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INUIT TAPIRIIT KANATAMI

National Inuit Suicide Prevention Strategy

www.itk.ca

About Inuit Tapiriit Kanatami

Inuit Tapiriit Kanatami (ITK) is the national representational organization for Canada's 60,000 Inuit, the majority of whom live in four regions of Canada's Arctic, specifically, the Inuvialuit Settlement Region (Northwest Territories), Nunavut, Nunavik (Northern Quebec), and Nunatsiavut (Northern Labrador). Collectively, these four regions make up Inuit Nunangat, our homeland in Canada. It includes 53 communities and encompasses roughly 35 percent of Canada's landmass and 50 percent of its coastline.

The comprehensive land claim agreements that have been settled in Inuit Nunangat continue to form a core component of our organization's mandate. These land claims have the status of protected treaties under section 35 of the *Constitution Act, 1982*, and we remain committed to working in partnership with the Crown toward their full implementation. Consistent with its founding purpose, ITK represents the rights and interests of Inuit at the national level through a democratic governance structure that represents all Inuit regions.

ITK advocates for policies, programs and services to address the social, cultural, political and environmental issues facing our people.

ITK is governed by a Board of Directors composed of the following members:

- President, Inuvialuit Regional Corporation
- President, Makivik Corporation
- President, Nunavut Tunngavik Incorporated
- President, Nunatsiavut Government

In addition to voting members, the following non-voting Permanent Participant Representatives also sit on the Board:

- President, Inuit Circumpolar Council Canada
- President, Pauktuutit Inuit Women of Canada
- President, National Inuit Youth Council

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1. Letter from ITK's President

We are all affected by suicide. We think of those who are no longer with us and feel intense sadness in knowing our society is diminished without them sharing our path through life. Our collective loss is difficult to discuss, but we are finding a way beyond this tragic reality by confronting it head-on.

Inuit Tapiriit Kanatami's top priority, as we identified in our *2016-2019 Strategy and Action Plan*, is to take action to prevent suicide among Inuit. Suicide is a preventable public health crisis in our communities, and through the National Inuit Suicide Prevention Strategy (NISPS; "the Strategy"), we are taking steps to address this issue through evidence-based, Inuit-specific actions that can transform our society. Implementing the NISPS is an important step toward reducing the rate of suicide among Inuit to the national Canadian rate or lower.

We know that our ancestors had relatively low rates of suicide. Life could be difficult in the past but the challenges our people faced were very different than those facing families today. Our ancestors were strong and resilient, and persevered through hardship, which is why we are here. We must provide our people who are struggling — especially our young people — with the support they need to be strong and resilient throughout their lives.

The Strategy is designed to coordinate suicide prevention efforts at the national, regional, and community levels. It will integrate and provide support for existing community and regional efforts to prevent suicide.

The NISPS unites Inuit through a common understanding of what is putting many of our people at risk for suicide, and what can be done to help identify and respond to suicide risk so that fewer people reach the point where they contemplate this tragic act.

The success of the NISPS depends on the work we carry out through partnerships we have created or will create with stakeholders at the national, regional, and community levels. We imagine implementation efforts will reach all Inuit through this network of partnerships. In order for our specific interventions to be effective, it will take time, money, and dedication to creating social equity, community safety, and cultural continuity.

Many people have contributed to the creation of the National Inuit Suicide Prevention Strategy. I would like to acknowledge the contributions made by the Inuit Tapiriit Kanatami (ITK) Board of Directors, the National Inuit Committee on Health, the Alianait Inuit Mental Wellness Advisory Committee, and the National Inuit Youth Council. These bodies provided valuable input and feedback that helped shape this document. I would also like to recognize Health Canada; the Mental Health Commission of Canada; Dr. Allison Crawford of the Centre for Addiction and Mental Health; Jack Hicks, Adjunct Professor, Department of Community Health and Epidemiology, University of Saskatchewan; and, Dr. Brian Mishara, Director of the Centre for Research and Intervention on Suicide and Euthanasia, Université du Québec à Montréal, whose guidance and constructive criticism strengthen the Strategy. Finally, I would like to applaud ITK's NISPS drafting team, who worked diligently on this document from start to finish.

Nakummek,

Natan Obed

2. Executive Summary

The elevated rate of suicide among Inuit in Canada is the most urgent challenge facing our people and it demands a national response. The four Inuit regions in Canada (Inuvialuit Settlement Region in the Northwest Territories, Nunavut, Nunavik in Northern Quebec, and Nunatsiavut in Northern Labrador), collectively known as Inuit Nunangat, have rates of suicide that range from five to 25 times the rate of suicide for Canada as a whole.

Inuit did not, historically, suffer from disproportionately high rates of suicide. Globally, the World Health Organization characterizes suicide as an immense but preventable public health problem.[1] It is a public health crisis in Inuit Nunangat that can and must be prevented.

High rates of suicide among Inuit are a shared challenge across Inuit Nunangat, yet suicide prevention in each of our jurisdictions is not based on a shared understanding of the factors that create risk for suicide. Similarly, we have not had a shared, evidence-based, Inuit-specific approach to suicide prevention across Inuit Nunangat that informs a united response.

The NISPS envisions suicide prevention as a shared national, regional, and community-wide effort that engages individuals, families, and communities. It provides a unified approach to suicide prevention in Inuit Nunangat that transforms our collective knowledge, experience and research on suicide into action.

It does so by promoting a shared understanding of the context and underlying risk factors for suicide among Inuit, by providing policy guidance at the regional and national levels on evidence-based approaches to suicide prevention, and by identifying stakeholders and their specific roles in preventing suicide. The NISPS outlines how different stakeholders can effectively coordinate with each other to implement a more holistic approach to suicide prevention.

The NISPS will promote the dissemination of best practices in suicide prevention, provide tools for the evaluation of approaches, contribute to ongoing Inuit-led research, provide leadership and collaboration in the development of policy that supports suicide prevention, and focus on the healthy development of children and youth as the basis for a healthy society.

The specific objectives and actions ITK will take to prevent suicide among Inuit fall within six priority areas: (1) creating social equity, (2) creating cultural continuity, (3) nurturing healthy Inuit children from birth, (4) ensuring access to a continuum of mental wellness services for Inuit, (5) healing unresolved trauma and grief, and (6) mobilizing Inuit knowledge for resilience and suicide prevention.

Although making progress within each priority area is critical to achieving success in preventing suicide among Inuit, our strategy envisions holistic, concurrent actions across all six priority areas as the only way to effectively lower our rates of suicide. ITK will advance each of the objectives in the priority areas through actions within its own scope and mandate and will partner with governments and Inuit regional organizations to advocate and support existing Inuit regional strategies and suicide prevention initiatives.

3. Introduction

Each of the four regions of Inuit Nunangat have called for action to address the elevated rates of suicide among Inuit for decades, yet suicide endures as a leading cause of death among our people, especially young people. The loss of hundreds of Inuit who died by suicide in the past several decades has had a devastating impact on our small population and touches all of us. The elevated rates of suicide in Inuit Nunangat are a public health crisis whose roots we understand and, collectively, have the responsibility and opportunity to change.

The NISPS is a tool for assisting community service providers, policymakers, and governments in working together to reduce the rate of suicide among Inuit to a rate that is equal to or below the rate for Canada as a whole. Achieving this goal requires that we address the full breadth and complexity of underlying factors that create risk for suicide within our communities. It will promote the dissemination of best practices in suicide prevention, provide tools for the evaluation of approaches, contribute to ongoing Inuit-led research, provide leadership and collaboration in the development of policy that supports suicide prevention, and focus on the healthy development of children and youth as the basis for a healthy society.

The high rates of suicide in Inuit Nunangat are a symptom of the social and economic inequities that have existed between Inuit Nunangat and most other regions of Canada since Inuit began to be impacted by colonization and transition off the land into permanent settlements. The stress our people experienced during this transition, coupled with the prejudice and social inequities families faced in settlements, led to enduring social challenges that create risk for suicide in our communities.

These inequities make it challenging for people to meet their basic needs and place undue stress on the lives of our people. Inequity in this context refers to unfair, avoidable differences in social and economic status due to cultural or other forms of prejudice, and the failure of governments to act to address those differences. Creating equity for Inuit means eliminating unfair and avoidable differences in areas such as housing, education, and access to healthcare in ways that validate our language, culture and identity.

It is time for Canada to give suicide prevention in Inuit Nunangat the action and attention it deserves. It is difficult to imagine how the country would not be galvanized to action if a town in southern Canada with a population similar in size to Inuit Nunangat was struggling with comparable rates of suicide.

Canada has embraced and vowed to implement the Truth and Reconciliation Commission of Canada's 94 Calls to Action as a step toward reconciling the country's role in shaping many of the social inequities that face Inuit, First Nations, and Métis communities. The Truth and Reconciliation Commission has called on Canada to work with Indigenous Canadians to close gaps in health outcomes between Indigenous and non-Indigenous communities, including suicide.[2] But attitudes of indifference that have characterized Canada's response to suicide in Inuit Nunangat must change in order for Canada to achieve reconciliation.

At the regional and community levels, the NISPS is a tool for providing overarching guidance and support to existing regional suicide prevention initiatives and strategies, as well as for informing the development of new Inuit-led initiatives. It promotes an evidence-based, Inuit-specific approach to suicide prevention by identifying priority areas for intervention that would be most impactful in preventing suicide. In this Strategy, each priority area has specific objectives and actions that will be used to measure our progress.

Preventing suicide is entirely possible, but our success depends on our willingness to confront the social and economic inequities that place stress on many families and create environments where risk for suicide multiplies. We can restore health and equity to communities by ensuring that Inuit children are nurtured, from the womb to adolescence, in families and communities that support their healthy development. When someone ends their life by suicide, we know that an accumulation of life circumstances and events has shaped that decision.

Inuit are incredibly resilient, and each of us stands on the shoulders of our ancestors who have flourished in our Arctic environment since time immemorial. They sacrificed and persevered through hardship so that we might live; we must do the same by undertaking this important work.

The first half of the NISPS describes the evidence for effective suicide prevention by looking at suicide risk factors as well as protective factors. It outlines the evidence that supports our approach to suicide prevention through a focus on the impacts of historical trauma, social inequity, intergenerational trauma, childhood adversity, and mental and acute forms of stress. It also describes the role protective factors can play in buffering individuals and groups against suicide risk.

