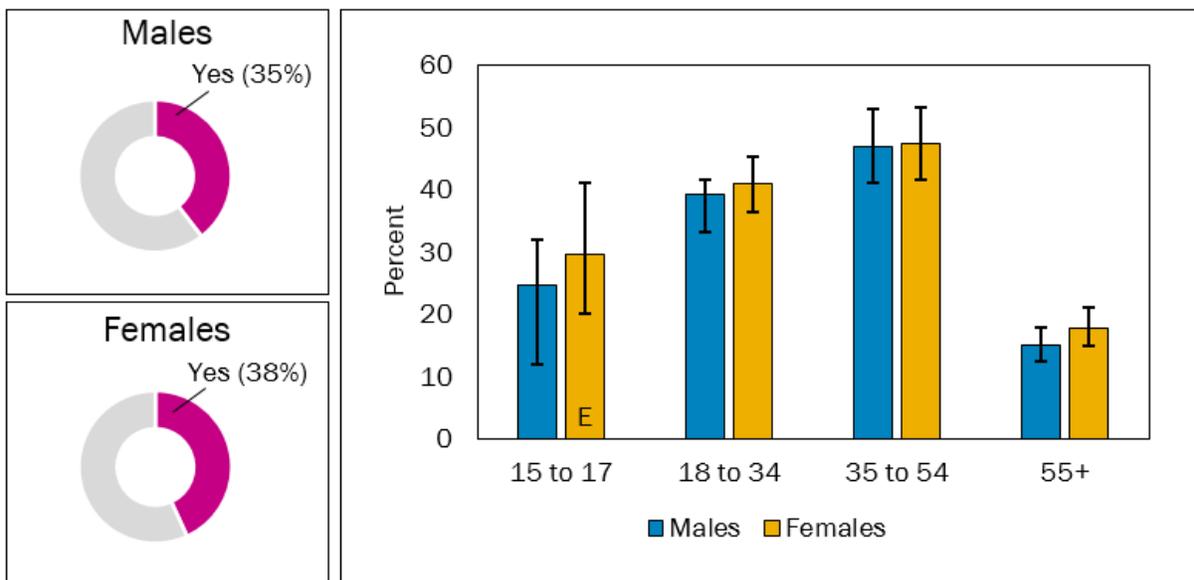


Note: “*” indicates a significant difference from Inuit Nunangat at the p<0.05 level.

2 Parents attended residential school

In 2017, 37% of the population age 15 and older in Inuit Nunangat had parents who attended residential school, including 25% of those aged 15 to 17, 39% of those aged 18 to 34, 47% of those aged 35 to 54 and 16% of those aged 55 and older (Figure 23). A significantly higher proportion of the population in the Inuvialuit Settlement Region (72%) had parents who attended residential school, and a significantly lower proportion in Nunavik (26%) and outside Inuit Nunangat (27%) had parents who attended residential school (Figure 24).

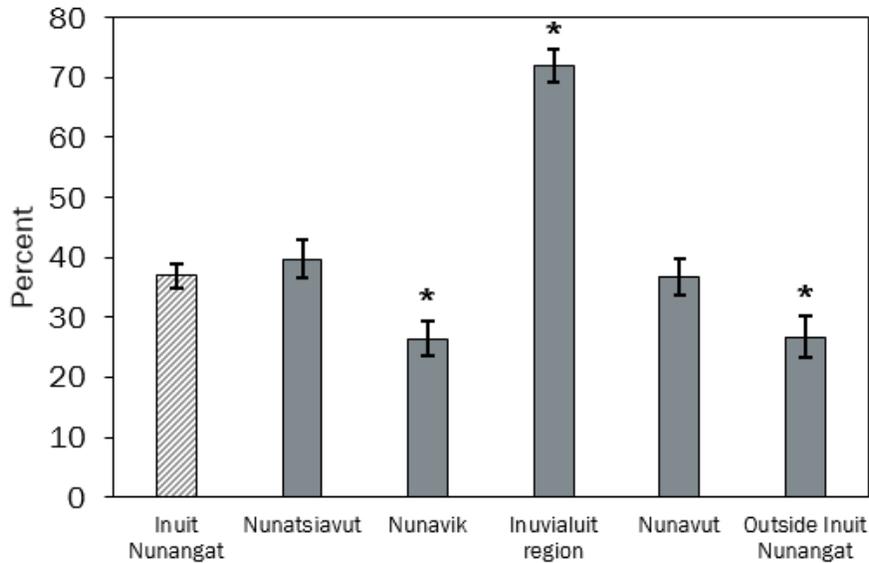
Figure 23. Parents attended residential school, by sex and age group



Note: “E” indicates high sampling variability; use with caution.



Figure 24. Parents attended residential school, by region

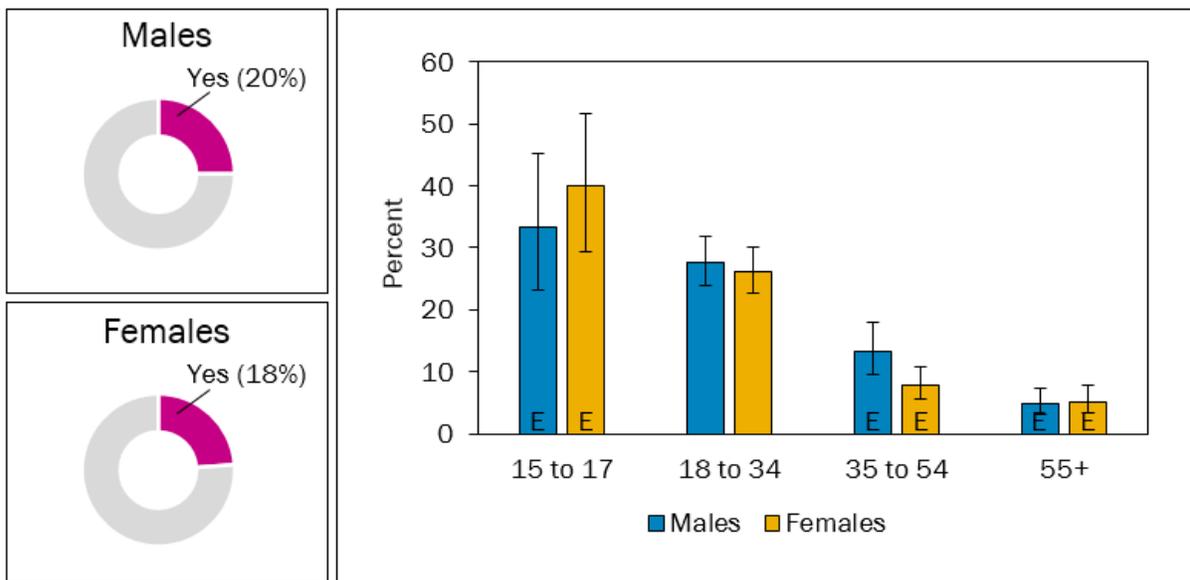


Note: “*” indicates a significant difference from Inuit Nunangat at the $p < 0.05$ level.

3 Grandparents attended residential school

In 2017, 19% of the population age 15 and older in Inuit Nunangat had grandparents who attended residential school, including 37% of those aged 15 to 17, 27% of those aged 18 to 34, 10.5% of those aged 35 to 54 and 5% of those aged 55 and older (Figure 25). A significantly higher proportion of the population in the Inuvialuit Settlement Region (43%) had grandparents who attended residential school and a significantly lower proportion in Nunavik (14%) had grandparents who attended residential school (Figure 26).

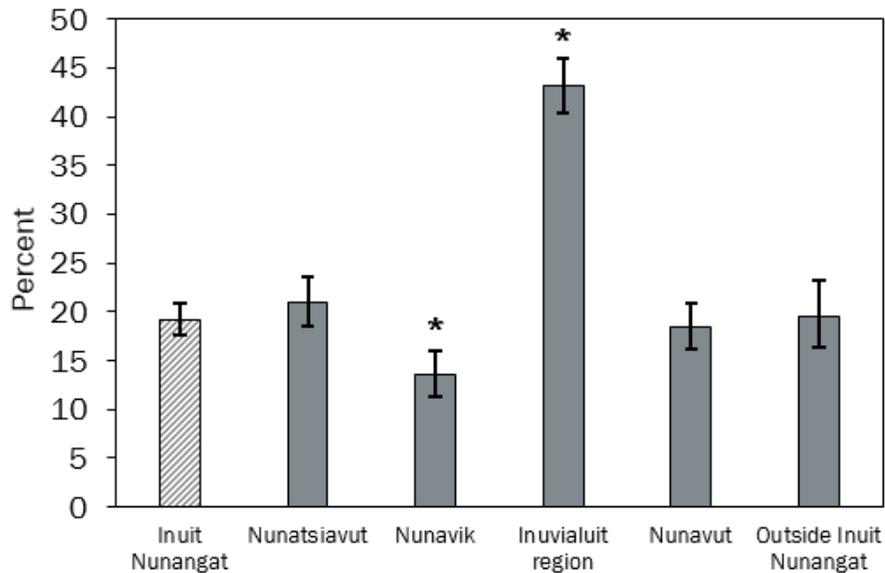
Figure 25. Grandparents attended residential school, by sex and age group



Note: “E” indicates high sampling variability; use with caution. “



Figure 26. Grandparents attended residential school, by region



Note: “*” indicates a significant difference from Inuit Nunangat at the $p < 0.05$ level.

Community Distress

The NISPS lists social inequities, including overcrowded housing, food insecurity and lack of access to services, as examples of community distress. These factors impact the health and well-being of Inuit. Key results on community distress from the 2012 and 2017 APS are as follows:

- In 2017, 17% of the population (age 15+) in Inuit Nunangat reported not being able to access health care in the past year when they needed it, an increase of 52% from 2012 when 12% reported not being able to access health care. Females (19%) were more likely than males (15%) to report not being able to access health care.
- In 2017, almost one in three individuals (age 15+) in Inuit Nunangat reported having food insecurity. The prevalence of food insecurity was the highest in Nunavik and Nunavut.
- In 2017, half of the population (age 15+) in Inuit Nunangat reported that their household income was not enough to meet their household’s needs for transportation, housing, food, clothing and other necessary expenses.
- In 2017, at least one third of the population (age 15+) in Inuit Nunangat had inadequate housing conditions.
- The most common reasons for being dissatisfied with housing conditions were that the housing was “Run down / Needs many repairs” (60%), the housing had “Poor insulation” (43%) and the housing was “Crowded / Not enough space” (41%).

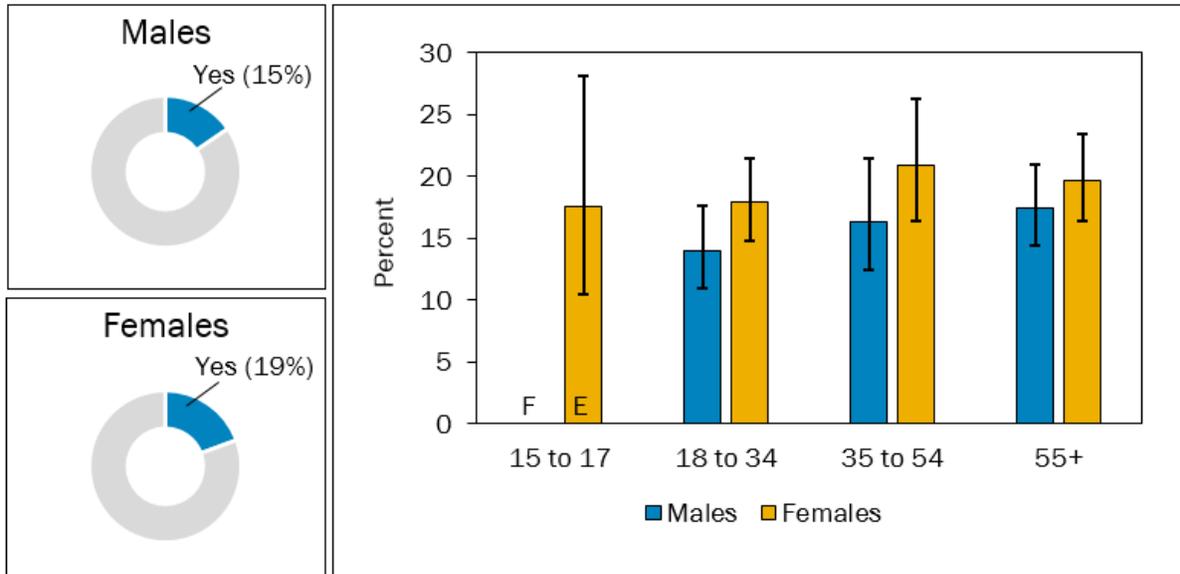
1 Past-year lack of access to health care

Both the 2012 and 2017 APS ask participants “During the past 12 months, was there ever a time when [you] felt that [you] needed health care but you didn’t receive it?” Note that this indicator does not specify whether the healthcare services are culturally relevant or informed. In 2017, 17% of the population (age 15+) in Inuit Nunangat reported not being able to access health care in the past year



when they needed it, including 15% of males and 19% of females (Figure 27). There was no significant difference between males and females about accessing health care overall and within each age group (Figure 27). There was also no significant difference across age groups overall. Between 2012 and 2017, there was a significant 54% increase from 12% to 17% in the proportion of the population in Inuit Nunangat that reported lack of access to health care in the past year, including a 75% increase among females.

Figure 27. Could not receive health care in the past year, by sex and age group

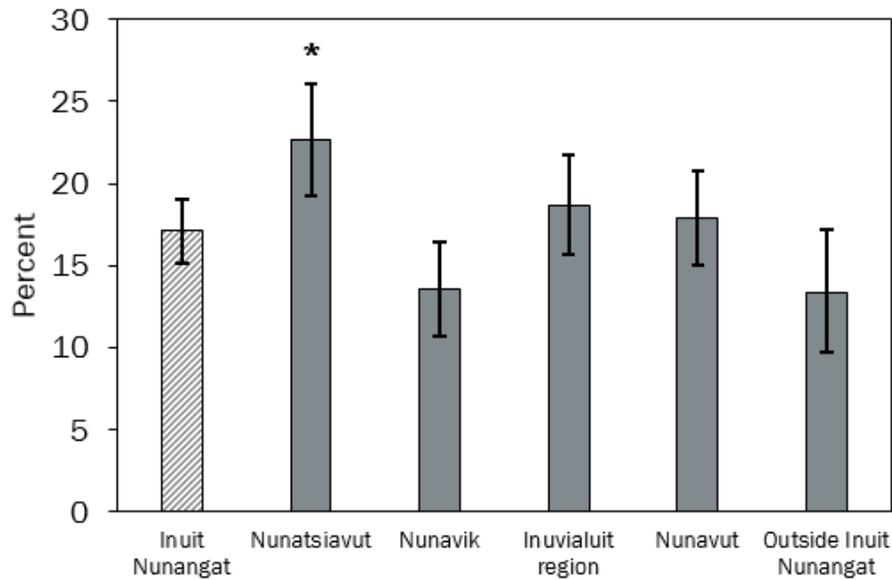


Note: "E" indicates high sampling variability; use with caution. "F" indicates data is suppressed for reasons of reliability.

