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NUNAVIK 2017

MENTAL HEALTH AND WELLNESS

QANUILIRPITAA? 2017

Nunavik Inuit Health Survey



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SOCIAUX DU NUNAVIK AND SOCIAL SERVICES

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Legal deposit - November 2020

Bibliothèque et Archives nationales du Québec

ISBN: 978-2-924662-20-5 (PDF)

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Muckle, G., Fraser, S., Desrochers-Couture, M., Pépin, C.,
Bélanger, R., Fletcher, C., Poliakova, N., Moisan, C. (2020).
*Mental Health and Wellness. Nunavik Inuit Health Survey
2017 Qanuillirpita? How are we now?* Quebec: Nunavik
Regional Board of Health and Social Services (NRBHSS)
& Institut national de santé publique du Québec (INSPQ).

If you or someone you know needs help, resources are available:

Kamaqtsiaqtut Help Line
1-800-265-3333

www.hopeforwellness.ca
(chat)
1-855-242-3310

Kids Help Phone
1-800-668-6868

www.kidshelpphone.ca

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819-xxx-9090

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QANUILIRPITAA? 2017 HEALTH SURVEY ACKNOWLEDGMENTS

On behalf of the Steering Committee, I would like to express my gratitude to all Nunavimmiut who participated in the *Qanuilirpitaa?* 2017 Health Survey.

This important health survey was made possible thanks to the long-lasting partnership between the Nunavik Regional Board of Health and Social Services, the *Institut national de santé publique du Québec* and researchers from the Centre de recherche du CHU de Québec – Université Laval, McGill University and Trent University.

The valuable contribution of Inuit research advisors, leaders from each community, as well as representatives from the Avataq Cultural Institute, the Ungava Tulattavik Health Centre, the Inuulitsivik Health Centre, the Kativik Regional Government, Kativik Ilisarniliriniq, Makivik Corporation, the northern villages and the Qarjuit Youth Council is gratefully acknowledged. The Steering Committee and the Data Management Committee of *Qanuilirpitaa?* 2017 guided and enriched this work throughout the different phases, from planning to data interpretation and contextualization.

We want to highlight the invaluable contribution of Pierre Ayotte and Françoise Bouchard, the scientific directors, and Danielle St-Laurent, the project's executive director. We are also indebted to Geneviève Hamel, Suzanne Bruneau, Suzanne Côté and Nathalie Ouellet who coordinated the planning and realization of the survey.

We are sincerely thankful to the Inuit interviewers who carried out exceptional work in often challenging circumstances.

We are also grateful to all of the professionals, technicians, students, ground team and clerical staff, as well as the crew of the Canadian Coast Guard Ship *Amundsen*.

Finally, this survey could not have been undertaken without the financial support of the Nunavik Regional Board of Health and Social Services, the Kativik Regional Government, Makivik Corporation, Kativik Ilisarniliriniq, the *ministère de la Santé et des Services sociaux du Québec*, ArcticNet, the Amundsen Science Ship Fund and the Northern Contaminants Program.

Numerous people have contributed at different stages of the survey process; many of them are listed below, and there are many more.

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In memory of Audrey Flemming and Linda Shipaluk.

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TABLE OF CONTENTS

LIST OF TABLES	V
LIST OF FIGURES	VI
1 BACKGROUND OF THE QANUILIRPITAA? 2017 HEALTH SURVEY	1
Target population	1
Survey frame	1
Data collection	2
Participation	2
2 INTRODUCTION	3
3 METHODOLOGICAL ASPECTS	5
4 RESULTS	9
4.1 Well-being	9
› 4.1.1 Life satisfaction	9
› 4.1.2 Quality of life	10
› 4.1.3 Self-esteem	13
› 4.1.4 Resilience	15

4.2 Psychological distress	15
› 4.2.1 Depressive symptoms	15
› 4.2.2 Suicide ideation and attempts	17
› 4.2.3 Situations people were in before they attempted suicide	19
› 4.2.4 Emotional support at the time of attempted suicide	20

5 DISCUSSION 21

6 CONCLUSION 24

REFERENCES 25

APPENDIX A - QUESTIONS ON MENTAL HEALTH 28

Well-being indicators 28

Psychological distress indicators 31

APPENDIX B - SUPPLEMENTARY RESULTS 34

Well-being indicators 34

Psychological distress indicators 39

LIST OF TABLES

<p>Table 1 Sociocultural indicators P. 7</p> <p>Table 2 Proportion of the population according to suicide ideation and attempts in lifetime and in the past 12 months (%), population aged 16 years and over, Nunavik, 2017</p> <p>Table A Proportion of the population according to well-being indicators (%), by sex, age group, coastal region, community size, marital status, education, employment, and income, population aged 16 years and over, Nunavik, 2017</p> <p>Table B Prevalence of well-being indicators (%), by cultural identity, spirituality, and cultural identity satisfaction, population aged 16 years and over, Nunavik, 2017</p> <p>Table C Proportion of the population according to well-being indicators (%), by social support, family cohesion, and community wellness and participation, population aged 16 years and over, Nunavik, 2017</p> <p>Table D Proportion of the population according to well-being indicators (%), by healing and wellness participation, and positive perception of health services, population aged 16 years and over, Nunavik, 2017</p> <p>Table E Prevalence of psychological distress indicators (%), by sex, age group, coastal region, community size, marital status, education, employment, and income, population aged 16 years and over, Nunavik, 2017</p>	<p>Table F Proportion of the population according to psychological distress indicators (%), by cultural identity, spirituality, and cultural identity satisfaction, population aged 16 years and over, Nunavik, 2017</p> <p>Table G Proportion of the population according to psychological distress indicators (%), by social support, family cohesion, and community wellness and participation, population aged 16 years and over, Nunavik, 2017</p> <p>Table H Proportion of the population according to psychological distress indicators (%), by healing and wellness participation, positive perception of health services, and Internet use as a source of information, population aged 16 years and over, Nunavik, 2017</p>
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LIST OF FIGURES

- Figure 1** P. 9 Proportion of the population that is very satisfied or satisfied with life in general (%), by sex and age, population aged 16 years and over, Nunavik, 2017
- Figure 2** P. 11 Proportion of the population that reported having enough money to meet their needs (%), by sex and age, population aged 16 years and over, Nunavik, 2017
- Figure 3** P. 12 Proportion of the population who considered their health as very good or excellent (%), by sex and age, population aged 16 years and over, Nunavik, 2017
- Figure 4** P. 14 Proportion of the population with high levels of self-esteem (%), by sex and age, population aged 16 years and over, Nunavik, 2017
- Figure 5** P. 16 Proportion of the population with clinically significant depressive symptoms on the CES-D-10 scale (%), by sex and age group, population aged 16 years and over, Nunavik, 2017
- Figure 6** P. 17 Proportion of the population by suicide ideation and attempts in lifetime and in the past 12 months (%), population aged 16 years and over, Nunavik, 2004 and 2017
- Figure 7** P. 19 Proportion of the population having attempted suicide in the past 12 months according to the situation they were in just before attempting suicide, (%), population aged 16 years and over, Nunavik, 2017
- Figure 8** P. 20 Proportion of the population who reported attempting suicide in the past 12 months according to the source of emotional support they received at that time (%), population aged 16 years and over, Nunavik, 2017

1 BACKGROUND OF THE QANUILIRPITAA? 2017 HEALTH SURVEY

The *Qanuilirpitaa?* 2017 Health Survey is a major population health survey conducted in Nunavik that involved the collection, analysis and dissemination of information on the health status of Nunavimmiut. The last health survey conducted prior to it in Nunavik dated from 2004. Since then, no other surveys providing updated information on the health of this population had been carried out. Thus, in February 2014, the Board of Directors of the Nunavik Regional Board of Health and Social Services (NRBHSS) unanimously adopted a resolution to conduct a new health survey in all 14 Nunavik communities, in support of the Strategic Regional Plan.

The general objective of the 2017 health survey was to provide an up-to-date portrait of the health status of Nunavimmiut. It was also aimed at assessing trends and following up on the health and health determinants of adult participants since 2004, as well as evaluating the health status of Nunavik youth. This health survey has strived to move beyond traditional survey approaches so as to nurture the research capabilities and skills of Inuit and support the development and empowerment of communities.

