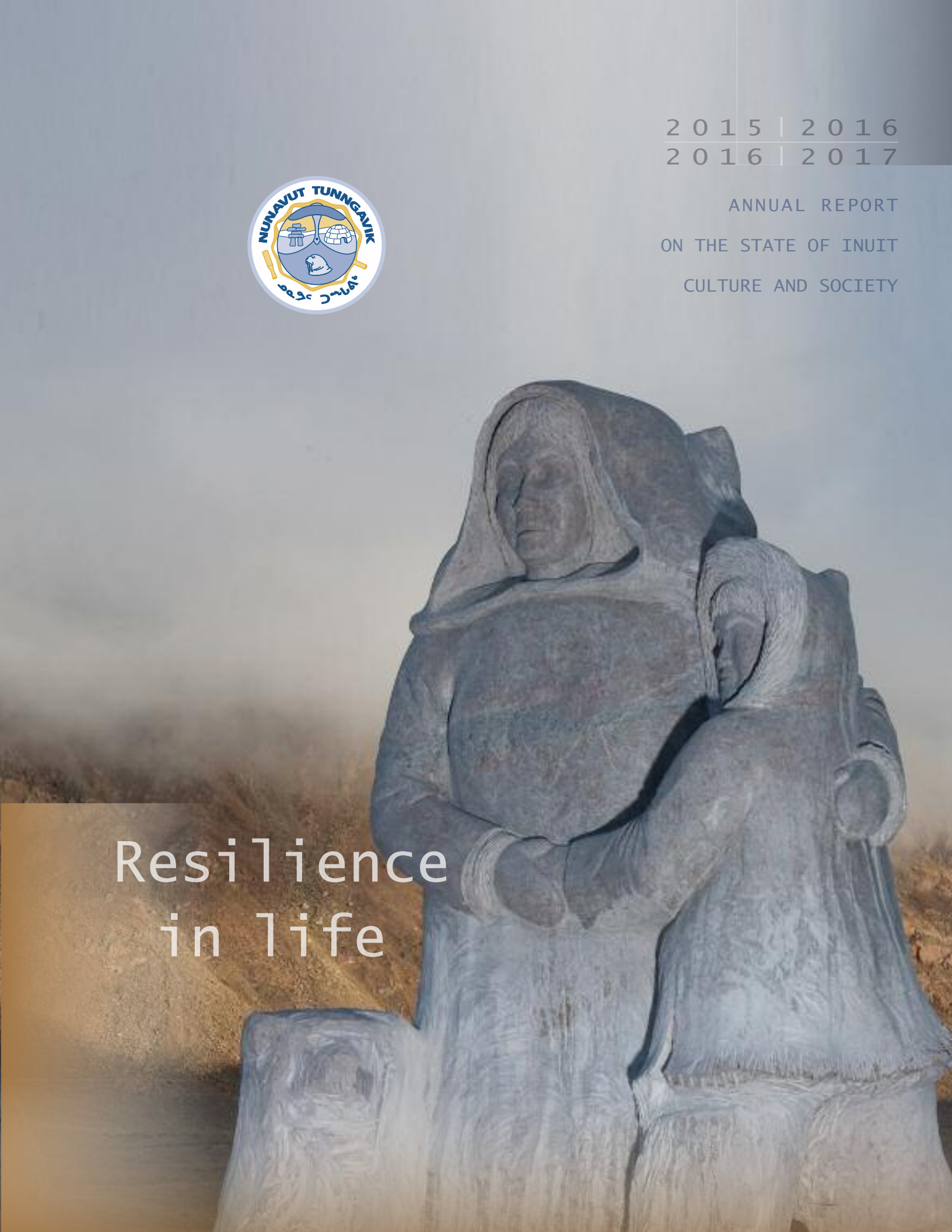
2015 | 2016
2016 | 2017

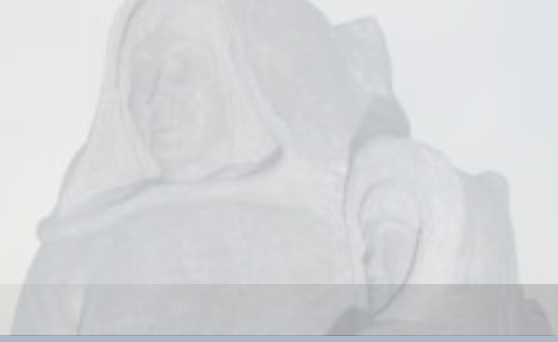
ANNUAL REPORT

ON THE STATE OF INUIT

CULTURE AND SOCIETY



Resilience in life



This report discusses sensitive topics that may be stressful to readers. Please consider the following options if you need support:

- Kamatsiaqtut Helpline is accessible 7:00 pm to midnight EST, seven days a week and is available in Inuktut and English **1-867-979-3333** or toll-free at **1-800-265-3333**.
- The First Nations and Inuit Hope for Wellness Help Line can be reached at **1-855-242-3310**, or the online chat at hopeforwellness.ca open 24 hours a day, 7 days a week.
- The Kids Help Phone is available 24 hours a day at **1-800-668-6868**.
- For more information for Nunavut specific resources and other information, please visit www.inuusiq.com.

Executive Summary

Nunavut Tunngavik Inc.'s (NTI) 2015–16/2016–17 *Annual Report on the State of Inuit Culture and Society* focuses on pathways to reducing suicide among Nunavut Inuit. Suicide is the second leading cause of death in the territory and remains the most urgent challenge facing Nunavummiut. It is a symptom of wider social and economic inequities that cause distress among too many Nunavut Inuit. This report provides clarity about the causes of suicide risk and explores solutions for reducing suicide through Inuit-specific, evidence-based policy approaches.

Colonialism and intergenerational trauma underpin the social and economic inequity affecting many Nunavut Inuit. Experiences, such as residential schooling, relocation, dog slaughter, and the loss of loved ones to epidemic diseases, have left deep imprints on our society. The rapid social and cultural transitions that coincided with these experiences gave rise to social challenges that we now understand as suicide risk factors, such as addictions, childhood adversity, and mental illness. These social challenges are compounded by inequities, such as lack of access to housing and health services, low educational attainment and employment, and food insecurity, that prevent many Inuit from reaching their highest levels of health and wellness.

The suicide rate among Inuit in the eastern Arctic first rose above the national rate for all Canadians in the early 1970s. This generation of Inuit was the first to grow up in settlements, where many people were exposed to a host of risk factors for suicide. Successive generations of Inuit have continued to experience social inequities and their associated challenges because governments have never provided reciprocal investments in social equity or adequate services and supports to meet the needs of Inuit in our own languages.

Children are paying the highest price for government inaction. More than half of Inuit women and nearly one-quarter of Inuit men experienced severe sexual abuse in childhood. Nearly one-third of Inuit adults say they experienced severe physical abuse as children.

Childhood adversity is the strongest predictor of future suicide attempt. The Government of Nunavut (GN) and the Government of Canada can take steps to reduce suicide by protecting children and youth.

Suicide prevention needs to be a priority of the federal government. Canada is one of the few developed countries that does not have a national suicide prevention strategy. Leading policymakers, including appropriate Government Minister(s), should be working closely with the *Nunavut Suicide Prevention Strategy* Partners to strengthen Canada's understanding of this complex challenge. The GN has twice declared suicide a crisis and has yet to fully implement the 2010–2014 *Nunavut Suicide Prevention Strategy Action Plan*, the development of which is the most significant suicide prevention action taken to date by the GN.

Promising initiatives and interventions do exist that point to solutions on the horizon. The opening of a child and youth advocacy office in 2015, as well as the GN's appointment of a senior bureaucrat within the Department of Health who is responsible for coordinating suicide prevention across departments is encouraging. With this appointment, we have embarked on a similar journey in our efforts to prevent suicide in the territory but with a more meaningful approach. Partners are working more closely together and have been making conscious efforts to achieve more substantive outreach. The release in July 2016 of the *National Inuit Suicide Prevention Strategy* by Inuit Tapiriit Kanatami (ITK) is helping to support suicide prevention initiatives in Nunavut. Finally, the success of the White Mountain Apache tribe in reducing suicide through a coordinated evidence-based approach is exciting, as are innovative public health interventions, such as the Nurse–Family Partnership, that seek to create social equity.

Recommendations

Government of Nunavut

- Implement Article 32 of the *Nunavut Agreement* to ensure that suicide prevention actions are developed in partnership with Nunavut Inuit and reflect our distinct language, culture, and society.

- Ensure that all suicide prevention programs, services, and supports are evidence based and target known risk factors for suicide.

- Develop a mandatory curriculum in partnership with NTI that educates all public servants about historical trauma, as well as suicide risk, and protective factors among Nunavut Inuit.

- Create social equity by addressing poverty, educational attainment, access to health care, housing, and food security.

- Gather data on an ongoing basis on suicide ideation (thoughts or plans to carry out self-harm), suicide attempt, and adverse childhood experiences.

- Establish an addictions treatment centre in Nunavut that is Inuit-specific, available in Inuktut, and planned in partnership with NTI.

- Work in partnership with NTI and the federal government to develop policy solutions for offsetting the potentially regressive impacts of carbon pricing on vulnerable Nunavut Inuit households consistent with the federal government's commitments to Indigenous peoples in the *Pan-Canadian Framework on Clean Growth and Climate Change*.

- Reinstate the Nunavut Child Health Surveillance Registry, incorporating as a core component the gathering of data on parent suicide ideation, suicide attempt, and adverse childhood experiences.

- Reduce family violence through a coordinated, evidence-based, cross-sector initiative, akin to the Embrace Life Council, that develops a meaningful strategy and action plan on ending family violence in Nunavut.

- Create a Department of Suicide Prevention responsible for coordinating an evidence-based, government-wide approach to suicide prevention.

- Work in partnership with NTI, as obligated in Article 32 of the *Nunavut Agreement*, to strengthen the *Mental Health Act* by including evidence-based, suicide prevention, intervention, and postvention components.

- Fund and implement the *Inuusivut Anninaqtuq 2017–2022 Nunavut Suicide Prevention Strategy Action Plan* and commit to scientifically evaluating its impacts on suicide ideation, suicide attempt, and suicide rate.

- Reduce suicide risk by adapting evidence-based "upstream" public health approaches to building resilience in families and children.

- Develop a suicide and self-injury surveillance system to provide targeted services and ongoing follow-up to individuals who are at risk for suicide.

- Coordinate seamless access to suicide prevention programs, supports, and services through a "no-wrong-door" policy that links individuals to help at multiple points of contact including schools, the justice system, and the healthcare systems.

- Ensure that all public servants are trained in suicide intervention and mental health programs (i.e., Applied Suicide Intervention Skills Training and Mental Health First Aid).

- Work with NTI, the Nunavut Law Society, Nunavut Association of Municipalities, and other stakeholders to explore cemetery plot planning and address burial costs to reduce stress on families.

Government of Canada

- Create social equity among Nunavut Inuit by implementing Article 32 of the *Nunavut Agreement* to address persistent gaps in areas such as housing, formal education, food security, and health care.

- Fund Inuktut programs and services on a par with per-person federal allocations for the promotion of French.

- Partner with NTI to provide guidance to the GN on aligning its formal education system with the *United Nations Declaration on the Rights of Indigenous Peoples*.

- Ensure that suicide prevention is a federal priority and allocate the appropriate funding and other resources to develop and implement a National Suicide Prevention Strategy that includes Inuit-specific interventions developed in partnership with Inuit.

- Develop a national suicide prevention strategy for Canada that includes Inuit Nunangat-specific interventions developed in partnership with Inuit.

- Streamline access to federal funding for Inuit-specific, community-based suicide prevention initiatives through the First Nations and Inuit Health Branch. This includes making these funding sources available to Regional Inuit Associations and non-profit community organizations leading suicide prevention efforts to reduce their administrative burden.

- Create safety for families through the 2019 budget by increasing federal housing contributions, as well as providing separate resources for building new family-violence shelters in Nunavut.

- Provide ongoing funding to Inuit Tapiriit Kanatami (ITK) to ensure implementation of the *National Inuit Suicide Prevention Strategy*.

- Implement the 94 *Calls to Action* of the Truth and Reconciliation Commission Canada, particularly Calls 19 and 21.

- Ensure that all Royal Canadian Mounted Police (RCMP) officers and federal public servants in Nunavut are trained in suicide intervention and mental health programs (i.e., Applied Suicide Intervention Skills Training and Mental Health First Aid).