Regarding regional differences, Nunatsiavut had a significantly higher proportion of the population reporting that they could not access health care when needed in the past year (23%) (Figure 28). Between 2012 and 2017, there was also a 120% increase in this proportion in Nunavik, particularly among the 35 to 54 age group (173%), and an 87% increase specifically among females in Nunavut (from 13% to 21%).



Figure 28. Could not receive health care in the past year, by region



Note: “*” indicates a significant difference from Inuit Nunangat at the $p < 0.05$ level.

2 Past-year food insecurity

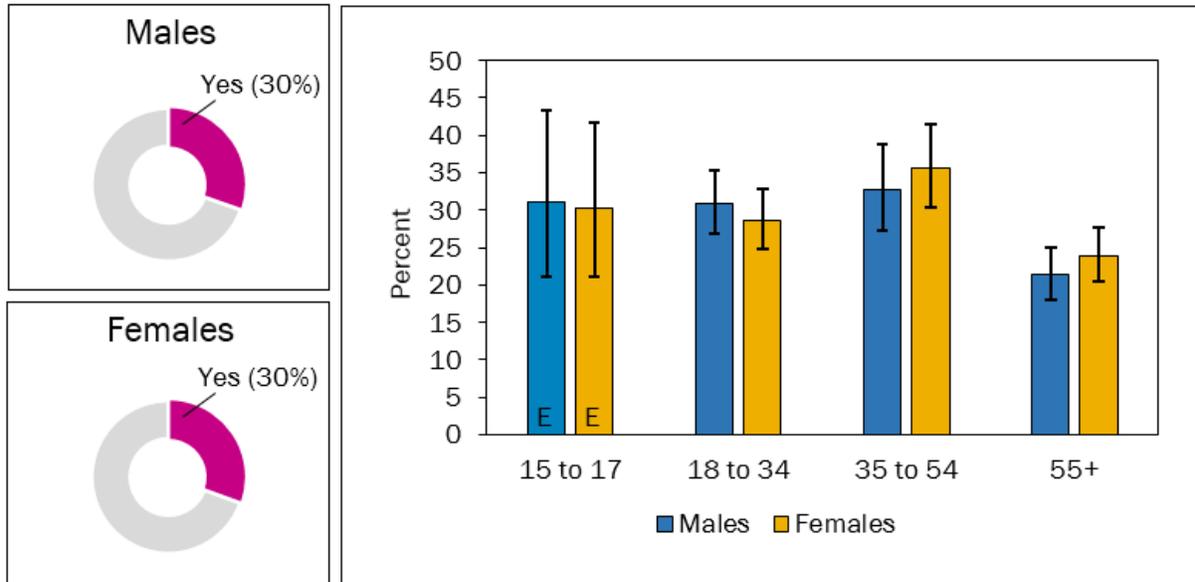
Food insecurity is generally defined as when people lack access to enough safe and nutritious food, often because of limited financial resources. Food insecurity is known to contribute to poor mental health and mental distress. The APS asks the following questions about food insecurity:

- In the past 12 months, were you ever hungry but didn’t eat because you couldn’t afford enough food?
- In the past 12 months, did [you/you and other household members] ever cut the size of your meals or skip meals because there wasn’t enough money for food?
- In the past 12 months, did you ever eat less than you felt you should because there wasn’t enough money to buy food?

In 2017, 30% of the population (age 15+) in Inuit Nunangat could not afford food when hungry (Figure 29). 42% of the population (age 15+) reported cutting the size of meals or skipping meals and 40% reported eating less than they felt they should. There were generally no significant differences between males and females and across age groups. Between 2012 and 2017, there was a significant 24% overall increase in the proportion of the population reporting they went hungry and a 34% increase among females. The proportion of the population reporting that they cut the size of or skipped meals also increased 47% in Inuit Nunangat between 2012 and 2017.



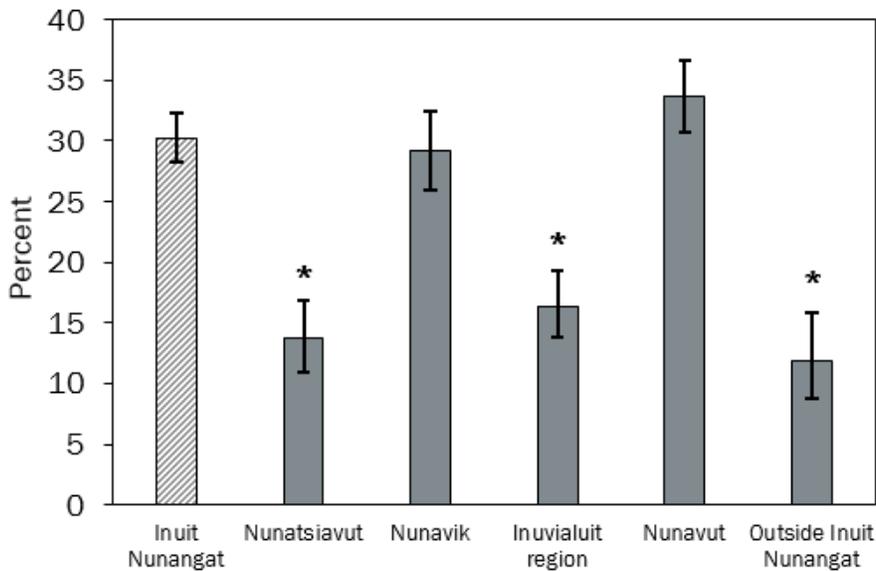
Figure 29. Could not afford food when hungry in past year, by sex and age group



Note: "E" indicates high sampling variability; use with caution.

The prevalence of all three indicators for food insecurity was significantly lower outside Inuit Nunangat, and in Nunatsiavut and the Inuvialuit Settlement Region (Figure 30). Between 2012 and 2017, the largest increase in food insecurity occurred in Nunavik with significant increases in the prevalence of not being able to afford food when hungry (from 20% to 29%) and of cutting the size of meals or skipping meals (from 22% to 46%).

Figure 30. Could not afford food when hungry in past year, by region



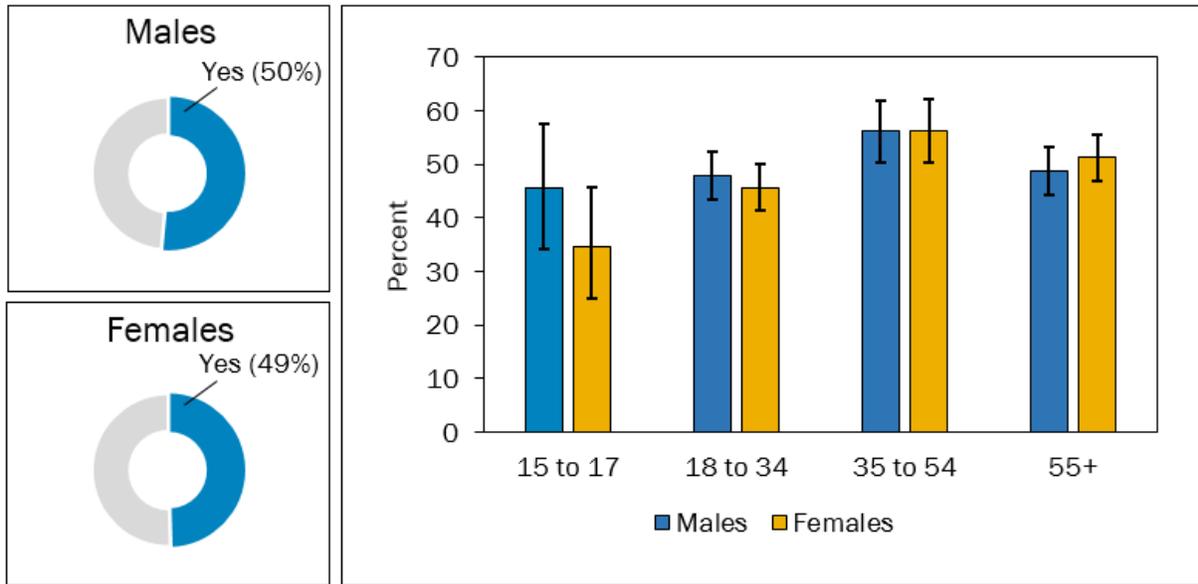
Note: "*" indicates a significant difference from Inuit Nunangat at the $p < 0.05$ level.



3 Household income did not meet needs in the past year

In 2017, 50% of the population (age 15+) in Inuit Nunangat, including a roughly equal proportion of males and females, reported that their household income was not enough to meet their household's needs for transportation, housing, food, clothing and other necessities (Figure 31). The prevalence of household income not meeting these needs was significantly higher among the 35 to 54 and 55+ age groups (56% and 50% respectively) compared to the 15 to 17 and 18 to 34 age groups (40% and 47% respectively).

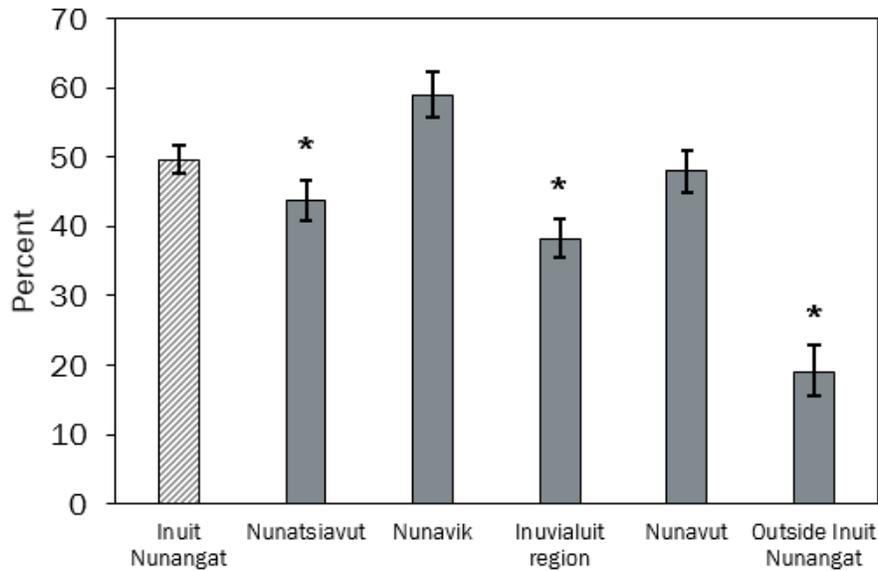
Figure 31. Household income did not meet needs in past year, by sex and age group



The prevalence of household income not meeting needs was significantly higher in Nunavik (59%) and significantly lower in Nunatsiavut (44%), the Inuvialuit Settlement Region (38%) and outside Inuit Nunangat (19%) (Figure 32). The 2012 APS does not ask about whether income met basic needs, so a comparison across the two survey years is not available.



Figure 32. Household income did not meet needs in past year, by region



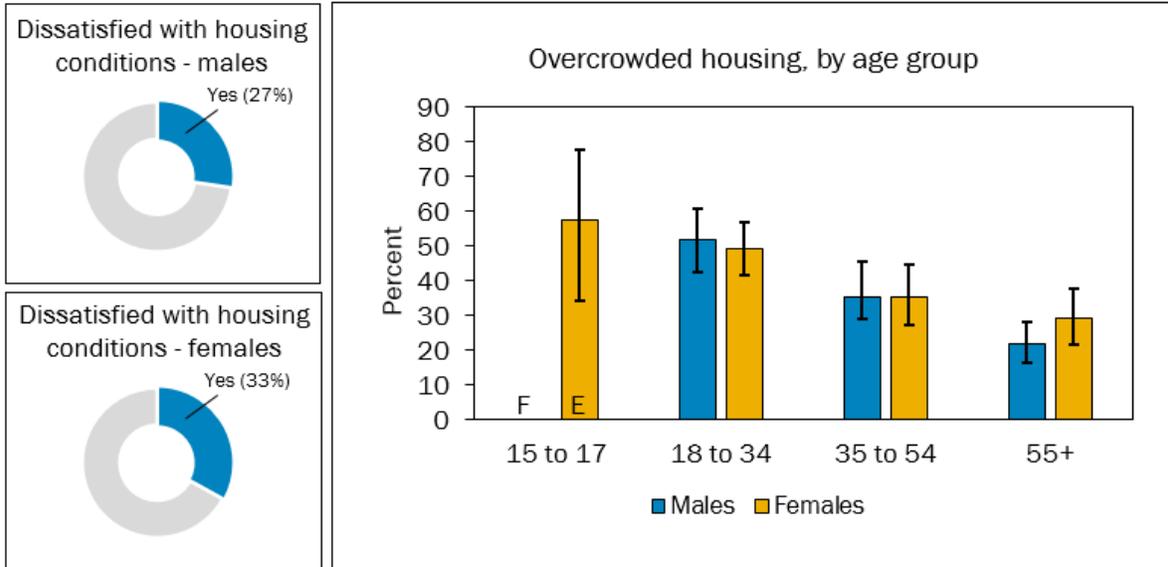
Note: “*” indicates a significant difference from Inuit Nunangat at the $p < 0.05$ level.

4 Overcrowded housing

Housing is an important social determinant of health among Inuit and inadequate housing is common in Inuit Nunangat. In 2017, 30% of the population (age 15+) in Inuit Nunangat reported being dissatisfied or very dissatisfied with their housing conditions, including 27% of males and 33% of females (Figure 33). The most common reasons for being dissatisfied with housing conditions were that the housing was “Run down / Needs many repairs” (60%), the housing had “Poor insulation” (43%) and the housing was “Crowded / Not enough space” (41%). A comparison of overcrowded housing by region shows that the Inuvialuit Settlement Region had significantly lower prevalence of individuals reporting overcrowded housing (24%) (Figure 34). The 2012 APS does not ask about satisfaction with housing conditions, including overcrowded housing, so a comparison across the two survey years is not available.

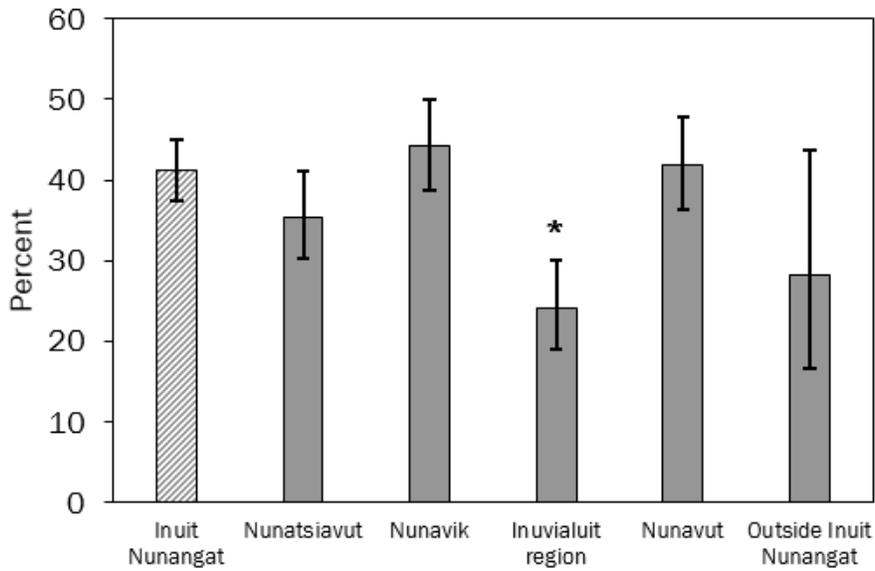


Figure 33. Housing conditions, by sex and age group



Note: "E" indicates high sampling variability; use with caution. "F" indicates data is suppressed for reasons of reliability.