Qanuilirpitaa? 2017 included four different components: 1) an adult component to document the mental and physical health status of adults in 2017 and follow up on the adult cohort of 2004; 2) a youth component to establish a new cohort of Nunavimmiut aged 16 to 30 years old and to document their mental and physical health status; 3) a community component to establish the health profiles and assets of communities in a participatory research approach; and 4) a community mobilization project aimed at mobilizing communities and fostering their development.

This health survey relied on a high degree of partnership within Nunavik (Nunavik Regional Board of Health and Social Services (NRBHSS), Makivik Corporation, Kativik Regional Government (KRG), Kativik Ilisarniliriniq (KI), Avataq Cultural Institute, Qarjuit Youth Council, Inuulitsivik Health Centre, Ungava Tulattavik Health Centre), as well as

between Nunavik, the Institut national de santé publique du Québec (INSPQ) and academic researchers from three Canadian universities: Université Laval, McGill University and Trent University. This approach followed the OCAP principles of Ownership, Control, Access and Possession (First Nations Information Governance Centre, 2007).¹ It also emphasized the following values and principles: empowerment and self-determination, respect, value, relevance and usefulness, trust, transparency, engagement, scientific rigour and a realistic approach.

TARGET POPULATION

The survey target population was all permanent Nunavik residents aged 16 years and over. Persons living full time in public institutions were not included in the survey. The most up-to-date beneficiaries register of all Inuit living in Nunavik, provided by the Makivik Corporation in spring 2017, was used to construct the main survey frame. According to this register, the population of Nunavik was 12 488 inhabitants spread out in 14 communities. This register allowed respondents to be selected on the basis of age, sex and coast of residence (Hudson coast and Ungava coast).

SURVEY FRAME

The survey used a stratified proportional model to select respondents. Stratification was conducted based on communities and age groups, given that one of the main objectives of the survey was to provide estimates for two subpopulations aged, respectively, 16 to 30 years and 31 years and over. In order to obtain precise estimates, the targeted sample size was 1 000 respondents in each age group. Assuming a 50% response rate, nearly 4 000 people were required to obtain the necessary sample size. From this pool, the number of individuals recruited from each

1. OCAP® is a registered trademark of the First Nations Information Governance Centre (FNIGC).

community was proportionate to population size and took into account the number of days that the survey team would remain in each community – a situation that imposed constraints on the number of participants that could be seen. Within each stratum, participants were randomly selected from the beneficiaries register. However, the individuals from the 2004 cohort, all 31 years old and over (representing approximately 700 individuals), were automatically included in the initial sample.

DATA COLLECTION

Data were collected from August 19, 2017 to October 5, 2017 in the 14 villages. The villages were reached by the *Amundsen*, a Canadian Coast Guard Icebreaker, and participants were invited on board the ship for data collection purposes.

Two recruitment teams travelled from one community to another before the ship's arrival. An Inuk assistant in each community helped: identify, contact and transport (if necessary) each participant; inform participants about the sampling and study procedures; obtain informed consent from participants (video) and fill in the identification sheet and sociodemographic questionnaire.

Data collection procedures for the survey included questionnaires, as well as clinical measurements. The survey duration was about four hours for each wave of participants, including their transportation to and from the ship. Unfortunately, this time frame was sometimes insufficient to complete the data collection process. This survey received ethical approval by the Comité d'éthique de la recherche du Centre Hospitalier Universitaire de Québec – Université Laval.

Aboard the ship, the survey questionnaires were administered by interviewers, many of whom were Inuit. Face-to-face interviews were conducted using a computer-assisted interviewing tool. If there were problems with the laptop connections, paper-form questionnaires were filled out. The questionnaires were administered in Inuktitut, English or French, according to the preference of the participants. Interviewers received training in administering the questionnaires prior to the start of the survey. The questionnaires were divided into five blocks: psychosocial interview (blocks 1 and 3), physical health and food security interview (block 2), food frequency questionnaire (block 4), and sociodemographic interview (block 5).

The survey also included a clinical component, with tests to document aspects of physical health, sampling of biological specimens (such as blood, oropharyngeal swabs, urine, stool, and vaginal swabs), spirometry, and an oral clinical exam. These sessions were supervised by a team comprised of nurses, respiratory therapists, dentists, dental hygienists and assistants, and laboratory technicians.

PARTICIPATION

There were a total of 1 326 participants, including 574 Nunavimmiut aged 16 to 30 years old and 752 Nunavimmiut aged 31 years and over, for total response rates of 30.7% and 41.5%, respectively. The participants' distribution between the two coasts (Ungava and Hudson) was similar. The distribution of men and women was unequal, with twice as many women (873) than men (453) participating in the survey. If the results obtained from this sample are to be inferred to the target population, survey weights must be used.

Overall, as compared to the 2004 survey, the response rate (i.e., the rate of participants over the total number of individuals on the sampling list) was lower than expected, especially among young people. This includes the refusal rate and especially a low contact rate. Several reasons might explain the low response rate, including the short time period available to contact individuals prior to the ship's arrival in the community and non-contact due to people being outside of the community or on the land. Nevertheless, among the individuals that were contacted ($n = 1\,661$), the participation rate was satisfactory with an internal participation rate of 79.7%. More details on the collection, processing and analysis of the data are given in the Methodological Report (Hamel, Hamel et Gagnon, 2020).

2 INTRODUCTION

The Public Health Agency of Canada (Government of Canada, Public Health Agency of Canada, 2019) defines mental health as “... the capacity of each and all of us to feel, think, act in ways that enhance our ability to enjoy life and deal with the challenges we face.” Similarly, the World Health Organization (World Health Organization, 2004) defines positive mental health as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”. Inuit tend to view mental wellness as being represented by physical, emotional, mental, and spiritual wellness, as well as strong cultural identity (National Aboriginal Health Organization, 2013).

General questions on life satisfaction have been widely used in studies and surveys to document perceived well-being in numerous groups and different circumstances. Measures of life satisfaction also predict important behaviours related to mental health, such as suicide (Diener, Inglehart, & Tay, 2013). Among Inuit, family relationships, communication, cultural practices, and values are important components of life satisfaction (Kral, Idlout, Minore, Dyck, & Kirmayer, 2011).

A similar concept and important aspect of mental health is quality of life, which the World Health Organization (2014) defines as “an individual’s perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns”. Quality of life is a multidimensional concept that includes such aspects as material living conditions, physical functioning, social relations and health perception (Godefroy & Lollivier, 2014). In the *Qanuillirpita?* 2017 survey, quality of life was assessed using one question about respondents’ general perception of health and one question about their perception of having sufficient financial resources to meet their needs.

A person’s general perception of health integrates many health-related factors and consequently represents an effective measure of general health status and health-related quality of life (Fayers & Hays, 2005). Previous

studies and surveys have shown that minorities and Indigenous populations systematically report lower rates of perceived health than other population groups and have highlighted between-culture health disparities (Bombak & Bruce, 2012). For example, among Greenlandic Inuit adolescents, suicidal thoughts have been associated with poor perception of health (Spein et al., 2013).

Important disparities are observed with regard to financial resources. In 2011, the median income of Nunangat Inuit was \$20 961 compared to \$30 195 for the non-Indigenous population of Canada (Statistics Canada, 2011). The unemployment rate in 2011 was also twice as high in Nunavik as in the province of Québec (Duhaime, Caron, & Lévesque, 2015). In the context of the cost of living being 28.7% higher in Nunavik than in Quebec City (Robitaille, Guénard, Lévesque, & Duhaime, 2018), low income and unemployment can be paramount in the perception of not having sufficient financial resources and are therefore likely to have a major impact on Nunavimmiut’s quality of life. In addition, low employment possibilities in communities can lead to low self-esteem, violence and suicide (Inuit Tapiriit Kanatami, 2014).

Self-esteem is defined by the feeling of self-acceptance and self-respect (Rosenberg, 1965), and plays an important role in mental wellness. For individuals who have had their cultural identity compromised through colonization, cultural identity clarity, via personal identity clarity, is linked to self-esteem and well-being (Usborne & Taylor, 2010).

Resilience is another aspect of positive mental health and is described as the ability to bounce back or recover from stress (Smith, Dalen, Wiggins, Tooley, Christopher, & Bernard, 2008). Resilience in the Inuit context can also be understood as taking source in interactions between people and their surroundings, and finding new meanings to collective history, revitalizing language and culture, and healing (Kirmayer, Dandeneau, Marshall, Phillips, & Williamson, 2011). The capacity of an individual to be resilient depends on many factors. Being on the land, connecting to Inuit culture, building strong communities

and relationships with family and friends, staying busy (Petrasek MacDonald et al., 2015), and maintaining cultural connectedness (Chandler & Lalonde, 1998) have been identified as protective factors fostering resilience, mental health and well-being.