Introduction

The elevated rate of suicide among Nunavut Inuit is a preventable public health crisis that is rooted in the severe social and economic inequities faced by too many Nunavummiut. These inequities prevent many Inuit from attaining their highest level of health and wellness against a backdrop of historical trauma and colonialism and disrupt our value system that thrived before Inuit were settled into communities. The challenges that create social and economic hardship for Nunavut Inuit have arguably grown worse, and many families continue to grapple with unresolved historical trauma, made worse by government inaction. The good news is that our understanding of the risk factors for suicide among Inuit has evolved significantly in the last decade, as has our understanding of the actions that can be taken to reduce risk factors for suicide.

The elevated rate of suicide among Inuit that we see today is a relatively recent challenge in the long time span of Inuit culture and society. Historically, Inuit did not suffer from disproportionately high rates of suicide nor did Inuit in the past experience the same prevalence of social and economic distress (with attendant risk factors for suicide) that many families experience today. We know that it is possible to reduce the rate of suicide among Inuit to a level equal to or below the rate for Canadians as a whole, starting with practical actions that support the most vulnerable people in our society.

This report is intended to provide clarity about this challenge at a time of continued misinformation about suicide at the highest levels of government. During an emergency parliamentary debate on suicide among Indigenous youth held in April 2016, Carolyn Bennett, at the time Minister of Indigenous and Northern Affairs and currently Minister of Crown-Indigenous Relations, used her comments to draw a link between strong cultural identity and resilience that she said would result in "good health, education, and positive economic outcomes."[1] Prime Minister Justin Trudeau echoed this sentiment in June 2016, suggesting that restoring Indigenous languages is key to preventing suicide among Indigenous youth.[2]

These and similar statements about suicide among Inuit and other Indigenous peoples promote an overly-simplistic, culture-as-solution approach to suicide prevention that usually results in inaction because culture-focused interventions cannot, by themselves, address the complex social and health disparities that we know create risk for suicide.

Through this report, Nunavut Tunngavik Inc. (NTI) seeks to provide a more comprehensive understanding of the causes of the elevated rates of suicide among Nunavut Inuit. It provides policy recommendations to the Government of Nunavut (GN) and the Government of Canada about actions that governments can take to reduce suicide. Recommendations are stated at the end of Part 1 and Part 2 of this report.

Resilience in life

This report provides an overview of promising approaches and initiatives within Nunavut, as well as at national and international levels. The evidence base for a more coordinated, Inuit-specific approach to suicide prevention is also outlined in this report.

Suicide has always been the most urgent challenge facing Nunavummiut. However, what has changed in recent years is the reduction of the stigma surrounding suicide that has led to recent commitments by the GN to take action. The suicide rate among Nunavut Inuit remained elevated at more than 10 times the rate for the general population of Canada throughout the duration of Nunavut's history. Suicide impacts all Inuit, and this constant exposure to suicide creates greater risk for suicide within our society.

The Inuit leaders who negotiated the *Nunavut Land Claims Agreement* (hereafter *Nunavut Agreement*) had high hopes for our territory, envisioning a jurisdiction that does not shelter us from our problems but allows us, in the words of Jose Kusugak, "to make our own decisions about how best to confront and take on those problems."[3] Article 32 of the *Nunavut Agreement* was negotiated to ensure that Inuit have a partnership role in making decisions about challenges, such as suicide by Inuit. It affirms our right to participate in the development of social and cultural policies, as well as in the design and delivery of social and cultural programs and services.[4] Inuit have consistently urged the GN and the Government of Canada to honour their Article 32 obligations in the interest of advancing the social and economic well-being of our people.[5] In order to reduce suicide among Nunavut Inuit it is critical that we use this policy mechanism as a platform for cooperation on this issue.

Part 1 of this report focuses on what we know about suicide. It describes the origins of the elevated rates of suicide among Inuit, as well as evidence for suicide risk factors. Part 2 describes suicide prevention initiatives in Nunavut, as well as programs and initiatives outside Nunavut that address suicide risk factors. It highlights opportunities for greater coordination within the GN and the Government of Canada to address suicide risk factors in our communities.

Part 1:
Why Nunavut Inuit suffer from elevated rates of suicide

Prevalence of suicide among Nunavut Inuit

Prevalence in this section means the proportion of our population that has died by suicide (the rate of suicide) in any given year, expressed as the number of deaths per 100,000. This standard unit of measurement allows us to compare the suicide rate among Nunavut Inuit with the suicide rate in other jurisdictions. Nunavut's Office of the Chief Coroner records data on deaths by suicide, broken down by community, sex, ethnicity, year, age, and means. However, the Chief Coroner carries out limited analysis of these data. Much of what we know about the characteristics of suicide prevalence among Inuit comes from analysis by third-party sources.

Nunavut has the highest rate of death by suicide among all the provinces and territories in Canada.[6] The suicide rate among Nunavut Inuit rose sharply in the mid-1970s and remains elevated (Figure 1). We know much more about the prevalence of completed suicides among Nunavut Inuit than about suicide attempts or suicide ideation (thoughts about attempting suicide). Between 1999, when Nunavut became a separate territory, and Nov. 1, 2016, 514 Nunavut Inuit died by suicide. The majority of these deaths were by young men: 63 per cent of the 514 who died were under the age of 25 and 80 per cent were male.[7] The most common means of suicide completion was hanging (73 per cent) followed by firearms (24 per cent).[8]

Nunavut's population is comparable to that of a small Canadian city, such as Penticton, British Columbia, magnifying the impacts on our close-knit communities of these many deaths by suicide over such a short time period.

Suicide rates can seem abstract compared with the raw number of deaths recorded in any given year. Figure 2 shows the number of deaths by suicide among Nunavut Inuit recorded each year since 1967. Data for the years 1967 to 1999 were obtained from the Government of the Northwest Territories.

FIGURE 1

Crude rate of death by suicide for Nunavut Inuit and Canadians as a whole, 1972–2015[9]

Note: Rates for Nunavut Inuit are five-year rolling averages

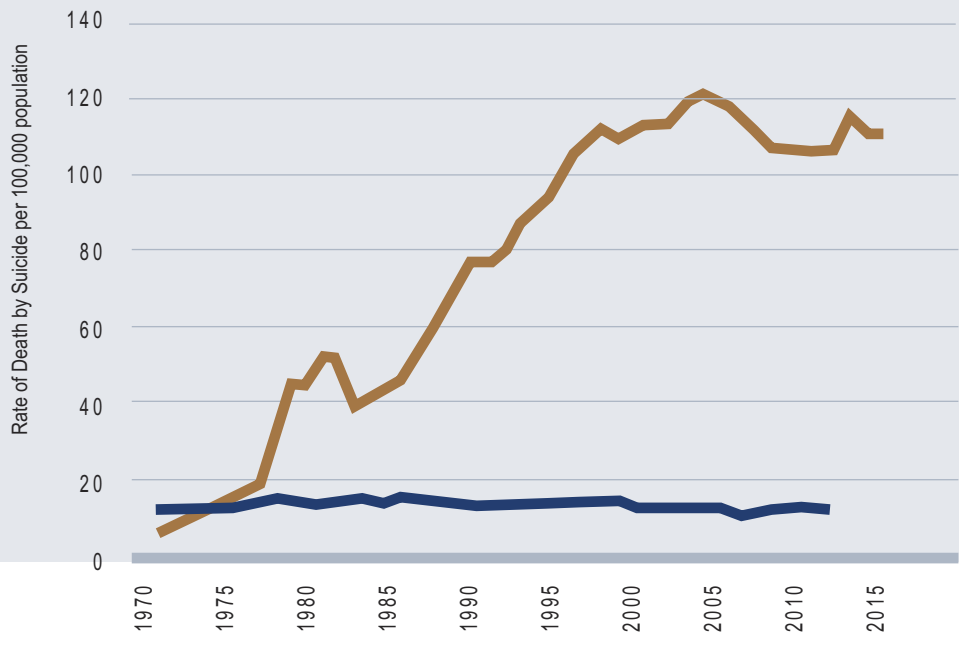


FIGURE 2

Number of deaths by suicide among Nunavut Inuit, 1967–2015[10]

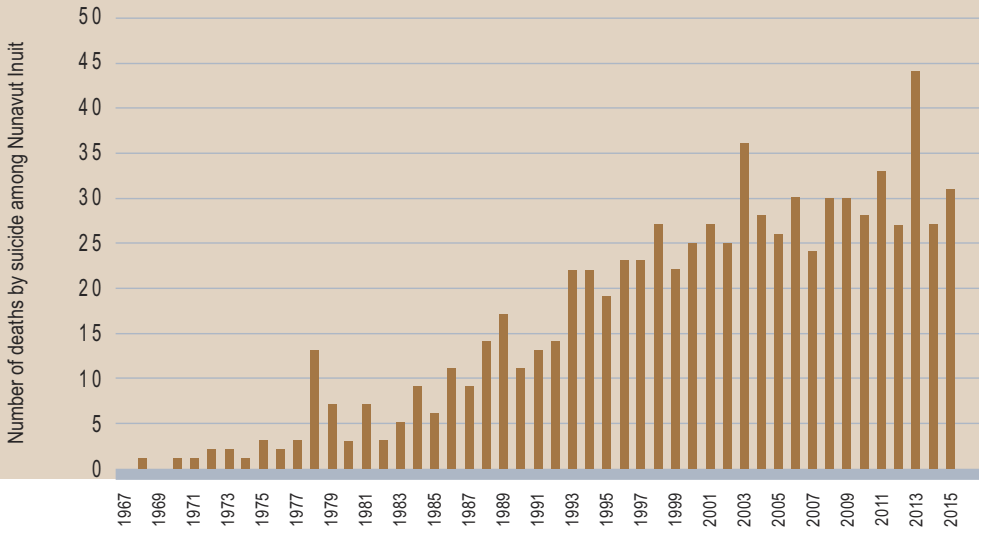
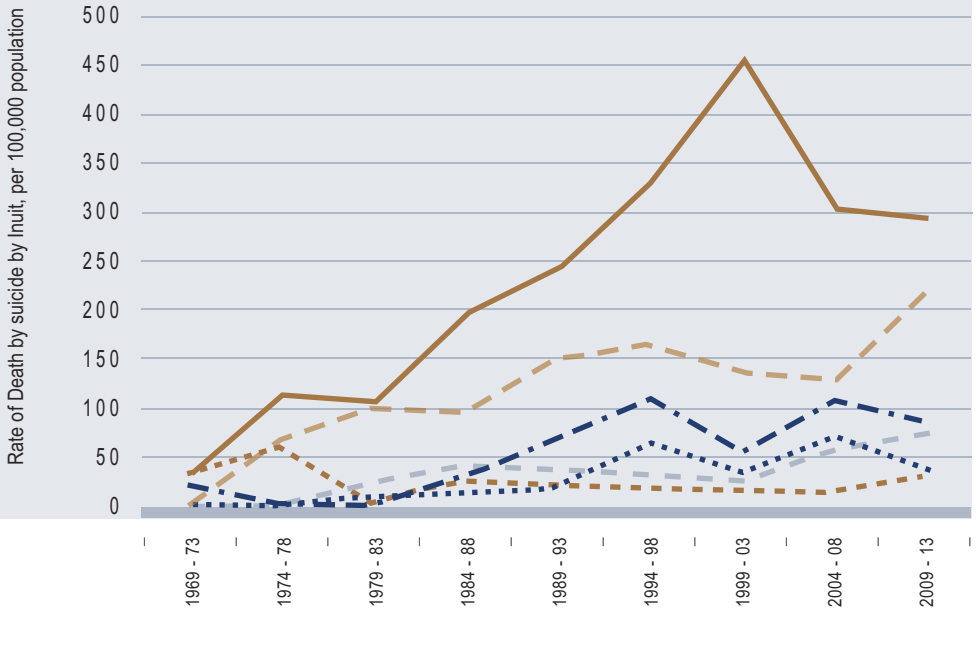


FIGURE 3

Nunavut Inuit suicide rates, 1969–2013, by age group[11]



Since the mid-1970s the overall trend in suicide rates has been increasing, particularly among young Inuit aged 15–24. Figure 3 shows how the suicide rates for this age group rose sharply between 1969 and 2013, peaking at more than 450 per 100,000 in the early 2000s.

It is significant that rates vary considerably among regions in Nunavut, with rates tending to be highest in the Qikiqtani region (Figure 4).

We also know that suicide impacts genders differently, with the suicide rate for Inuit men being much higher than for Inuit women (Figure 5).