The second half of the NISPS outlines the six priority areas for action and investment that we have identified as necessary for guiding regional and community suicide prevention efforts in Inuit Nunangat. These priority areas are as follows: (1) creating social equity, (2) creating cultural continuity, (3) nurturing healthy Inuit children from birth, (4) ensuring access to a continuum of mental wellness services for Inuit, (5) healing unresolved trauma and grief, and (6) mobilizing Inuit knowledge for resilience and suicide prevention.

Families can raise their children in safe and supportive environments free from violence. Parents and communities can provide children with strong connections to Inuit culture and values and help them develop into resilient people who, although they will face stress and loss in life, have a sense of purpose and meaning.

3.1. Why We Need a National Inuit Suicide Prevention Strategy

The majority of Inuit live in 53 communities spread across four jurisdictions which, combined, encompass 35 percent of Canada's landmass and 50 percent of its coastline. Policies and health systems differ in each jurisdiction, as does each jurisdiction's approach to suicide prevention. Preventing suicide is a shared priority across Inuit Nunangat, yet current efforts are not based on a shared, evidence-based understanding of the known risk and protective factors for suicide.

National suicide prevention strategies do not attempt to replace local and community efforts to prevent suicide; they are a means to creating understanding and fostering communication and cooperation among stakeholders. The NISPS fosters a unified, Inuit-led approach to this urgent, Inuit Nunangat-wide challenge. It transforms our collective knowledge, experience, and research on suicide, into action. It does so by:

1. Promoting a shared understanding of the context and underlying risk factors for suicide among Inuit;
2. Guiding policy at the regional and national levels on evidence-based approaches to suicide prevention;
3. Identifying stakeholders and their specific roles in preventing suicide; and,
4. Outlining how different stakeholders can coordinate with each other more effectively to prevent suicide.

Figure 1 (*How the NISPS can create change*) uses the example of housing to show how the NISPS can be harnessed to educate about policy issues in order to create a safer reality for vulnerable children and families.

Other jurisdictions have developed and implemented suicide prevention strategies for high-suicide populations that have enabled them to lower their rates of suicide.[3] Effective national suicide prevention strategies share several characteristics: they provide leadership, integrate suicide prevention efforts across social institutions and domains of prevention (e.g. education, health, policing), identify a model to understand why suicide occurs and align interventions with that model, apply what is known about suicide prevention (evidence and best practices), and link with communities and community organizations.

Scotland and the Province of Quebec (not including Nunavik), have reduced their suicide rates through concerted suicide prevention efforts that were made possible by a strategy. Suicide prevention strategies are themselves important prevention tools.

Other countries, most notably New Zealand and Australia, have developed Indigenous-specific suicide prevention strategies, although the results of these efforts have not been fully evaluated. In New Zealand, Waka Hourua, a partnership between government and Maori and Pasifika peoples, was created and funded to lead suicide prevention for Maori and Pasifika peoples. Although it is aligned with a larger national strategy, the Waka Hourua program is led by Indigenous peoples. In the circumpolar context, Greenland has a national suicide prevention strategy for its majority Inuit population. Inuit in Canada need our own national and regional suicide prevention strategies. This is the only way that factors specific to our history and context will be addressed.

Figure 1: *How the NISPS can create change*

HOW THE NISPS CAN CREATE CHANGE

A look at housing and shelter as an example of how the NISPS could reduce suicide

EVIDENCE

People who were abused as children may be at greater risk for suicide than those who were not abused as children.[1] In Nunavut, for example, Inuit who died by suicide were found to be significantly more likely to have experienced physical or sexual abuse as children.[2]

PROTECTIVE FACTORS

Growing up in a safe household acts as a protective factor against suicide, reducing a person's risk for suicide later in life.

SHELTERS AND SAFETY

Many families who are experiencing abuse where they live have nowhere safe to go because they lack access to shelters and housing.

NATIONAL INUIT SUICIDE PREVENTION STRATEGY (NISPS)

The NISPS is a tool that Inuit can use to secure resources for housing and shelters and ensure the safety of children and families. The NISPS also guides policymakers to make more focused, efficient and impactful investments in suicide prevention.

POLICY

Policymakers determine how resources are allocated for housing and family violence shelters, yet they may not understand how housing is connected to violence and suicide risk.

CREATING CHANGE

The NISPS guides how resources are allocated in order to address the underlying causes of suicide in our communities.

1. V. J. Felitti et al., "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. The Adverse Childhood Experiences (ACE) Study," *American Journal of Preventive Medicine* 14, no. 4 (May 1998): 245–58.
2. Eduardo Chachamovich and Monica Tomlinson, *Learning from Lives that Have Been Lived: Nunavut Suicide Follow-Back Study 2005–2010* (Montréal, QC: Douglas Mental Health University Institute, 2013).

3.2. A New Approach to Suicide Prevention in Inuit Nunangat

Through the NISPS, ITK is embarking on a holistic approach to suicide prevention that focuses on intervening and providing support much earlier in life so that individuals are less likely to reach the point where they consider suicide. Many people have made commendable efforts to prevent suicide among Inuit through programs, projects and initiatives that address different aspects of this challenge. Efforts have mainly used culture-affirming interventions, anti-suicide campaigns, and training programs that teach suicide intervention to instill hope and resilience in young people and help them develop practical skills. Each of these diverse efforts has an important role to play in suicide prevention but cannot, in isolation, systematically reduce suicide in Inuit Nunangat.

The Strategy's evidence-based approach to suicide prevention considers the entire lifespan of the individual, as well as what can be done to provide support for families and individuals in the wake of adverse experiences that we know increase suicide risk. Focusing our resources and efforts on supporting families and nurturing healthy Inuit children is the most impactful way to ensure that people never reach the point where they consider suicide. A person's experiences, especially during the early years of life, shape how they see themselves and their place in the world, as well as how they cope with adversity.

3.3. Prevalence of Suicide Among Inuit

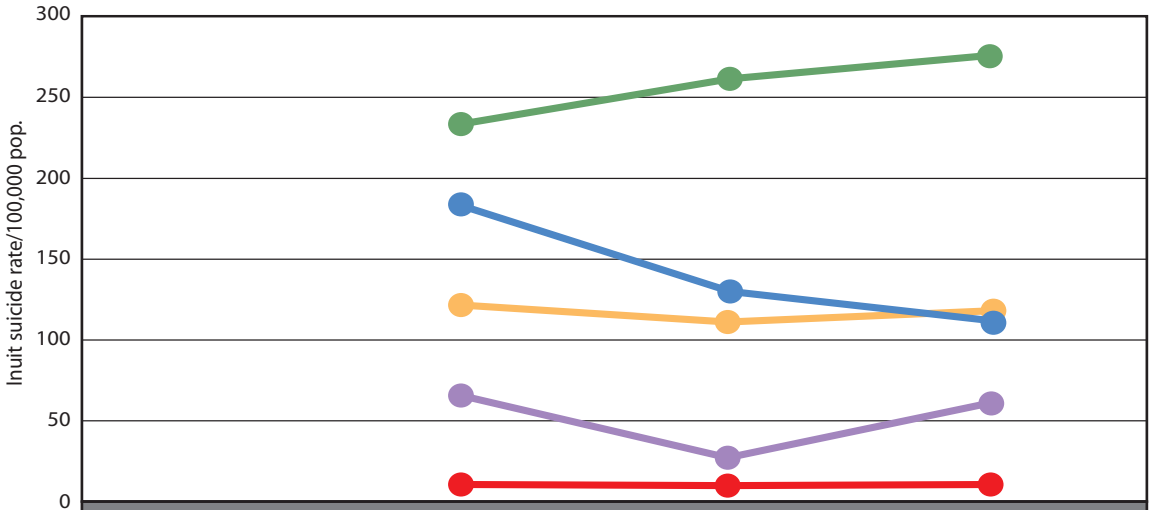
There were 745 Inuit who died by suicide during the 14-year period between 1999 and 2013 in Inuit Nunangat. The impact of this many deaths by suicide on a population of 60,000 is challenging to convey. More disturbing is how little the overall rate of suicide among Inuit has changed over time.

Figure 2 (*Suicide rates, Inuit in Inuit regions and total population of Canada, 1999-2013*) shows the rates of suicide among Inuit by region for the periods of 1999-2003, 2004-2008, and 2009-2013.

In the most recent five-year period, from 2009-2013, Canada's suicide rate was 11 per 100,000. In Inuit Nunangat, rates ranged from 60 per 100,000 in the Inuvialuit Settlement Region to 275 per 100,000 in Nunatsiavut. Nunavik and Nunavut's rates for this period were each more than 10 times the national rate.

The trend in rates varies by region over the entire 14-year timespan. In Nunatsiavut, the rate of suicide has gradually become more elevated in contrast to Nunavik, where the rate gradually decreased. Rates in Nunavut and the Inuvialuit Settlement Region were more varied. Nunavut's suicide rate decreased slightly before becoming elevated again; in the Inuvialuit Settlement Region, the rate decreased by half to 32 per 100,000 before returning to 60 per 100,000. The national suicide rate decreased from 12 per 100,000 to 11 per 100,000 during this period.

Figure 2: *Suicide rates, Inuit in Inuit regions and total population of Canada, 1999-2013*



	1999-2003	2004-2008	2009-2013
Inuvialuit Region	61.4	32.1	60.4
Nunavut	119.7	109.6	116.7
Nunavik	181.2	129.2	113.5
Nunatsiavut	238.8	259.3	275.3
Total Canada	11.9	10.8	11.3

Note: Rates for all populations are crude. Total Canada rates are for 2001, 2006 and 2011.
Sources: a) Inuit data prepared for ITK by J. Hicks; b) Total Canada data – Statistics Canada, Table 102-0552 – Deaths and mortality rate, by selected grouped causes and sex, Canada, provinces and territories, annual.

While 20 percent of our population lives outside of Inuit Nunangat, there is no statistical information about the rate of suicide among urban Inuit. There is no reliable way to calculate the suicide rate for Inuit living outside of Inuit Nunangat because death certificates in the provinces are not coded by ethnicity the way they are in the territories.

Although the most high risk group is Inuit males aged 15-29, with rates almost 40 times the national rate in some Inuit regions, young females are also at increasing risk with high rates of suicide attempts.

4. Evidence for Effective Suicide Prevention

Effective suicide prevention should reduce suicide risk, while increasing protective factors and building resilience in individuals, families, and communities.[4] Risk refers to factors in a person's life that increase their chances of illness or death. Suicide risk can be something in the environment, an experience, a behavior, something inherited, or an unknown cause. Conversely, a protective factor is something that decreases a person's chances of illness or death. A protective factor can also come from the environment, an experience, a behavior, an inherited characteristic, or an unknown cause.