The available empirical data indicate that Indigenous populations face a higher burden of mental and physical health issues than non-Indigenous populations (King, Smith, & Gracey, 2009; Kirmayer et al., 2007). Results from the *Qanuippitaa?* health survey in 2004 indicate that 13% of the Nunavik population possibly suffered from depression or other mental health disorders at that time. Also, in 2004, 35% of Nunavimmiut reported having had suicide ideation in their lifetime, while 21% had made a suicide attempt in their lifetime (Kirmayer & Paul, 2007). Psychological distress remains a great concern for Nunavik communities and there is a need for up-to-date data to guide policies and actions.

This report covers both well-being and psychological distress. Well-being was assessed using questions on life satisfaction, quality of life, self-esteem, and resilience, while distress was characterized by the presence of depressive symptoms and the experience of suicide ideations and attempts. The report also presents associations between these mental health indicators and selected sociodemographic and sociocultural indicators. Finally, whenever possible, comparisons are made with the results of the *Qanuippitaa?* 2004 Health Survey, as well as with other Inuit Nunangat populations and the non-Indigenous Canadian population.

3 METHODOLOGICAL ASPECTS

Questions on well-being and distress were answered by Nunavimmiut aged 16 years and older. Most of the questions were included in the psychosocial questionnaire of *Qanuilirpitaa?* 2017. The survey questions for this theme are listed in Appendix A.

The first section of this report focuses on well-being, which was documented using perception of life satisfaction, quality of life, self-esteem, and resilience. Life satisfaction was examined with the question “How satisfied are you with your life in general?” using a Likert scale ranging from 1-Very satisfied to 5-Very dissatisfied. This question was also used in *Qanuippitaa?* 2004. Scores were regrouped into two categories: high satisfaction (Very satisfied and Satisfied) versus low satisfaction (all other answers).

Quality of life was evaluated using the two following questions assessing the perception of having sufficient financial resources to meet one’s needs and the general perception of health: “Do you have enough money to meet your needs?”, “In general, would you say your health is...”). For the perception of financial resources, a Likert scale ranging from 1-Not at all to 5-Completely was used and then the 5 categories were combined into 3 (Not at all vs. A little or Moderately vs. Mostly or Completely). Similarly, a Likert scale ranging from 1-Excellent to 5-Poor, was used to assess perception of health. Two categories were then created: Excellent and Very good vs. other answers (Good, Fair, Poor) as a way to reduce small proportions within some categories.

Self-esteem was measured with the Rosenberg self-esteem scale (Rosenberg, 1965). Originally designed to measure the self-esteem of high school students, the scale has been used widely and is considered to be the standard against which other measures of self-esteem are compared. This scale includes seven positive and negative statements such as “I feel that I have much to be proud of”, “On the whole, I am satisfied with myself” or “I certainly feel useless at times”. Negative statements were inverted and the items summed to create a continuous score from 0 to 28 ($\alpha_{\text{Cronbach}} = 0.77$). As no official clinical cut-off has been identified, the top 30 percentile was used as a cut-off for between-group comparisons. It should be mentioned that some score

distributions may have made it impossible to use the 30th percentile specifically. In such situations, an effort was made to use the closest percentile.

Resilience was addressed using the six items from the Brief Resilience Scale (Smith, Dalen, Wiggins, Tooley, Christopher & Bernard, 2008). Participants were asked to rate their ability to face stressful events using a 4-point Likert scale ranging from 1 - Very well to 4-Not at all. As difficulties were encountered by interviewers while administering this tool and a high non-response rate for the reversed items was observed, additional validity analyses were performed to identify a coherent set of items. The three following items were kept and summed to create a continuous score: “I tend to bounce back quickly after hard times”, “It does not take me long to recover from a stressful event”, and “I usually come through difficult times with little trouble” ($\alpha_{\text{Cronbach}} = 0.66$). Participants with a higher score (top 30 percentile) were considered to have a higher resilience score in comparison analyses. Again, the score distribution prevented us from using the 30th percentile specifically, but an effort was made to use the closest percentile.

The second section of this report focuses on distress indicators, which include depressive symptoms and suicide thoughts and attempts. Depressive symptoms were evaluated using the 10-item version of the Center for Epidemiologic Studies Depression Rating Scale (CES-D-10; Radloff, 1977), which was validated in a North American Indigenous adolescent population (Armenta, Hartshorn, Whitbeck, Crawford, & Hoyt, 2014) and judged to have strong psychometric properties for identifying people suffering from depression (Björgvinsson, Kertz, Bigda-Peyton, McCoy, & Aderka, 2013). Rating of self-reported depressive symptoms during the week prior to the interview was done on a 4-point Likert scale ranging from 0-Almost never to 3-All of the time. Participants were considered to present clinically depressive symptoms if their total score was 10 points or higher ($\alpha_{\text{Cronbach}} = 0.71$).

Additionally, two yes/no questions assessed whether participants had seriously thought about committing suicide in their lifetime and in the past 12 months. Two

other questions were used to ask if participants had attempted suicide in their lifetime and in the past 12 months. Contrary to the *Qanuillirpita? 2004* survey, in which questions on suicidal attempts were asked only following a positive answer to the suicidal ideation questions, in the current survey, all participants were questioned on suicide attempt. Indeed, findings from the Nunavik Child Development Study showed that some youth reported having tried to commit suicide without having experienced suicidal ideation (Muckle, Bélanger, Abdous, Ayotte, & Plusquellec, 2016). It is important to consider this methodological difference when comparing results between the two surveys.

Reasons for attempting suicide were examined using a question from the Nunavut 2007-2008 Inuit Health Community Survey (Galloway & Saudny, 2012). Participants who had attempted suicide in the past 12 months were asked whether they had experienced different difficult situations just prior to the attempt (e.g., being in trouble with the law or having drug or alcohol problems). Participants who had attempted suicide in the past 12 months were also asked if they had received emotional support at the time and from whom (e.g., friends or relatives, professionals, a hotline or a website). In addition, as suggested by the Nunavik Regional Board of Health and Social Services representatives during the consultation process, the 2017 survey documented use of the Internet during the 12 months preceding the survey as a source of information about depression, anxiety, stress or suicide.

The analyses presented in this thematic report include cross-tabulations by sex (men/women), coastal region (Hudson/Ungava),² age group (16 to 30/31 to 54/55 years and over), marital status (single/married or common law/separated, divorced or widowed), education (elementary school or less/secondary school not completed/secondary school or higher), employment (employed/not employed),³ annual personal income (less than \$20 000/\$20 000 or more), and community size (large/small).⁴

To integrate cultural specificities, which may influence well-being and distress, associations with several sociocultural indicators were examined (Table 1). Additional information on these sociocultural indicators as well as the related list of questions can be found in the Sociocultural Determinants of Health and Wellness thematic report. (Muckle & al. 2020) Appendix B