Figure 34. Overcrowded housing, by region



Note: "*" indicates a significant difference from Inuit Nunangat at the $p < 0.05$ level.



Protective Factors

Cultural Continuity

The NISPS lists being strongly grounded in Inuit language, culture and history as examples of cultural continuity. Key results on cultural continuity from the 2012 and 2017 APS are as follows:

- In 2017, at least 95% of the population (age 15+) in Inuit Nunangat had some knowledge of an Inuit language, and the proportion increased slightly between 2012 and 2017 among those aged 18 to 34.

1 Knowledge of Inuit language

In 2017, 95.5% of the population (age 15+) in Inuit Nunangat reported having some knowledge of an Inuit language, either understanding or speaking, even if only a few words (Figure 35). There were no significant differences between males and females or across age groups. Compared to all of Inuit Nunangat, knowledge of an Inuit language was significantly higher in Nunavik (99.7%) and significantly lower in Nunatsiavut (86%) and the Inuvialuit Settlement Region (82%). Between 2012 and 2017, there were generally no changes in the prevalence of the population reporting knowledge of an Inuit language across males, females and all age groups, except for a small but significant increase (3.4%) among those aged 18 to 34 (from 92% to 95.6%). Inuit living in the Inuvialuit Settlement Region, Nunatsiavut and outside Inuit Nunangat had the lowest knowledge of an Inuit language (Figure 36). Between 2012 and 2017, there was a significant decrease in the prevalence of respondents indicating some knowledge of an Inuit language in Nunatsiavut (7%) and the Inuvialuit Settlement Region (8%), and an increase in Nunavik (7%).

Figure 35. Knowledge of an Inuit language, by sex and age group

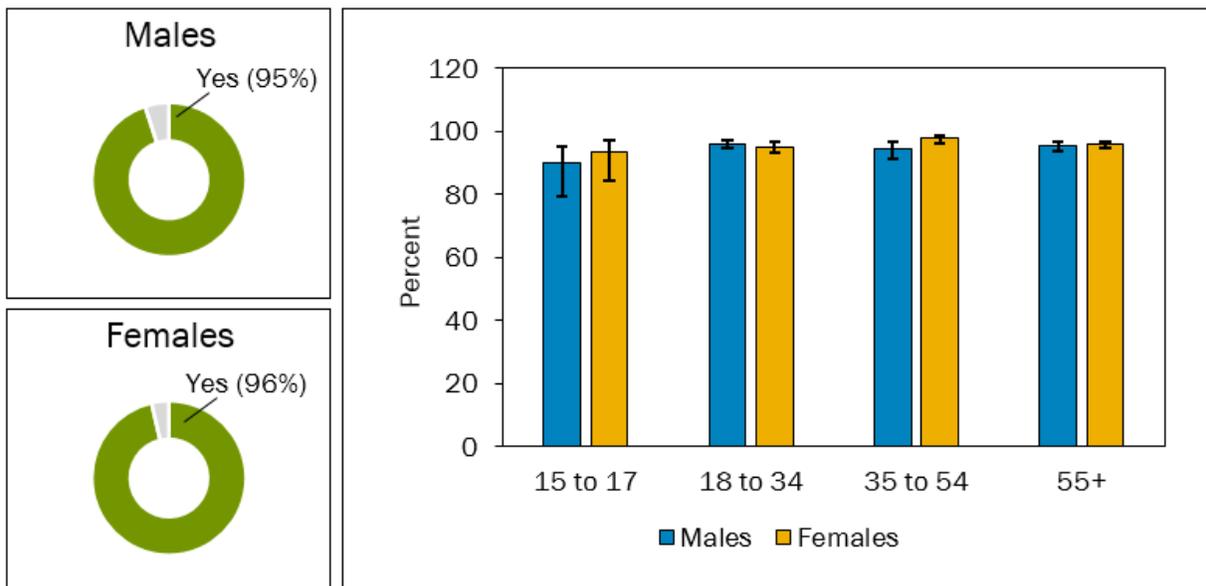
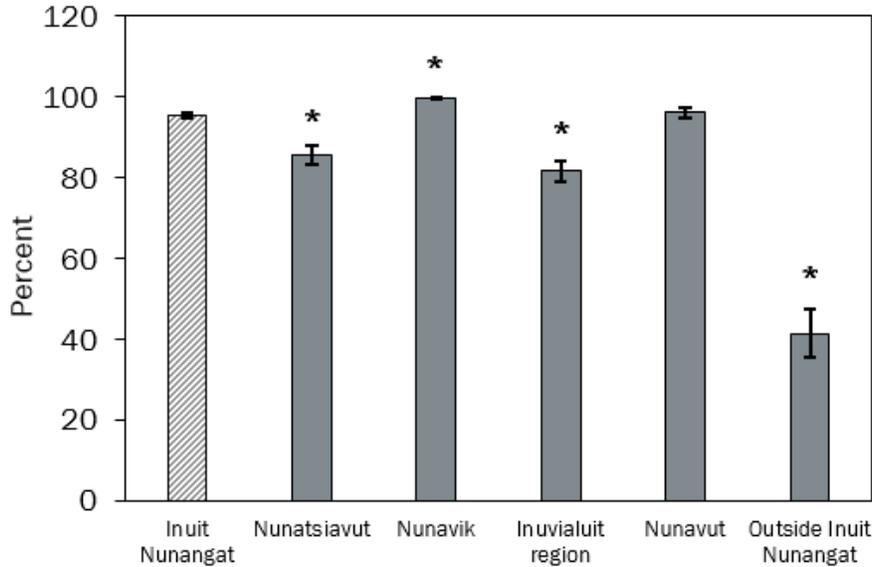




Figure 36. Knowledge of an Inuit language, by region



Note: “*” indicates a significant difference from Inuit Nunangat at the $p < 0.05$ level.

Social Equity

The NISPS lists adequate economic, educational, health and other resources to support and foster resilience as examples of social equity. Key results on social equity from the 2012 and 2017 APS are as follows:

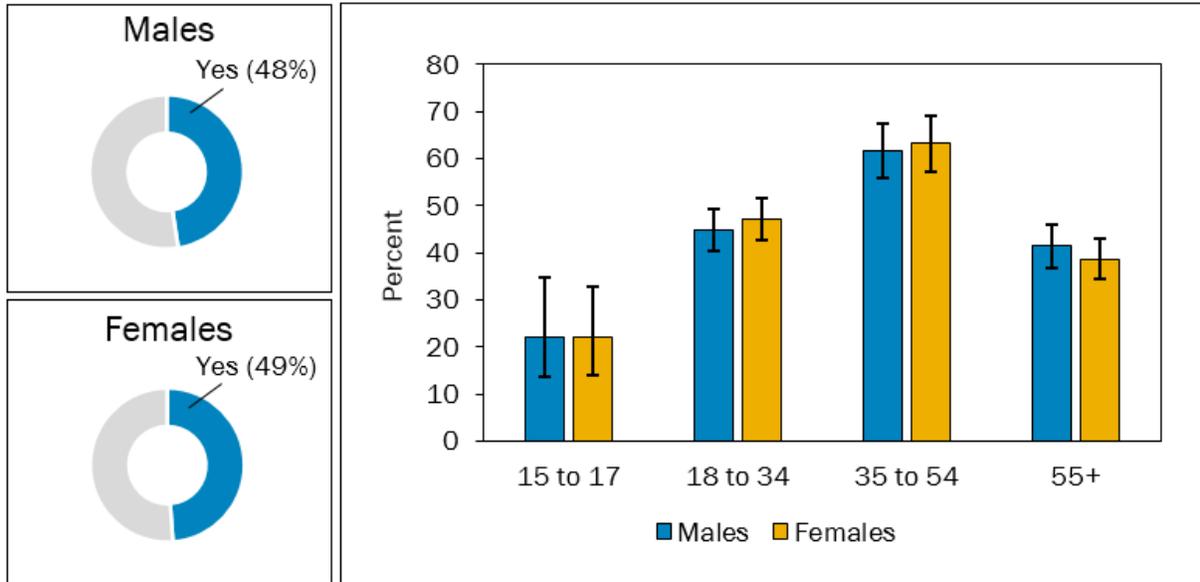
- In 2017, 48% of the population in Inuit Nunangat (age 15+) reported working at a job or business in the last week, roughly unchanged from 2012.
- In 2017, one-third of the population (age 18+) in Inuit Nunangat had completed a high school diploma or equivalent, including 31% of males and 38% of females. Those aged 18 to 34 and 35 to 54 were more likely to have completed a high school diploma compared to those aged 55 and older (32.5%, 25% and 11% respectively).
- In 2017, 77% of youth aged 15 to 17 attended high school.

1 Current employment

Livelihood is an important social determinant of health among Inuit and lack of adequate employment is a challenge in Inuit communities (Inuit Tapiriit Kanatami, 2014). In 2017, 48% of the population in Inuit Nunangat (age 15+) reported working at a job or business in the last week (referred to as “current employment,” regardless of the number of hours), including 22% among those aged 15 to 17, 46% among those aged 18 to 34, 63% among those aged 35 to 54, and 40% among those aged 55 and older. A roughly equal proportion of males and females overall and within each group reported working in the last week (Figure 37). A comparison between the 2012 and 2017 APS showed no significant change in the proportion of the population in Inuit Nunangat who reported current employment (44% in 2012 to 48% in 2017).

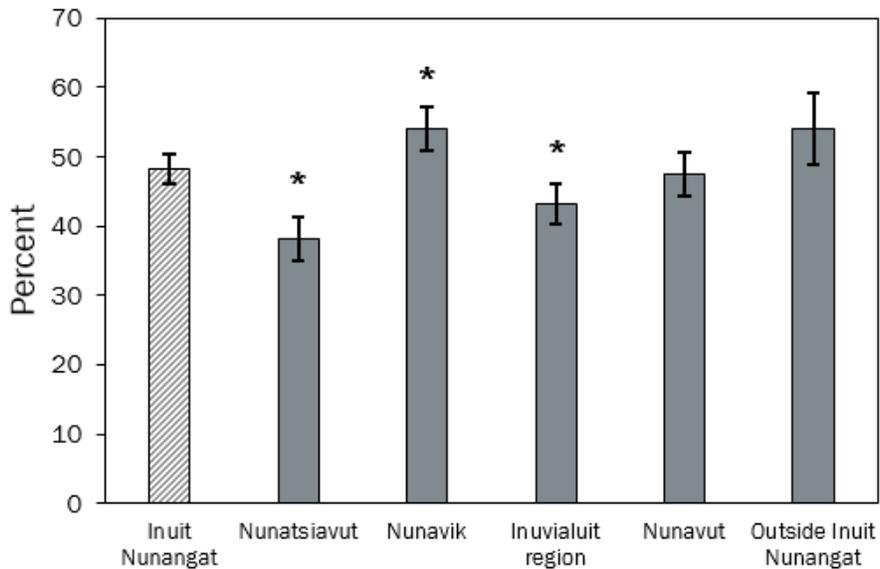


Figure 37. Current employment, by sex and age group



A significantly lower proportion of the population reported current employment in the Inuvialuit Settlement Region (43%) and Nunatsiavut (38%), and a significantly higher proportion reported current employment in Nunavik (54%) (Figure 38). The only significant regional change between 2012 and 2017 was a 22% increase in the proportion of individuals aged 18 to 34 in Nunavik who reported current employment (from 46% in 2012 to 56% in 2017).

Figure 38. Current employment, by region



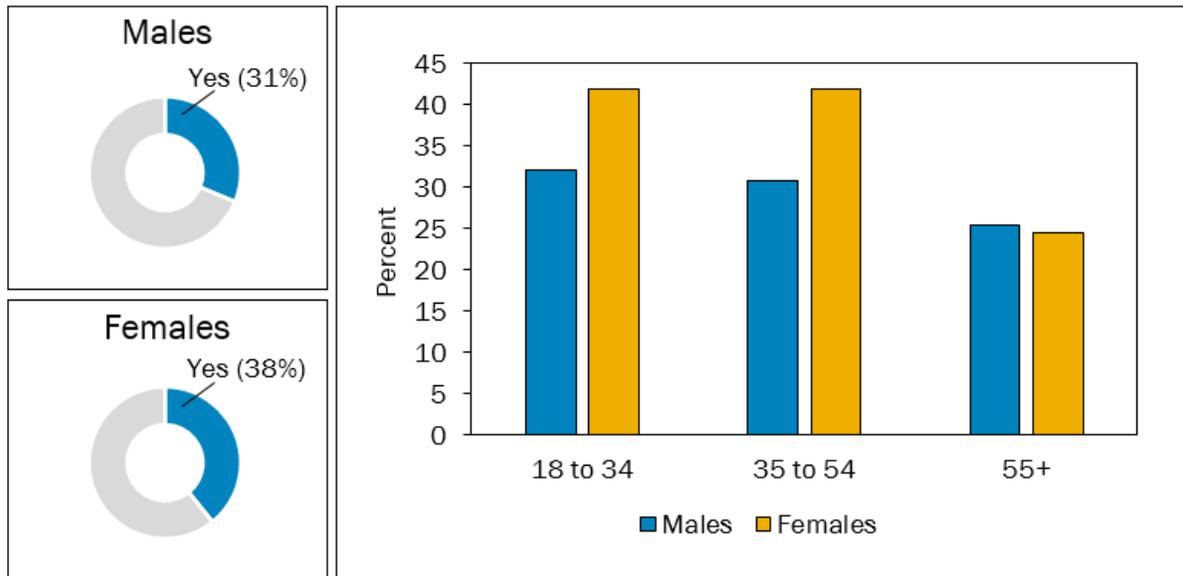
Note: "*" indicates a significant difference from Inuit Nunangat at the p<0.05 level.



2 Completed high school or equivalent

Educational attainment is an important social determinant that positively impacts Inuit health (Inuit Tapiriit Kanatami, 2014). Overall, 32% of the Inuit population (age 18+) in Inuit Nunangat completed a high school diploma or equivalent, including 31% of males and 38% of females (Figure 39). Those aged 18 to 34 and 35 to 54 were significantly more likely to have completed a high school diploma compared to those aged 55 and older (32.5%, 25% and 11% respectively). The 2012 estimates for high school attendance are not reported so survey questions on educational attainment are not comparable between the 2012 and 2017 APS.