Resilience can be defined in a number of ways. Resilience is the ability to adapt or even grow in the face of stress or adversity. Resilience is also a resource that grows through an accumulation of protective factors, sometimes called health assets, which contribute to positive mental wellness, increased ability to deal with stress or adversity, and resilience-building behaviours (e.g., seeking social support and engaging in meaningful activities).

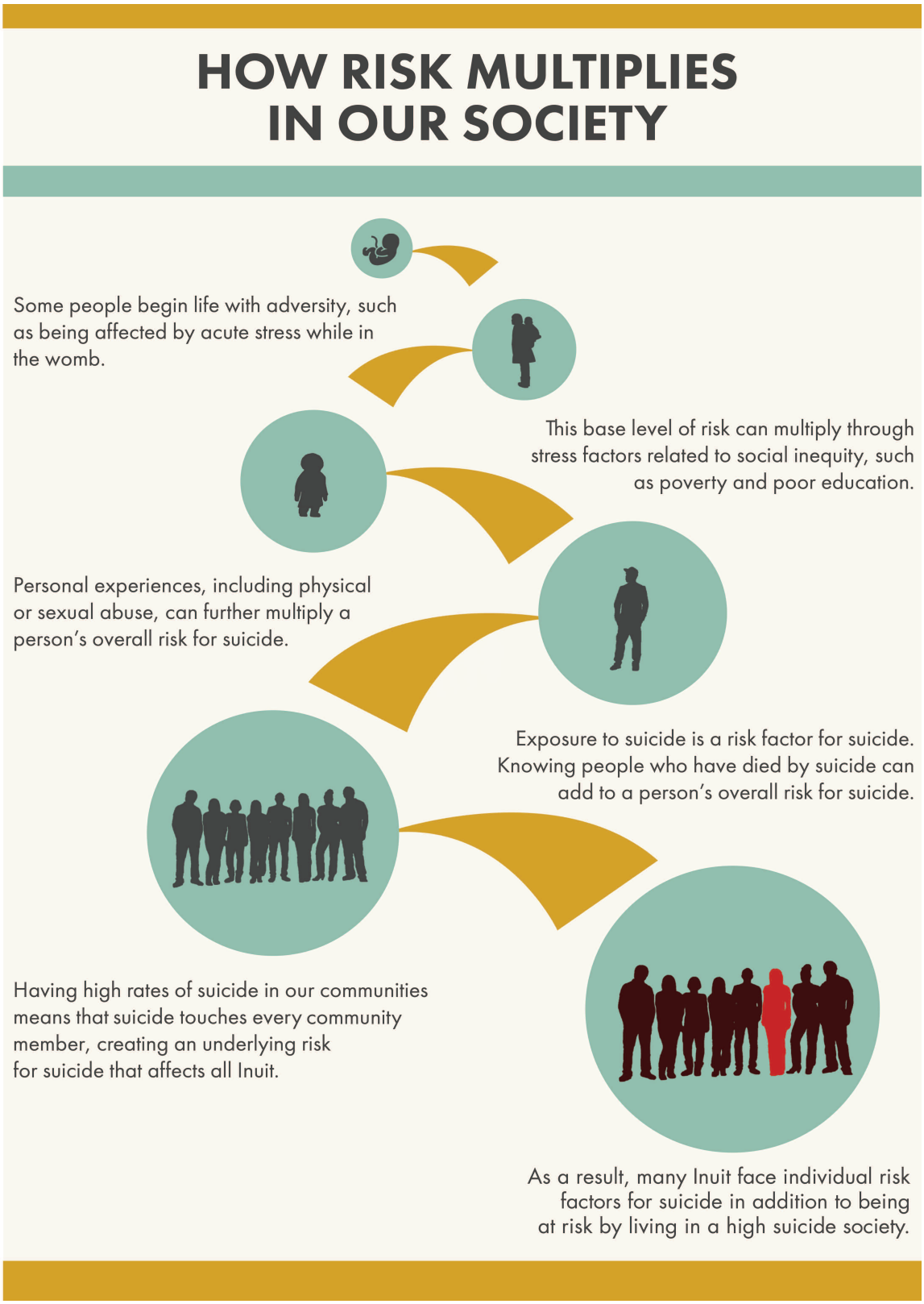
In the sections below, we identify and discuss a number of risk factors for suicide (see **Figure 3:** *Suicide risk and protective factors for Inuit in Canada*). The ways these risk factors link to suicide in our population form the evidence base for the NISPS priority areas, as well as the specific objectives and actions within each priority area. Risk factors for suicide are the experiences, events or conditions that research has linked to suicidal behaviour within a population. This means that the lives of people who have died by suicide are more likely to share certain characteristics, including historical or intergenerational trauma, poverty and inequity, and child abuse. However, there is no recipe for suicide at the individual level, and people who have been exposed to one or more risk factors are not destined to die by suicide.

Our approach to suicide prevention is based on our understanding of the risk factors that are present in our communities and the manner in which they can multiply to cause severe stress in a person's life. It is important to note that the risk factors we have identified below do not make up an exhaustive list, but are those that are prevalent in our communities.

Figure 4 (*How risk multiplies in our society*) shows how people can be impacted by adversity beginning in the womb, and how suicide risk can multiply in a person's life through continued exposure to certain types of adversity. It shows how exposure to suicide is itself a risk factor for suicide that creates a base level of suicide risk in our communities.

Figure 3: *Suicide risk and protective factors for Inuit in Canada*

Figure 4: *How risk multiplies in our society*



4.1. Historical Trauma and Suicide Risk

The rate of death by suicide among Inuit in Canada rose rapidly in the 1970s among the first generation of young people to grow up in settlements. There is no evidence that Inuit society had particularly high rates of suicide prior to this time. Elders interviewed in the 1991 Igloolik Oral History Project talk about suicide being "known to have had happened every now and then" or "once in a long while," usually in response to an extraordinary event.[5] Suicide was often attributed to keeping a person's problems inside their own mind rather than discussing them with others.

The elevated rates of suicide experienced by Inuit today can be traced back to major social and cultural upheavals in our society that created the conditions under which suicide risk factors multiplied and, within some families, were passed from one generation to the next. These social and cultural upheavals are tied to Canada's colonization of Inuit Nunangat, where federal government policy directed institutions and systems to undermine our ability to be self-reliant. These events and their ongoing impacts underpin the widespread social inequities that exist in our communities today.

Prior to World War II, the majority of Inuit lived at seasonal camps on the land in smaller family units. Many families were coerced into living in settlements by religious missionaries and the Royal Canadian Mounted Police (RCMP), often under the promise of free government housing, and sometimes through the threat of withholding government services, such as the Family Allowance that was then being distributed to Inuit families.

Lillian Elias of Inuvik, Northwest Territories, recounts her experiences attending the Aklavik Roman Catholic Residential School to the Legacy of Hope Foundation. "I don't remember why they had to send me to school until later on in the years, after I had been there for three or four years," she said. "I found out that the reason [my parents] had to put me in there was because they were going to lose my Family Allowance, or all the children's Family Allowance if one of the children didn't go to school."[6]

The transition into settlements was rapid for many Inuit. For example, the majority of Kangiqtugaapingmiut moved into the settlement of Clyde River, Nunavut, during the 1960s, encouraged directly and indirectly by the promise of education, healthcare, and housing. In 1961, the Inuit population of Clyde River was 32; by 1969 it had reached 210.[7]

Some Inuit in Nunatsiavut experienced a similar rapid transition into settlements. Inuit in Hebron and Nutak were evicted from their communities between 1956 and 1959 by missionaries, government, and medical officials. The plan unfolded without the consent of Inuit and against their protests. Reverend F.W. Peacock, the Superintendent of the Moravian Church at Nain, described part of the rationale for the closure of Hebron and Nutak in a 1955 letter: "If the Eskimos are to become self-supporting citizens they must have all the social amenities possible and these amenities are not possible to folk living in bays and on islands often in squalid houses."[8] In the view of Reverend Peacock and others, progress for Inuit meant moving off the land and assimilating into settlements.

Perhaps the most infamous example of forced relocation involves Inuit families who were relocated in the early 1950s from present day Inukjuak, Nunavik and Pond Inlet, Nunavut, to what would become the High Arctic communities of Resolute Bay and Grise Fiord, Nunavut. The relocations were intended to further Canada's sovereignty claims to the region.

Inuit who moved into communities found government housing to be of poor quality and in short supply. The "matchbox" housing provided by the federal government lacked adequate sanitation, insulation or ventilation. Inuit who moved into settlements but did not have access to government housing improvised by building houses out of scrap lumber, tin, skins, newspaper, and cardboard.

For example, in 1962 at Arviat, Nunavut, there were 82 Inuit families crowded into 64 wooden and snow houses. These conditions were a public health disaster in the making, leading to the spread of diseases such as tuberculosis.[9] In late 1962 and early 1963, an epidemic of tuberculosis affected 55 percent of these households, half the children in the community, and 24 percent of the adult population.[10] Crowding was similar at Clyde River, Nunavut, where in 1965 there were 18 one-room houses for an estimated Inuit population of 238.[11]

By the early 1960s, nearly 50 percent of Inuit had spent time in sanatoria in southern Canada receiving treatment for tuberculosis. These Inuit faced language barriers and experienced isolation and loneliness.[12] Many people who were brought south to receive treatment never returned home, and loved ones often had no way of learning about their fate.

Canadian schooling, including residential and day schools, was imposed on Inuit families who moved into settlements and was used to separate children from families who still lived on the land. The first government-regulated school specifically for Inuit opened in 1951 in Chesterfield Inlet, Nunavut. Residential schools were often far away from the new Inuit settlements, and students who attended them often faced loneliness and estrangement from our language and culture.

Some children experienced physical and sexual abuse at these schools. Residential schools for Inuit continued to operate until the 1960s. In 2001, about one-quarter of Inuit age 35 and over reported having attended residential schools.[13] The construction of day schools and hostels was a major catalyst for the movement of Inuit into settlements, yet the curriculum that children were taught had little relevance to life in Inuit Nunangat, and was delivered almost exclusively in English.[14]

Inuit felt the Crown's influence in the new settlements in every aspect of their lives, including their ability to provide for their families. In the 1950s, the Canadian Wildlife Service, fearful that newly available technology such as snowmobiles and outboard motors would lead to overharvesting of fish and game, imposed strict limits on the type and number of animals that Inuit could harvest, and restrictions on the dates animals could be hunted. Inuit who ignored hunting regulations faced fines or threats of incarceration.