Table 1 Sociocultural indicators

Sociocultural indicators	Measurements
CULTURAL IDENTITY	Thirteen statements asking about the importance of Inuit values and identity (e.g., perceived connection among community members, adherence to cultural values) Likert scale: 1-Strongly agree to 5-Strongly disagree; Comparisons: high cultural identity (top 30 percentile) vs. other
FREQUENCY OF GOING ON THE LAND	“From the Spring until now, how often did you go on the land?” Likert scale: 1-Never, 2-Occasionally, 3-Often; Comparisons: Often vs. Occasionally or Never
ABILITY TO PRACTICE TRADITIONAL ACTIVITIES	4 questions. How satisfied are you with your... “ability to go out on the land hunting, fishing and berry picking”, “ability to satisfy country food cravings”, “ability to communicate with others in Inuktitut”, “knowledge and skills of cultural and traditional activities, games, and arts” Likert scale: 1-Very satisfied to 5-Very dissatisfied; Comparisons: Very satisfied vs. other answers
IMPORTANCE OF SPIRITUAL VALUES	“Do spiritual values play an important role in your life?” Yes/No answer
PARTICIPATION IN RELIGIOUS ACTIVITIES	“During the past 12 months, not counting events such as weddings or funerals, how often did you participate in religious activities or attend religious services or meetings?” Likert scale: 1-Never to 4-One or a few times a week; Comparisons: participation at least once a month vs. < once a month
FOUR TYPES OF SOCIAL SUPPORT	6 questions. Frequency of four types of social support: <ul style="list-style-type: none"> > positive interactions: “Have someone to have a good time with” > emotional support: “Have someone to talk to if I feel troubled or need emotional support”, “Have someone to count on when I need advice”, “Have someone to listen to me when I need to talk” > tangible support for transportation to health services: “Have someone to take me to the doctor or another health professional if needed” > love and affection: “Have someone who shows me love and affection” Likert scale: 1-All of the time to 5-Never. Comparisons: All and Most of the time (for the item or for all three items) vs. other answers
FAMILY COHESION	6 questions: 5 from the Brief Family Relationship Scale questionnaire + one adapted to Inuit culture. In my close family... “there is a feeling of togetherness”, “we really help and support each other”, “we really get along well with each other”, “we spend a lot of time doing things together at home”, “we spend a lot of time doing things together on the land”, “I am proud to be a part of my family” Likert scale: 1-Very true to 3-Not true; Comparisons: high family cohesion (top 30 percentile) vs. other
COMMUNITY COHESION	4 questions on respondent’s perception of social cohesion in the community: “There is a feeling of togetherness or closeness”, “People help others”, “People can be trusted”, “I feel like I belong” Likert scale: 1-Strongly agree to 5-Strongly disagree; Comparisons: high community cohesion (top 30 percentile) vs. other

Table 1 Sociocultural indicators (*continued*)

Sociocultural indicators	Measurements
<p>INVOLVEMENT IN COMMUNITY ACTIVITIES</p>	<p>Frequency of involvement in two types of community activities: “Participation in cultural, community or sports events such as festivals, dances, feasts or Inuit games”, “Volunteered for a group, an organization or community event such as a rescue team, church group, feasts, spring clean-up” Likert scale: 1-Always to 5-Never; Comparisons: Always or Often vs. Sometimes, Rarely or Never</p>
<p>PARTICIPATION IN HEALING AND WELLNESS ACTIVITIES</p>	<p>“In the past 12 months, have you taken part in any activities to promote your own healing or wellness?” Yes/No answer</p>
<p>POSITIVE PERCEPTION OF HEALTH SERVICES</p>	<p>5 questions: “I have confidence in health services”, “I have confidence in social services”, “I am aware of the resources to help solve my health problems”, “Health services are sensitive to Inuit realities”, “Social services are sensitive to Inuit realities” Likert scale: 1-Strongly agree to 5-Strongly disagree; Comparisons: positive perception of health services (top 30 percentile) vs. other</p>
<p>SEDENTARY TIME</p>	<p>“During the last 7 days, how much time did you spend sitting on a week day?”; Comparisons: > 7 hours vs. ≤ 7 hours</p>

Comparison tests were performed with a global chi-square test for categorical variables to find out if any proportion was different across categories. In the presence of a significant result ($p < 0.05$; coloured cells in tables), two-by-two comparisons were performed to further identify statistically significant differences between categories. These tests involved the construction of a Wald statistic based on the difference between the logit transformations of the estimated proportions. Only significant differences at the 5% threshold are reported in the text and all other tested factors found to be non-related are presented in the tables in Appendix B. Significant differences between categories are denoted in the tables and figures using superscripts. Proportions for comparison between 2004 and 2017 are age-adjusted. All data analyses for this thematic report were done using SAS software, Version 9.4 (SAS Institute Inc., Cary, NC, USA).

Limitations. Only bivariate analyses were performed to describe associations with selected social and cultural indicators. These analyses do not take into consideration possible confounding or interaction effects. Consequently, these results should be interpreted with caution.

Accuracy of estimates. The data used in this report come from a sample and are thus subject to a certain degree of error. Following the guidelines of the Institut de la Statistique du Québec (ISQ), coefficients of variation (CV) were used to quantify the accuracy of estimates. Estimates with a CV between 15% and 25% are accompanied by a * to indicate that they should be interpreted carefully, while estimates with a CV greater than 25% are presented with a ** and are shown for information purposes only.

4 RESULTS

This section presents indicators of well-being and psychological distress among Nunavimmiut, according to levels of sociodemographic and sociocultural factors.

4.1 WELL-BEING

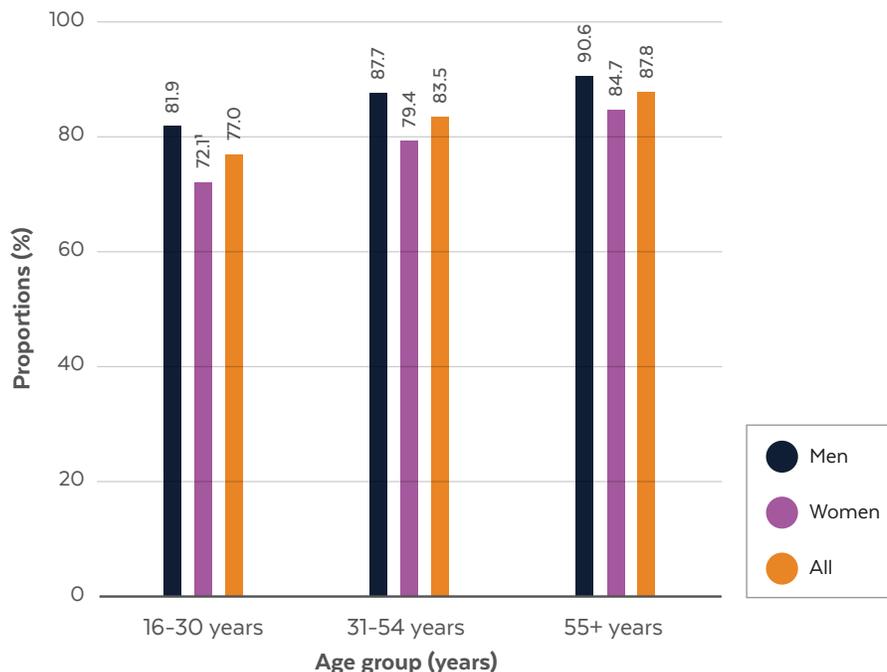
4.1.1 Life satisfaction

A large majority of the Nunavik population (81%) reported being satisfied or very satisfied with their life in general. The proportion is greater than that of 73% observed in 2004. Overall, men reported being satisfied or very satisfied with their life in greater proportion than women

(86% vs. 77%). Variations were observed according to sex and age group (Figure 1). Women aged 55 and older and 31 to 54 were more likely to report being satisfied or very satisfied than those aged 16 to 30.

Higher satisfaction in life was reported by Nunavimmiut who were in a relationship (88% vs. 73% for people who were single), and by people earning \$20 000 or more per year (85% vs. 78% for people earning less) (Appendix B, Table A).

Figure 1 Proportion of the population that is very satisfied or satisfied with life in general (%), by sex and age, population aged 16 years and over, Nunavik, 2017



NOTE

1. Statistically significant difference observed using the 5% threshold compared to women aged 31 to 54 years old and women aged 55 years and over.

Higher satisfaction in life was also observed in greater proportion among Nunavimmiut (Appendix B, Table B):

- > with stronger cultural identity (91% vs. 78% with lower cultural identity),
- > who were very satisfied with their knowledge and skills of cultural and traditional activities, games, and arts (89% vs. 79% who were less satisfied),
- > who went often out on the land (86% vs. 78% who went occasionally or never),
- > who were very satisfied with their ability to go out on the land hunting, fishing and berry picking (89% vs. 74% who were less satisfied),
- > who were very satisfied with their ability to meet their country food cravings (86% vs. 77% who were less satisfied),
- > who were very satisfied with their ability to communicate with others in Inuktitut (87% vs. 75% who were less satisfied).

Nunavimmiut who were satisfied or very satisfied with their life in general reported the following characteristics (Appendix B, Table C):

- > greater emotional support (85% vs. 80% for lower emotional support),
- > more positive interactions (85% vs. 75% for less positive interactions),
- > more love and affection (84% vs. 74% for less love and affection),
- > greater family cohesion (94% vs. 76% for lower family cohesion),
- > greater community cohesion (89% vs. 77% for lower community cohesion),

- > more frequent participation in cultural community events (86% vs. 79% for people who participated less),
- > more frequent volunteering in groups or organizations (88% vs. 78% for people who volunteered less).