FIGURE 4

Rate of death by suicide by Nunavut Inuit, by region, five-year rolling average[12]

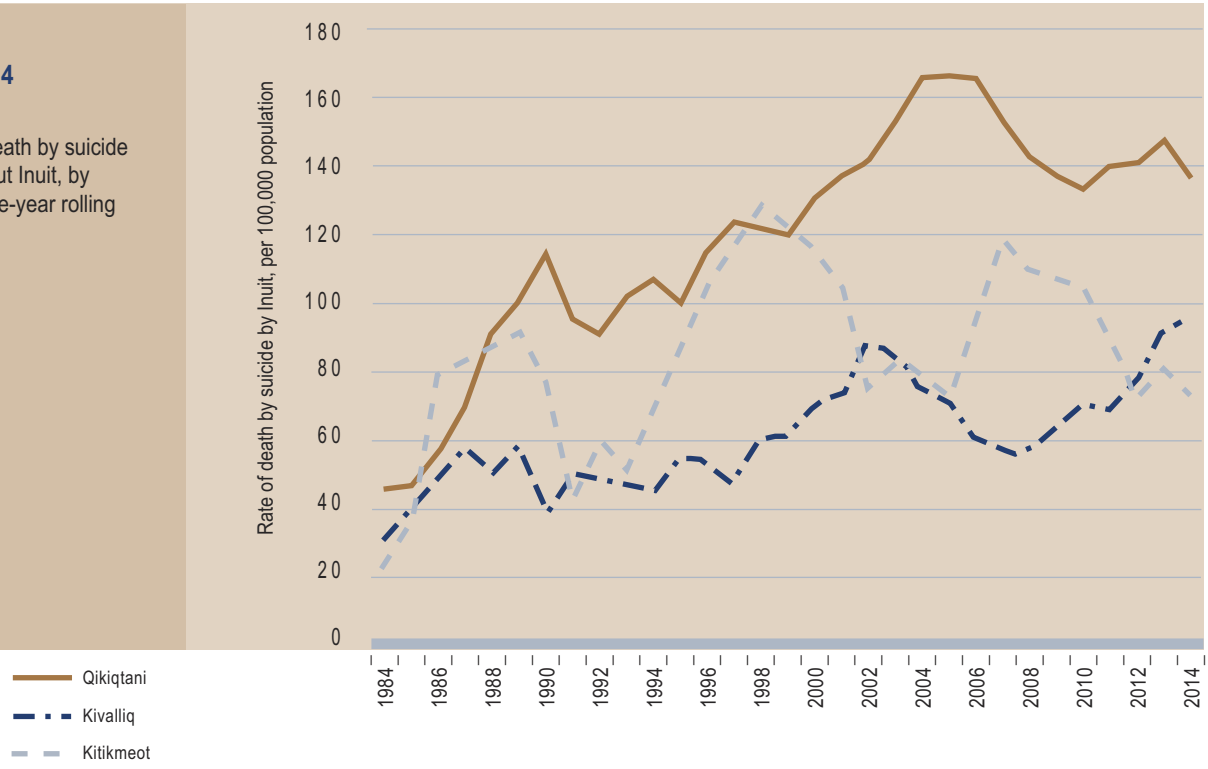
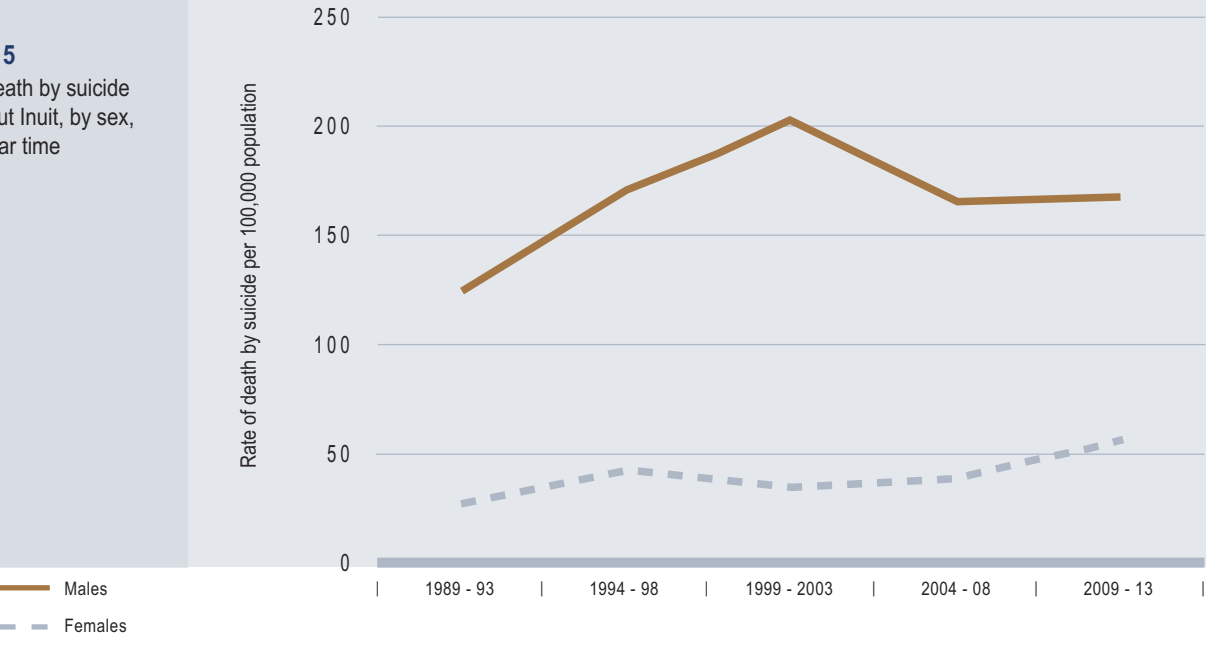


FIGURE 5

Rate of death by suicide by Nunavut Inuit, by sex, by five-year time periods[13]



Men tend to be at greater risk for suicide than women in the general Canadian population. However, in contrast to Inuit, suicide rates among Canadians as a whole tend to be highest for people in their late 40s.[14]

These data provide a helpful overview of the characteristics of completed suicides among Nunavut Inuit. However, we continue to lack a full understanding of the prevalence of suicidal behaviour in Nunavut. Previous suicide attempt(s) are the single biggest risk factor for suicide, yet the GN does not systematically gather these data as part of an ongoing surveillance or monitoring system to identify those at risk. This information could provide them with appropriate resources and supports.[15]

The *Inuit Health Survey* carried out between 2007 and 2008 among a representative sample of Nunavut Inuit found that 48 per cent of respondents had thought seriously about committing suicide in their lifetime, including 14 per cent in the last 12 months of the survey. For suicide attempts, 29 per cent of respondents reported having attempted suicide in their lifetime, including five per cent in the last 12 months of the survey.[16] This snapshot in time of the prevalence of suicide ideation and suicide attempt shows an extremely high frequency of suicidal thoughts and attempts among Nunavut Inuit.

Historical context for suicide among Nunavut Inuit

Prior to World War II, the majority of Inuit lived on the land in seasonal camps where families and community leaders were responsible for housing, feeding their families, and educating their children. People were largely responsible for their own health and wellness. Families decided when and where they wanted to move according to the seasons and the availability of fish and game. The Qikiqtani Truth Commission (QTC) reported that "The rich expression of ilagiit nunagivaktangat communicates the importance of kinship among people who share a community, and the permanent relationship they have with the land."[17] Social challenges, such as violence, hunger, and suicide, were not unknown but were rare and took place in a social and economic context that was equipped to deal with them. This was disrupted when Inuit moved, some by coercion and some by forcible relocation.

Inuit participated in a mixed economy, first through commercial whaling activities that peaked in the 1860s and 1870s and later through the fur trade that established footholds in some regions of the Inuit homeland in the early 1900s. By the 1930s some Inuit were dependent on staple foods, such as salt, flour, tea, and sugar, to supplement the country foods people relied on. They were also dependent on goods, such as ammunition, rifles, tea kettles, and oil-burning lamps. After the collapse of fur prices, the Government of Canada initiated relief programs throughout the 1930s and 1940s to assist struggling families.[18]

The impacts of colonialism on Inuit culture and society became more pronounced after World War II.

The 46 Distant Early Warning (DEW) Line radar stations that were built by the United States and Canada in what is now Nunavut, created centres where Inuit sought employment and medical services, and traded goods, thereby accelerating the establishment of permanent communities in some regions.

The DEW Line stations brought Inuit into contact with Americans who were critical of what they perceived as Canada's neglectful approach to Inuit affairs. Canada had advocated for the maintenance of a traditional way of life for Inuit throughout the 1930s and during World War II. Some disapproving observers saw government inaction as being neglectful of Inuit education, health care, employment, and the need for a long-term policy for Inuit affairs.[19]

By the mid-1950s, Inuit were receiving family allowances in the form of credit on account or payment in goods rather than by cheque. The federal

government had taken control of formal education from Anglican and Catholic missionary organizations, which were the first institutions to provide schooling to Inuit. It was during this period that families began to be actively coerced or, in some cases, relocated to sedentary communities, sometimes in response to crises such as starvation. The details and rationale for such relocations depended on the whims of southern planners and the biases of fieldworkers.[20]

In 1957, for example, the Ennadai Lake Inuit west of Hudson Bay were relocated by plane to Henik Lake by Department of Indian Affairs and Northern Development officials in partnership with the Hudson's Bay Company and the Royal Canadian Mounted Police (RCMP). Game was supposedly more plentiful in this location, and it was considered easier for government fieldworkers to supervise relocated Inuit from nearby Padlei. The Ennadai Inuit were directed to transition from a caribou-based diet to a fish-based diet. During the winter of 1957 to 1958, some Inuit died of starvation at Henik Lake, and a murder took place. The remaining Ennadai Inuit were then relocated to Eskimo Point (now Arviat), where Walter Rudnicki, Chief of Arctic Division of the Department of Indian Affairs and Northern Development, described the relocated Ennadai Inuit families in Arviat as being dispirited and no longer having any aim in life. [21]

In 1958, the Ennadai Lake Inuit were relocated once again, this time to Whale Cove on the Hudson Bay coast, along with other inland Inuit from Garry Lake, where 17 people had died of starvation between February and March of that year. Inuit from Baker Lake and Arviat were also relocated to Whale Cove, a settlement that was created by the federal government for the express purpose of settling relocated Inuit, many of whom were from inland and had never seen sea mammals before.

In the most extreme examples, Inuit were treated as human flagpoles and forcibly relocated to further Canada's sovereignty claims to the Arctic, as was the experience of the High Arctic Exiles. These Inuit families were relocated in 1953 from Inukjuak (Nunavik) and Pond Inlet to Grise Fiord and Resolute in the previously uninhabited High Arctic.

Many families who moved into sedentary communities began to experience a breakdown of the social cohesion that was characteristic of life on the land. In the words of Annie Shappa of Arctic Bay:

> …when we were in the outpost camp, we had this tradition: we ate together, lived together in one place. The family system that was harmonious was lost when we moved to the community.[22]

The transitions families were making into settlements coincided with the introduction of federal residential and day schools that sought to culturally assimilate children. The first government-regulated school specifically for Inuit opened in 1951 in Chesterfield Inlet, drawing Inuit children from as far away as Igloolik and Pond Inlet.