The introduction of game regulations coincided with the culling of Inuit sled dogs from the mid-1950s onward. Hundreds of sled dogs were shot by the RCMP and other authorities because they were considered a danger in settlements or because of fears that they could spread disease.[15] Sled dogs served as the primary means of travel for Inuit and symbolized hunter success and self-reliance. Those affected were devastated by the loss of their sled dogs and the subsequent challenges this created for maintaining our traditional way of life in settlements.

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.

The miserable living conditions that some families faced in settlements were not consistent with what they had been promised. The squalor, coupled with overwhelming pressures from schooling, and the rapid transition from a traditional economy to a cash economy was overwhelming. The breakdown in some families began to occur in this chaotic environment, placing children at greater risk for adversity, including suicide.

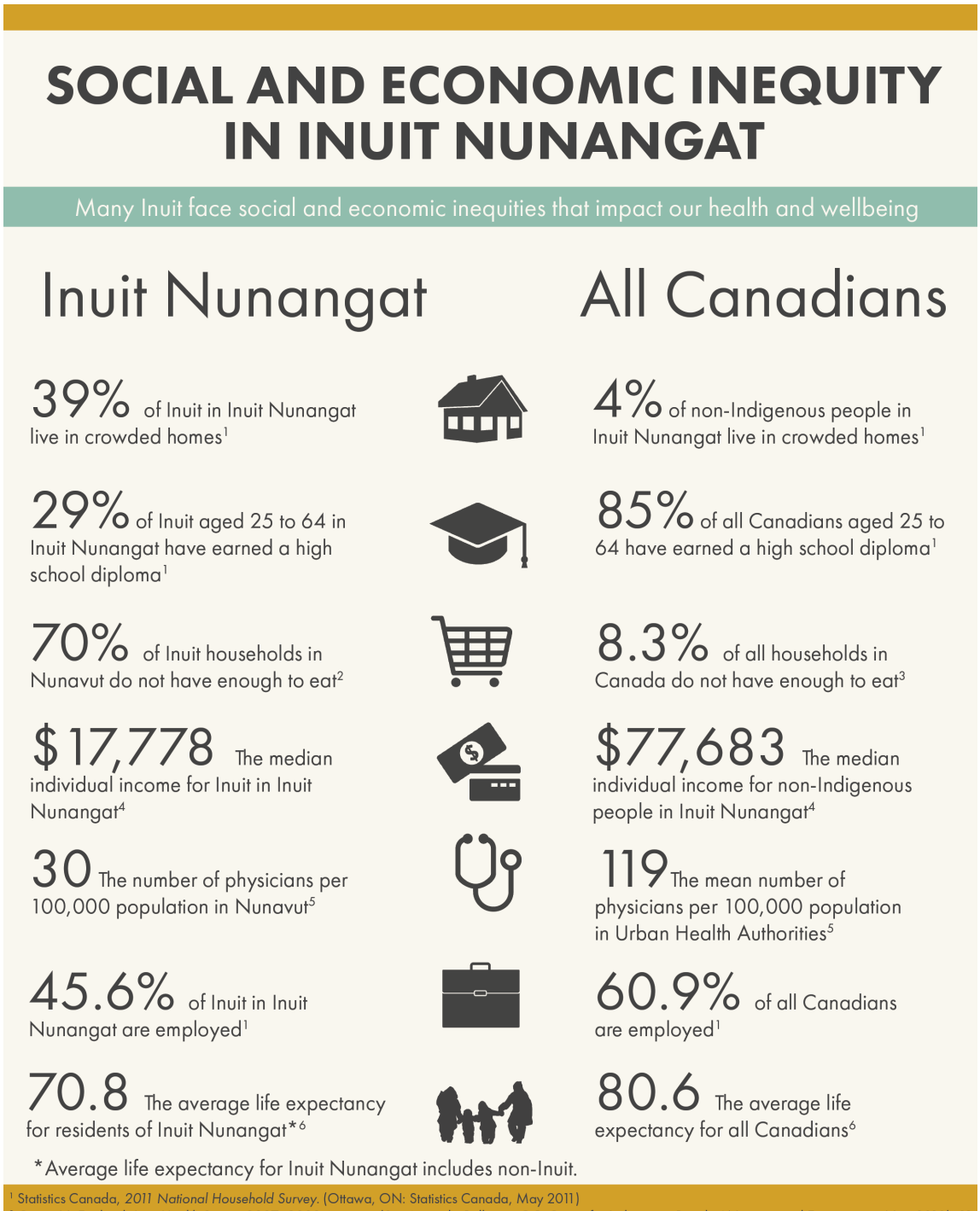
Many of the families who moved into settlements had little chance of succeeding against the adversity they faced, although many miraculously have. It is a testament to the resilience of our people that the majority of Inuit are thriving today despite enduring barriers to health and wellness that too often mirror those of the past.

Motivated largely by this history, Inuit have pursued political autonomy and self-determination through the negotiation of the comprehensive land claim agreements that define Inuit political status in Canada today. Self-determination for Inuit means the right to choose and define our own path forward on our own terms, including in the areas of governance, education and research. Our experience has shown us that when people prescribe solutions to our challenges from outside of our communities, those solutions rarely work. Inuit self-determination is a necessary facet of suicide prevention and, in order to be successful, Inuit must decide for ourselves how to address the challenges that exist in our communities.

4.2. Social Inequity and Suicide Risk

Inuit communities have struggled with social inequity since permanent settlements were created, and these inequities still exist (see **Figure 5**: *Social and economic inequity in Inuit Nunangat*). Suicide and other enduring social and economic challenges in our communities took shape within this environment. Indicators of social inequity include crowded and/or inadequate housing, low educational attainment, poverty, and food insecurity.

Figure 5: *Social and economic inequity in Inuit Nunangat*



Today, the average life expectancy in Inuit Nunangat is 10 years less than the Canadian average, due in part to suicide. Despite living in communities with the highest cost of living in Canada, the unadjusted, median individual income for Inuit in Inuit Nunangat is $12,000 less than the Canadian average. This difference in median individual incomes widens to $60,000 when Inuit earnings are compared to non-Indigenous people living in Inuit Nunangat.[16]

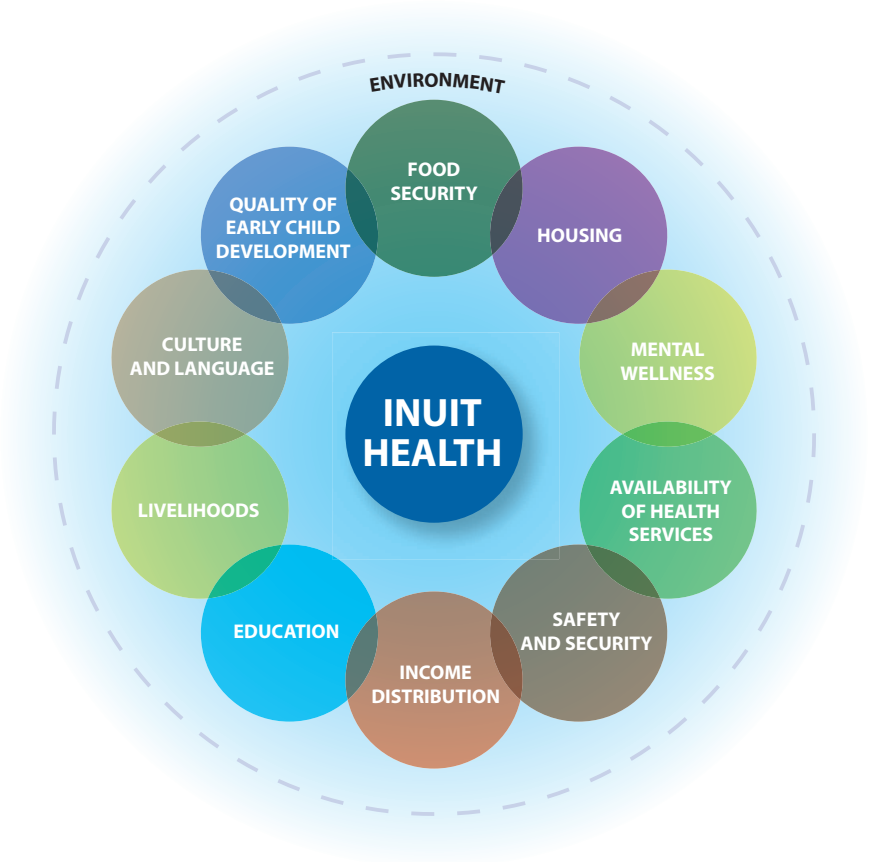
Poverty and other indicators of social inequity translate into stress and adversity for families, and can lead to disparities in health status, and increased risk of suicide among individuals, families and populations. Most studies that have examined connections between social disadvantage and suicide or suicide attempt have reported increased risk of suicidal behaviour among individuals from socially disadvantaged backgrounds characterized by poverty and low educational attainment.[17]

Creating social equity is therefore a critical aspect of suicide prevention. The factors that create social equity are known as social determinants of health. Social determinants of health include the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems (i.e. economic policies, social policies and political systems) shaping the conditions of daily life.[18]

Globally, the social determinants of health include things like income and social status, social support networks, education, employment/working conditions, social environments, physical environments, personal health practice and coping skills, healthy child development, gender, and culture.[19]

The social determinants of health may vary from one culture and society to another. **Figure 6** (*Social determinants of Inuit health*) shows the 11 social determinants of Inuit health in Inuit Nunangat, identified by our people: quality of early childhood development; culture and language; livelihoods; income distribution; housing; safety and security; education; food security; availability of health services; mental wellness; and the environment.[20]

Figure 6: *Social determinants of Inuit health*



4.3. Intergenerational Trauma and Suicide Risk

Most of us experience trauma and loss over the course of our lives. However, when provided with support under the right circumstances, we can heal and even grow from these experiences. For many people, trauma or loss can be overwhelming to cope with or move past. Unresolved traumatic experiences can create lasting distress and contribute to cumulative risk for suicide, especially when traumatic experiences lead to depression and substance misuse.

The elevated rate of suicide in Inuit Nunangat reflects the fact that our people are more likely than the average Canadian to be exposed to suicide risk factors, including risk factors that are linked to traumatic experiences.

Trauma can occur in response to an event or multiple events that cause a person to fear for their life or physical wellbeing, or the lives and physical wellbeing of others. This includes experiences such as witnessing or being the victim of violence, serious injury, or physical and sexual abuse or assault. It can also include the traumatic loss or death of a loved one, either by crime, accident, or suicide.