Cross tabulations with sociocultural indicators are presented in Appendix B, Tables A, B and D.

4.1.2 Quality of life

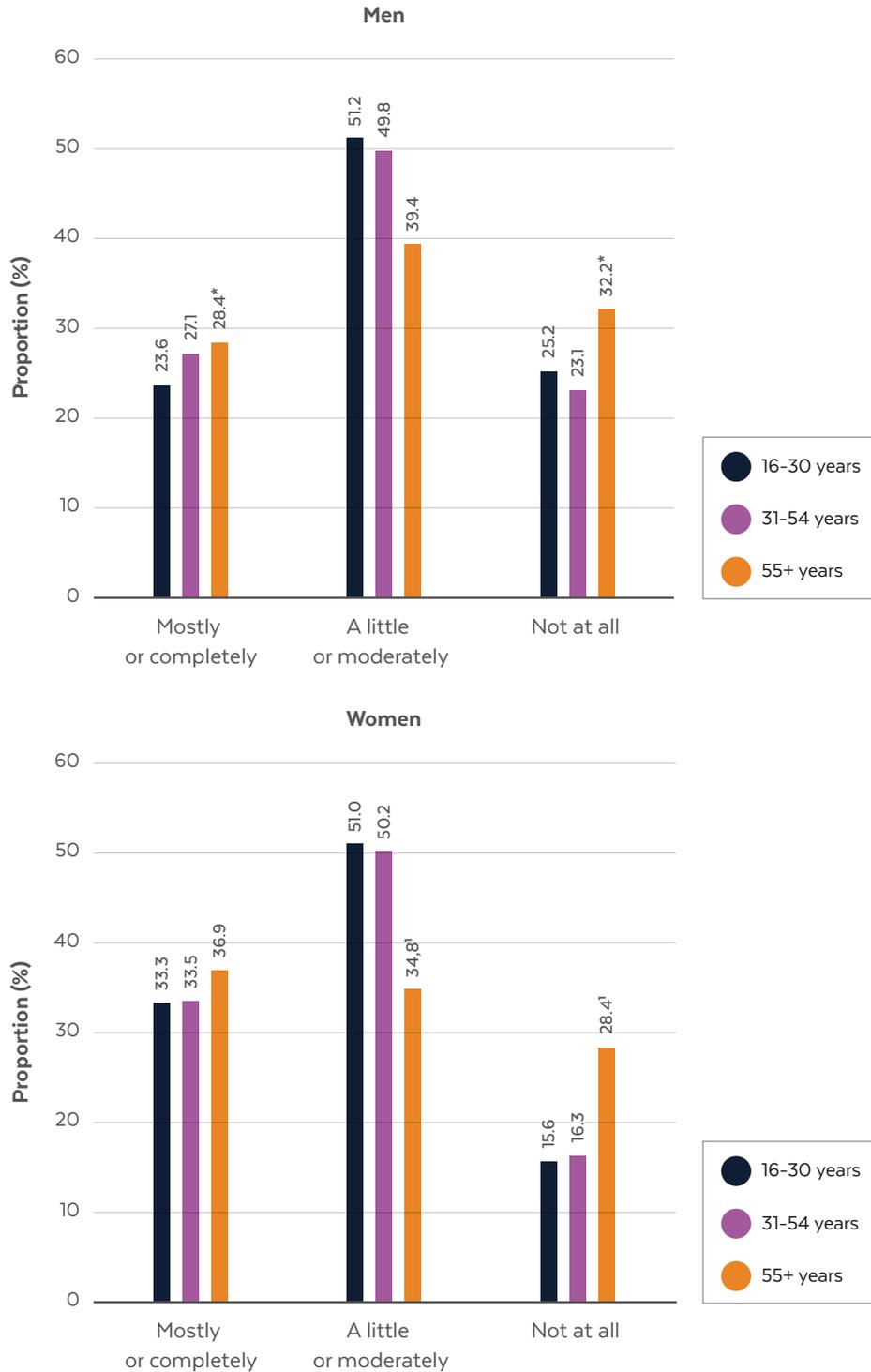
Two dimensions of quality of life were assessed: the perception of having enough money to meet one's need and the general perception of one's health.

4.1.2.1 Having enough money to meet needs

While 30% of the Nunavik population was satisfied with the money available to meet their needs (answered mostly or completely to the question "Do you have enough money to meet your needs?"), 22% reported they did not have enough money at all. Women were more likely than men to consider that their financial resources met their needs mostly or completely (34% vs. 26%), while a greater proportion of men considered that they did not have enough money at all (26% vs. 18% for women). Globally, Nunavimmiut aged 55 and older reported in higher proportion not having enough money to meet their needs (Appendix B, Table A).

Variations according to sex and age are presented in Figure 2. A greater proportion of women aged 55 years and over reported not having enough money at all to meet their needs compared with younger women.

Figure 2 Proportion of the population that reported having enough money to meet their needs (%), by sex and age, population aged 16 years and over, Nunavik, 2017



NOTES

- * The coefficient of variation is greater than 15% and lower than or equal to 25%. The proportion should be interpreted carefully.
- 1. Statistically significant difference observed using the 5% threshold compared to women aged 16 to 30 years old and women aged 31 to 54 years old.

The feeling of having enough money (mostly or completely) to meet one’s needs was associated with the following characteristics (Appendix B, Tables A to D):

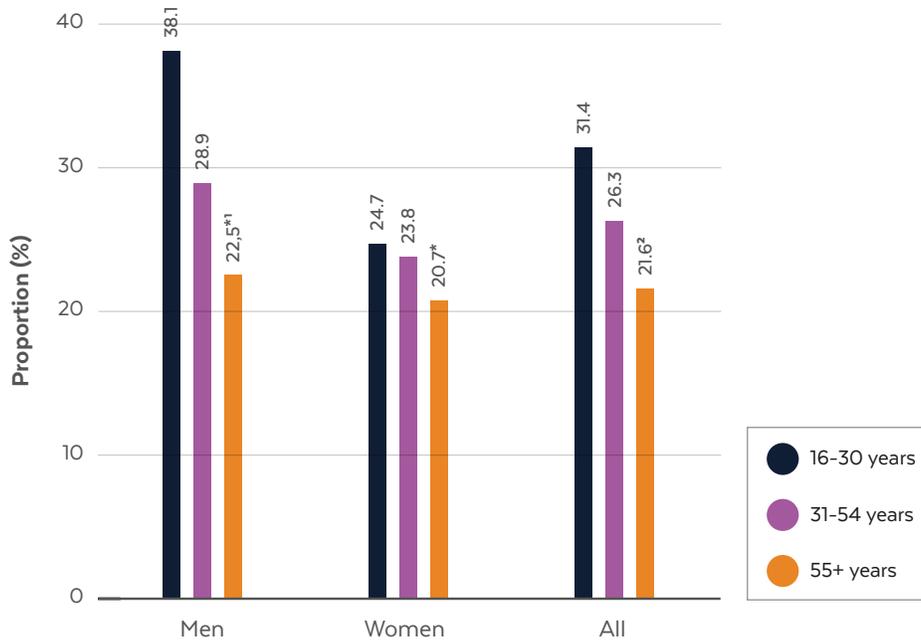
- > marital status (35% for married or common law vs. 23% for single and 29% for separated, divorced or widowed),
- > more education (43% for secondary school or higher vs. 25% for secondary school not completed and 24% for elementary school or less),
- > currently employed (35% vs. 20% for not employed),
- > greater annual personal income (41% for at least \$20 000 vs. 19% for less than \$20 000),
- > very high satisfaction with the ability to go out on the land, hunting, fishing and berry picking (33% vs. 26% for lower satisfaction),
- > higher emotional support (40% vs. 25% for lower emotional support),
- > more love and affection (33% vs. 20% for less love and affection),

- > higher family cohesion (34% vs. 27% for lower family cohesion),
- > frequent participation in cultural community activities (35% vs. 26% for lower participation).

4.1.2.2 General perception of health

In response to the question “In general, would you say your health is...”, 28% of Nunavimmiut answered very good or excellent, statistically, than that of 23% observed in the *Qanuillirpita?* 2004 Health Survey. A higher proportion of men than women considered their health as very good or excellent (32% vs. 24%). Variations according to age and sex were observed (Figure 3). Younger men (16 to 30 years old) were more likely to consider their health as very good or excellent compared to men aged 55 years and older; such differences according to age were not observed among women.