Peter Irniq describes how an Oblate priest arrived at his family's outpost camp outside Naujaat in 1958 when he was 11 and how he was then flown to the Sir Joseph Bernier Federal Day School in Chesterfield Inlet. The physical structures, food, and many of the academic concepts were foreign to students who were brought there. Students had no contact with their families for nine months of the

year; some were physically and psychologically abused by the Catholic nuns for speaking Inuktut (includes all Inuit languages). Some children were sexually abused. The experience created divisions within families and between generations. In the words of Irniq, "My parents no longer knew anything about me after I had been to a residential school."[23]

Inuit children were being sent to residential schools as recently as the late 1960s, some so young that they were still bottle feeding, as was the case for Marius Tungilik from Naujaat. They were deprived of the opportunity to be immersed in their own rich culture while being pressured to abandon it. In the words of Tungilik, who attended Chesterfield Inlet's Sir Joseph Bernier Federal Day School between 1963 and 1969:

> We were told that we were Eskimos. We did not amount to anything. The only way we could succeed was to learn the English way of life. So, in that sense it was psychologically degrading as well. We were made to hate our own people, basically, our own kind. We looked down on them because they did not know how to count in English, speak English or read or any of those things that we were now able to do. That's sick.[24]

In 1955, less than 15 per cent of school-aged Inuit in Canada were enrolled in some form of federal schooling; by June 1964 that number had increased to 75 per cent of Inuit aged 6 to 15.[25]

Most Inuit who transitioned into settlements in the 1950s faced a host of challenges in addition to the stress schools placed on Inuit culture and society. One such challenge was the availability and quality of housing. Many Inuit families were promised free housing or at least very low rent in exchange for moving into settlements, yet an insufficient number were built, and these were often of poor quality.[26]

In Arviat in 1962, for example, 82 families were crowded into 64 wooden and snow houses, contributing to the spread of diseases, such as tuberculosis. A tuberculosis outbreak affected 55 per cent of these households in 1962 and early 1963.[27] The situation was similar at Clyde River where in 1965, 238 Inuit were crowded into 18 one-room houses.[28]

Tuberculosis had a devastating effect on families during this time, with nearly 50 per cent of Inuit spending time in sanatoria in southern Canada by the early 1960s.[29] Inuit in sanatoria faced language

barriers, isolation, and loneliness; families that were separated sometimes never learned where their loved ones who had died had been laid to rest.[30]

In settlements, Inuit who had previously been self-reliant felt the Crown's influence in every aspect of their lives. In the 1950s, the Canadian Wildlife Service began imposing strict limits on harvesting by Inuit. Inuit who ignored hunting regulations faced fines and possible incarceration. Hundreds of sled dogs were also killed by the RCMP and other authorities during this time because they were considered a danger in settlements or because of fears that they could spread disease.[31]

Sled dogs were a status symbol for Inuit, symbolizing hunter success and self-reliance. Families whose sled dogs were killed were cut off from the land and their way of life, and many Inuit believe that sled dogs were killed in order to immobilize families and expedite assimilation. Many families were devastated by the loss of their dogs, which created added pressures for people already struggling with social, cultural, and economic upheaval.

The stress and loss families faced during the 1950s and 1960s occurred over a short period of time in an environment in which the elders and community leaders who traditionally provided guidance in times of hardship were enduring the same challenges. In settlements, people who were struggling lacked access to psychological and emotional supports; families had to find their own ways of coping with the loss of loved ones to disease, as well as with pressures to assimilate. Substance abuse, family violence, and other suicide risk factors became more prevalent under these conditions, which happened against a backdrop of social inequity. Martha Idlout of Resolute Bay describes these struggles as follows:

> Everyone was hurting inside, not living as they should. People growing up with a lot of pain. I don't want my grandchildren to grow up with that kind of pain and end up like us. We know that we took all the substances, alcohol and drugs…There was a bar here too, and the military as well. The whole time they would get drunk and us children would have to find a place to stay…When men got drunk…we would hide under houses…Back then, the whole town would be drunk for a whole week or three days.[32]

The traumas, stress, and coping behaviours associated with these challenges have accumulated in the lives of many Nunavut families. These pressures are compounded by persisting inequities, such as crowded housing, limited access to Inuit-specific social services, and low educational attainment.

The increase in the prevalence of suicide risk factors within our society coincides with the elevation of suicide rates among Inuit in the 1970s; these were the first generation of Nunavut Inuit to grow up in settlements. These suicide risk factors persist today.

Suicide risk and protective factors

Suicide risk factors are the experiences, events, or conditions that research has linked to suicidal behaviour within a population (see Figure 6). People who have either died by suicide or people who have attempted or contemplated attempting suicide are more likely to have been exposed to historical or

FIGURE 6

Suicide risk and protective factors for Inuit in Canada[33]

intergenerational trauma; poverty and systemic inequity; and experiences of physical or sexual abuse. However, there is no recipe for suicide, and people who have been exposed to one or more risk factors are not destined to die by suicide. Similarly, protective factors, such as having a supportive family and community, as well as a strong language and culture, do not completely shield individuals from suicide risk.

Figure 7 shows how suicide risk factors can multiply through continued exposure to certain types of adversity throughout a lifetime, accumulating in a person's life beginning in the womb. Suicide is itself a risk factor for suicide that creates a base level of suicide risk in our communities.[34]

Protecting children and youth from serious adversity is the most impactful step our society can

FIGURE 7

Suicide risk and protective factors for Inuit in Canada[35]

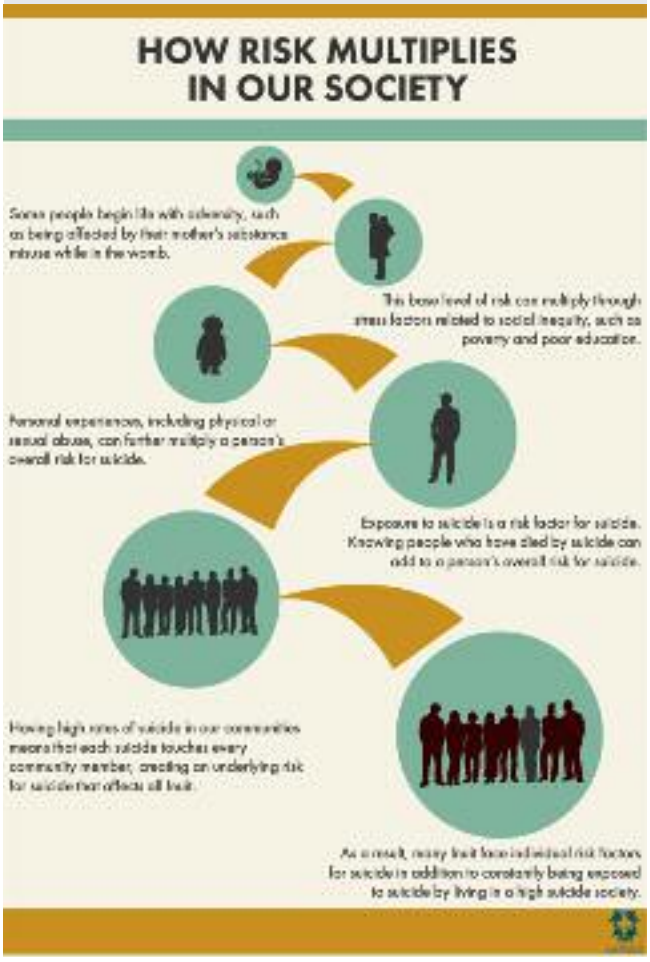
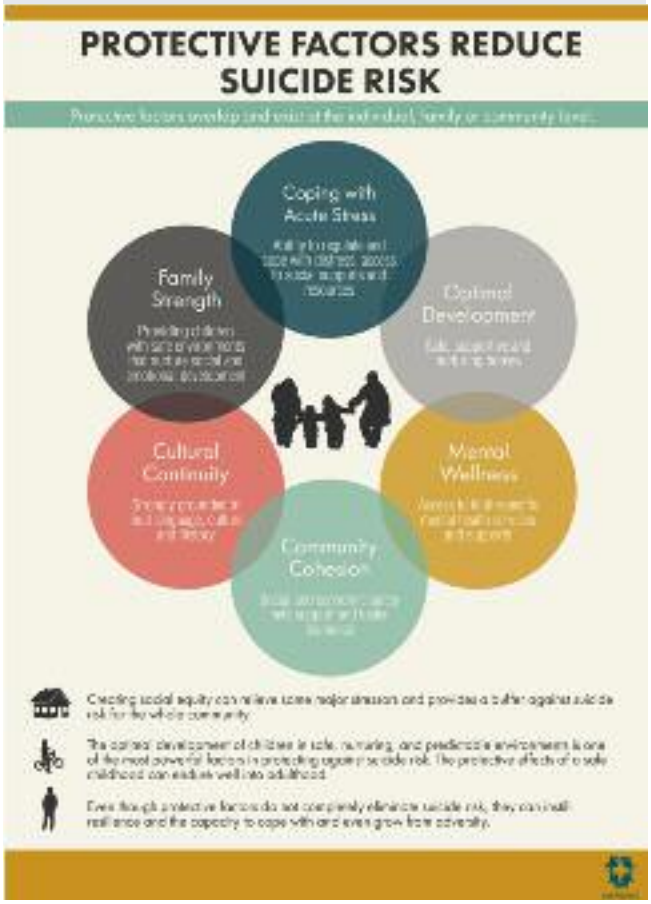


FIGURE 8

Suicide risk and protective factors for Inuit in Canada[36]



take to reduce suicide. In contrast to risk factors, protective factors provide a buffer against suicide risk although they do not completely eliminate it. Protective factors can instill resilience and the capacity to cope with and even grow from adversity through 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). Protective factors (see Figure 8) can support positive outcomes for people who experience stressful events and challenges in their lives through strong relationships and support, positive coping strategies, intact self-esteem and self-worth, and intelligence and academic achievement.

Impacts of language and culture on suicide risk are unclear

Inuit have advocated for the protection, promotion, and revitalization of Inuktut throughout the territory's history, and we maintain that Inuit language and cultural continuity (i.e., having a resilient language and culture) are foundational to Inuit wellness.[37] The majority of Nunavut Inuit speak Inuktut as a first language and enhancing Inuktut language of instruction in schools is critical for improving educational attainment and employment.[38] Cultural continuity contributes to the well-being of any society. Each Inuk who has participated in the revitalization or promotion of our language and culture knows that doing so is empowering. Cultural continuity can contribute positively to self-esteem and identity in ways that may, for some individuals under certain circumstances, be a protective factor against suicide.

However, the potential role of cultural continuity as an independent protective factor against suicide among Inuit is not fully understood. High rates of suicide persist among Inuit even in jurisdictions, such as Greenland, where Inuit language fluency is universal and the language is promoted at every sector of society.[39] The greatest reductions in suicide by men in Greenland have occurred in Nuuk, the most populous community where cultural activities, such as hunting and fishing are limited.[40] Nunavik Inuit also suffer from elevated rates of suicide despite living in a relatively "traditional" society in which the

Inuit language is spoken by most children and youth. At the opposite end of the spectrum, suicide rates among Inuit in Canada are lowest in the Inuvialuit Settlement Region where the regional dialect is considered moribund, meaning that the majority of speakers are elders.[41]

The impacts of language and culture on suicide risk within Inuit Nunangat (includes all Inuit regions in Canada) and the wider Inuit world (i.e., North Alaska and Greenland) requires more research. However, what we know to be true about Inuit as a whole from Alaska to Greenland is that too many children and youth face serious adversity within environments of inequity, coupled with limited services that evidence links to increased risk for suicide.

For example, one in three girls in Greenland and about one in 10 boys under the age of 15 has experienced unwanted sexual contact.[42] Among the Alaska Native population as a whole (inclusive of Alaskan Inuit), one in two women and over one in four men has experienced physical or sexual violence in their lifetimes.[43] The prevalence of people experiencing physical and sexual violence is similar in Nunavik.[44]

These circumpolar patterns in the type and prevalence of adversity faced by many Inuit children and youth are playing out in social and political environments in which resources and supports for trauma and violence prevention are limited compared with more populous regions of the United States, Canada, and Denmark. The evidence suggests that suicide risk is linked to environmental factors that disproportionately impact young people and that these risk factors are compounded by persistent inequities in health and social services that prevent too many families and young people from achieving their highest levels of health and wellness.

Social equity and suicide risk

Creating social equity means that everyone in society has the opportunity to attain their highest level of health and wellness. Too many Nunavut Inuit today face significant social and economic barriers to health and wellness that in some cases place them at greater risk for suicide. Suicide is the most tragic symptom of the social inequity that exists in our society because of the vulnerabilities this inequity creates for our population.

Conditions of social inequity are defined as the unfair and avoidable differences in health status seen within and between populations.[45] Taking action to create social equity means addressing the root causes of the social and health disparities that we experience today, many of which are risk factors for suicide, such as violence, lack of access to health care, and poverty.

Taking action also means ensuring that Nunavut Inuit are not inadvertently burdened by policies that put additional economic strain on households. For example, the carbon tax policy included in the federal government's *Pan-Canadian Framework on Clean Growth and Climate Change* may lead to an increase in the cost of living for Nunavummiut.[46]

The stark differences in the social and health status of Nunavut Inuit compared with Canadians as a whole is well documented. Inuit have faced social inequity since we transitioned off the land into settlements where families lacked access to housing, health services, and culturally appropriate schooling. The impacts of residential schooling, fatal diseases, and poverty added another layer of stress on top of these challenges that have made it difficult for families to attain their highest level of health and wellness, contributing to suicide risk in our population.

Inequity can be seen in areas such as the following:

- *Food security:* 70 per cent of Inuit households in Nunavut do not have enough food to eat compared with 8 per cent of all households in Canada.[47]

- *Housing:* Approximately 35 per cent[48] of dwellings in Nunavut were classified as crowded based on the lack of sufficient bedrooms compared with 4 per cent[49] of Canada's non-Indigenous population.