Figure 39. Completion of high school or equivalent, by sex and age group

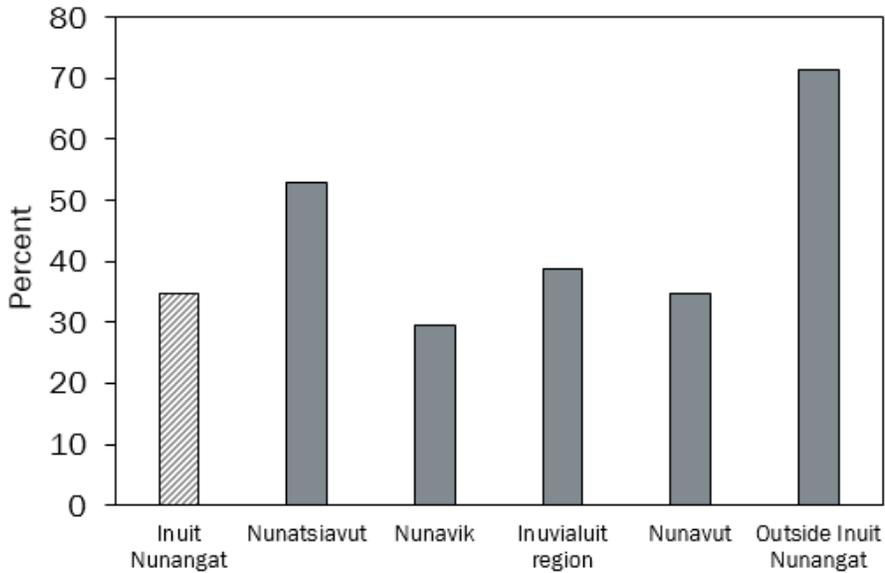


Note: Estimates are combined responses for completed a “high school diploma” and a “high school equivalency program such as a General Education Diploma (GED) or Adult Basic Education (ABE).” Confidence intervals were calculated for each response separately and not for combined estimates.

Access to formal education is limited in northern Inuit communities (Inuit Tapiriit Kanatami, 2014), so it is not surprising that in 2017 the proportion of the Inuit population (age 18+) in Inuit Nunangat who completed a high school diploma (24%) was significantly lower than among Inuit living outside Inuit Nunangat (56%) (Figure 40). Within Inuit Nunangat, Nunatsiavut had the highest prevalence of high school completion (53%) and Nunavik had the lowest (29%) (Figure 40).



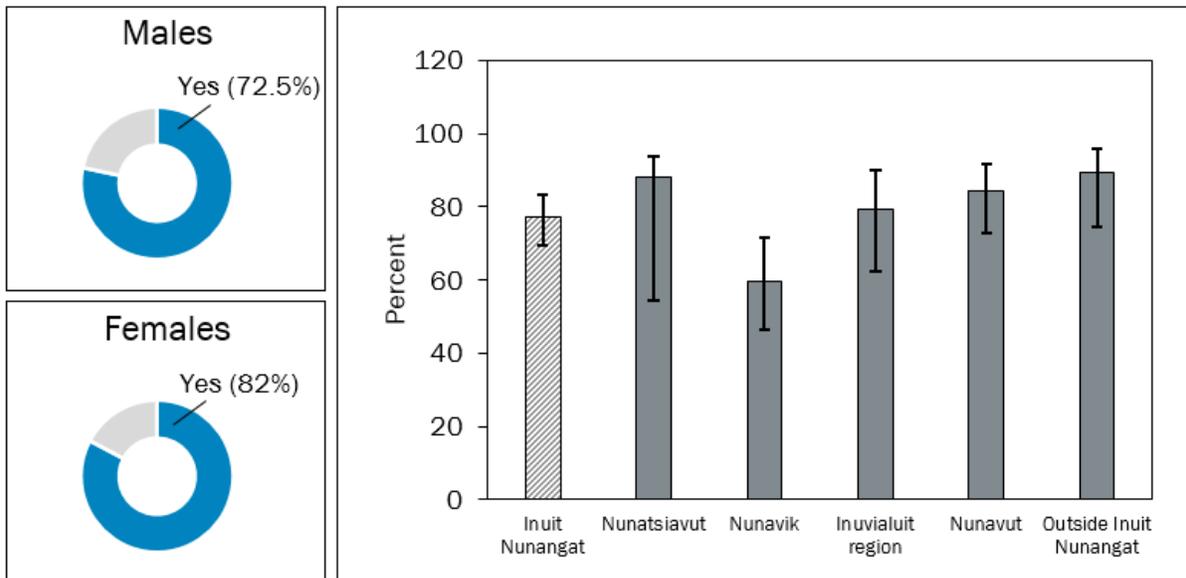
Figure 40. Completion of high school or equivalent, by region



Note: Estimates are combined responses for completed a “high school diploma” and a “high school equivalency program such as a General Education Diploma (GED) or Adult Basic Education (ABE).” Confidence intervals were calculated for each response separately and not for combined estimates.

The above statistics capture information on Inuit age 18+. Generally, most students attending secondary education would graduate at the age of 18. In 2017, 77% of youth aged 15 to 17 attended high school, including 72.5% of males and 82% of females (Figure 41). There were no significant differences in high school attendance across regions of Inuit Nunangat or compared to Inuit youth living outside Inuit Nunangat (Figure 41).

Figure 41. Current attendance at high school or equivalent, by sex and region



Note: Estimates are for currently attending high school diploma only, as estimates for attending a high school equivalency are suppressed due to data reliability.



Family Strength

The NISPS lists safe, supporting and nurturing homes as examples of family strength. No indicators from the 2017 APS aligned closely with this protective factor.

Healthy Development

The NISPS lists providing children with safe environments that nurture social and emotional development as an example of healthy development. No indicators from the 2017 APS aligned closely with this protective factor.

Mental Wellness

The NISPS lists access to Inuit-specific mental health services and supports as an example of mental wellness. Key results on mental wellness from the 2012 and 2017 APS are as follows:

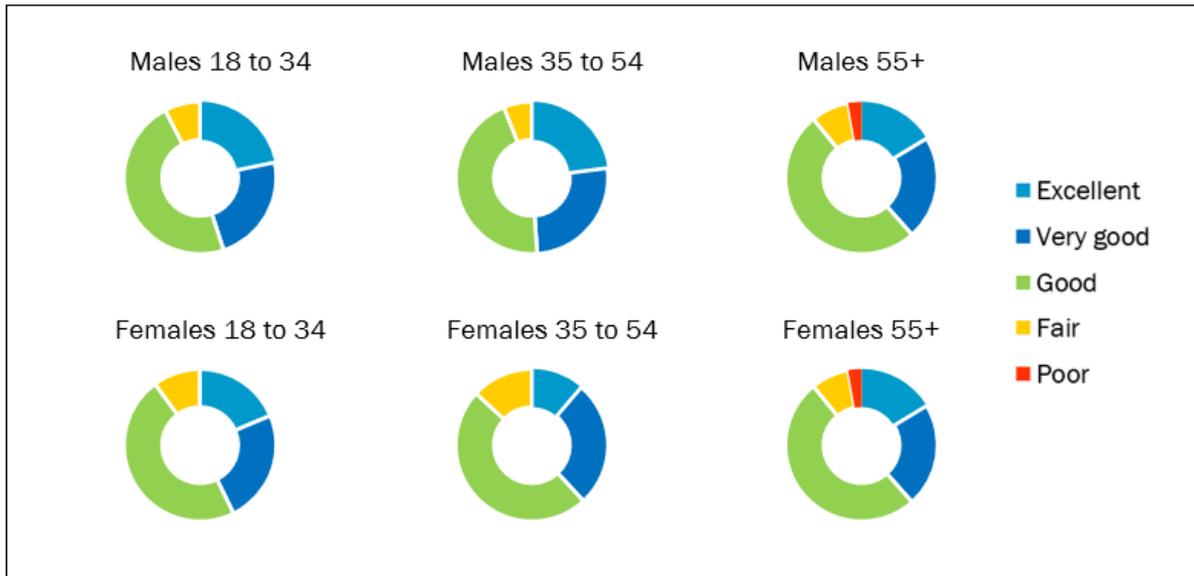
- In 2017, most of the population in Inuit Nunangat (age 18+) reported their mental health was good (47%) or very good (25%). 1.7% reported their mental health was poor, and approximately 9% reported their mental health was fair. General positive mental health increased between 2012 and 2017.
- In 2017, 22% of the population in Inuit Nunangat (age 18+) indicated they had consulted with someone about their mental health or use of alcohol or drugs, including with a healthcare professional, friend or family member. Females were more likely to have done so (27%) compared with males (17%).

1 General mental health

Most of the population in Inuit Nunangat (age 18+) reported their mental health was good (47%) or very good (25%). Only 1.7% report their mental health was poor and about 9% report their mental health was fair. Overall, males were more likely to report excellent mental health and females were more likely to report fair mental health (Figure 42). Between 2012 and 2017, there was an 8% increase in reported positive mental health (any of “good,” “very good” or “excellent” responses) across all three age groups and among both males and females, including an 11% increase among males and a 6% increase among females. For the prevalence of poor or fair mental health, there were no other differences across regions of Inuit Nunangat compared to Inuit Nunangat overall (Figure 43).

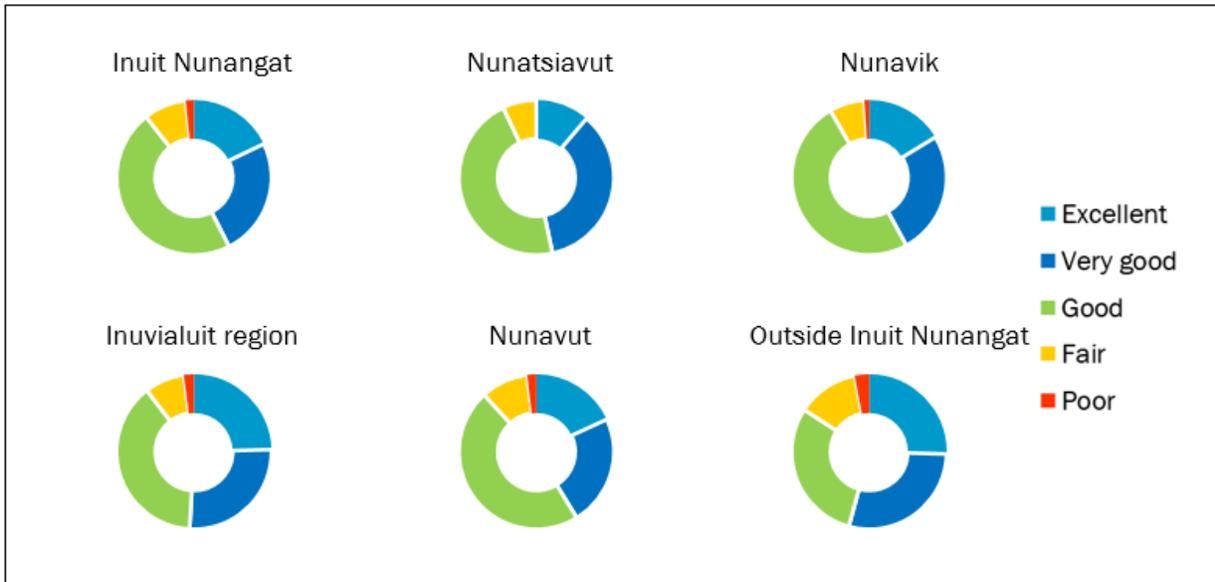


Figure 42. Reported general mental health, by sex and age group



Note: Estimates for poor general mental health among the 18 to 34 and 35 to 54 age group are suppressed for reasons of reliability. Estimates for poor responses among the 55+ age group have high sampling variability and should be interpreted with caution.

Figure 43. Reported general mental health, by region



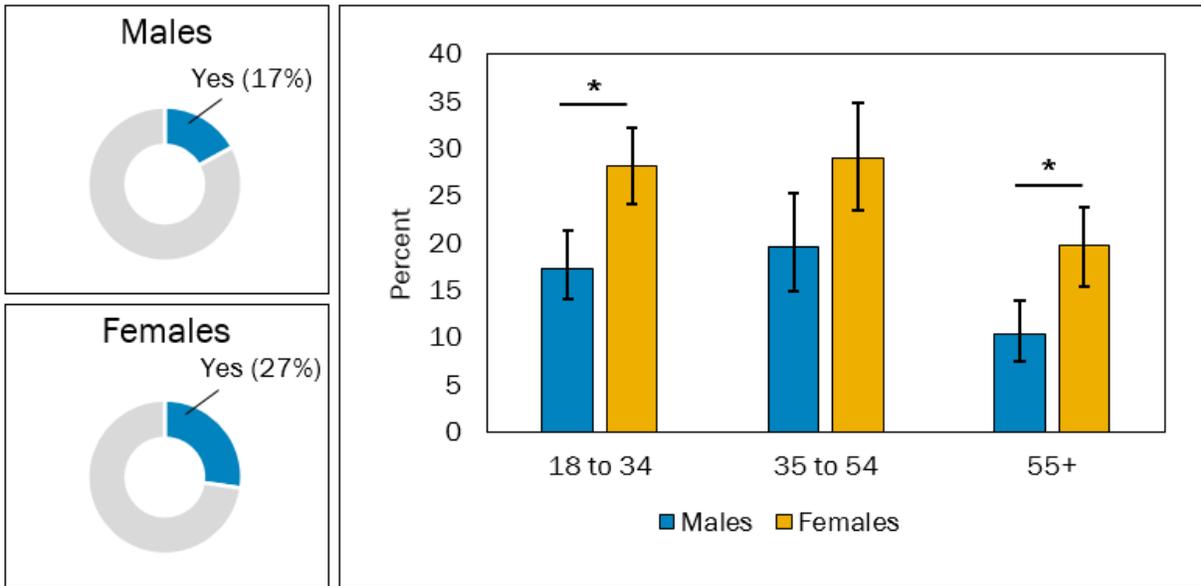
Note: Estimates for poor general mental health in all regions have high sampling variability and should be interpreted with caution. The estimate for poor general mental health in Nunatsiavut is suppressed for reasons of reliability.



2 Past-year mental health support

The indicator for mental health support in the 2017 APS is whether in the past year respondents indicated that they had consulted with anyone about their mental health or use of alcohol or drugs.⁸ In 2017, 22% of the population in Inuit Nunangat (age 18+) reported doing so, including a significantly higher proportion of females (27%) compared to males (17%) (Figure 44). Those in the 55+ age group were significantly less likely (15%) to have consulted with anyone compared to the younger age groups (Figure 44). A question about consulting with anyone about mental health or substance use issues was not asked in the 2012 survey, so a comparison across the two datasets is not possible. Regarding regional differences, the population in Nunatsiavut was significantly less likely to have consulted with anyone (13.5%), while individuals in the Inuvialuit Settlement Region were significantly more likely to have done so (28%) (Figure 45).

Figure 44. Consulted with someone about their own mental health, by sex and age group

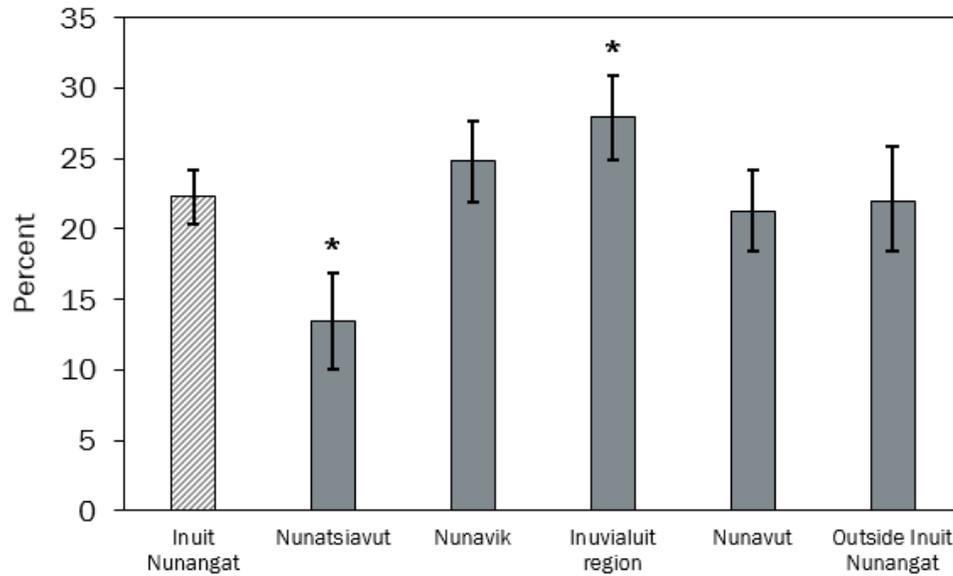


Note: "**" indicates significant difference between groups at the $p < 0.05$ level.