Figure 3 Proportion of the population who considered their health as very good or excellent (%), by sex and age, population aged 16 years and over, Nunavik, 2017



NOTES

- * The coefficient of variation is greater than 15% and lower than or equal to 25%. The proportion should be interpreted carefully.
- 1. Statistically significant difference observed using the 5% threshold compared to men aged 16 to 30 years old.
- 2. Statistically significant difference observed using the 5% threshold compared to Nunavimmiut aged 16 to 30 years old.

Working people also considered their health as very good or excellent in higher proportions than people who were not working (30% vs. 24%) (Appendix B, Table A).

Regarding cultural identity, values, and activities, the proportion of people considering their health as very good or excellent was higher among those who were (Appendix B, Table B):

- > in agreement with most of the statements related to cultural identity (35% vs. 25% for people who agreed less),
- > very satisfied with their ability to go out on the land, hunting, fishing and berry picking (34% vs. 22% for people who were less satisfied),
- > very satisfied with their ability to fill their country food cravings (30% vs. 26% for people who were less satisfied),
- > very satisfied with their ability to communicate in Inuktitut (31% vs. 24% for people who were less satisfied),
- > very satisfied with their knowledge and skills of cultural and traditional activities, games, and arts (37% vs. 24% for people who were less satisfied).

Regarding social support and family and community cohesion, people with very good or excellent health perception reported in higher proportion the following characteristics (Appendix B, Tables C and D):

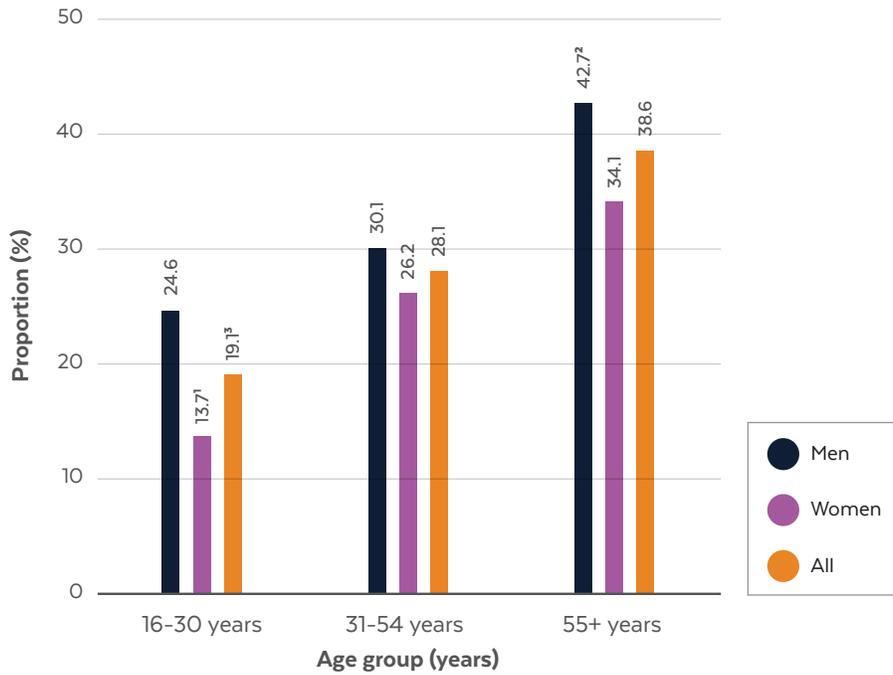
- > higher emotional support (33% vs. 25% for lower emotional support),
- > higher positive interactions (33% vs. 18% for lower positive interactions),

- > higher family cohesion (36% vs. 24% for lower family cohesion),
- > higher community cohesion (33% vs. 24% for lower community cohesion),
- > frequent participation in cultural community activities (32% vs. 25%) for people who participated less,
- > regular or frequent participation in activities promoting healing and wellness (34% vs. 25% for people who participated less).

4.1.3 Self-esteem

Using a mean score, no difference was observed for self-esteem between *Qanuilirpitaa?* 2017 and *Qanuippitaa?* 2004, (mean score of 21 on a maximum score of 28 for both surveys). For ease of interpretation, subsequent cross-tabulation analyses for *Qanuilirpitaa?* 2017 are presented using the top 30th percentile as the criterion for high self-esteem. Thus, about one out of four (26%) Nunavimmiut had a high level of self-esteem. Men were more likely to meet this criterion than women (30% vs. 22%), as were older people compared to younger ones of both sexes (Figure 4).

Figure 4 Proportion of the population with high levels of self-esteem (%), by sex and age, population aged 16 years and over, Nunavik, 2017



NOTES

1. Statistically significant difference observed using the 5% threshold compared to people of the same sex aged 31 to 54 years old and 55 years and over.
2. Statistically significant difference observed using the 5% threshold compared to people of the same sex aged 16 to 30 years old and 31 to 54 years old.
3. Statistically significant difference observed using the 5% threshold compared to Nunavimmiut aged 31 to 54 years old and 55 years and over.

Higher self-esteem was seen in greater proportion among Nunavimmiut (Appendix B, Table A):

- > from Hudson coast (31% vs. 23% for Hudson coast),
- > who were not single at the time of the survey (31% for married or common law people and 33*% for divorced, separated or widowed people vs. 19% for single people),
- > with a higher level of education (37% for secondary school or higher vs. 23*% for elementary school or less and 21% for secondary school not completed),
- > with a higher annual personal income (37% for \$20 000 or more vs. 19% for less than \$20 000),
- > who are currently employed (29% vs. 20% for those not employed).

Regarding cultural identity, values, and activities, the proportion of people with a high self-esteem level was higher among those who (Appendix B, Table B):

- > agreed with most of the statements related to their cultural identity (34% vs. 23% for people who agreed less),

- > went often out on the land (30% vs. 23% for people who went occasionally or never),
- > were very satisfied with their ability to go out on the land, hunting, fishing and berry picking (32% vs. 20% for people who were less satisfied),
- > were very satisfied with their ability to communicate in Inuktitut (33% vs. 18% for people who were less satisfied),
- > were very satisfied with their knowledge and skills of cultural and traditional activities, games, and arts (34% vs. 23% for people who were less satisfied).

Regarding people’s perception about social support and family and community cohesion, those with a high self-esteem score reported in higher proportions the following characteristics (Appendix B, Table C):

- > higher emotional support (41% vs. 19% for lower emotional support),
- > higher tangible support for transportation to health services (33% vs. 21% for lower tangible support),

- > higher positive interactions (28% vs. 21% for less positive interactions),
- > more love and affection (30% vs. 16% for less love and affection),
- > higher family cohesion (39% vs. 20% for lower family cohesion),
- > higher community cohesion (31% vs. 23% for lower community cohesion),
- > frequent participation in cultural or community activities (33% vs. 21% for people who participated less),
- > frequent volunteering in groups or organizations (32% vs. 23% for people who volunteered less).

4.1.4 Resilience

Overall, about one out of five Nunavimmiut (18%) exhibited a high level of resilience (top 30 percentile). Specifically, about two to three out of ten were very much in agreement with the resilience questions: “I tend to bounce back quickly after hard times” (26%), “It does not take me long to recover from a stressful event” (25%), and “I usually come through difficult times with little trouble” (21%). Higher resilience scores were observed in greater proportion among older people (32% among people aged 55 years and over vs. 15% in two other groups) (Appendix B, Table A).

High resilience scores were also seen in greater proportion among Nunavimmiut who (Appendix B, Table B):

- > agreed with most of the statements related to their cultural identity (33% vs. 12% for people who agreed less),
- > presented high satisfaction with their ability to go out on the land, hunting, fishing and berry picking (21% vs. 14% for people who were less satisfied),
- > presented high satisfaction with their ability to meet their country food cravings (21% vs. 15% for people who were less satisfied),
- > presented high satisfaction with their ability to communicate in Inuktitut (21% vs. 14% for people who were less satisfied),
- > presented high satisfaction with their knowledge and skills of cultural and traditional activities, games, and arts (27% vs. 14% people who were less satisfied),
- > participated in religious activities at least once a month (21% vs. 16% for people who participated less).

Regarding people’s perception about social support and family and community cohesion, members of the Nunavik population with the following characteristics were more likely to have high resilience (Appendix B, Table C):

- > people with more positive interactions (20% vs. 14% for people with less positive interactions),
- > people with higher family cohesion (27% vs. 14% for people with a lower level of family cohesion),
- > people with higher community cohesion (22% vs. 15% for people with a lower level of community cohesion),
- > people who volunteered more often in groups or organizations (25% vs. 15% for people who volunteered less).