- *Access to health care:* There are 30 physicians per 100,000 population in Nunavut compared with 119 in Urban Health Authorities.[50]

- *Life expectancy:* Average life expectancy in Nunavut is just 71.8 years, 10 years less than the average life expectancy for Canadians as a whole.[51]

- *Educational attainment:* Nunavut's high school graduation rate* between 1999 and 2015 was never higher than 37 per cent.[52]

- *Employment:* the employment rate for Nunavut Inuit aged 15 and over is 50 per cent compared with 86 per cent for non-Inuit in Nunavut.[53]

- *Earnings:* the median total income for Nunavut Inuit aged 15 and over in 2010 was $17,369 compared with $85,406 for non-Inuit in Nunavut.[54]

These and other indicators of social inequity contribute to Nunavut ranking forty-sixth as a jurisdiction compared with other nation states using the Human Development Index, with Nunavummiut facing a quality of life similar to that found in Latvia or Croatia.[55] In contrast to Nunavut's low ranking, Canada ranks 9th among 188 nation states.

The Human Development Index is a tool used to measure the well-being of nations based on life expectancy, education, and income per capita indicators. The life expectancy for Nunavut Inuit, an indicator of overall health, is lower than in war-torn Iraq.

Creating social equity is necessary to reduce suicide risk in our population and get us on a path to a low suicide reality, with the rate of suicide among Inuit being equal to or below the rate for Canada as a whole. This means ensuring that children have the healthiest start in life and grow up in safe and supportive environments, providing impoverished and struggling parents with ongoing support, and investing in people who are striving to cope with hardship but who lack the resources needed to achieve their highest level of health and wellness.

Intergenerational trauma and suicide risk

The increase in suicidal behaviour in Nunavut in recent decades is tied to changes in the prevalence of suicide risk factors—among them the intergenerational transmission of historical trauma in all of its forms (emotional, physical and sexual abuse, violence, substance abuse, etc.).

* Gross graduation rate is calculated by dividing the number of graduates by the average of estimated 17- and 18-year-old populations (as the typical age of graduation).

Resilience in life

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

In addition to affecting individuals and families, trauma can also affect groups of people. The term historical trauma is used to describe the traumatic stress experienced by an entire group resulting from a cumulative and psychological wounding over a lifespan and across generations.[56]

Unresolved traumatic experiences can create lasting distress and contribute to cumulative risk for suicide, especially when traumatic experiences lead to depression and substance abuse. Nunavut Inuit are more likely than the average Canadian to be exposed to suicide risk factors, including risk factors linked to traumatic experiences because Inuit families and communities have experienced disproportionate trauma yet continue to lack access to the resources and supports needed to heal from that trauma.

There is no in-patient substance abuse treatment centre in Nunavut, for example, despite the fact that substance abuse is a common way for people to cope with traumatic stress. The GN relies on mental health services outside the territory to provide psychiatric care to Nunavummiut, meaning there is nobody in Nunavut who can diagnose serious mental illness or prescribe medication and ongoing treatment. There are also too few family-violence shelters in the territory to assist people experiencing violence, and available housing is insufficient for the population.

Child adversity and suicide risk

There are strong links between experiencing child adversity and risk for suicide later in life. The trauma symptoms that commonly result from experiencing or witnessing violence in the home, sexual abuse, and other forms of child adversity can place individuals at greater risk for suicidal behaviour later in life. Research on the links between child adversity and negative health outcomes and behaviours must drive investments in services and supports for Inuit children and families.

The Adverse Childhood Experiences (ACE) Study is the most robust analysis of childhood abuse and neglect and later-life health and well-being. The study looked for connections between the health status of 17,000 American adults and the number and type of self-reported, adverse childhood experiences they had. Ten adverse childhood experiences were studied, including child abuse (emotional, physical, and sexual), neglect (emotional and physical), and growing up in a seriously dysfunctional household (witnessing domestic violence, alcohol, or other substance abuse in the home, living with mentally ill or suicidal household members, experiencing parental marital discord or crime in the home).[57]

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 adverse experiences increased. In other words, the greater the number of adverse childhood experiences a child is exposed to the more likely they were as adults to be smokers, to be obese and physically inactive, to suffer depression, and to attempt suicide.

The likelihood of attempting suicide was found to be more than 12 times greater for those who had four ACEs than for those with zero such experiences. The prevalence and risk of alcoholism, drug use, sexual promiscuity, and sexually transmitted diseases followed a similar pattern.[58]

People who experience ACEs often end up trying to raise their own children in households where ACEs are more common, contributing to cycles of childhood adversity that can lock successive generations of families into poor health and risky behaviour for generations.[59] This is why some governments are carrying out ACE studies of their own in order to target communities most affected by ACEs and to more effectively direct existing support services to those communities.

New Zealand's Christchurch Health and Development Study also found that childhood adversity, such as extreme poverty, abuse, or neglect, place people at greater risk for negative outcomes linked to suicidal behaviour, such as poor mental health, substance abuse, and poverty.[60] The study followed the health, education, and life progress of a group of 1,265 children born in Christchurch (New Zealand) beginning in 1977.

This research supports what has been long observed in our communities: people who die by suicide have often endured adverse experiences as children. The *Inuit Health Survey* carried out between 2007 and 2008 asked a representative sample of Inuit adults about their experiences of assault, sexual abuse during childhood, sexual abuse during adulthood, depression, and suicide. The following participant responses paint a grim picture of adversity among Nunavut Inuit:

Assault

- 31 per cent of participants reported experiencing severe physical abuse as children (31 per cent of women and 31 per cent of men).[61]
- 50 per cent of participants reported experiencing at least one form of physical violence as an adult (52 per cent of women and 46 per cent of men).[62]

Sexual abuse during childhood

(any form of unwanted sexual touching, sexual coercion, or forced sexual intercourse)

- 41 per cent of respondents reported experiencing severe sexual abuse during childhood (52 per cent of women and 22 per cent of men).[63]

Sexual abuse during adulthood

- 18 per cent of respondents reported experiencing forced or attempted forced sexual activity (27 per cent of women and 5 per cent of men).[64]

Depression

- 43 per cent of respondents reported feeling so depressed that nothing could cheer them up some of the time in the last 30 days.[65]
- 9 per cent of respondents reported feeling so depressed that nothing could cheer them up all or most of the time in the last 30 days.[66]

Suicide

- 48 per cent of respondents reported having had suicidal thoughts at some point in their lives; 14 per cent had had them in the past 12 months.[67]
- 29 per cent of respondents reported having attempted suicide at some point in their lives (31 per cent of women and 25 per cent of men).[68]
- 5 per cent of respondents had attempted suicide in the 12 months prior to the survey.[69]

These suicide risk factors can be seen reflected in the lives of Inuit who have died by suicide. The *Learning from Lives that Have Been Lived: Nunavut Suicide Follow-Back Study* analyzed the lives of the 120 Inuit who died by suicide between 2003 and 2006.[70] Researchers used interviews with friends and family members of the deceased to identify commonalities in the life experiences of people who died by suicide and compared them with those of their living peers of the same age, gender, and community of origin.

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

The evidence linking childhood adversity and suicidal behaviour must drive investments in services supporting vulnerable families, children, and youth. The policy implication for suicide prevention in Nunavut is that a more coordinated approach to

suicide prevention is required that considers both the entire lifespan of individuals and the environments in which they grow up.

The *Nunavut Suicide Follow-Back Study* also highlights social and economic characteristics of the individuals who died by suicide between 2003 and 2006; people in the suicide group tended to be unmarried, had higher levels of unemployment, and had lower educational attainment, indicating that suicide involves many other developmental and social risk factors.

Mental Distress and Suicide Risk

There are strong links between mental health disorders and suicide. Mental health disorders are generally characterized by dysregulation of mood, thought, and/or behaviour.[71] Some studies demonstrate that the majority of people who die by suicide suffer from a mental health disorder.[72] Mood disorders, substance abuse disorders, schizophrenia, and personality disorders are the most common diagnoses among those who have died by suicide. Mood disorders are among the most pervasive of all mental health disorders and include major depressive disorders.

The interaction between mental health disorders and suicidal behaviour is complex, with each disorder interacting with a range of factors that can increase suicide risk. For example, previous depressive disorders, suicide attempts, drug abuse, agitation or motor restlessness (inability to sit still), fear of mental disintegration, poor adherence to treatment, and recent loss are linked to a higher risk of suicide among people with schizophrenia.[73]

The *Nunavut Suicide Follow-Back Study* found greater rates of depression, personality disorder, substance abuse, and also characteristics of impulsivity and aggression (which may be underlying aspects of a mental health disorder) among Inuit who died by suicide compared with their living peers.[74] This study reflects global findings about the links between mental health disorders and suicide, demonstrating that we must diagnose and treat mental health disorders as an integral component of suicide prevention in Nunavut.

The links between mental health disorders and suicidal behaviour prompt most suicide prevention efforts to focus on preventing and treating mental health disorders. A high proportion of people who die by suicide have a mental health disorder, but the majority of people who suffer from mental health disorders do not attempt suicide. However, the specific ways in which mental health disorders influence suicidal behaviour are not fully understood.

Recommendations

Government of Nunavut

- Implement Article 32 of the *Nunavut Agreement* to ensure that suicide prevention actions are developed in partnership with Nunavut Inuit and reflect our distinct language, culture, and society.

- Ensure that all suicide prevention programs, services, and supports are evidence based and target known risk factors for suicide.

- Develop a mandatory curriculum in partnership with NTI that educates all public servants about historical trauma, as well as suicide risk and protective factors among Nunavut Inuit.

- Create social equity by addressing poverty, educational attainment, access to health care, housing, and food security.

- Gather data on an ongoing basis on suicide ideation (thoughts or plans to carry out self-harm), suicide attempt, and adverse childhood experiences.

- Establish an addictions treatment centre in Nunavut that is Inuit-specific, available in Inuktut, and planned in partnership with NTI.

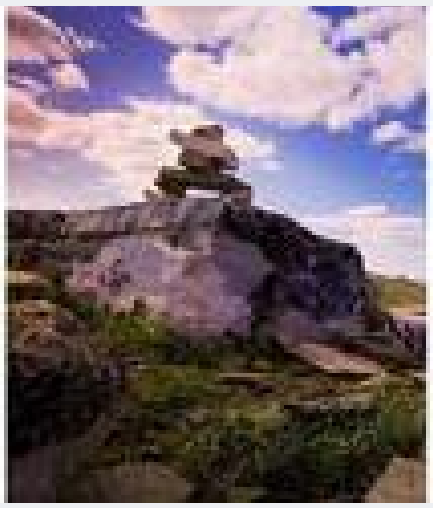
- Work in partnership with NTI and the federal government to develop policy solutions for offsetting the potentially regressive impacts of carbon pricing on vulnerable Nunavut Inuit households consistent with the federal government's commitments to Indigenous peoples in the *Pan-Canadian Framework on Clean Growth and Climate Change*.

Government of Canada

- Create social equity among Nunavut Inuit by implementing Article 32 of the *Nunavut Agreement* to address persistent gaps in areas such as housing, formal education, food security, and health care.

- Fund Inuktut programs and services on a par with per-person federal allocations for the promotion of French.

- Partner with NTI to provide guidance to the GN on aligning its formal education system with the *United Nations Declaration on the Rights of Indigenous Peoples*.



Part 2: Promising policies, programs, and practices

Part 2 of this report describes the status of suicide prevention in Nunavut. It provides an overview of promising suicide prevention initiatives and explores possibilities for coordinating similar actions in the territory. This section builds on the evidence for suicide prevention presented in Part 1 and identifies domestic policy developments that create leverage for further suicide prevention advocacy and action. Nunavummiut have come a long way in our understanding of why so many Nunavut Inuit die by suicide, attempt suicide, or contemplate suicide. Recent suicide prevention planning in the territory shows how an approach based on coordinated upstream action and evidence are slowly replacing long-held assumptions about why people die by suicide. However, our task is to translate this understanding into policies and actions that support the most vulnerable in our society.

What is suicide prevention?

The term suicide prevention describes all measures that we know can reduce suicide risk in populations throughout the lifespan. Suicide prevention differs from suicide intervention, which involves recognizing the warning signs of suicidal behaviour and intervening in the moment to de-escalate suicide risk. Suicide postvention involves a series of planned interventions with those affected by suicide, such as family and friends of the deceased.

Suicide among Inuit is not an isolated challenge within our society but one that is tied to 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, cultural policies, and political systems) shaping the conditions of daily life.[75] Successfully preventing suicide requires societies to address these complex relationships.