Traumatic stress can occur when people respond to these experiences in ways that continue to haunt them, such as reliving the traumatic event in intrusive memories or nightmares, feeling intense anxiety or irritability, or by changing the way they view themselves, others, or the future. Traumatic stress is often associated with depression, withdrawal, or substance misuse, and can make it difficult for individuals to function in life.[21]

Having access to appropriate assistance and support in the wake of a traumatic event is a critical ingredient for coping and recovery. In the absence of support, people who have had traumatic experiences may develop traumatic stress symptoms that make it difficult for them to lead healthy lives and succeed. Children are especially vulnerable to the harmful effects of trauma, particularly in the absence of safety and support in relationships with caregivers.

Traumatic stress combined with ongoing feelings of danger can impair children's ability to develop and learn, increasing the likelihood of school hardship, future challenges related to low educational attainment, and possible involvement in the criminal justice system. The impacts of trauma can multiply over time if the trauma is repeated or prolonged, and can also place the child on a path of increasing risk to experiencing future traumas and other kinds of mental distress, including risk for suicide.

Children can also be impacted by traumatic experiences that impact their caregivers, even if the child does not experience the trauma directly. For example, a mother or father with their own unresolved symptoms of trauma can experience challenges that make it difficult for them to provide a sense of safety and security to their children. These are often referred to as the intergenerational effects of trauma.

It is important to remember that traumatic stress *symptoms* have the potential to create risk for suicide in individuals, not traumatic experiences themselves. Many people who have had traumatic experiences go on to live happy and healthy lives, especially if they receive care and support from friends and family, or have access to and are able to utilize appropriate services in the wake of traumatic experiences. The vast majority of people who have experienced trauma do not attempt or die by suicide, though a significant number of Inuit who have died by suicide have experienced trauma. Loss of loved ones and community members to suicide can also create and worsen traumatic stress, resulting in increasing risk for suicide.[22]

In addition to affecting individuals and families, trauma can also impact groups of people. The term historical trauma is commonly used to describe the traumatic stress experienced by an entire group as a result of a cumulative and psychological wounding over a lifespan and across generations.[23] It is used in this context to refer to traumatic events that impacted entire groups of people or communities as a direct result of colonization. We are learning more about the links between historical trauma and loss and risk for depression and suicidal behaviour.[24]

Addressing the known risk factors for suicide, such as those linked to trauma, is one of the most powerful steps we can take to prevent suicide in Inuit Nunangat. Preventing suicide is complex and there are no quick fixes. Nonetheless, evidence shows that trauma is linked to suicide risk, and that our society is heavily impacted by trauma, while at the same time lacking the necessary supports people need to cope with its effects.

4.4. Childhood Adversity and Risk for Suicide

The majority of Inuit children grow up in healthy families that love and support them. Still, 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.

The abuse and trauma that some Inuit children face is burdening them with suicide risk that can multiply throughout their lives each time they experience additional risk factors. Focusing on the early years and ensuring that children grow up in safe, nurturing, and predictable environments, in which they can achieve optimal development and build resilience, is the most impactful, long-term approach to preventing suicide among Inuit.

International studies, such as New Zealand's Christchurch Health and Development Study, have demonstrated that social disadvantage in childhood directly contributes to suicidal behaviour in later adolescence.[25] Childhood adversity, such as extreme poverty, abuse, or neglect, is linked to negative outcomes that are associated with suicidal behaviour, such as poor mental health, substance abuse, and poverty. The elevated rate of suicide among Inuit in Inuit Nunangat can be partially explained by the prevalence of childhood adversity in our communities.

Child abuse, neglect and even the physical disciplining of children is not a part of our history or culture. Yet the prevalence of physical and sexual violence against children is disturbingly high in our communities. Nearly one-third of Inuit respondents to the 2004 Nunavik Inuit Health Survey's confidential questionnaire reported being made to perform, or having the behaviour of sexual touch performed or attempted on them during childhood.[26]

The prevalence of self-reported child sexual abuse is similarly high in Nunavut. Out of the 1,710 Inuit respondents to the Community and Personal Wellness module of the *Inuit Health Survey 2007-2008*, 41 percent (52 percent of female and 22 percent of male respondents) said they had experienced severe sexual abuse during childhood, which includes someone threatening to have sex with them, touching the sex parts of their body, trying to have sex with them, or sexually attacking them.[27]

People who have experienced adversity in childhood tend to be at greater risk for suicide than people who have had little or no adversity.[28] Adversity includes: living with caregivers with untreated mental illness, substance misuse, or experiencing childhood physical, sexual or emotional abuse. Adverse childhood experiences, including childhood maltreatment, dramatically increase the risk of suicidal behaviour. Child maltreatment is a broad term referring to physical abuse, sexual abuse, emotional abuse, and neglect during childhood. Child maltreatment plays a powerful role in shaping the lifelong health and wellbeing of individuals, creating risk for negative outcomes later in life that can include risk for suicide.

The Adverse Childhood Experiences (ACE) study, conducted in the United States, provides strong evidence that supports what many Inuit have experienced and observed in our families and communities in relation to suicidal behaviour, which is that childhood experiences of abuse, neglect and family dysfunction can negatively shape lifelong outcomes and can, in some cases, place individuals at greater risk for suicide. The ACE study is one of the largest investigations of childhood abuse and neglect and later-life health and wellbeing.

The ACE study looked for connections between the health status of 17,000 American adults and the number of self-reported, adverse childhood experiences. Ten adverse childhood experiences were studied, including child abuse (emotional, physical, sexual), neglect (emotional, physical), and growing up in a seriously dysfunctional household (witnessing domestic violence, alcohol, or other substance abuse in the home, mentally ill or suicidal household members, parental marital discord, or crime in the home).[29]

The prevalence and risk for alcoholism, drug use, sexual promiscuity, and sexually transmitted diseases followed a similar pattern.[30] The ACE study found that the prevalence and risk for smoking, severe obesity, physical inactivity, depression, and suicide attempts increased as the number of childhood exposures to these adverse experiences increased. Adverse events in childhood have a strong, graded relationship to suicide attempts during adolescence and adulthood, with the highest levels of adversity increasing risk of suicide attempts in youth by 51-fold and 30-fold among adults.[31]

The relationship between child maltreatment and suicide can also be seen in research carried out in Nunavut, where an in-depth analysis of the lives of Inuit who have died by suicide took place. The *Learning from Lives that Have Been Lived: Nunavut Suicide Follow-Back Study*, examined the lives of all 120 Inuit who died by suicide in Nunavut between 2003 and 2006.[32] It compared the backgrounds of the deceased with 120 of their living Inuit peers of the same age, gender and community of origin. Researchers used interviews with the friends and family members of the deceased in order to identify commonalities in the life experiences of those who died by suicide and to compare them with their living peers.

The study found that significantly more individuals in the suicide group had experienced childhood abuse than in the comparison group, and that significantly more individuals in the suicide group had been physically or sexually abused in childhood than the comparison group. Levels of both impulsiveness and aggression were also significantly higher among those who died by suicide, as was the number of individuals with current or lifetime major depressive disorders.

Preventing suicide among Inuit requires that we provide the investments and supports needed to ensure that children have a safe and healthy start in life, and that those who have experienced child maltreatment or other forms of trauma have access to a network of supports that can aid them in their recovery.

4.5. Mental Distress and Suicide Risk

Many studies show a strong association between mental health disorders and suicide. The most common methods for establishing this link are psychological autopsy studies, in which the characteristics of the person who died by suicide and the circumstances of their death are reconstructed through interviews with their friends and family as well as by reviewing available medical histories. Such studies demonstrate that up to 90 percent of people who die by suicide had been suffering from a mental health disorder.[33] The most common diagnoses are mood disorders, substance abuse disorders, schizophrenia, and personality disorders.

The time of greatest risk for suicide varies depending on the mental health diagnosis. The highest risk of suicide for major depression and Alzheimer's disease is early in the disorder.[34] For people with schizophrenia the risk of suicide is highest two to 16 years after diagnosis.[35] For people suffering from alcohol misuse disorders, suicide risk increases markedly after 10 years of abuse.[36] There are many explanations for these timings, which may include biological changes that are part of the mental disorder, stigma associated with diagnosis, and negative life and social consequences of living with chronic illness over time.

Research supports similar findings among Inuit communities. 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.[37] This study highlights commonalities with global findings, demonstrating that we must diagnose and treat mental health disorders as an integral component of suicide prevention within Inuit communities.

The same study also found other important differences between the two groups, including demographic differences (the group that died by suicide tended to be unmarried, have higher levels of unemployment, and have lower educational achievement) and greater experiences of childhood adversity, including childhood sexual abuse, compared to the group that died by suicide. This clearly shows that mental disorder is an important risk factor for suicide, and also that suicide is multi-determined and involves many of the other developmental and social risk factors discussed in earlier sections of this document.

Because a high proportion of people who die by suicide have a mental health disorder, most suicide prevention strategies strongly emphasize preventing and treating mental health disorders. It is certain that the prevention and treatment of mental disorders can contribute to reducing suicide yet it is also important to note that only a small proportion of people with mental health disorders die by suicide. Furthermore, we do not yet fully understand the mechanisms by which mental health disorders may be linked with increased risk for suicide. It may be that similar genetic and biological factors underlie both the mental health disorder and suicide; or that symptoms of disorders directly increase suicide risk; or that some aspect of living with a mental health disorder, such as poverty, stigma, or loss of social support, may lead to greater risk of suicide.[38]

Better understanding of these pathways through future research will have implications for the kinds of prevention and intervention activities that should be taken to reduce suicide. Current knowledge strongly suggests that, to have a significant impact on suicide rates, the treatment of mental health disorders must be combined with addressing the social, economic and cultural consequences of living with a mental disorder in society.

4.6. Acute Stress and Suicide Risk

Despite the strong link between suicide and mental disorder, there are hundreds of other factors that are associated with suicide risk.[39] It is difficult to predict which people, even in the presence of many of the risk factors described above, will contemplate, attempt, or die by suicide. Influences that occur around the time of death are also important. These may include recent crises, such as loss of a relationship or job, and other environmental factors, such as access to lethal means, including firearms.