Results involving resilience scores have to be interpreted with caution considering the difficulties encountered by the interviewers while administering the questions and the limited internal consistency of the instrument.

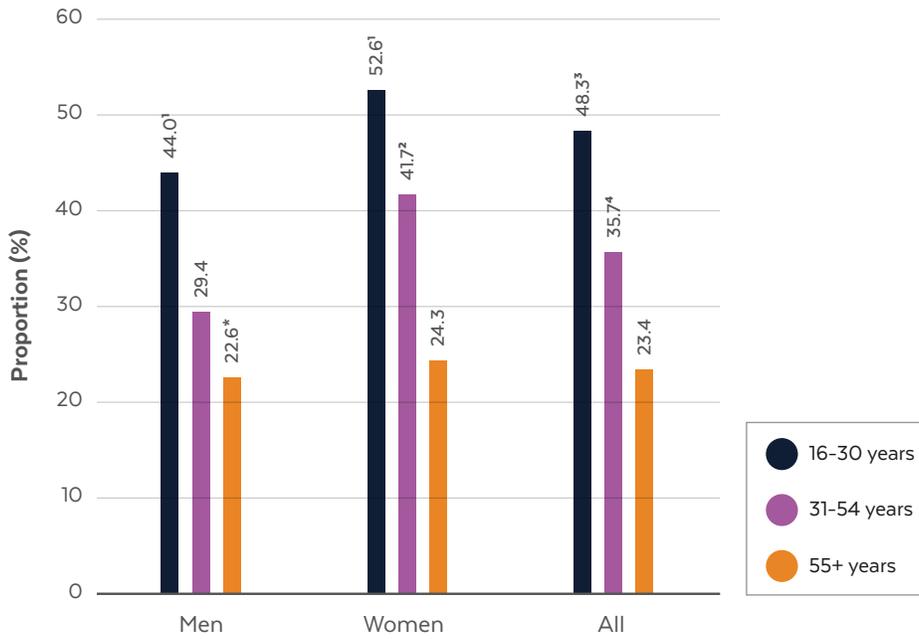
4.2 PSYCHOLOGICAL DISTRESS

4.2.1 Depressive symptoms

Depressive symptoms during the week preceding the survey were documented using the CES-D-10 depression scale with the standardized cut-off of 10 out of 30 to identify people with clinically significant symptoms. Overall, 39% of the Nunavik population reached this cut-off of clinically significant depressive symptoms, and the proportion was greater among women than men (44% vs. 35%).

Sociodemographic characteristics that potentially increase the likelihood of having a depression score above the clinical cut-off are presented in Figure 5 and Table E in Appendix B. For both men and women, the prevalence of clinically significant depressive symptoms was higher among younger people (aged 16 to 30) than older ones.

Figure 5 Proportion of the population with clinically significant depressive symptoms on the CES-D-10 scale (%), by sex and age group, population aged 16 years and over, Nunavik, 2017



NOTES

* The coefficient of variation is greater than 15% and lower than or equal to 25%. The proportion should be interpreted carefully.

1. Statistically significant difference observed using the 5% threshold compared to people of the same sex aged 31 to 54 years old and 55 years and over.
2. Statistically significant difference observed using the 5% threshold compared to people of the same sex aged 55 years and over.
3. Statistically significant difference observed using the 5% threshold compared to people aged 31 to 54 years old and 55 years and over.
4. Statistically significant difference observed using the 5% threshold compared to people aged 55 years and over.

Furthermore, the greatest proportions of clinically significant depressive symptoms were observed among people who (Appendix B, Table E):

- > were single at the time of the survey (48% vs. 33% for married or common law people, 32% for separated, divorced or widowed people),
- > had a lower level of education (42% for secondary school not completed vs. 33% for secondary school or higher),
- > earned less than \$20 000 per year (45% vs. 31% for people who earned more),
- > did not work (46% vs. 36% for people who worked),
- > lived in small communities (46% vs. 34% for residents of large communities).

As with the differences observed according to personal income and employment status, people who reported enough money (mostly or completely) to meet their needs were less likely to reach the clinically significant cut-off for depression (24% vs. 34%) (data not shown).

For the first time in a health survey conducted in Nunavik, proportions of clinically significant depressive symptoms were examined according to sociocultural indicators (Appendix B, Tables F, G and H). Higher depression scores were seen in greater proportion among people who:

- > agreed less with most of the statements related to cultural identity (42% vs. 33% for people who agreed more),
- > considered themselves not very satisfied with their knowledge and skills of cultural and traditional activities, games, and arts (42% vs. 31% for people who were very satisfied),
- > reported lower satisfaction with their ability to communicate in Inuktitut (44% vs. 35% for people who were very satisfied),
- > reported lower satisfaction with their ability to go out on the land hunting, fishing and berry picking (44% vs. 34% for people who were very satisfied).

The proportions of the Nunavik population with clinically significant depressive symptoms were compared according to people’s perception of support, family cohesion and community involvement. The following characteristics were associated with a higher likelihood of depression (Appendix B, Tables G and H):

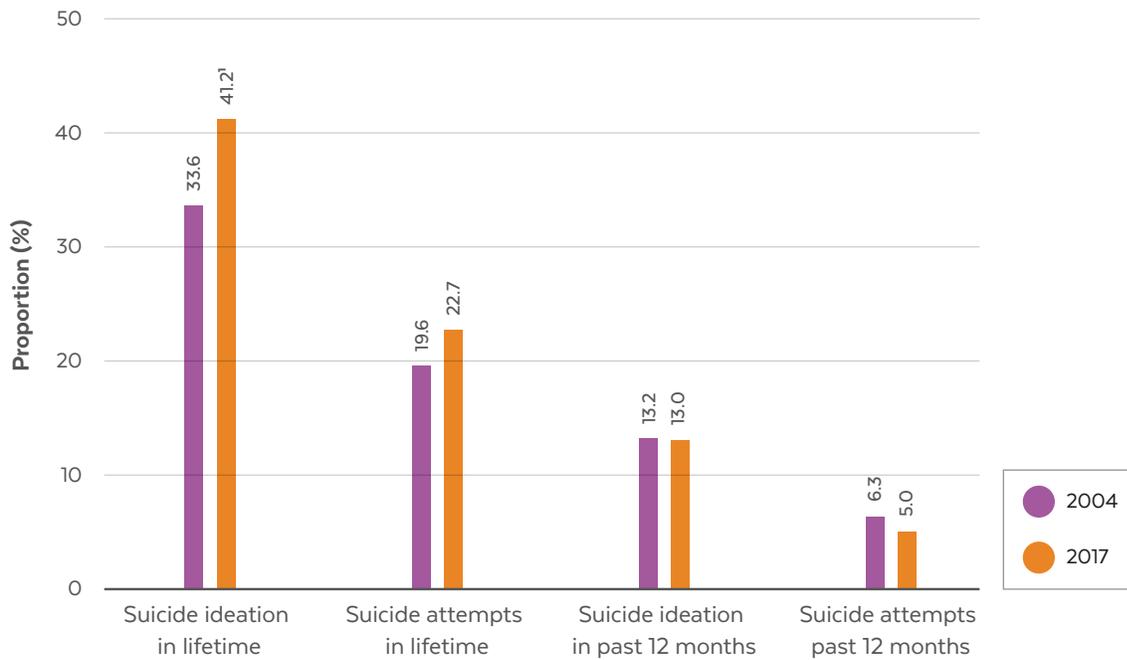
- > lower emotional support (43% vs. 32% for higher emotional support),
- > lower positive interactions (44% vs. 37% for higher positive interactions),
- > lower family cohesion (42% vs. 32% for higher family cohesion),
- > less frequent participation in cultural or community events (42% vs. 35% for more frequent participation),
- > less frequent participation in religious activities (42% vs. 35% for people who participated at least monthly),
- > higher participation in activities promoting healing and wellness (44% vs. 37%).

Interestingly, about five out of ten Nunavimmiut (54%) with clinically significant depressive symptoms declared having used the Internet to look up information about depression, anxiety, stress, or suicide during the previous year, compared to 37% for those who felt better (Appendix B, Table H).