We know, for instance, that people who grow up in safe and stable households have a reduced risk for suicide compared with those who frequently face violence and stress. Upstream approaches to suicide prevention may include providing ongoing support, resources, and education to expectant and new parents who are economically vulnerable, linking families to early childhood education, and ensuring that families have access to social supports, such as family-violence shelters. Such upstream interventions for children are about creating a strong foundation for lifelong health and wellness.

Article 32 of the *Nunavut Agreement*

Article 32 of the *Nunavut Agreement* affirms that Inuit have the right to participate in the development of social and cultural policies in Nunavut and in the design of social and cultural programs and services, including their method of delivery.[76] Implementing Article 32 is necessary to support the development of more effective policies, programs, and services for Inuit, including the area of suicide prevention.

Article 32 is an essential platform for trilateral cooperation between the GN, the Government of Canada, and Inuit; it is the legal mechanism through which Nunavut Inuit exercise our right to self-determination within a public government.

Implementing Article 32 is critical for the success of suicide prevention in Nunavut. Through it, we can address social, cultural, and economic inequity, work together to coordinate robust interventions that create health and wellness, and fill gaps in information and research. NTI's 2014/15 *Annual Report on the State of Inuit Culture and Society* underscores the link between implementing Article 32 and improved social and economic outcomes for Inuit.[77]

Truth and Reconciliation

The Truth and Reconciliation Commission (TRC) of Canada was established under the Indian Residential Schools Settlement Agreement to contribute to truth, healing, and reconciliation for survivors of residential schools in Canada.[78] In order to redress the legacy of residential schools and advance the process of Canadian reconciliation, the TRC of Canada made 94 Calls to Action to federal, provincial, territorial, and Aboriginal governments, some of which address suicide among Indigenous peoples. In December 2015, the Government of Canada vowed to take immediate government action on the 94 Calls to Action.[79]

Action 19 calls upon the federal government to establish, in consultation with Indigenous peoples, measurable goals to identify and close the gaps in health outcomes between Indigenous and non-Indigenous communities with a focus on indicators such as infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.[80]

Action 21 calls upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harm caused by residential schools and to ensure that funding of healing centres in Nunavut and the Northwest Territories is a priority.[81]

The Government of Canada must take action to create social equity in Nunavut and prevent suicide as part of its larger commitment to achieving reconciliation. Article 32 of the *Nunavut Agreement* is the policy mechanism through which this important reconciliation work in Nunavut can be advanced.

Nunavut Suicide Prevention Strategy Action Plan

The *Nunavut Suicide Prevention Strategy Action Plan* (hereafter *Action Plan*) was released in 2011 to provide leadership for territory-wide suicide prevention efforts. It remains the most comprehensive suicide prevention initiative taken in Nunavut to date. The *Action Plan* was a collaborative effort of the GN, NTI, Embrace Life Council, and the RCMP that set out policy actions for implementing the 2010 *Nunavut Suicide Prevention Strategy* between Sep. 1, 2011 and Mar. 31, 2014.

The document tasks partners with fulfilling eight commitments and 42 objectives by specific deadlines, as well as with carrying out ongoing evaluation and monitoring of progress. It imagines, among other things, that implementation would lead to access to a wide range of mental health and addiction resources

for Nunavummiut in their own communities; increased cooperation between government, schools, and the RCMP so that children and youth experiencing distress have a better opportunity of receiving appropriate help; and the introduction of social and emotional learning at school to help students develop resilience and positive coping mechanisms.[82]

An independent evaluation of the *Action Plan* carried out in 2016 concluded that it had not been adequately resourced.[83] The lack of funding and human resources for the *Action Plan* are cited as the primary reason for its failure.[84] A second action plan is being developed for implementation between 2017 and 2022 with more community-based direction and involvement.

The 2017 to 2022 action plan will focus on priorities identified by participants at the *Atausiuqatigiingniq Inuusirmi United for Life* summit held in Iqaluit in May 2016. More than 100 Nunavummiut from across the territory attended the summit. Participants called for transmission of Inuit language and culture, early childhood development programs, greater support for children and youth, and more mental health services for all ages, among other identified priorities. The *Inuusivut Anninaqtuq: Action Plan 2017–2022* was released in June 2017.[85]

Nunavut Chief Coroner inquest into suicide

In 2013, 45 Inuit died by suicide in Nunavut, prompting the territory's Chief Coroner to carry out a special inquest into suicide in 2015 with the aim of informing the public about the underlying social conditions that contribute to suicide risk in our population. The inquest's six-member jury urged the GN to declare suicide a public health emergency.[86] The jury made more than 30 non-binding recommendations to all partners who created Nunavut's failed 2011 *Nunavut Suicide Prevention Strategy Action Plan*, as well as the federal government.

Jurors learned that the *Nunavut Suicide Prevention Strategy Action Plan* lacked decision-making leadership and funding.

Juror recommendations included the following:

- Open substance abuse treatment centres in each of the three regions in Nunavut by 2018.
- Provide adequate and dedicated multi-year funding for suicide prevention initiatives of the Embrace Life Council, the Kamatsiaqtut Helpline, and the Regional Inuit Associations by April 2016.
- Adopt 41 of the 42 evaluation report recommendations of the *Nunavut Suicide Prevention Strategy Action Plan* (excluding recommendation 18 that recommends peer-to-peer youth counselling, which is still being examined for effectiveness in reducing suicide risk and creating greater risk in crisis situations).
- Appoint a minister responsible for suicide prevention at the next sitting of the Legislative Assembly, as well as a secretariat responsible for reporting directly to that Minister on progress in reducing suicide.
- Release the second *Nunavut Suicide Prevention Strategy Action Plan* with dedicated resources and evaluation criteria by March 2016.
- Establish a National Suicide Prevention Strategy by September 2016.

In October 2015, Nunavut Premier Peter Taptuna declared suicide a crisis and appointed then Health Minister Paul Okalik as the minister responsible for suicide prevention. Okalik was charged with heading a special cabinet committee to implement the recommendations made by the inquest.

In the spring of 2016, NTI, the GN, Embrace Life Council, and the RCMP released *Resiliency Within: An Action Plan for Suicide Prevention in Nunavut 2016/2017*[87]. The document is an attempt to resuscitate the *Action Plan* and focuses only on 2016/17. It is organized along the lines of the original eight commitments in the *Nunavut Suicide Prevention Strategy* and seeks to implement the jury recommendations made at the conclusion of the 2015 coroner's inquest.

Child and youth advocacy

The GN joined all other jurisdictions in Canada when, in June 2014 after almost a decade of lobbying and a delay of six years, it created the Office of the Representative for Children and Youth. The Office is an independent body that works on behalf of young Nunavummiut to ensure that the GN protects and advances their rights and interests. The Office will have an important role to play in suicide prevention among Inuit, and its creation is a positive step forward in efforts to protect children and youth in the territory.

The Office of the Representative for Children and Youth is responsible for safeguarding the rights and interests of children and youth in Nunavut by fulfilling a range of responsibilities under Nunavut's *Representative for Children and Youth Act*.[88] These responsibilities include individual-based advocacy, systemic and special reviews, and public education.

Child and youth advocates are responsible for ensuring that the rights, interests, and well-being of all children and youth are valued and respected in Canadian communities and in government legislation, policy, programs, and practices.[89] Their work in each province and territory is guided by the 1989 United Nations *Convention on the Rights of the Child*, a legally binding human rights treaty that sets out the civil, political, economic, social, health, and

cultural rights of children. These rights include the right to protection (e.g., from abuse and exploitation); provision (e.g., of education, health care, and an adequate standard of living); and participation (e.g., listening to children's views and respecting their evolving capacities).[90]

In its first year, Nunavut's Office of the Representative for Children and Youth heard directly from youth that addressing the high rate of suicide in the territory is a priority. The Office has also undertaken the creation of an inventory of child and youth programs, services, and facilities during its first year of operation to aid in its advocacy work, one of the Office's core functions.[91] The Representative for Children and Youth, Sherry McNeil-Mulak, learned in this process that a holistic approach to delivering youth programs and services by the GN tends to be missing.[92]

Nunavut Suicide Prevention Strategy partners will be closely watching this new office to see how it will advocate on behalf of children and youth. Their contribution will be pivotal to the overall success of suicide prevention efforts in the territory. Childhood adversity, coupled with high social inequity and lack of access to services, contributes to the high suicide risk in Nunavut. The Office has an essential role to play in marshalling a more coordinated approach to delivering services that address the complex challenges facing Nunavut families and that too often contribute to suicide risk.

Child & Youth Advocates across Canada have been effective in encouraging the fullest possible implementation of the United Nations *Convention on the Rights of the Child*. British Columbia's Representative for Children and Youth published a report in October 2016 highlighting the alarming number of children and youth in the care of the provincial government—including a highly disproportionate number of Indigenous children and youth—who have experienced sexual violence.[93]

The British Columbia Representative reviewed 145 reports of sexualized violence against 121 children and youth in the care of the Ministry of Children and Family Development and the province's 23 delegated Aboriginal Agencies between 2011 and 2014. Nearly two-thirds of the victims in the review were Indigenous despite Indigenous children only making up one-quarter of the youth in foster care in British Columbia.[94] The report takes the British Columbia Minister of Children and Family Development to task for the agency's failure to protect the most vulnerable members of our society, which includes demanding that the Ministry "create and implement a broad strategy…to address sexualized violence against children and youth in care, with a particular focus on sexualized violence against Aboriginal girls."[95] The report has spurred national debate and a commitment for action by the Minister of Indigenous and Northern Affairs to work with provincial and territorial ministers of social services on "overhauling the system."[96]

Given these revelations, the high number of Inuit in care who may be experiencing similarly disproportionate violence, thereby increasing their risk for suicide, underscores the need for effective child and youth advocacy in Nunavut. The Ottawa-based Inuit community organization, Tungasuvvingat Inuit, estimates that in Ottawa alone, more than 250 Inuit children have had some contact with the Ottawa Children's Aid Society in the past five years related to cases dealing with temporary apprehension, short- and long-term foster care, and adoption.[97]

National Inuit Suicide Prevention Strategy

Inuit Tapiriit Kanatami (ITK) released the National Inuit Suicide Prevention Strategy (NISPS) in July 2016.[98] The NISPS promotes a shared understanding of the context and underlying risk factors for suicide in Inuit communities and guides policy at the regional and national levels on evidence-based approaches to suicide prevention. It describes the historical context for suicide among Inuit as well as the persisting challenges in Inuit communities that research has linked to suicide risk. The NISPS promotes the sharing of best practices in suicide prevention, commits to providing tools for the evaluation of approaches, contributes to ongoing Inuit-led research, provides leadership and collaboration in the development of policy that supports suicide prevention, and focuses on the healthy development of children and youth as the basis for a healthy society. The document outlines the following six priority areas for action:

1. Create social equity
2. Create cultural continuity
3. Nurture the health of Inuit children
4. Ensure access to a continuum of mental wellness services for Inuit
5. Heal unresolved trauma and grief
6. Mobilize Inuit knowledge for resilience and suicide prevention

Each priority area contains the specific objectives and actions ITK has identified for addressing risk factors for suicide.[99] Actions include creation of an Inuit-specific resource on cultural safety and trauma-informed care (Priority Area 2); education about the links between early childhood adversity and risk for later suicide (Priority Area 3); and creation of resources to guide communities in responding to suicide, including social media, with the goal of decreasing exposure effects (Priority Area 5).

Health Canada dedicated $9 million to be allocated over the course of three years to help support the implementation of NISPS. These resources will be used by ITK for coordination, outreach, and education on suicide prevention, ITK-led suicide intervention training, enhancement of mental health services, enhancement or expansion of early childhood development programs, and creation of a fund for suicide prevention projects, programs, and initiatives administered by ITK and the First Nations and Inuit Health Branch.

The NISPS provides the first evidence-based approach to suicide prevention for Inuit Nunangat. It is a valuable blueprint for action that is now being implemented through the National Inuit Committee on Health. Inuit regions are using initial federal funding to align and implement community-based programming and services with the evidence outlined within the NISPS.

National suicide prevention programs have been shown to play a pivotal role in reducing suicide.[100] The World Health Organization advises all countries to develop comprehensive prevention strategies in a multi-sectoral public health approach.[101] In Canada, Quebec (not including Nunavik) cut its suicide rate by half between 1999 and 2015 through concerted suicide prevention efforts that were made possible by having a strategy.[102] Calls persist in Canada for a national suicide prevention strategy for Canadians as a whole.[103]

The Public Health Agency of Canada released *The Federal Framework for Suicide Prevention* in November 2016 but has stopped short of developing a national suicide prevention strategy.[104] The *Framework* does not include goals, timelines, or specific activities intended to reduce suicide nor does it assign responsibilities for any multi-jurisdictional actions.[105] Its calls for collaboration, research, and best practices are unlikely to lead to national r eductions in suicide, which indicates that suicide prevention is not currently a federal priority. This is a troubling signal for Inuit and Indigenous communities.