Exposure to negative life events is a key factor associated with adolescent self-harm and suicide.[40] Additionally, individuals who self-harm report more stressful life events than those who experience thoughts of suicide or self-harm but do not act on them.[41] Interpersonal difficulties during adolescence (such as isolation; conflict with adults, peers, or those in authority; and loneliness) are independent predictors of suicide attempts in late adolescence or early adulthood.[42] School-based studies have demonstrated an association between bullying and self-harm in adolescents of both genders.[43]

It may be that there are different groups whose risks for suicide take different paths. One path may involve a long-term, developmental course of adversity, unstable behavior and difficult family circumstances; another path may include mental health disorder; yet a third may only involve risk related to recent life stress and loss that places the person at immediate risk.[44]

Traits or characteristics related to mental health disorder or developmental adversity, such as perfectionism, impulsivity, aggression, or hopelessness, may impair an individual's ability to cope with or adapt to life stress or change.[45] Within each course or path, acute stress or loss, coupled with access to lethal means, may play a strong role in suicidal behavior.

Suicide prevention strategies need to provide a means of identifying those at risk in the aftermath of a personal crisis, and direct supports to those in crisis. In a crisis situation, the availability of a crisis intervention, such as a helpline, may decrease the risk of death by suicide.[46] New potentialities in suicide prevention may be harnessed through social media and other e-technologies, which can be used to bolster social support, and to identify and intervene with those who are at increased risk of suicide.[47] Controlling access to means of suicide, such as firearms control, safe storage of pesticides, and barriers on bridges, has also been shown to decrease suicide.[48]

4.7. Protective Factors

People who experience stressful life situations react differently depending on their coping skills and the support and help they receive from their family and community. A negative outcome and the development of mental health problems are not inevitable. In fact, many people experience severe stress and adversity and have no long-term negative consequences. The following section discusses protective factors that can support positive outcomes for people who experience stressful events and challenging difficulties in their lives.

In the context of suicide prevention in Indigenous populations, emphasis is often placed on the importance of protective factors as well as the concept of life promotion. Life promotion is grounded in the belief that youth "are capable of finding their own path to a meaningful life,"[49] and efforts are strengths-based and focused on youth empowerment.[50] This approach aligns with many aspects of the NISPS, including a more holistic and integrated approach that understands that suicide prevention goes beyond the individual to encompass community, culture, and systems of meaning. However, life promotion-centred approaches to suicide prevention have limits in contexts where mental health and other critical services that enable empowerment and resilience are lacking.

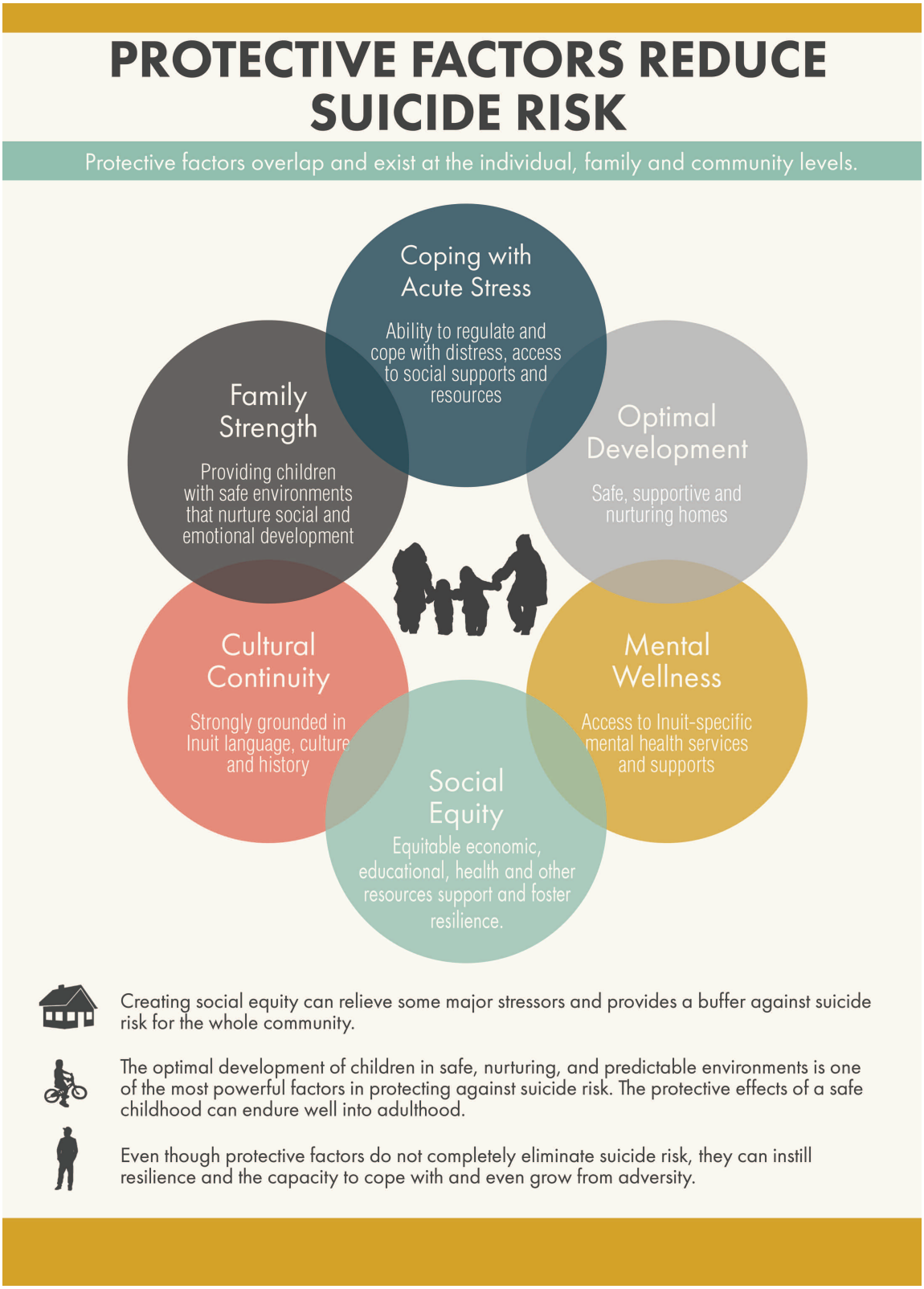
Protective factors can be both general and specific to suicide; they can contribute to overall wellbeing and also decrease the likelihood that someone will engage in self-harm or suicidal behaviour. One way to understand protective factors is as a buffer against suicide (see **Figure 7:** *Protective factors reduce suicide risk*).[51]

Protective factors may reside within an individual, family or at the community level. Many interventions that promote protective factors and the development of resilience involve an "upstream" approach, meaning that they are delivered early in the lives of individuals, but are protective into adulthood. An example of this would be an intervention that strengthens parenting skills of people with young children, which then leads to a decrease in child maltreatment, thus decreasing in those children a known risk factor for suicide later in life. The protection provided by responsive parenting contributes to general wellbeing, but also theoretically reduces the risk of later suicide.

Although the evidence for these upstream approaches is just beginning to emerge, they are important, theoretically guided interventions that promise to provide protection, build resilience, and contribute meaningfully to reducing the individual and community-wide risk for suicide.[52]

Important protective factors at an individual level are strong relationships and support; positive coping strategies; intact self-esteem and self-worth; and intelligence and academic achievement.[53] Many of these protective factors instill resilience and the capacity to cope with and even grow from adversity. Healthy lifestyle choices including exercise, nutrition, and sleep can protect against depression.[54] Spiritual beliefs can provide a sense of hope and meaning, although in spiritual and religious communities that do not support people with mental illness, this may contribute to stigma and be of mixed benefit.[55] At the family level, strong cohesion and support are protective. At the community level, strong networks of cohesion and support and youth engagement can all be understood as protective factors.[56]

Figure 7: *Protective factors reduce suicide risk*



Several protective factors have been proven to be associated with lower suicide risk. Having social support and good coping skills are protective factors that have well-documented benefits. For example, research has found that some people who reported having a confidant, someone with whom they were able to talk to about their problems, had half the rate of suicide attempts in the preceding year, when compared to people who did not report having a confidant.[57]

Several studies comparing adolescents and young adults who attempted suicide with others who experienced similar adversities but who did not attempt suicide have found that suicide attempters could think of fewer ways of coping with their problems and reported using fewer and less helpful ways of coping in their daily lives.[58] These research studies suggest that building stronger relationships and more supportive social environments where people can talk about their problems, and teaching better coping skills at a young age, can play an important role in suicide prevention.

We believe a strengths-based approach mobilizes Inuit knowledge to take action to reduce known risks, in addition to sustaining and building new sources of strength that will offer protection for all members of Inuit society, and for those who are vulnerable. This protective support will enable Inuit to further develop our inner resources and resilience.