⁸ Persons sought for consultation include any of the following: psychiatrist, family doctor, general practitioner, psychologist, nurse, social worker, counsellor, case worker, psychotherapist, family member, friend, co-worker, supervisor, boss, teacher, school principal or elder (see Appendix A).



Figure 45. Consulted with someone about their own mental health, by region



Note: “*” indicates a significant difference from Inuit Nunangat at the $p < 0.05$ level.

Coping with Acute Stress

The NISPS lists ability to regulate and cope with distress, and access to social supports and resources as examples of acute stress management. No indicators from the 2017 APS aligned closely with this protective factor.



Discussion

Summary

Acquiring detailed statistics related to suicide and mental well-being among Inuit across regions of Inuit Nunangat is a priority for the NISPS (Inuit Tapiriit Kanatami, 2016). This report summarizes data related to suicide risk and protective factors among Inuit. The report provides the most recently available statistics on suicide ideation and attempts across Inuit Nunangat, on mental health outcomes and substance use patterns, as well as statistics on social determinants of health, including historical trauma, economic and food insecurity, and access to health care.

When possible, these statistics are stratified by region of Inuit Nunangat. Many of the publicly available statistics related to Inuit mental health and wellbeing are not region-specific, and often Inuit statistics are combined together with other Indigenous groups. Regional data are useful for informing suicide prevention activities, which are often specific to regions and implemented at the community level. Statistical profiles for regions of Inuit Nunangat show important differences in demographics, social determinants of health and health behaviours (Arriagada, 2016; Smith & Li, 2016a; Smith & Li, 2016b; Smith & Li, 2016c) that could impact the prevalence of suicide risk and protective factors. Access to and availability of alcohol and other substances also varies by region, which impacts the prevalence of harms related to alcohol and substance use .

Prevalence estimates are compared between 2012 and 2017 when possible. To inform activities recommended in the NISPS, data on suicide risk and protective factors need to be collected consistently over time. These efforts will be useful for tracking health status over time and in relation to suicide prevention activities and changes in social determinants of health. And finally, the statistics in this summary are also stratified by sex and age as these variables affect levels of exposure to risk and protective factors, the strength of association with these factors, and the ways in which these factors are experienced (Aboriginal Healing Foundation, 2007; Dube et al., 2001; Fraser et al., 2015; Kirmayer, Boothroyd, & Hodgins, 1998; Kumar & Tjepkema, 2019). These detailed statistics will help inform ITK's research agenda with an understanding of the current mental health and well-being of Inuit, and by identifying areas that need to be addressed in future data collection efforts.

Limitations

The surveys used for this report are limited in scope to providing statistics on all the main risk and protective factors for suicide among Inuit as outlined in the NISPS. However, the IHS and APS are currently the only two surveys providing population-level data on all Inuit who live in Inuit Nunangat. Also, neither of the surveys used for this report capture statistics for adolescents under the age of 15 and largely focus on individuals aged 18 and older. Statistics about adolescent mental health and well-being are important because they experience the highest rates of suicide and many risk factors are most likely to impact adolescents.

A balanced representation of protective factors is also lacking as questionnaires from both the IHS 2007–2008 and the 2012 and 2017 APS tend to overemphasize survey questions that capture information about risk factors for suicide such as factors relating to mental and community distress. While these indicators are important, future surveys should collect a more comprehensive picture of protective factors for suicide among Inuit. Research and data on protective factors among Inuit remain sparse and this will be an important gap to address (Beaudoin et al., 2019). CCSA recognizes



the importance of a strengths-based approach to research and data collection among Inuit populations to limit stigmatizing narratives and to inform the development of programs that build on individual and community resilience.

As with any survey data, the statistics related to the prevalence of risk and protective factors are subject to individual interpretation of the survey questions. One person's interpretation of suicide ideation or a mental health disorder is different from another's. It can also be difficult to obtain accurate estimates for some sensitive indicators related to suicide, mental health and substance use, possibly leading to under or over-reporting. Methodological and governance differences across surveys can also impact survey data. For example, estimates for the prevalence of suicide ideation and attempts across Inuit Nunangat from the 2012 APS were two to three times higher compared to the IHS 2007–2008 (Appendix B, Table 1). It is not clear if these differences reflect changes over time, changes in demographic composition between the surveys or differences in how the surveys were conducted.

The APS is intended to capture a broad range of health, social and economic conditions among Inuit and other Indigenous populations, and so many topics cannot be completely or adequately explored. For instance, the APS is not designed to provide insights about the prevalence of use for specific substances, behaviours related to substance use and harms directly related to substance use. Improving indicators for both mental health and substance use can ensure that interventions, treatment and policies being developed and implemented on an ongoing basis are effective across different demographics and regions. The APS is not Inuit-determined or developed by Inuit and so it may not fully capture the most relevant population-level risk and protective factors related to suicide among Inuit. Moreover, the validity of self-reported data from the 2017 APS could be questioned given the sensitivity and stigma surrounding the use of illegal substances. Indigenous peoples in Canada, including Inuit, Métis and First Nations, are more likely to experience stigma and discrimination around substance use (Urbanoski, 2017; Winters & Harris, 2020) and may be less likely to disclose their substance use in surveys.

A final limitation to note is that direct access to the primary survey data for the APS was not available at the time this report was written. The option for analysis of the dataset was largely limited to prevalence estimates due to the logistics and timelines of obtaining survey data indirectly via Statistics Canada. Future reports would benefit from additional statistical analyses to determine the strength or degree to which each risk and protective factor is associated with suicide. Examples of such analyses are presented in Kumar & Nahwegahbow (2016) using data from the 2012 APS.

Spotlight on Substance Use and Suicide

The 2017 APS is the most up to date and comprehensive source for data on the prevalence and frequency of substance use across Inuit Nunangat. Regarding alcohol use, the statistics in this report indicate that as of 2017, almost one-third of Inuit in Inuit Nunangat reported heavy episodic drinking at least once a month (almost half of those who drink at all) and almost 10% reported heavy episodic drinking at least once a week. The prevalence of heavy episodic drinking increased between 2012 and 2017, particularly among females.

The 2017 APS data indicate that the past-year prevalence of illegal substance use (excluding cannabis) is low across Inuit Nunangat (1% or less), although the lifetime prevalence of illegal substance use (excluding cannabis) in 2012 varied between 5% and 20% depending on sex and region of Inuit Nunangat (Appendix B, Table 10). Moreover, harms experienced from other substances is significant. In Nunavut, where 85% of the population is Inuit (Statistics Canada, 2017), there was an estimated 541 deaths per 100,000 and 169 hospitalizations per 100,000 attributable



to illegal substance use and other substances not specified in the APS (e.g., opioids, other depressants, cocaine, other stimulants and other psychoactive substances including hallucinogens and inhalants) in 2017 (Canadian Substance Use Costs and Harms Scientific Working Group, 2020).

The NISPS notes that substance “misuse” contributes to risk for suicide. “Misuse” can be difficult to define, but the link between substance use and suicide is generally much stronger with frequent use of substances or dependence on them (Connor et al., 2019; Esang & Ahmed, 2018; Poorolajal et al., 2016). The pathways through which substance use can increase the risk for suicide are complex and can be direct or indirect (Canadian Centre on Substance Abuse, 2016). For example, one indirect pathway is that substance use increases the risk for depression and other mental health conditions, which can lead to suicide ideation. A more direct pathway is that acute intoxication from substance use is associated with impaired judgment and decision making, reduced inhibition, increased impulsivity and changes in mood that can lead to both suicide ideation and acting on these thoughts to attempt suicide. For example, between 34% and 64% of Inuit (age 18+) in 2007–2008 who attempted suicide reported drinking alcohol just before the attempt (Appendix C, Table 4). Finally, other risk factors, including stressful or traumatic experiences, independently increase the risk for both substance use and suicide. Only a handful of publications have characterized the relationship between substance use and suicide specifically among Inuit populations in Canada (Chachamovich et al., 2015; Fortin et al., 2015).

Not all substance use is related to mental health concerns and not all use of substances results in harms related to substance use such as substance use disorders, mental health issues, family problems, violence, self-harm, injury or death. This highlights the need to collect information on the harms associated with substance use in addition to information on the prevalence and frequency of substance use. For example, knowing the number and characteristics (e.g., for which substances) of those seeking treatment can inform decisions about the development of in-territory services (Konefal, Maloney-Hall, Urbanoski, & the National Treatment Indicators Working Group, 2021). Many risk factors that influence substance use among Inuit are specific to them, notably inequities related to social determinants of health and the intergenerational effects of residential schools and other historical traumas (McKenzie, Dell, & Fornssler, 2016; National Collaborating Centre for Aboriginal Health, 2010; Reading & Wein, 2009).

Several initiatives in the NISPS target substance use, including increasing alcohol-related information available to communities, and investing in treatments and services at the community level (Inuit Tapiriit Kanatami, 2016). Promising practices that reduce harms from substance use among Inuit include social-emotional learning curricula, programs that teach children and youth to manage emotions, relationships and conflicts, and programs focused on wellness that provide holistic and culturally relevant supports, including engagement with traditional activities on the land (Inuit Tapiriit Kanatami, 2019b). Improving data collection related to substance use and substance-related harms across Inuit Nunangat can help inform services and supports, as well as population- and community-level health interventions.

Spotlight on Cannabis Use, Mental Health and Suicide

Due to the legalization of cannabis and evidence that cannabis use, including frequent use, is common among Inuit, there has recently been interest among Inuit organizations and communities on the impacts of cannabis use on Inuit mental health and well-being (Mental Health Commission of Canada, Canada Centre on Substance Use and Addiction, & Inuit Tapiriit Kanatami, 2019; Wolfson et al., 2020). Regular cannabis use (weekly or more frequent use over periods of months or years) is a risk factor for suicide (Borges, Bagge, & Orozco, 2016; Gobbi et al., 2019; Shalit et al., 2016), but



there are no recent data on cannabis use and suicide risk among Inuit in Canada. Cannabis dependence in the last six months was linked to suicide among Inuit in Nunavut in a study conducted between 2003 and 2006 (Chachamovich et al., 2015). Another study based on the Nunavik Inuit Health Survey 2004 reported that any use of cannabis in the past year was linked to increased likelihood of attempting suicide (Fortin et al., 2015). The 2017 APS indicates that 40% of Inuit in Inuit Nunangat reported using cannabis in the past year (non-medical use only) and 20% reported using cannabis on a daily or near daily basis. The prevalence of daily or near daily cannabis use varied substantially across regions. Similar to previous reports (Wolfson et al., 2020), the 2017 APS data indicate that cannabis use is more common among males and those in younger age groups. Statistical analyses showed that daily cannabis use was associated with increased odds of past-year suicidal behaviours (ideation and attempt) and self-reported mood disorders among Inuit ages 15 and older. However, less than daily cannabis use was associated only with increased odds of reporting a mood disorder and not with suicidal behaviours. This report is the first to link daily or near daily cannabis use to outcomes related to suicide among Inuit in Canada.

An Inuit forum on cannabis and mental health held in October 2019 identified the lack of linkages in data sets between cannabis, mental health and suicide among Inuit populations as an important research and data gap (Mental Health Commission of Canada, Canada Centre on Substance Use and Addiction, & Inuit Tapiriit Kanatami, 2019). Future analyses could examine the relationship between cannabis use (daily or near daily) and mental health outcomes by sex, gender, age and region. Additional attention to other potential confounders besides demographics, substance use and mental health status would shed further light on the link between cannabis use and mental health outcomes including suicide. As noted previously, it is important to evaluate differences among regions, particularly as it is regional communities that implement the programs and practices aimed at reducing harms from substance use and other suicide risk factors.

Future Directions for Research, Data Collection and Reporting

Despite being one of the most researched populations in Canada, there continues to be a consistent deficit of Inuit-specific data available for use by Inuit rights holders. ITK along with other national organizations and Indigenous governments have called for enhanced monitoring and surveillance of data related to mental health to guide program planning and interventions, and track progress over time (Government of Nunavut, 2016; Inuit Tapiriit Kanatami, 2016; Mental Health Commission of Canada, 2014). Adequate, accurate and accessible data on the mental health and well-being of Inuit is essential for understanding their status and the disparities that exist, and for informing suicide prevention activities. This report underscores the need for an improved framework for data collection related to mental health and well-being among Inuit that is Inuit-led and Inuit-determined.

The report also highlights the importance of having an Inuit health survey governed and led by Inuit to help ensure that data reflect Inuit health and wellness accurately. The upcoming [National Inuit Health Survey](#) led by ITK in partnership with regional Inuit organizations will help address some limitations of this statistical summary, including the limited range of indicators relevant to risk and protective factors for suicide among Inuit. This survey begins data collection in 2021 and will be Inuit-determined, strength-based and focused on Inuit health and social equity. It is anticipated that the data it collects will more accurately reflect Inuit health and wellness, and can also be used to assess the impact of suicide prevention activities.

It will, however, still be helpful to integrate Inuit indicators into other population health datasets, and for these datasets to improve data quality, comprehensiveness and timeliness. These other data



collection and reporting platforms need to ensure that data is collected in consultation with Inuit partners and accessible to Inuit partners and rights holders. These efforts are aligned with the Truth and Reconciliation Commission, which underscores the need for population health data among Inuit, First Nations and Métis. CCSA will continue to support ITK's NISPS and to support data collection and reporting processes as they relate to substance use and mental health.

In addition to data collection and reporting, ITK continues to lead ongoing initiatives to improve health and well-being among Inuit in Canada, addressing a broad range of issues related to health. These initiatives include the National Inuit Committee on Health, the Inuit Nunangat Housing Strategy and the National Inuit Committee on Education. They support many of the NISPS priority areas and will help decrease the prevalence and impact of risk factors while increasing the prevalence and impact of protective factors. These initiatives will also help reduce the disproportionate susceptibility of Inuit communities to risks from the COVID-19 pandemic (Inuit Tapiriit Kanatami, 2020). Improving the social determinants of health, including housing, education and access to culturally safe health care, is integral for mental well-being and suicide prevention.



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Appendix A: Survey Questions, 2017 Aboriginal Peoples Survey

The following survey questions and possible response choices are from the 2017 Aboriginal Peoples Survey (APS) for indicators included in the statistical summary. Additional information, instructions and all operational definitions for the 2017 APS are available from [Statistics Canada](#).

SUICIDE (SU)

SU_Q05) Have you ever seriously contemplated suicide?

- 1: Yes
- 2: No
- 8: RF
- 9: DK

SU_Q10) Has this happened in the past 12 months?

- 1: Yes
- 2: No
- 8: RF
- 9: DK

SU_Q15) Have you ever seriously attempted suicide?