Taking action to support children and families

Investing in the health and well-being of Nunavut Inuit, rooted in Inuit culture, especially during the early years of a child's life, is a sensible approach to breaking cycles of social dysfunction and distress that we know contribute to suicide risk.

Supporting children in the early years of life is critical to healthy growth and development. Which is why organizations, such as the United Nations International Children's Emergency Fund (UNICEF), advocate for investments in early childhood develop-

ment as part of their global public health strategies.[106] The role early childhood development can play in suicide prevention is recognized in Commitment 7 ("Early Childhood Development") of Nunavut's *Resiliency Within* suicide prevention action plan.[107] This commitment calls for the prevention of child sexual abuse, training for people to lead parenting programs, the creation of Family Resource Worker positions that support children and families in the home, school, and in care, as well as adequate resourcing of family-violence facilities.[108]

Evidence linking adversity during childhood and adolescence to risky behaviour and negative health outcomes later in life has spurred the development of innovative programs and initiatives that provide support for children and their parents.

Programs, such as the Nurse–Family Partnership, have potential application in Nunavut. The Nurse–Family Partnership is one of a growing number of public health interventions whose approach to supporting vulnerable populations recognizes that providing children with a healthy early start in life must also prioritize the well-being of their caregivers. It is an initiative of the United States that exists in 46 states and is currently being implemented in Ontario and British Columbia as the Canadian Nurse–Family Partnership.[109] The program's impacts are currently being evaluated in British Columbia where it is known as the BC Healthy Connections Project.[110]

The Nurse–Family Partnership helps transform the lives of vulnerable first-time mothers and their babies. Through a program of ongoing home visits from registered nurses, low-income, first-time mothers receive the care and support they need to have a healthy pregnancy, provide responsible and competent care for their children, and become more economically self-sufficient. Nurse–Family Partnership nurse home visitors establish trusting relationships with first-time mothers, through up to 65 home visits over the course of two and a half years, that empower them to achieve a better life for their families and themselves.

The effectiveness of the Nurse–Family Partnership is supported by over three decades of research that has followed families who have participated in the program. The documented effects of the program on first-time, low-income mothers include the following:

- 48 per cent reduction in child abuse and neglect
- 56 per cent reduction in emergency room visits for accidents and poisonings
- 32 per cent reduction in subsequent pregnancies
- 67 per cent reduction in behavioural and intellectual problems at age six
- 59 per cent reduction in arrests at age 15
- 82 per cent increase in number of months when mothers were employed[111]

Families continued to experience these effects more than 12 years after nurse visits ended. The Nurse–Family Partnership provides an unparalleled cost-benefit when compared with other U.S. health interventions. The RAND Corporation estimates that Nurse–Family Partnership initiatives provide a net benefit to society of $34,148 (in 2003 dollars) per high-risk family served, with the bulk of the savings accruing to government, equating to a $5.70 return for every dollar invested in the Nurse–Family

Partnership program. This holistic "upstream" approach is being taken by notable like-minded organizations, such as the Center for Youth Wellness in San Francisco, California.

The Center for Youth Wellness works in partnership with a local clinic that screens children during their intake for the ACE Study discussed in Part 1 of this report. The clinic dispatches wellness coordinators to work with families who may need support based on a child's ACE score. Wellness coordinators coordinate care within the Center's programs and with outside resources. The suite of services and supports available to families include home visits that engage families at home and school, education to help families better understand how they can prevent the kind of harmful chronic stress that can negatively affect children's health and well-being, access to psychotherapy ("talk therapy" with a mental health professional), and psychiatry (the treatment of mental illness, emotional disturbance, and abnormal behaviour).

Wellness coordinators also educate families and other providers about the impacts of adverse childhood experiences and harmful forms of stress on health, engage families at home and school, and provide consistent guidance, modelling self-care, making referrals as needed.[112]

Nutaqqavut Health Information System

The Nutaqqavut Health Information System (NHIS) was developed by the GN in order to gather and centralize maternal and prenatal to preschool child healthcare data across the territory, enabling healthcare providers to better understand the determinants of health for infants and children.[113] The program's approach to creating health and wellness in families was similar to the Nurse–Family Partnership. It aimed to provide the best information for parents to help them make decisions about their health and the health of their children and to use information gathered through the program to develop programs and materials that would help every woman have the healthiest pregnancy possible.

The GN began gathering data on Nunavut mothers and babies in July 2011 including social determinants, such as income, crowding, poor nutrition, and the high cost of food, in order to improve the health status of mothers and children by giving health practitioners more insight into the links between the health status of mothers and their babies. It was inspired by similar health surveillance programs in British Columbia, Alberta, and Nova Scotia that use information gathered about pregnancies, births, infant deaths, and birth defects to enable the provision of targeted public health interventions for citizens. After more than a year of listening to feedback from the healthcare providers and adapting the primary care forms for ease of use, the official launch of the NHIS was announced and celebrated in July 2012.

The GN quietly dismantled the program in 2013 following a decision by the Department of Health's Senior Management Committee. The recommendation to dismantle the NHIS was based on an evaluation of the surveillance system conducted by non-evaluation scientists who were staff of the Department of Health. The NHIS represented an investment of $1.4 million and countless, in-kind work hours from numerous stakeholders in maternal child health.

The dismantling of the NHIS limits our understanding of how Inuit mothers and babies are doing, limits our ability to connect vulnerable families with resources that support health and wellness, and limits our ability to identify and reduce forms of early adversity that are linked to suicide risk later in life. The upstream approach used by the NHIS to create health and wellness through early intervention needs to be a core component of the territory's approach to suicide prevention.

Coordinating services to support the most vulnerable

Suicide prevention planning in Nunavut has evolved toward coordinated upstream approaches. This is reflected by the actions identified in *Resiliency Within* that focus on early childhood development and equipping youth with the resources and skills to help them cope with adversity. It is also encouraging that *Resiliency Within* is premised on a coordinated approach to suicide prevention that would see each department's activities support suicide prevention, consistent with promising practices in other jurisdictions.

In Arizona, the White Mountain Apache tribe established the Celebrating Life surveillance system in 2001. The unique community surveillance system was created to track and triage suicide deaths, attempts, and ideation on the Fort Apache Indian Reservation. It mandates that all persons, departments, and schools take responsibility for reporting individuals at risk for self-injuring behaviours.

The surveillance system functions through initial reports of behaviour (suicide ideation, non-suicidal self-injury, binge substance use, suicide attempt, or suicide death) to the Apache Behavioral Health Services (ABHS). The ABHS offers formal treatment services to individuals while, simultaneously, a Celebrating Life community mental health specialist seeks out the individual to complete an in-person interview to validate the initial report and facilitate linkages to and compliance with care.[114]

Information gathered through the interviews is coded and analyzed for trends and patterns, aiding the tribe in evaluating the impacts of its various suicide prevention and intervention efforts. These prevention and intervention efforts have included public outreach and education, development of a coping skills curriculum delivered to middle schoolers, as well as provision of Applied Suicide Intervention Skills Training (ASIST) to community members, tribal departments, such as law enforcement and fire, and to emergency medical technicians, school nurses, social workers, guidance counsellors, tribal leaders, and ABHS staff.[115]

The White Mountain Apache credit the Celebrating Life suicide surveillance and prevention system with reducing suicide deaths and attempts among adolescents, young adults, and adults by systematically identifying at-risk individuals and providing a range of interventions for those individuals that are tailored to address behavioural patterns illuminated through data. Data link the surveillance system and its associated interventions with reductions in the on-reserve suicide rate from 40 per 100,000 to 24.7 per 100,000 between 2001 and 2012, with decreases in the suicide rate in every age group except those aged 10 to 14.[116]

Nunavut's *Mental Health Act*

The White Mountain Apache example demonstrates how it is possible to reduce suicide through coordinated actions that identify individuals at risk for suicide and dispatch targeted resources to ensure those at risk have access to the help they need.

The tribe's approach contrasts with approaches that focus on crisis intervention or other narrow aspects of mental health and wellness. The GN is currently revamping its *Mental Health Act*, which represents an opportunity to give priority to more effective policies for reducing suicide.

The GN inherited the *Mental Health Act* from the Government of the Northwest Territories in 1999. The legislation dates from 1988 and governs how the most severe cases of mental illness are to be handled including when people either need to be held against their will or, for medical reasons, need to be evacuated to another community for treatment. Mental health workers in communities utilize the *Act* when a person is in crisis and are deemed a threat to themselves or others. However, the *Act* dates from an era when suicide and suicide risk factors were not well understood. It has the potential to play an influential role in suicide prevention.

The *Mental Health Act* was criticized during the Nunavut Chief Coroner's inquest in 2015, particularly the aspects of the *Act* dealing with confidentiality. Under the *Act*, health practitioners cannot tell family members when someone is being held under the legislation, for instance, in the case of attempted suicide or suicide ideation. Nor does the *Act* include provisions for follow-up or ongoing support for vulnerable individuals despite suicide attempt being the single greatest predictor of suicide.

One of the 42 recommendations of the Chief Coroner's inquest jury was that the GN Department of Health amend the *Mental Health Act* to allow the families of individuals to be contacted and immediately involved after a suicide attempt, regardless of the age of the person who attempted suicide. Some families learned of past suicide attempts by family members only after reading coroner's reports about loved ones who died by suicide.[117]

The GN Department of Health has committed to overhauling the *Mental Health Act* to "reflect Inuit values throughout."[118] To that end, the GN carried out consultations in 11 communities and in Ottawa from November 2015 to March 2016 to gather feedback about the legislation with the aim of improving it and is in the process of drafting legislation; NTI has been engaged and involved in this process thus far.

The frontline mental health staff tasked with responding to mental health crises in communities include a child and youth mental health worker, a psychiatric nurse, and mental health clinicians. Psychiatric nurses are responsible for assessing the mental health of individuals and making referrals for psychiatric assessment or psychological therapy as needed. Mental health clinicians are responsible for providing community education and addressing mental health problems in individuals before they become a crisis.

However, recruiting and retaining staff to fill these positions in each of Nunavut's 25 communities remains a challenge. As of February 2016, 23 communities were staffed by full or part-time psychiatric nurses, eight had a child and youth worker, and nine communities were staffed with a mental health clinician.

Inuit Ilagiingniq

The protective factors shown in Figure 8 of this report can instill resilience and the capacity to cope with and even grow from adversity through positive mental wellness, increased ability to deal with stress or adversity, and resilience-building behaviours. The strong relationships and support provided by cultural continuity, community cohesion, and family strength can support positive outcomes for people who experience stressful events and challenges in their lives. However, the disruption of the Inuit value system that thrived before Inuit were settled into communities has threatened the strength of these relationships and supports. Inuit acknowledge that we must work hard to adapt to a new way of life in an authoritative system that threatened our way of life in the first place.

Many Inuit believe that although we cannot go back to the traditional Inuit way of life, there are ways to ensure cultural continuity. Through interviews with Inuit elders, Mariano Aupilaarjuq recognized that we will not be able to use all Inuit Qaujimajatuqangit (Inuit worldview) but the core principles do not change or diminish in value.[119] The QTC report illustrates the importance and interconnectedness of both kinship and place. Indeed, Inuit kinship systems are vastly different from those in European and Western cultural traditions, and the concept of ilagiit is based on the root word ila, which simply means "to be with" or "accompany."[120] Inuit will, for the most part, continue to live in communities and may never return to the traditional semi-nomadic nature but Inuit must be supported in rebuilding and strengthening our relationships with the land as well as among our family – those that are a result of birth, circumstance, and choice. Strengthening Inuit kinship models is critical and necessary for an effective social safety network based on Inuit culture and understanding.

Suicide intervention training

Suicide intervention training, such as ASIST as well as Mental Health First Aid, can play a critical role in suicide prevention. With ASIST, participants learn to use a suicide intervention model to identify persons with thoughts of suicide, seek a shared understanding of reasons for dying and living, develop a safe plan based on a review of risk, and be prepared to follow up. Suicide intervention training prepares citizens to play an active role in suicide prevention.