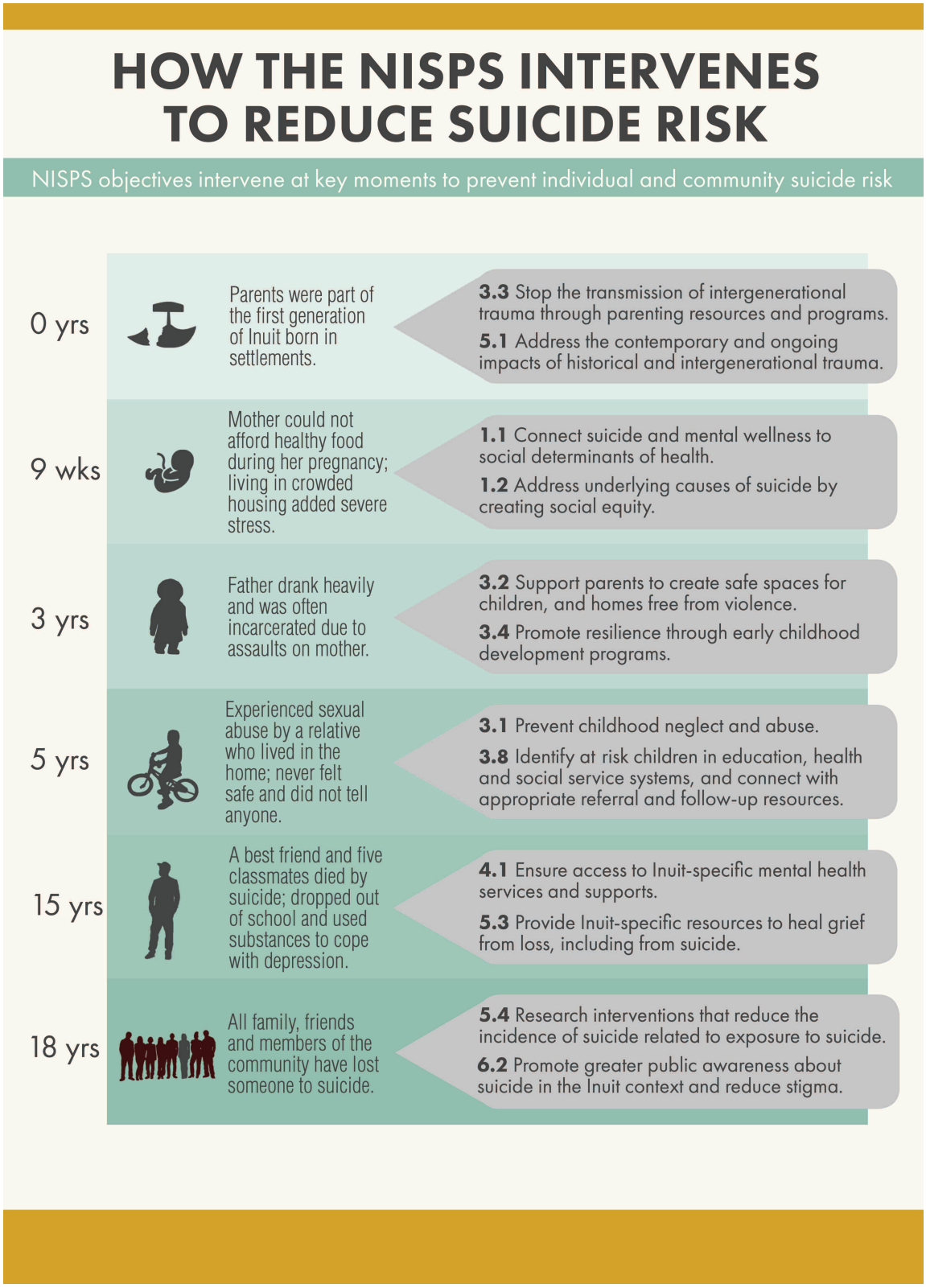
Risk and protective factors do not work in isolation from one another, but can shape a person's ongoing pathway through life. These are sometimes called cumulative or pathway effects.[59] For example, early life in a supportive nurturing family environment paves the way for continued development of strengths and resilience. In contrast, early experiences of adversity, such as abuse or loss, can lead to cumulative risk. Of course, individual lives do not usually follow simple models — a person's path can take detours and involve complex interplay of risk and protective factors. Having every single risk factor also does not mean a person will end their life by suicide.

5. Priority Areas for Reducing Suicide Among Inuit

ITK has outlined six priority areas for action and investment that are necessary for guiding regional and community suicide prevention efforts in Inuit Nunangat. **Figure 8** (*How the NISPS intervenes to reduce suicide risk*) shows how the NISPS priority areas will address risk factors for suicide at critical moments in a person's life. The six priority areas are:

1. **CREATE SOCIAL EQUITY:** Address the social determinants of health and wellbeing, including early childhood development; culture and language; livelihoods; income distribution; housing; safety and security; education; food security; availability of health services; mental wellness; and the environment.
2. **CREATE CULTURAL CONTINUITY:** Support the development and sustainability of approaches that connect Inuit with our land, culture, and language to foster healing. Evaluate these approaches as a way of contributing to Inuit knowledge. Require trauma-informed care and cultural safety in health-care, social services, justice, education, and policing
3. **NURTURE HEALTHY INUIT CHILDREN:** Support the healthy behavioural, cognitive, and emotional development of children at all stages of their growth by supporting families to create secure, non-violent spaces for the growth of children. Work to prevent child abuse and neglect. Support programs and approaches that build resilience and skills for coping in children and youth. Reduce the number of Inuit children in care and avoid cultural loss by ensuring strong efforts are made for Inuit children to remain in Inuit homes and communities.
4. **ENSURE ACCESS TO A CONTINUUM OF MENTAL WELLNESS SERVICES FOR INUIT:** Mental distress and mental illness, including depression and substance misuse, contributes to risk for suicide, and acute stress or loss can precipitate a suicide attempt. We need a full range of culturally relevant mental wellness services at the community level to identify and follow those who are at risk of suicide and those who have attempted suicide.
5. **HEAL UNRESOLVED TRAUMA AND GRIEF:** Address unresolved trauma and grief, including the impacts of historical trauma stemming from colonization and rapid social change, through culturally relevant programs and approaches. This includes grief related to loss through suicide, at community and individual levels.
6. **MOBILIZE INUIT KNOWLEDGE FOR RESILIENCE AND SUICIDE PREVENTION:** Promote best and promising practices in suicide prevention by and for Inuit by sharing of strategies, programs and interventions that help children develop coping skills, resilience, healing, and wellness. Contribute to Inuit knowledge through evaluation of initiatives and programs. Create an Inuit-led research agenda that addresses knowledge gaps in suicide prevention and wellness.

Figure 8: *How the NISPS intervenes to reduce suicide risk*



Priority Area 1: Create Social Equity

There is a clear evidence from around the world that social disadvantage, such as living in poverty and not getting enough to eat, is linked to higher rates of suicide. Achieving social equity is necessary to prevent suicide; it is also a broad and overarching goal that will improve many other areas of life.

Suicide is the most tragic expression of wider social and health disparities that exist within a context of social inequity. Through the NISPS, ITK will connect suicide and other problems of mental wellness to larger social determinants of health and inequity. We will address the underlying causes of suicide by creating social equity.

ITK's National Inuit Committee on Health has made contributions in this area in Inuit Nunangat by identifying the social determinants of Inuit health, such as food security, housing, and mental wellness, and the ways they connect to larger issues of social inequity and distress. The NISPS will build on this work by advocating for resources that address social and health gaps, share information across Inuit regions about the connections between social inequity and suicide, and support Inuit-led research that fills gaps in knowledge about social inequity and suicide prevention.

Eleven social determinants of Inuit health (**Figure 5:** *Social determinants of Inuit health*) have been identified by our people: quality of early childhood development; culture and language; livelihoods; income distribution; housing; safety and security; education; food security; availability of health services; mental wellness; and the environment.

Objectives

1.1. Connect suicide and other problems of mental wellness to social determinants of health.
1.2. Address underlying causes of suicide by creating social equity.

ITK actions

- Work with provincial, territorial and federal governments to address social determinants of health as a means of improving Inuit wellbeing and reducing suicide.
- Foster communication and knowledge-sharing among Inuit regions to target social equity, and to learn from successful efforts.
- Track the impact of improved social determinants of health on suicide rates, through Inuit-led research.

Priority Area 2: Create Cultural Continuity

The strength and vibrancy of our language and culture is a cornerstone of Inuit health and wellness, and yet an increasing number of young people do not have access to this source of strength. At the same time, Inuit have often had to set our language and culture aside in order to succeed in school or to access and utilize basic services, such as counselling or psychiatric care. When people exhibit symptoms of suicidal behaviour in a crisis or are in need of support, the ability to access services and care within a culturally safe space is imperative for suicide prevention. Inuit need to be able to access our rich heritage, as well as services that affirm and improve on our language and identity, to help us create social equity, build health and wellness, and prevent suicide.

Through the NISPS, ITK will work with Inuit regions to connect Inuit youth with Inuit language, culture, and history. While the NISPS recognizes the importance of preventing suicide through a multi-level strategy that addresses a range of individual and community factors, strength and continuity in culture is an important priority that is woven throughout our approach. We will support regions in incorporating Inuit culture and language into mental health programming and lead research on Inuit-specific mental health interventions.

Objectives

2.1. Connect Inuit youth with Inuit language, culture, and history.
2.2. Foster social connection at the community level and across generations.
2.3. Incorporate Inuit culture and language into mental health programming.
2.4. Research best practices in Inuit-specific interventions, including impact on suicide prevention.

ITK actions

- Support community and regional access to cultural activities and education within the context of suicide prevention.
- Create an Inuit-specific resource on cultural safety and trauma-informed care.
- Ensure that health, education, social services, and policing are trauma-informed and culturally safe.
- Work to reduce stigma related to mental illness and suicide.

Priority Area 3: Nurture Healthy Inuit Children

Investing in the safety and wellbeing of children is the most important and cost-effective investment a society can make, with child wellness linked to long-term health, education, and economic mobility. Investing in the safety and wellness of children is also the most impactful way to prevent suicide. Children who grow up in safe, nurturing and predictable environments have a foundation for healthy lifelong growth and development and are more likely to live healthier, happier lives with a reduced risk for suicide. We must nurture healthy Inuit children by ensuring that the robust evidence linking specific types of childhood adversity and risk for suicide informs and guides policies, programs and services that serve children and families.

Through the NISPS, ITK will work with Inuit regions to ensure that children and families are safe, and reduce intergenerational trauma. We will do this by advocating for resources and interventions that strengthen families, particularly those families that are struggling or vulnerable. We will promote lifelong resilience in Inuit and skills to support healthy social and emotional development, by focusing on early childhood development programs. We will provide support to regions to identify children at risk and educate youth about healthy relationships. We also recognize the growing importance of social media as both a potential risk for children and youth (for instance, through exposure to traumatic details of suicide) and as a potential opportunity to develop public health outreach.

ITK's work on child development has included assessing the impacts of Inuit childcare options across Inuit Nunangat. We will build on this work by sharing knowledge with regions about the links between child maltreatment and risk for suicide, and advocating for safe shelters and access to early childhood education programs. We will also advocate for a more integrated system of child protection that is more responsive to the needs of children in care, including supporting improvements to the child protection and fostering system, and putting more supports in place to maximize the success of keeping children in Inuit families and communities.

Objectives

3.1. Prevent childhood maltreatment.
3.2. Support parents to create safe spaces for children, and homes free from violence.
3.3. Reduce the transmission of intergenerational trauma through parenting resources and programs.
3.4. Promote resilience through early childhood development programs.
3.5. Teach skills to support social-emotional development in schools.
3.6. Teach youth about healthy relationships and educate about the impacts of intimate partner violence.
3.7. Research the role of social media in suicide prevention, including possibilities for building a network of connection, support and resilience among Inuit youth.
3.8. Identify at risk children within the education, healthcare and social services systems, and connect with appropriate referral and follow-up resources.
3.9. Develop Inuit-led research that explores the links between childhood adversity and later suicide, including links with experience in child protection, foster care, and adoption; and research into upstream interventions that aim to mitigate this risk.

ITK actions

- Educate about links between early childhood adversity and risk for later suicide.
- Communicate and advocate for the need to protect children from any form of child maltreatment.
- Advocate for safe shelters.
- Advocate for early childhood education and Inuit-specific kindergarten to grade 12 schooling.
- Advocate for an integrated system of child protection that provides continuity in supports and services to children and families within their communities.
- Advocate for child protection services that put the needs of children first by providing responsive foster placements when needed, providing environments for children in care that maintain connections with culture and community, and providing a full range of supports for vulnerable families that maximize the success of keeping children and families united.