- 1: Yes
- 2: No
- 8: RF
- 9: DK

SU_Q20) Did this happen in the past 12 months?

- 1: Yes
- 2: No
- 8: RF
- 9: DK

CHRONIC CONDITIONS (CC)

CC_Q80) Do you have a mood disorder such as depression, bipolar disorder, mania or dysthymia?

- 1: Yes
- 2: No
- 8: RF
- 9: DK



CC_Q85) Do you have an anxiety disorder such as a phobia, obsessive-compulsive disorder or a panic disorder?

- 1: Yes
- 2: No
- 8: RF
- 9: DK

DISABILITY SCREENING QUESTIONS (DSQ)

DSQ_Q33) Do you have any emotional, psychological or mental health conditions? These may include anxiety, depression, bipolar disorder, substance abuse, anorexia, etc.

- 1: No
- 2: Sometimes
- 3: Often
- 4: Always
- 8: RF
- 9: DK

ALCOHOL USE (ALC)

ALC_R05

The next questions are about drinking alcoholic beverages. When I use the word 'drink' it means:

- one bottle or can of beer or a glass of draft
- one glass of wine or a wine cooler
- one drink or cocktail with 1 ½ ounces of liquor

ALC_Q05) During the past 12 months, have you had a drink of beer, wine, liquor or any other alcoholic beverage?

- 1: Yes
- 2: No
- 8: RF
- 9: DK

ALC_Q10) During the past 12 months, how often did you drink alcoholic beverages?

- 1: Less than once a month
- 2: Once a month
- 3: 2 to 3 times a month
- 4: Once a week
- 5: 2 to 3 times a week
- 6: 4 to 6 times a week
- 7: Every day
- 8: RF
- 9: DK



ALC_Q15) How often in the past 12 months have you had [five/four] or more drinks on one occasion?

- 1: Never
- 2: Less than once a month
- 3: Once a month
- 4: 2 to 3 times a month
- 5: Once a week
- 6: More than once a week
- 8: RF
- 9: DK

DRUG USE (DU)

DU_Q05) In the past 12 months, how often have you used cannabis (marijuana, pot, grass, hash)? Please exclude use of cannabis exclusively for medical purposes.

- 1: Not at all
- 2: Less than once a month
- 3: At least once a month
- 4: At least once a week
- 5: Daily or almost daily
- 8: RF
- 9: DK

DU_Q10) In the past 12 months, how often have you used street drugs (such as cocaine, speed, solvents or steroids)?

- 1: Not at all
- 2: Less than once a month
- 3: At least once a month
- 4: At least once a week
- 5: Daily or almost daily
- 8: RF
- 9: DK

DU_Q15) In the past 12 months, how often have you used prescription drugs for recreational purposes?

- 1: Not at all
- 2: Less than once a month
- 3: At least once a month
- 4: At least once a week
- 5: Daily or almost daily
- 8: RF
- 9: DK



RESIDENTIAL SCHOOL (RS)

RS_Q05) Were you ever a student at a residential school?

- 1: Yes
- 2: No
- 8: RF
- 9: DK

RS_R10A

The next questions ask about residential schools for Aboriginal students. The last of these schools was closed in the 1990s.

RS_Q10A) Were any of the following members of your family ever a student at a residential school?

[Your] parents?

- 1: Yes
- 2: No
- 8: RF
- 9: DK

RS_Q10B) (Were any of the following members of your family ever a student at a residential school?)

Any of your grandparents?

- 1: Yes
- 2: No
- 8: RF
- 9: DK

GENERAL HEALTH 2 (GH2)

GH2_Q30) During the past 12 months, was there ever a time when [you] felt that [you] needed health care but you didn't receive it?

- 1: Yes
- 2: No
- 8: RF
- 9: DK



BASIC NEEDS (BN)

BN_Q05) Overall, in the past 12 months, was your household income enough to meet your household's needs for transportation, housing, food, clothing and other necessary expenses? Was it... ?

- 1: More than enough
- 2: Enough
- 3: Not enough
- 8: RF
- 9: DK

HOUSING (HOU)

HOU_Q05) How would you rate your level of satisfaction with your housing conditions? Would you say you are... ?

- 1: Very satisfied
- 2: Satisfied
- 3: Neither satisfied nor dissatisfied
- 4: Dissatisfied
- 5: Very dissatisfied
- 8: RF
- 9: DK

HOU_Q10) What are the reasons you are dissatisfied with your housing conditions?

- 01: Location (too far from work/school/stores)
- 02: Crowded / Not enough space
- 03: Safety concerns
- 04: Run-down / Needs many repairs
- 05: High costs
- 06: Poor insulation
- 07: Presence of mould or mildew
- 08: Presence of unwanted pests such as mice, bedbugs or cockroaches
- 09: Other - Specify
- 98: RF
- 99: DK

ABORIGINAL LANGUAGE (LAN)

LAN_Q05

Do you understand or speak an Aboriginal language, even if only a few words?

- 1: Yes
- 2: No
- 8: RF
- 9: DK



LABOUR MARKET ACTIVITIES MINIMAL (LMAM)

LMAM_Q01) Last week, did you work at a job or business?
(regardless of the number of hours)

- 1: Yes
- 2: No
- 8: RF
- 9: DK

ELEMENTARY AND HIGH SCHOOL (EHS)

EHS_Q10) Did you complete a high school diploma or its equivalent?

- 1: Yes, a high school diploma
- 2: Yes, a high school equivalency program such as GED or ABE
- 3: No
- 8: RF
- 9: DK

EHS_Q15) Are you currently attending high school or a high school equivalency program (such as a GED or ABE program)?

- 1: Yes, high school
- 2: Yes, high school equivalency program
- 3: No
- 8: RF
- 9: DK

GENERAL MENTAL HEALTH (GMH)

GMH_Q05) In general, would you say your mental health is... ?

- 1: Excellent
- 2: Very good
- 3: Good
- 4: Fair
- 5: Poor
- 8: RF
- 9: DK

CONSULTATIONS ABOUT MENTAL HEALTH (CMH)

CMH_Q05) During the past 12 months, have you seen or talked on the telephone to anyone about problems with your emotions, mental health or use of alcohol or drugs?

- 1: Yes
- 2: No
- 8: RF
- 9: DK



CMH_Q10) Who did you talk to?

- 01: Psychiatrist
- 02: Family doctor or general practitioner
- 03: Psychologist
- 04: Nurse
- 05: Social worker, counsellor, case worker or psychotherapist
- 06: Family member
- 07: Friend
- 08: Co-worker, supervisor or boss
- 09: Teacher or school principal
- 10: Elder
- 11: Other - Specify
- 98: RF
- 99: DK



Appendix B: Prevalence Estimates for Each Indicator from the IHS 2007–2008 and the 2012 and 2017 APS

The following tables present prevalence estimates for each indicator aligned where possible across the Inuit Health Survey 2007–2008 (IHS) and the 2012 and 2017 Aboriginal Peoples Survey (APS). Estimates are proportions (%) of the population and stratified by sex (males, females) and region. 95% confidence intervals are also included where possible. A description or comparison of the indicators from each survey and year are included in the notes to each table.

Mental Distress

Table 1. Prevalence of suicide ideation* (2008, 2012 and 2017)

	2008 IHS		2012 APS		2017 APS	
	Males	Females	Males	Females	Males	Females
Lifetime						
Inuit Nunangat	-	-	22.1 (19.2, 25.3)	20.8 (18.2, 23.7)	20.8 (18.2, 23.6)	24 (21.3-27)
Nunatsiavut	36	42	15.4 (11.6, 20.3)	27.2 (22.2, 32.9)	15.6 (12.2, 19.8)	15.5 (12.1, 19.6)
Nunavik†		35	19.6 (15.9, 23.9)	21.2 (17.8, 25.1)	28.8 (24.4, 33.6)	26.9 (22.6, 31.8)
Inuvait region	34	42	21.7 (16.4, 28)	16.2 (11.6, 22.3) ^E	15.8 (12.8, 19.4)	22.8 (19.3, 26.8)
Nunavut		48	24 (19.6, 29)	20.6 (16.8, 25)	21.5 (18.8, 24.4)	23.8 (19.9, 28.2)
Outside Inuit Nunangat	-	-	15.2 (8.9, 24.7) ^E	22.3 (14.5, 32.8) ^E	15.7 (10.5, 22.8) ^E	21.8 (17.6, 26.6)
Past year						
Inuit Nunangat	-	-	4.7 (3.4, 6.5)	6.3 (4.9, 8.0)	4.6 (3.4, 6.2)	6.8 (5.3, 8.7)
Nunatsiavut	5		F	5.6 (3.6, 8.6)	4.2 (3.1, 5.9)	3.2 (2.0, 5.1) ^E
Nunavik	14		4.5 (3.0, 6.9) ^E	6.7 (4.8, 9.4)	7.5 (6, 9.5)	9.1 (6.7, 12.2) ^E
Inuvait region	6		5.7 (3.4, 9.5) ^E	F	3.6 (2.6, 4.9)	4.0 (2.8, 5.8) ^E
Nunavut†	14		4.8 (2.9, 7.9) ^E	6.6 (4.7, 9.4)	5.5 (4.1, 7.4)	6.6 (4.6, 9.4) ^E
Outside Inuit Nunangat	-	-	F	F	6.0 (4.3, 8.3) ^E	5.9 (4.2, 8.2) ^E

Note: Estimates are not comparable between the IHS and APS. “E” indicates high sampling variability; use with caution. “F” indicates data is suppressed for reasons of reliability.

* The indicator for suicide ideation in the 2012/2017 APS is having “ever seriously contemplated suicide” and whether this happened in the past 12 months. The IHS asks “Have you ever in your life thought seriously about committing suicide?” and “In the past 12 months, have you thought seriously about committing suicide?”

† The 2007-2008 IHS did not collect data from Nunavik; estimates from Nunavik are from the 2004 Nunavik Inuit Health Survey.



Table 2. Prevalence of suicide attempt* (2008, 2012 and 2017)

	2008 IHS		2012 APS		2017 APS	
	Males	Females	Males	Females	Males	Females
Lifetime						
Inuit Nunangat	-	-	2.6 (1.7, 3.9) ^E	4.0 (2.9, 5.5) ^E	10.4 (8.5, 12.8)	12.6 (10.6, 14.9)
Nunatsiavut	15	23	F	4.5 (2.7, 7.4) ^E	5.0 (3.2, 7.7) ^E	6.6 (4.5, 9.4) ^E
Nunavik [†]	21		3.4 (2.1, 5.5) ^E	3.9 (2.6, 5.9) ^E	15.2 (11.8, 19.4)	14.3 (11.2, 18.2)
Inuvialuit region	15	25	F	F	7.1 (5.1, 9.7)	13.9 (11.1, 17.2)
Nunavut	25	31	F	4.3 (2.7, 6.8) ^E	9.6 (6.9, 13.1)	12.3 (9.5, 15.7)
Outside Inuit Nunangat	-	-	F	F	6.8 (3.9, 11.5) ^E	9.7 (7.0, 13.2)
Past year						
Inuit Nunangat	-	-	2.0 (1.3, 3.0) ^E	3.2 (2.2, 4.6) ^E	1.9 (1.2, 2.8) ^E	2.3 (95% CI) ^E
Nunatsiavut	3		F	F	F	F (95% CI)
Nunavik [†]	6.7		2.9 (1.7, 4.8) ^E	2.6 (1.5, 4.3) ^E	2.4 (1.4, 4.0) ^E	3.9(95% CI) ^E
Inuvialuit region	-	-	F	F	F	F
Nunavut	5		F	5.1 (3.1, 8.4) ^E	F	1.8 (1.0, 3.3) ^E
Outside Inuit Nunangat	-	-	F	F	F	F

Note: Estimates are not comparable between the IHS and APS. “E” indicates high sampling variability; use with caution. “F” indicates data is suppressed for reasons of reliability.

* The indicator for suicide attempts in the 2012/2017 APS is having “ever seriously attempted suicide” and whether this happened in the past 12 months. The IHS indicator is any lifetime attempted suicide and any past year attempted suicide.

[†]The 2007-2008 IHS did not collect data from Nunavik; estimates from Nunavik are from the 2004 Nunavik Inuit Health Survey.

Table 3. General mental health reported as poor* / Experienced serious psychological distress in past 30 days (2008, 2012 and 2017)**

	2008 IHS	2012 APS	2017 APS
Inuit Nunangat	-	2.7 (1.9, 3.9) ^E	1.7 (1.2, 2.4) ^E
Nunatsiavut	4	F	F
Nunavik [†]	13	1.5 (0.9, 2.5) ^E	1.0 (0.6, 1.8) ^E
Inuvialuit region	7	F	2.1 (1.4, 3.2) ^E
Nunavut	13	3.5 (2.2, 5.5) ^E	1.9 (1.2, 3.1) ^E
Outside Inuit Nunangat	-	F	3.0 (2.1, 4.2) ^E

Note: Estimates are not comparable between the IHS and APS. “E” indicates high sampling variability; use with caution. “F” indicates data is suppressed for reasons of reliability.

* The APS indicator is “In general, would you say your mental health is...?” with the following possibly responses: Excellent/very good/good/fair/poor/refused/don’t know.

**The IHS measures psychological distress in the last 30 days using the Kessler 6-distress scale. Estimates are the proportion of individuals who reported experiencing serious psychological distress.

[†]The 2007-2008 IHS did not collect data from Nunavik; estimates from Nunavik are from the 2004 Nunavik Inuit Health Survey.



Table 4. Self-reported mood disorder* / Reported feeling depressed in past 30 days (2008, 2012 and 2017)**

	2008 IHS		2012 APS		2017 APS	
	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
Inuit Nunangat	-	-	4.2 (3.1, 5.7) ^E	4.9 (3.7, 6.4)	7.7 (6.3, 9.4)	14.5 (12.5, 16.7)
Nunatsiavut	2	3	F	6.9 (4.3, 10.8) ^E	5.0 (3.2, 7.6) ^E	9.6 (7.1, 12.8)
Nunavik [‡]	-	-	3.0 (1.9, 4.7) ^E	4.6 (3.2, 6.6) ^E	9.4 (7.1, 12.4)	18.7 (15.4, 22.6)
Inuvialuit region	3	5	F	7.1 (4.6, 10.7) ^E	9.7 (7.2, 13.1)	12 (9.4, 15.3)
Nunavut	6	11	5.0 (3.4, 7.5) ^E	4.5 (2.9, 6.9) ^E	7.1 (5.2, 9.5)	13.5 (10.7, 16.9)
Outside Inuit Nunangat	-	-	10.8 (5.9, 19.1) ^E	13.2 (8.2, 20.4) ^E	12.2 (8.0, 18) ^E	21.1 (16.9, 25.9)

Note: Estimates are not comparable between the IHS and APS. IHS estimates are for ages 18+ and APS estimates are for ages 15+. "E" indicates high sampling variability; use with caution. "F" indicates data is suppressed for reasons of reliability.

* The APS indicator is having "a mood disorder such as depression, bipolar disorder, mania or dysthymia."

**The IHS indicator is feeling so depressed in the past 30 days that nothing could cheer you up (estimate is for all/most of the time response).

[‡]The 2007-2008 IHS did not collect data from Nunavik; estimates from Nunavik are from the 2004 Nunavik Inuit Health Survey.