These skills can be life-saving in our small communities where everyone is affected by a completed suicide, placing those who are exposed to suicide at greater risk for suicide. It is, in part, because of these "exposure effects" that, in the absence of intervention, a completed suicide is sometimes followed by a cluster of suicide attempts or completed suicides.[121]

Evidence-based suicide intervention training educates participants to intervene and help prevent the immediate risk of suicide by helping reduce suicidal feelings for those at risk. Despite its practical benefits, suicide intervention training workshops have been provided unevenly in Nunavut and are not mandatory for most public servants nor do most Nunavummiut have access to training.

Ensuring that as many people as possible in Nunavut have the practical skills needed to intervene when a person is at risk for suicide and to connect

them with appropriate supports is a practical, near-term step that the GN and the Government of Canada can take to reduce suicide among Nunavut Inuit. The policy implication for Nunavut is that we need as many people as possible to be trained in evidence-based suicide intervention.

Coordinated services are needed in Nunavut to prevent suicide

Ensuring that access to health and social services is seamless can improve the efficiency and impact of services by having every service provider act as a path toward health and wellness.

Some governments are seeking to coordinate health and social services for Indigenous peoples in their jurisdictions in order to improve the connections between services or between people and services in ways that benefit individuals, families, communities, and societies.[122]

The Government of Quebec, realizing that fragmented services could be deadly for people exhibiting suicidal behaviour, applied this approach to suicide prevention beginning in the 1990s.

Quebec's successful suicide prevention strategy puts forward a coordinated approach to suicide prevention, intervention, and postvention that sees the isolation of caseworkers as a major barrier to reducing suicide. Quebec's strategy instructs each community organization or resource likely to provide services for individuals experiencing a suicidal crisis or who have attempted suicide, their friends and relatives, or people in mourning as a result of a suicide, to develop protocols for intervention that enable stakeholders to better define their responsibilities and to provide services more efficiently.[123]

Quebec's strategy emphasizes the importance of having service agreements in place that bind all partners (hospitals, schools, police, local community service centres, etc.) and that reinforce the application of established protocols by facilitating recourse to services deemed essential.[124] It describes how partners must have access to practical tools, such as counselling guides and reference tools, for connecting people to appropriate services and supports, as well as access to clinical support. This approach sees suicide prevention not as the responsibility of a single government department but as a shared responsibility across government.

The GN has acknowledged that the prevention and response to suicide must involve collaboration and action across all departments.[125] The appointment in 2015 of a senior bureaucrat within the GN's Department of Health responsible for operationalizing this principle is encouraging. However, such an approach can only be successful if there are services, supports, and resources in place to refer people to.

Recommendations

Government of Nunavut

- Reinstate the Nunavut Child Health Surveillance Registry incorporating as a core component the gathering of data on parent suicide ideation, suicide attempt, and adverse childhood experiences.

- Reduce family violence through a coordinated, evidence-based, cross-sector initiative, akin to the Embrace Life Council, that develops a meaningful strategy and action plan for ending family violence in Nunavut.

- Create a Department of Suicide Prevention responsible for coordinating an evidence-based, government-wide approach to suicide prevention.

- Work in partnership with NTI, as obligated in Article 32 of the *Nunavut Agreement*, to strengthen the *Mental Health Act* by including evidence-based suicide prevention, intervention, and postvention components, rooted in Inuit values.

- Fund and implement the *Inuusivut Anninaqtuq 2017–2022 Nunavut Suicide Prevention Strategy Action Plan* and commit to scientifically evaluating its impacts on suicide ideation, suicide attempt, and suicide rate.

- Reduce suicide risk by adapting evidence-based "upstream" public health approaches to rebuilding resilience in families and children.

- Develop a suicide and self-injury surveillance system to provide targeted services and ongoing follow-up to individuals who are at risk for suicide.

- Coordinate seamless access to suicide prevention programs, supports, and services through a "no-wrong-door" policy that links individuals to help at multiple points of contact including schools, the justice system, and the healthcare system.

- Ensure that all public servants are trained in suicide intervention and mental health programs (i.e., Applied Suicide Intervention Skills Training and Mental Health First Aid).

- Work with NTI, the Nunavut Law Society, Nunavut Association of Municipalities, and other stakeholders to explore cemetery plot planning and address burial costs to reduce stress on families.

Government of Canada

- Ensure that suicide prevention is a federal priority and allocate appropriate funding and other resources to develop and implement a National Suicide Prevention Strategy.

- Develop a national suicide prevention strategy for Canada that includes Inuit Nunangat-specific interventions developed in partnership with Inuit.

- Streamline access to federal funding for Inuit-specific, community-based suicide prevention initiatives through the First Nations and Inuit Health Branch. This includes making such funding sources available to reduce the administrative burden on Regional Inuit Associations and non-profit community organizations who are leading suicide prevention efforts.

- Create safety for families through the 2019 budget by increasing federal housing contributions and by providing separate resources for building new family-violence shelters in Nunavut.

- Provide ongoing funding to Inuit Tapiriit Kanatami (ITK) to ensure implementation of the *National Inuit Suicide Prevention Strategy*.

- Implement the 94 Calls to Action of the Truth and Reconciliation Commission of Canada, with priority being given to Calls 19 and 21.

- Ensure that all Royal Canadian Mounted Police (RCMP) officers and federal public servants in Nunavut are trained in suicide intervention and mental health programs (i.e., Applied Suicide Intervention Skills Training and Mental Health First Aid).

Conclusion

Suicide rates among Nunavut Inuit have been elevated since the mid-1970s, and in the last six years suicide has twice been declared a crisis. Between 1999, when Nunavut separated from the Northwest Territories, and Nov. 1, 2016, 514 Inuit died by suicide; the majority were young men. Suicide among Nunavut Inuit is not an inexplicable phenomenon. Links between the harmful effects of colonialism and intergenerational trauma, persistent social and economic inequities, and suicide risk factors associated with those inequities, explain why Nunavut Inuit continue to experience elevated rates of suicide.

Sadly, Nunavut remains in the early stages of taking action to prevent suicide among Inuit. The failure of the GN to implement the 2011 *Nunavut Suicide Prevention Strategy* delayed the implementation of promising, coordinated actions to reduce suicide by more than half a decade. A second action plan has been developed for implementation between 2017 and 2022.

We know that it is possible to reduce suicide through evidence-based, coordinated actions that identify people who need help and that ensure they do not slip through the cracks. Quebec's suicide prevention strategy is credited with helping reduce suicide rates in the province by half. The White Mountain Apache tribe has achieved promising reductions in suicide through a similar approach based on coordinating resources and monitoring those at risk. The NISPS was produced by ITK and released it in July 2016 in an attempt to coordinate evidence-based, Inuit-specific suicide prevention efforts across Inuit Nunangat in a similar fashion. These initiatives, coupled with impactful public health interventions that focus on providing the vulnerable with the healthiest start in life, paint a promising picture of what can be accomplished through strategic investments and political willpower.

It is promising that the special inquest into suicide in 2015 by the Chief Coroner of Nunavut led to the appointment of a senior bureaucrat within the GN's Department of Health who is responsible for coordinating suicide prevention across government. The long-awaited opening of the Nunavut Children and Youth Representative's office is also a sign of progress. Long-overdue revisions to the *Mental Health Act* may help modernize the delivery of mental health services and supports and align care with best practices for suicide prevention. Stigma is eroding around suicide and suicide risk factors, such as child sexual abuse. In terms of our understanding of this challenge, the GN and the Government of Canada are better positioned than ever before to take the necessary actions needed to prevent suicide. The question remains whether either is willing to summon the political will needed to do so.

Our children are our future. It is essential that we have the political will and find the resources to make a difference in their lives. The loss of every single Nunavut Inuk represents unfulfilled potential and is a tragic loss to our families, our communities, and to the future of Nunavut.

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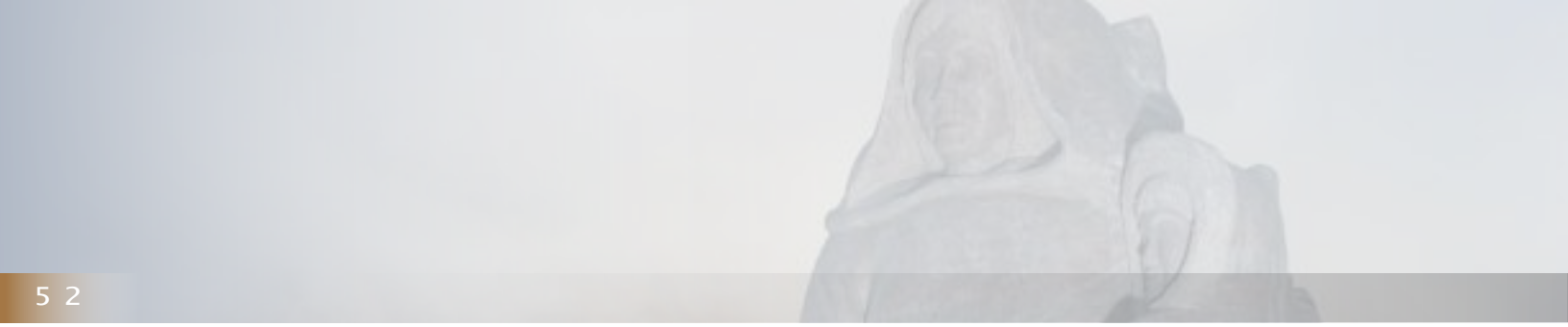

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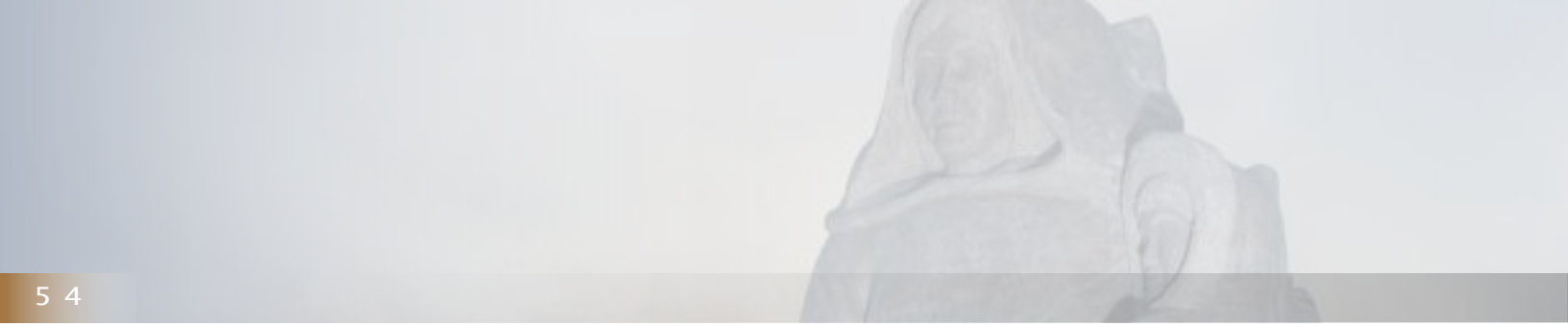

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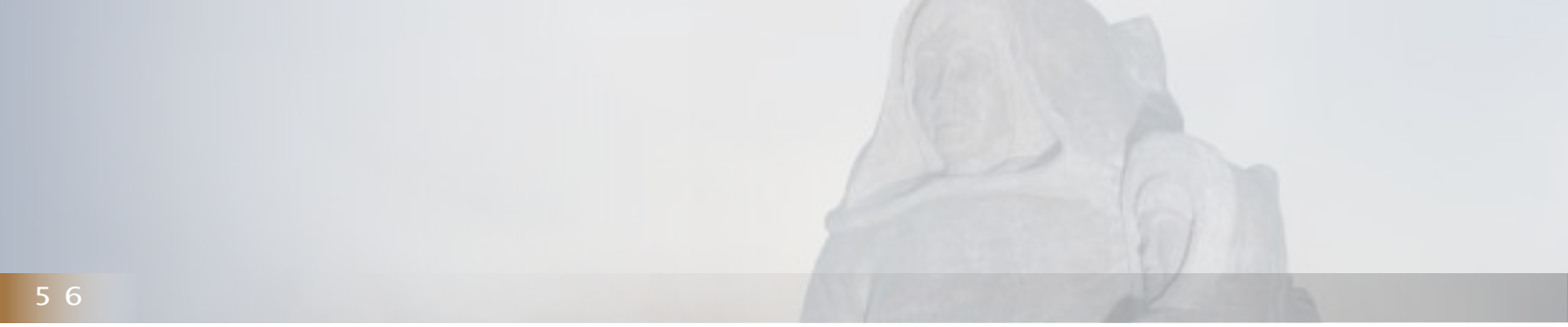

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