Priority Area 4: Ensure Access to a Continuum of Mental Wellness Services for Inuit

A continuum of mental wellness services is needed to ensure that Inuit who are impacted by trauma and adversity can be identified and provided with the supports they need before risk for suicide multiplies. Mental distress and mental illness, including depression and substance misuse, contributes to risk for suicide, and acute stress or loss can precipitate a suicide attempt. A continuum of mental wellness services within the context of suicide prevention includes universal prevention; targeted prevention to build resilience in groups that may be at risk (e.g., youth, or those involved in the legal system); crisis intervention services for those facing acute stress and mental distress; and interventions for those with high or imminent risk for suicide (e.g., those who have made previous suicide attempts).

A continuum of mental wellness services also extends beyond the healthcare system and includes services provided by the education system, criminal justice system, and family and child services system. Coordination across these services forms a safety net that helps identify those who are vulnerable and links them to appropriate supports that can reduce their risk for suicide. Together, these services are comprised of a range of providers from the community level to regional centres, and include frontline mental health service providers and helpers in schools, churches and community organizations, to trained professionals in health centres and social services. If all of these individuals understand their role in suicide prevention and receive appropriate training, we can increase the strength of our community safety and support.

The use of trauma-informed and culturally safe approaches by service providers is an important component of such a continuum and helps to improve access to essential services for Inuit who often do not see our language and culture reflected in the services we receive. We must also address gaps in critical services in Inuit Nunangat, such as the availability of treatment centres, to address psychiatric illness and substance misuse.

Through the NISPS, ITK will address this priority area by working with regions to ensure access to Inuit-specific mental health services and supports, by supporting training in best practices in suicide prevention and intervention for community-based and frontline workers, and by advocating for Inuit-specific addictions treatment at the community level.

One of the major challenges in the training and practice of mental health services, as well as social services and health services in general, is the use of an individualistic model of treatment where people are treated without involvement by their families and community members. It is essential for Inuit that people working in suicide prevention and mental health involve family and community in prevention and treatments, and that they are trained in the skills necessary to use these approaches, rather than intervening with individuals independent of their family, community and cultural context. This involves recruiting mental health workers who have skills in family counselling and community development, and are knowledgeable of Inuit culture, and/or provided with appropriate training.

Members of ITK's Alianait Inuit Mental Wellness Advisory Committee have provided key input on improving mental health and wellness among Inuit, including improving access to Inuit-specific mental health services and supports. ITK will build on this work by engaging with regions to create a network of Inuit helplines to be available in Inuktut (the Inuit language) across all regions, fostering communication and knowledge-sharing about best practices in suicide prevention, intervention and postvention, and by supporting suicide-intervention training programs in Inuit regions.

Objectives

4.1. Ensure access to Inuit-specific mental health services and supports, particularly services that address health promotion, suicide prevention, and interventions for those who are at risk of suicide or have attempted suicide.
4.2. Ensure education and training in best practices in suicide prevention and intervention for community-based and frontline workers.
4.3. Ensure access to Inuit-specific addictions treatment at the community level.
4.4. Ensure access to Inuit-specific mental health and wellness services to those involved in the justice system.

ITK actions

- Engage the Alianait Inuit Mental Wellness Advisory Committee in creating a strategy for promoting Inuit wellness across a continuum of mental wellness services.
- Create a network of Inuit helplines to be available in Inuktut across all regions, including e-technologies that may enhance the network of support.
- Foster communication and knowledge-sharing across Inuit regions to support training in best practices in suicide prevention, intervention and postvention.
- Strongly encourage and, when possible, coordinate, train-the-trainer courses for identified suicide intervention and mental health programs (such as Applied Suicide Intervention Skills Training and Mental Health First Aid), as well as facilitate the exchange of Inuit trainers between the four regions and for Inuit living in southern Canada to develop the strongest possible training teams.
- Ensure that all mental health, and health and social service workers have or receive training in skills to integrate families and communities in treatment and prevention plans, rather than treatment that engages only the individual.

Priority Area 5: Heal Unresolved Trauma and Grief

Traumatic loss in Inuit society stems from historical trauma that can be passed on across generations within some families, resulting in ongoing grief and suffering in the present. Traumatic losses from suicide and other tragic events further add to this hardship. There is limited research on interventions that can help heal this grief or interrupt the intergenerational impacts. There are also limited services that address the effects of loss, and the ongoing risk for suicide that can follow. Many families are struggling to overcome historical loss even as they experience new traumatic events and ongoing stress.

Culturally relevant services and approaches need to be developed to address unresolved trauma and grief, including the impacts of historical trauma stemming from colonization and rapid social change.

Through the NISPS, ITK will offer public education about the prevalence of trauma in our communities and its implications for the social and cultural development of our society. We will create resources that assist communities in their response to suicide, with the goal of decreasing risk for suicide resulting from exposure to suicide.

Objectives

5.1. Address the contemporary and ongoing impacts of historical and intergenerational trauma.
5.2. Develop Inuit-specific postvention approaches and resources.
5.3. Provide Inuit-specific interventions and resources to heal grief from loss, including from suicide.
5.4. Research interventions that reduce the incidence of suicide related to exposure to suicide and that help to establish best practices in immediate response to suicide within Inuit communities.
5.5. Provide services for first-responders within communities who may be impacted by exposure to the aftermath of suicide and suicide attempts.

ITK actions

- Educate about the prevalence of trauma in our communities and its implications for social cohesion, wellbeing, educational attainment, employment and suicide.
- Create resources to guide communities in responding to suicide, including the role of social media, with the goal of decreasing exposure effects.
- Create media guidelines for reporting about Inuit, specifically reporting related to suicide, and conduct outreach with media outlets to disseminate this information.

Priority Area 6: Mobilize Inuit Knowledge for Resilience and Suicide Prevention

Inuit knowledge is a source of strength that can foster resilience and contribute to suicide prevention. We know that efforts intended to help our communities often fail when they are not guided by local knowledge and expertise. Inuit regions, communities and local organizations must lead the development and implementation of specific suicide prevention initiatives in order to ensure that they are successful.

Through the NISPS, ITK will decrease stigma surrounding suicide in Inuit Nunangat using public outreach and education. In doing so we will partner with Inuit regions to evaluate promising suicide prevention programs, and facilitate Inuit-led research on suicide that adds to our understanding of suicide prevention. A fundamental Inuit-led research priority will be to disseminate accurate data to Inuit regions that reflects the most up-to-date statistics related to suicide and suicide attempts by Inuit.

ITK will take action to mobilize Inuit knowledge for resilience and suicide prevention by acting as a resource to support Inuit regions in creating regional suicide prevention strategies, assisting regions with evaluation, sharing best and promising practices across regions, and by fundraising to support regional and local suicide prevention resources and initiatives. ITK will also lead the creation of a research agenda that addresses our gaps in knowledge about suicide prevention.

Objectives

6.1. Put Inuit knowledge into action to foster resilience and prevent suicide.
6.2. Promote greater public awareness about suicide in the Inuit context and reduce stigma.
6.3. Evaluate promising programs to contribute to knowledge and best practices in suicide prevention.
6.4. Create an Inuit-led research agenda to add to knowledge in suicide prevention.
6.5. Acquire and disseminate accurate data that reflects the most up-to-date statistics related to suicide and suicide attempts by Inuit.

ITK actions

- Assist Inuit regions in creating regional suicide prevention strategies.
- Share best and promising practices across regions through an online knowledge-sharing resource.
- Gather and communicate Inuit-specific data related to suicide and suicide attempts.
- Advocate for sustainable funding for suicide prevention activities.
- Engage in fundraising to create a fund for suicide prevention projects, programs and initiatives.
- Create and/or culturally adapt needed resources to foster resilience and prevent suicide.
- Lead the creation of a research agenda that will address knowledge gaps in suicide prevention, and that will adhere to Inuit-specific ethics in research practices.
- Create an evaluation toolkit resource to incorporate evaluation into existing programs.

6. Evaluation

ITK will evaluate our progress in achieving the objectives we have identified in the NISPS in two-year increments. Evaluation will be critical in each priority area, both to assess advances towards addressing the priorities, and also to highlight gaps in our understanding and approaches. The NISPS envisions evaluation as a way of continuing to add to Inuit knowledge in suicide prevention, advancing promising practices, and enabling communities and regions to learn from each other. In evaluation, as in all other research activities related to Inuit wellbeing, efforts should be led by Inuit, and guided by Inuit knowledge and values.

Evaluation of the NISPS itself will be a key focus of its implementation. One of ITK's initial implementation tasks will be to finalize an evaluation framework for the NISPS, by identifying key indicators and outcomes for each action item, and processes for collecting necessary data in an ongoing way.

7. Conclusion

The elevated rates of suicide among Inuit demand that we respond with action. This public health crisis has continued for decades, despite being preventable. We have lost hundreds of people to suicide and each of these losses diminishes our society. In our young people, who we look to for the survival of our way of life, we have lost political leaders, hunters and educators; we have lost grandparents, mothers, fathers, and siblings, aunts and uncles; we have lost fierce advocates for our language and culture; doctors, nurses, lawyers, and all manner of potential role models for future generations of our people. Through the NISPS, we have the collective responsibility and opportunity to reduce this loss and transform our knowledge, experience and research on suicide into actions that transform this reality into one in which the rate of suicide among Inuit is equal to or below the rate for Canada as a whole.

Creating social equity is essential for improving the health and wellness of Inuit and is a critical aspect of achieving reconciliation in Canada. Too many families continue to face adversity that contributes to suicide risk, and has existed since Canada colonized Inuit Nunangat and families transitioned into settlements. The healing process from historical and intergenerational trauma has been difficult in a context where, too often, people are unable to meet their basic needs.

We have the responsibility and opportunity to break this cycle of adversity. The holistic approach to suicide prevention outlined in the NISPS addresses the underlying factors that create risk for suicide in our population.

The bright light of resilience that characterizes our people will burn through this difficult chapter in our long history. We have flourished in our Arctic environment for millennia through cooperation, adaptation, and ingenuity. Through the NISPS, we are harnessing these strengths by transforming our knowledge about why people die by suicide into Inuit-specific action. Implementing the NISPS demands that we acknowledge Canada's role in shaping the enduring challenges we face today, and partnering with all stakeholders to begin the important work of addressing those challenges. The sustainability of our Inuit culture, society, and way of life depends on it.

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