Table 5. Self-reported anxiety disorder* / Reported feeling anxious in past 30 days (2008, 2012 and 2017)**

	2008 IHS	2012 APS		2017 APS	
	<i>Both sexes</i>	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
Inuit Nunangat	-	2.5 (1.7, 3.7) ^E	3.8 (2.8, 5.2)	4.4 (3.3, 5.8)	12 (10.1, 14.1)
Nunatsiavut	10	F	5.2 (3.0, 8.6) ^E	3.0 (1.9, 4.7) ^E	7.6 (5.5, 10.5)
Nunavik [‡]	-	2.5 (1.4, 4.6) ^E	2.7 (1.7, 4.1) ^E	4.3 (2.8, 6.5) ^E	11.8 (9.0, 15.4)
Inuvialuit region	8	F	5.4 (3.2, 9.1) ^E	6.3 (4.2, 9.2) ^E	13.9 (11.2, 17)
Nunavut	14	2.3 (1.3, 4.2) ^E	3.9 (2.5, 6.2) ^E	4.3 (2.8, 6.5) ^E	12.2 (9.5, 15.4)
Outside Inuit Nunangat	-	5.9 (3.3, 10.6) ^E	12.2 (7.4, 19.5) ^E	12.5 (8.3, 18.4) ^E	19.7 (15.7, 24.4)

Note: Estimates are not comparable between the IHS and APS. IHS estimates are for ages 18+ and APS estimates are for ages 15+. "E" indicates high sampling variability; use with caution. "F" indicates data is suppressed for reasons of reliability.

* The APS indicator is having "an anxiety disorder such as a phobia, obsessive-compulsive disorder or a panic disorder."

**The IHS indicator is feeling anxious all or most of the time in the past 30 days.

Table 6. Any emotional, psychological or mental health conditions* (2017)

	2008 IHS		2012 APS		2017 APS	
	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
Inuit Nunangat	-	-	-	-	F	16.5 ^E
Nunatsiavut	-	-	-	-	F	F
Nunavik	-	-	-	-	F	F
Inuvialuit region	-	-	-	-	F	20.8
Nunavut	-	-	-	-	F	F
Outside Inuit Nunangat	-	-	-	-	F	31.6 ^E

Note: Estimates are not comparable between the IHS and APS. IHS estimates are for ages 18+ and APS estimates are for ages 15+. "E" indicates high sampling variability; use with caution. "F" indicates data is suppressed for reasons of reliability.

* These may include "anxiety, depression, bipolar disorder, substance abuse, anorexia, etc." Estimates are for combined "sometimes", "often" and "always" responses.



Substance Use

Table 7. Past-year alcohol use (2008, 2012 and 2017)

	2008 IHS		2012 APS		2017 APS	
	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
Inuit Nunangat	-	-	59.9 (56.6, 63.2)	52 (48.8, 55.3)	63.6 (60.8, 66.3)	57.9 (55, 60.8)
Nunatsiavut	72	68	75.8 (70.1, 80.6)	65.9 (60.1, 71.2)	65.1 (60.8, 69.1)	56.6 (52.1, 61)
Nunavik [‡]		77	64.3 (59.9, 68.4)	54.6 (50.1, 58.9)	75.6 (71.5, 79.3)	67.3 (63, 71.3)
Inuvialuit region	70	66	69.9 (63.7, 75.5)	63.7 (57.6, 69.4)	70.9 (66.8, 74.8)	63.5 (59.3, 67.5)
Nunavut	65	55	54.9 (49.8, 59.9)	48.3 (43.5, 53.1)	58 (53.8, 62)	53.5 (49.2, 57.8)
Outside Inuit Nunangat	-	-	83.3 (76.6, 88.4)	75.6 (67.2, 82.4)	81 (75.6, 85.4)	70.1 (64.3, 75.4)

Note: Estimates are not comparable between the IHS and APS. IHS estimates are for ages 18+ and APS estimates are for ages 15+.

[‡] 2004 Nunavik Health Survey: "occasional or regular drinker."

Table 8. Past-year heavy episodic drinking* (2008, 2012 and 2017)

	2008 IHS		2012 APS		2017 APS	
	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
Inuit Nunangat	-	-	35.2	38.5	49.5	45.6
Nunatsiavut	-	-	52.7	66.5	55	43.1
Nunavik [‡]		24	36.6	37.4	68	65.1
Inuvialuit region	-	-	45.6	55.3	53.8	45.8
Nunavut	-	-	30.5	32.4	39	35.4
Outside Inuit Nunangat	-	-	F	F	29.8	33.6

Note: "E" indicates high sampling variability; use with caution. "F" indicates data is suppressed for reasons of reliability.

* Heavy episodic drinking is having five (for males) or four (for females) drinks on one occasion at least once a month in the past year.

[‡] The 2007-2008 IHS did not collect data from Nunavik; estimates from Nunavik are from the 2004 Nunavik Inuit Health Survey.

Table 9. Non-medical use of prescription drugs* (2008, 2012 and 2017)

	2008 IHS		2012 APS [†]		2017 APS [†]	
	<i>Both sexes</i>		<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
Inuit Nunangat	-	-	4 (3.0, 5.4)	1.8 (1.2, 2.5) ^E	F	F
Nunatsiavut	10		F	F	F	F
Nunavik [‡]	-		5.8 (3.8, 8.6) ^E	2.8 (1.8, 4.2) ^E	F	F
Inuvialuit region	3		F	F	F	F
Nunavut	4		3.6 (2.3, 5.7) ^E	F	F	F
Outside Inuit Nunangat	-		F	F	F	F

Note: Estimates are not comparable between the IHS and APS. "E" indicates high sampling variability; use with caution. "F" indicates data is suppressed for reasons of reliability.

* The indicator for reported for the APS is any use of "prescription drugs for recreational purposes." The IHS indicator is any use of "regular medicine or prescription drugs to get high (e.g., Tylenol, Ativan, cough syrup)."

[†] The 2012 APS reports lifetime use while the 2017 APS reports past year use. Note that estimates obtained from the 2012 and 2017 were broken down by frequency of use and not overall (see Appendix A).

[‡] The 2007-2008 IHS did not collect data from Nunavik; estimates from Nunavik are from the 2004 Nunavik Inuit Health Survey.



Table 10. Use of other illegal substances* (2008, 2012 and 2017)

	2008 IHS		2012 APS [†]		2017 APS [†]	
	<i>Both sexes</i>		<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
Inuit Nunangat	-	-	13.8 (11.8, 16)	6.0 (4.7, 7.6)	F	F
Nunatsiavut	2	-	7.9 (5.4, 11.5) [‡]	F	F	F
Nunavik [‡]	7.5	-	20.3 (16.7, 24.5)	9.3 (7.2, 12)	F	F
Inuvait region	1	-	10.5 (6.7, 16) [‡]	7.6 (4.8, 11.6) [‡]	F	F
Nunavut	5	-	12.3 (9.4, 15.8) [‡]	4.8 (3.1, 7.5) [‡]	F	F
Outside Inuit Nunangat	-	-	21.8 (14, 32.5) [‡]	17.7 (10.1, 29.1) [‡]	F	F

Note: Estimates are not comparable between the IHS and APS. “E” indicates high sampling variability; use with caution. “F” indicates data is suppressed for reasons of reliability.

* The indicator reported for the APS is any use of “street drugs (such as cocaine, speed, solvents, or steroids)”. The IHS indicator is any use of “hard drugs (example: cocaine, crystal meth, etc.)” and past year use of solvents and inhalants is a separate question.

[†] The 2012 APS reports lifetime use while the 2017 APS reports past year use.

[‡] Nunavik Health Survey: reports past year cocaine use only.

Table 11. Cigarette (tobacco) smoking* (2008, 2012 and 2017)

	2008 IHS		2012 APS		2017 APS	
	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
Inuit Nunangat	-	-	67.3	67.2	71.2	72.4
Nunatsiavut	54	55	60.7	59.6	53.8	50.2
Nunavik [‡]	77	-	65	64.6	76.3	76.1
Inuvait region	62	67	68	67.6	66	67.3
Nunavut	70.5	74	69	69	71.6	73.5
Outside Inuit Nunangat	-	-	29.4	38.4	41.7	34.6

Note: Estimates are not comparable between the IHS and APS. IHS estimates are for ages 18+ and APS estimates are for ages 15+.

* The indicator is any daily or occasional cigarette smoking.

[‡] The 2007-2008 IHS did not collect data from Nunavik; estimates from Nunavik are from the 2004 Nunavik Inuit Health Survey.

Table 12. Cannabis use* (2008, 2012 and 2017)

	2008 IHS		2012 APS [†]		2017 APS [†]	
	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
Inuit Nunangat	-	-	71	53	52	29.2
Nunatsiavut	25	12	55.5	47.1	18.4 [‡]	10.6 [‡]
Nunavik [‡]	60	-	69.8	52.5	64.4	39.8
Inuvait region	39	25	71.3	53.6	49.9	26.9
Nunavut	53	37	73.3	53.8	50.9	26.9
Outside Inuit Nunangat	-	-	66.7	54.3	26.1	19.7

Note: Estimates are not comparable between the IHS and APS. “E” indicates high sampling variability; use with caution.

* The indicator in the IHS is “past 12 month use of recreational drugs, such as pot/marijuana, hashish etc.”

[†] The 2012 APS reports lifetime use of cannabis while the 2017 APS reports past year use of cannabis.

[‡] The 2007-2008 IHS did not collect data from Nunavik; estimates from Nunavik are from the 2004 Nunavik Inuit Health Survey.



Historical Trauma

Table 13. Was ever a student at a residential school (2012 and 2017)

	2008 IHS		2012 APS [†]		2017 APS	
	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
Inuit Nunangat	-	-	26.5 (23, 30.3)	23.6 (20.2, 27.4)	21.7 (19.2, 24.4)	21.9 (19.4, 24.6)
Nunatsiavut	-	-	28.3 (22.1, 35.5)	27.9 (22.1, 34.7)	17.8 (14.7, 21.5)	22 (18.1, 26.4)
Nunavik	-	-	19.4 (14.9, 24.9)	15.5 (11.8, 20.1)	16.4 (13.2, 20.3)	14 (11.1, 17.5)
Inuvuluit region	-	-	54 (47.3, 60.6)	42.2 (35.1, 49.6)	46.4 (41.4, 51.5)	40.9 (36.5, 45.5)
Nunavut	-	-	24.4 (19.4, 30.2)	23.8 (18.9, 29.5)	21 (17.4, 25.1)	22.4 (18.7, 26.7)
Outside Inuit Nunangat	-	-	10.6 (5.7, 18.9) [‡]	12.8 (7.7, 20.7) [‡]	8.0 (5.1, 12.4) [‡]	8.8 (6.5, 11.9)

Note: APS estimates are for ages 25+. "E" indicates high sampling variability; use with caution.

[†] The 2012 APS includes a separate "not applicable" response which may make estimates not comparable with the 2017 APS.

Table 14. Parents were ever a student at a residential school (2012 and 2017)

	2008 IHS		2012 APS [†]		2017 APS	
	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
Inuit Nunangat	-	-	38.5 (35.4, 41.6)	33.4 (30.8, 36.2)	21.7 (19.2, 24.4)	21.9 (19.4, 24.6)
Nunatsiavut	-	-	34 (28.6, 39.8)	42.9 (37.2, 48.7)	17.8 (14.7, 21.5)	22 (18.1, 26.4)
Nunavik	-	-	23.6 (20.4, 27.1)	19.2 (16.5, 22.2)	16.4 (13.2, 20.3)	14 (11.1, 17.5)
Inuvuluit region	-	-	73.4 (67.3, 78.6)	76.6 (71.1, 81.3)	46.4 (41.4, 51.5)	40.9 (36.5, 45.5)
Nunavut	-	-	39.9 (35.2, 44.7)	32.4 (28.6, 36.5)	21 (17.4, 25.1)	22.4 (18.7, 26.7)
Outside Inuit Nunangat	-	-	17.5 (12.1, 24.6) [‡]	29.1 (21.1, 38.6)	8.0 (5.1, 12.4) [‡]	8.8 (6.5, 11.9)

Note: APS estimates are for ages 15+. "E" indicates high sampling variability; use with caution.

[†] The 2012 APS includes a separate "not applicable" response which may make estimates not comparable with the 2017 APS.

Table 15. Grandparents were ever a student at a residential school (2012 and 2017)

	2008 IHS		2012 APS		2017 APS	
	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
Inuit Nunangat	-	-	21.7 (19.4, 24.1)	18.6 (16.5, 20.9)	20.2 (17.8, 22.8)	18.2 (16.2, 20.5)
Nunatsiavut	-	-	16.8 (13.5, 20.9)	19.4 (15.5, 24)	20.7 (17.3, 24.5)	21.2 (17.8, 25.1)
Nunavik	-	-	12 (9.6, 14.9)	10.3 (8.0, 13)	15.3 (12.2, 19)	12 (9.2, 15.4)
Inuvuluit region	-	-	50.8 (45.2, 56.5)	49.5 (44, 55)	41.9 (37.8, 46.1)	44.3 (40.2, 48.5)
Nunavut	-	-	21.8 (18.3, 25.7)	17.7 (14.7, 21.2)	19.5 (16.1, 23.4)	17.3 (14.4, 20.7)
Outside Inuit Nunangat	-	-	16.4 (10.8, 24.1) [‡]	26.8 (17.9, 38.1) [‡]	19.3 (13.8, 26.5) [‡]	19.8 (16, 24.3)

Note: APS estimates are for ages 15+. "E" indicates high sampling variability; use with caution.



Community Distress

Table 16. Could not access health care in past year* (2012 and 2017)

	2008 IHS		2012 APS		2017 APS	
	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
Inuit Nunangat	-	-	12.2 (10.2, 14.5)	12.4 (10.3, 14.7)	15.1 (13, 17.5)	19.1 (16.8, 21.7)
Nunatsiavut	-	-	17.3 (13.3, 22.3)	18 (13.9, 23)	20 (16.4, 24)	25.7 (21.7, 30.1)
Nunavik	-	-	7.6 (5.7, 10)	7 (5.5, 9)	14.5 (11.5, 18.2)	12.8 (10, 16.3)
Inuvaluit region	-	-	13.6 (10, 18.3)	16.3 (12.1, 21.7)	16.3 (13.1, 20.1)	20.9 (17.6, 24.7)
Nunavut	-	-	13.4 (10.3, 17.2)	13.3 (10.3, 17.1)	14.7 (11.7, 18.3)	20.9 (17.5, 24.9)
Outside Inuit Nunangat	-	-	11.4 (6.7, 18.6) ^E	18.3 (11.7, 27.5) ^E	12 (7.9, 17.9) ^E	14.2 (10.7, 18.6)

Note: Estimates are not comparable between the HIS and APS. APS estimates are for ages 15+. "E" indicates high sampling variability; use with caution.

* The indicator reported for the APS is whether in the past year, respondents have "felt that [you] needed healthcare but didn't receive it."

Table 17. Past-year food insecurity (1)* (2012 and 2017)

	2008 IHS		2012 APS		2017 APS	
	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
Inuit Nunangat	-	-	26.2 (23.4, 29.2)	22.6 (19.9, 25.6)	42.5 (39.6, 45.4)	41 (38.1, 43.9)
Nunatsiavut	-	-	19.1 (14.7, 24.3)	22.1 (17.7, 27.3)	29.7 (25.7, 33.9)	29.9 (25.7, 34.5)
Nunavik [†]	-	-	23.8 (20.2, 27.8)	15.7 (12.8, 19.1)	44.7 (40.2, 49.4)	47.2 (42.7, 51.8)
Inuvaluit region	-	-	13.2 (9.6, 17.9)	12.4 (8.9, 17)	26.4 (22.4, 30.7)	25.1 (21.6, 29)
Nunavut	-	-	29.9 (25.6, 34.7)	26.6 (22.5, 31.1)	44.7 (40.5, 49.1)	41.3 (37.1, 45.6)
Outside Inuit Nunangat	-	-	F	17.7 (11.1, 27) ^E	13.1 (8.6, 19.4) ^E	14.7 (11.1, 19.4)

Note: Estimates are not comparable between the IHS and APS. "E" indicates high sampling variability; use with caution. "F" indicates data is suppressed for reasons of reliability.

* The indicator reported for the APS is whether respondents reported cutting the size of their meals or skipping meals because there wasn't enough money for food in the past year.

Table 18. Past-year food insecurity (2)* (2017)

	2008 IHS		2012 APS		2017 APS	
	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
Inuit Nunangat	-	-	-	-	39.5 (36.6, 42.5)	39.9 (37, 42.9)
Nunatsiavut	-	-	-	-	26.6 (22.7, 31)	22.9 (19, 27.2)
Nunavik [†]	-	-	-	-	43 (22.7, 31)	42.2 (37.8, 46.7)
Inuvaluit region	-	-	-	-	24.5 (20.6, 28.8)	22.8 (19.5, 26.6)
Nunavut	-	-	-	-	41.2 (36.9, 45.7)	42.5 (38.2, 46.9)
Outside Inuit Nunangat	-	-	-	-	16.1 (10.9, 23.1) ^E	15 (11.3, 19.7)

Note: Estimates are not comparable between the IHS and APS. IHS estimates are for ages 18+ and APS estimates are for ages 15+. "E" indicates high sampling variability; use with caution.

* The indicator reported for the APS is whether respondents indicated they ever ate less than they felt they should because there wasn't enough money to buy food.



Table 19. Past-year food insecurity (3)* (2008, 2012 and 2017)

	2008 IHS [†]	2012 APS		2017 APS	
	<i>Both sexes</i>	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
Inuit Nunangat	-	26.2 (23.4, 29.2)	22.6 (19.9, 25.6)	30 (27.3, 33)	30.3 (27.6, 33.1)
Nunatsiavut	44	19.1 (14.7, 24.3)	22.1 (17.7, 27.3)	14.3 (11.4, 17.8)	13.3 (10.4, 17)
Nunavik [‡]	-	23.8 (20.2, 27.8)	15.7 (12.8, 19.1)	29.5 (25.4, 33.9)	28.9 (25.2, 33)
Inuvialuit region	54	13.2 (9.6, 17.9)	12.4 (8.9, 17)	18 (14.5, 22.1)	14.9 (12.2, 18)
Nunavut	70	29.9 (25.6, 34.7)	26.6 (22.5, 31.1)	33.2 (29.1, 37.6)	34.1 (30, 38.4)
Outside Inuit Nunangat	-	F	17.7 (11.1, 27) ^E	14.5 (9.6, 21.4) ^E	10.1 (7.1, 14.3) ^E

Note: Estimates are not comparable between the IHS and APS. IHS estimates are for ages 18+ and APS estimates are for ages 15+. "E" indicates high sampling variability; use with caution. "F" indicates data is suppressed for reasons of reliability.

* The indicator reported for the APS is whether respondents indicated they were hungry but could not afford food.

[†] The IHS indicator is reported household "severe or moderate food insecurity."

Table 20. Household income did not meet needs in past year* (2017)

	2008 IHS		2012 APS		2017 APS	
	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
Inuit Nunangat	-	-	-	-	50.4 (47.4, 53.5)	49.1 (46.2, 52)
Nunatsiavut	-	-	-	-	44.5 (39.8, 49.2)	42.9 (38.2, 47.7)
Nunavik [‡]	-	-	-	-	58.3 (53.8, 62.7)	59.6 (54.9, 64.1)
Inuvialuit region	-	-	-	-	37 (32.6, 41.7)	39.1 (35.1, 43.3)
Nunavut	-	-	-	-	49.5 (44.9, 54.1)	46.5 (42.2, 50.9)
Outside Inuit Nunangat	-	-	-	-	21.2 (14.7, 29.6) ^E	17.3 (13.6, 21.9)

Note: Estimates are not comparable between the IHS and APS. IHS estimates are for ages 18+ and APS estimates are for ages 15+. "E" indicates high sampling variability; use with caution.

* The indicator reported for the APS is whether household income was "not enough to meet needs for transportation, housing, food, clothing and other necessary expenses."

Table 21. Dissatisfied with housing conditions* (2017)

	2008 IHS [†]		2012 APS		2017 APS	
	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
Inuit Nunangat	-	-	-	-	26.9	32.8
Nunatsiavut	-	-	-	-	27.4	34.4
Nunavik [‡]	-	-	-	-	29.2	36.5
Inuvialuit region	-	-	-	-	20.2	27.2
Nunavut	-	-	-	-	26.8	31.8
Outside Inuit Nunangat	-	-	-	-	F	11.2

Note: APS estimates are for ages 15+. "F" indicates data is suppressed for reasons of reliability.

* The indicator reported for the APS is the rated level of satisfaction with housing conditions. Estimates are for the combined dissatisfied and very dissatisfied responses (see Appendix A).



Table 22. Overcrowded housing conditions* (2008 and 2017)

	2008 IHS [†]		2012 APS		2017 APS	
	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
Inuit Nunangat	-	-	-	-	40.4 (34.7, 46.4)	41.8 (36.8, 47)
Nunatsiavut	11	-	-	-	36 (28.1, 44.7)	34.9 (27.7, 42.9)
Nunavik [‡]	-	-	-	-	45.4 (37.3, 53.8)	43.3 (35.8, 51.8)
Inuvait region	13	-	-	-	19.9 (13.3, 28.6) ^E	26.9 (20.2, 34.9)
Nunavut	30	-	-	-	40.5 (32.3, 49.2)	43.2 (35.7, 51)
Outside Inuit Nunangat	-	-	-	-	F	27.6 (14.3, 46.6) ^E

Note: Estimates are not comparable between the IHS and APS. APS estimates are for ages 15+. “E” indicates high sampling variability; use with caution. “F” indicates data is suppressed for reasons of reliability.

* The 2017 APS asks about reasons for being dissatisfied with housing conditions. Estimates for “crowded/not enough space” are reported.

† The IHS specifies whether housing is overcrowded (>1 person per room).

Cultural Continuity

Table 23. Understands or speaks an Inuit language (2008, 2012 and 2017)

	2008 IHS		2012 APS		2017 APS	
	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
Inuit Nunangat	-	-	93.3 (91.6, 94.6)	94.5 (93, 95.7)	94.9 (93.4, 96)	96 (94.9, 96.9)
Nunatsiavut	7	-	91 (86.9, 94)	95 (91.8, 97)	82.4 (78.7, 85.5)	89.3 (85.7, 92)
Nunavik [‡]	-	-	93 (90.4, 95)	91.2 (88.8, 93.2)	99.9 (99.2, 100)	99.6 (99.2, 99.8)
Inuvait region	12	-	86.9 (82.5, 90.3)	91.4 (87.7, 94.1)	79 (75, 82.5)	84.2 (94.6, 97.8)
Nunavut	73.7	-	94.6 (91.9, 96.5)	96.1 (93.7, 97.6)	96 (93.5, 97.6)	96.5 (94.6, 97.8)
Outside Inuit Nunangat	-	-	40.9 (31, 51.6)	56.9 (45.6, 67.5)	38 (28.1, 49)	43.8 (38.3, 49.3)

Note: Estimates are not comparable between the IHS and APS. IHS estimates are for ages 18+ and APS estimates are for ages 15+.

* The indicator reported for the APS is whether respondents “understand or speak an Aboriginal language, even if only a few words.” The IHS indicator is the proportion of households reporting that an Inuit language is spoken in home.

Social Equity

Table 24. Current employment* (2008, 2012 and 2017)

	2008 IHS [†]	2012 APS		2017 APS	
	<i>Both sexes</i>	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
Inuit Nunangat	-	43.5 (40.4, 46.6)	44.9 (41.7, 48.1)	47.6 (44.6, 50.6)	48.8 (45.8, 51.9)
Nunatsiavut	68	38.8 (33.2, 44.7)	44 (38.4, 49.8)	34.5 (30.3, 38.9)	42.2 (37.5, 46.9)
Nunavik [‡]	-	47.5 (43.3, 51.7)	52.2 (48.1, 56.3)	53.2 (48.6, 57.7)	54.7 (50.2, 59.1)
Inuvait region	69	44 (37.7, 50.6)	44.4 (38.5, 50.4)	43.2 (38.9, 47.6)	43 (38.9, 47.3)
Nunavut	57	42.3 (37.5, 47.2)	42.3 (37.5, 47.2)	47.2 (42.8, 51.7)	47.7 (43.3, 52.2)
Outside Inuit Nunangat	-	61.7 (50.6, 71.8)	44.6 (35.6, 54)	54.2 (43.8, 64.2)	54.1 (48.1, 60)

Note: Estimates are not comparable between the IHS and APS. IHS estimates are for ages 18+ and APS estimates are for ages 15+.

* The indicator reported for the 2012/2017 APS is whether respondents worked at a job or business last week (regardless of the number of hours). The IHS indicator is whether respondents had full-time or part-time/occasional work.



Table 25. Completed high school or equivalency (age 18+) (2008 and 2017)

	2008 IHS		2012 APS		2017 APS	
	<i>Both sexes</i>		<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
Inuit Nunangat	-	-	-	-	30.7	38.5
Nunatsiavut	27	-	-	-	43.8	58.8
Nunavik	-	-	-	-	25.6	27.2
Inuvalluit region	31	-	-	-	33	37.8
Nunavut	15	-	-	-	28.5	38.4
Outside Inuit Nunangat	-	-	-	-	68.6	73.6

Note: Estimates are not comparable between the IHS and APS.

Mental Wellness

Table 26. Positive general mental health* (2012 and 2017)

	2008 IHS		2012 APS		2017 APS	
	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
Inuit Nunangat	-	-	82.3	82.6	91.2	87.2
Nunatsiavut	-	-	90.3	87.7	94.4	89.6
Nunavik [†]	-	-	79.2	75.5	93.4	89.2
Inuvalluit region	-	-	87.8	85.7	90.7	88.2
Nunavut	-	-	81.7	84.5	90	86
Outside Inuit Nunangat	-	-	91.6	77.5	84.3	83.6

Note: Estimates are not comparable between the IHS and APS. APS estimates are for ages 15+.

* Estimates are for the combined “excellent”, “very good”, and “good” responses.

Table 27. Consulted with someone about mental health or substance use* (2008 and 2017)

	2008 IHS		2012 APS		2017 APS	
	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
Inuit Nunangat	-	-	-	-	17 (14.5, 19.8)	27 (24.3, 29.7)
Nunatsiavut	66	71	-	-	10.9 (8.1, 14.6)	16.1 (12.7, 20.1)
Nunavik	-	-	-	-	19.6 (15.8, 24.1)	29.4 (25.2, 34.1)
Inuvalluit region	54	66	-	-	19.1 (15.8, 23)	35.8 (31.7, 40.2)
Nunavut	47	46	-	-	16.2 (12.8, 20.4)	25.8 (21.9, 30)
Outside Inuit Nunangat	-	-	-	-	15.3 (10.1, 22.5) ^E	26.5 (22.1, 31.4)

Note: Estimates are not comparable between the IHS and APS. IHS estimates are for ages 18+ and APS estimates are for ages 15+. “E” indicates high sampling variability; use with caution.

* The indicator reported for the APS is whether respondents have “seen or talked on the telephone to anyone about problems with emotions, mental health or use of alcohol or drugs.” The indicator for the IHS is whether respondents reported having someone to talk to if they felt troubled or for some reason needed emotional support (estimates are for “most of the time” and “all of the time” responses).



Appendix C: Prevalence Estimates for Additional Indicators from the IHS 2007–2008 and the Nunavik Inuit Health Survey 2004

The following tables present prevalence estimates for additional indicators related to suicide risk from the Inuit Health Survey 2007–2008 (IHS) and Nunavik Inuit Health Survey 2004 (those that were available from secondary reports). Estimates are proportions (%) of the population and are stratified by sex (males, females), age and region. Note that for the majority of indicators, estimates stratified by sex and age are not available. Estimates for the Inuvialuit Settlement Region, Nunatsiavut and Nunavut are from the IHS; estimates for Nunavik are from the Nunavik Inuit Health Survey 2004.

Mental Distress

Table 1. Experienced serious psychological distress in the past 30 days

	Inuvialuit Region	Nunatsiavut	Nunavut	Nunavik
Overall	7%	4%	13%	13%
Sex				
Males	6%	3%	9%	-
Females	7%	5%	16%	-
Age group				
18-29	9%	3%	16%	-
30-49	8%	3%	15%	-
50+	3%	7%	6%	-

Substance Use

Table 2. Reported losing a close relationship (spouse, friend) because of their drinking

	Inuvialuit Region	Nunatsiavut	Nunavut	Nunavik
Overall	13%	14%	16%	-
Sex				
Males	11%	19%	18%	-
Females	15%	10%	15%	-
Age group				
18-29	-	-	-	-
30-49	-	-	-	-
50+	-	-	-	-

Table 3. Someone in their childhood home had problems with alcohol (often or sometimes)

	Inuvialuit Region	Nunatsiavut	Nunavut	Nunavik
Overall	54%	45%	28%	-
Sex				
Males	46%	35%	26%	-
Females	59%	52%	32%	-
Age group				
18-29	50%	36%	34%	-
30-49	60%	58%	34%	-
50+	45%	33%	15%	-



Acute Stress or Loss

Table 4. Drank alcohol just before a suicide attempt

	Inuvialuit Region	Nunatsiavut	Nunavut	Nunavik
Overall	62%	64%	34%	-
Sex				
Males	-	-	-	-
Females	-	-	-	-
Age group				
18-29	-	-	-	-
30-49	-	-	-	-
50+	-	-	-	-

Traumatic Stress and Early Adversity

Childhood abuse statistics: complete statistics by age group are only available for the Inuvialuit region and Nunatsiavut, and only for questions around very specific types of abuse. There are no overall estimates for physical abuse, verbal abuse or sexual abuse. Suggest not including.

Community Distress

Table 5. Household reported severe or moderate food insecurity

	Inuvialuit Region	Nunatsiavut	Nunavut	Nunavik
Overall	54%	44%	70%	-
Sex				
Males	-	-	-	-
Females	-	-	-	-
Age group				
18-29	-	-	-	-
30-49	-	-	-	-
50+	-	-	-	-

Table 6. Overcrowded household (>1 person per room)

	Inuvialuit Region	Nunatsiavut	Nunavut	Nunavik
Overall	13%	11%	30%	-
Sex				
Males	-	-	-	-
Females	-	-	-	-
Age group				
18-29	-	-	-	-
30-49	-	-	-	-
50+	-	-	-	-