4.2.2 Suicide ideation and attempts

Lifetime experience of suicidal ideation was reported by 41% of Nunavimmiut, and 30% had made a suicide attempt in their lifetime. Proportions during the year prior to the survey were 13% for suicide ideation and 6% for suicide attempts. Figure 6 presents proportions of lifetime and past-12-month suicide ideation and attempts as derived from *Qanuippitaa? 2004* and *Qanuillirpita? 2017*, calculated with the procedure used in *Qanuippitaa? 2004* (in 2004, participants were asked about suicide attempts only when they reported suicide ideation, while in 2017, all respondents were asked about suicide attempts, regardless of the presence or not of suicidal ideation). Using the data computation procedure of 2004, the prevalence of suicide attempts was not different between the two surveys, although lifetime suicidal ideation significantly increased by 8% in 2017.

Figure 6 Proportion of the population by suicide ideation and attempts in lifetime and in the past 12 months (%), population aged 16 years and over, Nunavik, 2004 and 2017^a



NOTES

- a. Proportions for comparison between 2004 and 2017 are age-adjusted.
- 1. Statistically significant difference observed using the 5% threshold compared to 2004.

Table 2 lists the proportions of suicidal ideation and attempts according to sex and age in 2017. Overall, rates of suicide ideation and attempts in lifetime and in the year prior to the survey were higher among women as well as among younger Nunavimmiut of both sexes. However, these results should be interpreted carefully due to the high coefficients of variation and the small number of respondents.

Table 2 Proportion of the population according to suicide ideation and attempts in lifetime and in the past 12 months (%), population aged 16 years and over, Nunavik, 2017

	Sex		Men			Women		
	Men	Women	16-30	31-54	55+	16-30	31-54	55+
Lifetime								
Suicide ideation	35.4 ¹	47.0	40.9 ²	35.9 ²	21.2*	56.3 ^{2,3}	45.7 ²	24.4
Suicide attempts	26.5 ¹	33.4	29.4	28.6	15.0**	42.8 ^{2,3}	31.0 ²	13.5*
Past 12 months								
Suicide ideation	11.2*	14.7	20.5 ³	5.9**	NP	21.8 ³	11.7*	NP
Suicide attempts	3.9** ¹	7.2	7.4**	NP	NP	11.8	4.8**	NP

NOTES

Coloured cells indicate statistically significant comparisons.

NP: This value is not displayed since some categories have less than 5 respondents.

* The coefficient of variation is greater than 15% and lower than or equal to 25%. The proportion should be interpreted carefully.

** The coefficient of variation is greater than 25%. The proportion is shown for information only.

1. Statistically significant difference observed using the 5% threshold compared to women.
2. Statistically significant difference observed using the 5% threshold compared to people of the same sex aged 55 years and over.
3. Statistically significant difference observed using the 5% threshold compared to people of the same sex aged 31 to 54 years old.

Suicide ideation according to sociodemographic and sociocultural indicators (Appendix B, Tables E to H)

Nunavimmiut who had had suicidal ideations in their lifetime were more likely to:

- > have been single at the time of the survey (45% vs. 30% for separated, divorced or widowed people),
- > have a higher level of education (45% for secondary school or higher vs. 42% for secondary school not completed and 28%* for elementary school or less),
- > not consider that spiritual values play an important role in their life (49% vs. 39% for people who consider that spiritual values play an important role),
- > not participate monthly in religious activities (44% vs. 37% for participating monthly),
- > spend more than 7 hours per day seated (48% vs. 37% for spending 7 hours or less seated),
- > experience lower family cohesion (44% vs. 36% for higher family cohesion),
- > experience lower community cohesion (45% vs. 34% for higher community cohesion).

Suicide ideations during the year prior to the survey were declared in greater proportion by people who:

- > were single at the time of the survey (18% vs. 10% for married or common law people),
- > were residents of the Ungava coast (16% vs. 10% for people living on the Hudson coast),
- > did not consider that spiritual values play an important role in their life (20% vs. 11% considering that spiritual values play an important role),
- > reported lower family cohesion (16% vs. 7% for higher family cohesion),
- > reported lower community cohesion (15% vs. 9% for higher community cohesion).

Nunavimmiut experiencing suicidal ideations in the past 12 months were more likely to participate in activities promoting healing and wellness during the same time period (18% vs. 11%). Using the Internet to find information about depression, anxiety, stress, or suicide was more likely to be reported by people who experienced suicidal ideations (lifetime: 68% vs. 38%; previous year: 38% vs. 10%).

Suicide attempts according to sociodemographic and sociocultural indicators (Appendix B, Tables E to H)

Lifetime suicidal attempts were more likely to be declared by people who:

- > were single at the time of the survey (34% vs. 27% for married or common law people),
- > had not completed secondary school (34% vs. 21% for elementary school or less and 25% for secondary school or higher)
- > reported lower levels of love and affection (35% vs. 28% for higher levels of love and affection),

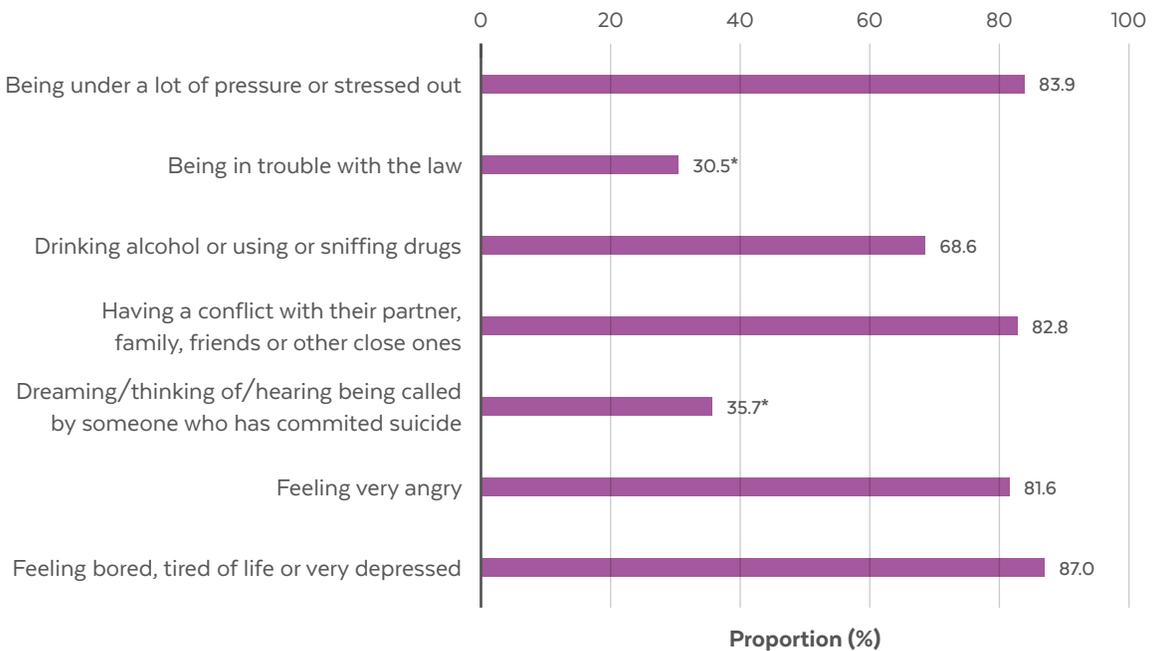
The proportions of people who declared having attempted suicide during the year prior to the survey were too small and imprecise to be cross-tabulated with sociodemographic and sociocultural indicators.

Regarding self-help behaviours, Nunavimmiut who had attempted suicide were more likely to have engaged in activities promoting health and wellness during the previous year (37% vs. 27%), and were more likely to have used the Internet to find information about depression, anxiety, stress, or suicide (46% vs. 28%).

4.2.3 Situations people were in before they attempted suicide

Nunavimmiut who reported having attempted suicide in the 12 months preceding the survey were asked to identify, among a list of situations, whether they had experienced any such situations just before attempting suicide. The following situations were reported simultaneously or independently by seven or eight out of ten people: “Feeling bored, tired of life or very depressed”, “Being under a lot of pressure or stressed out”, “Having a conflict with their partner, family, friends or other closed ones”, “Feeling very angry”, “Drinking alcohol or using or sniffing drugs” (Figure 7).

Figure 7 Proportion of the population having attempted suicide in the past 12 months according to the situation they were in just before attempting suicide, (%), population aged 16 years and over, Nunavik, 2017



NOTE

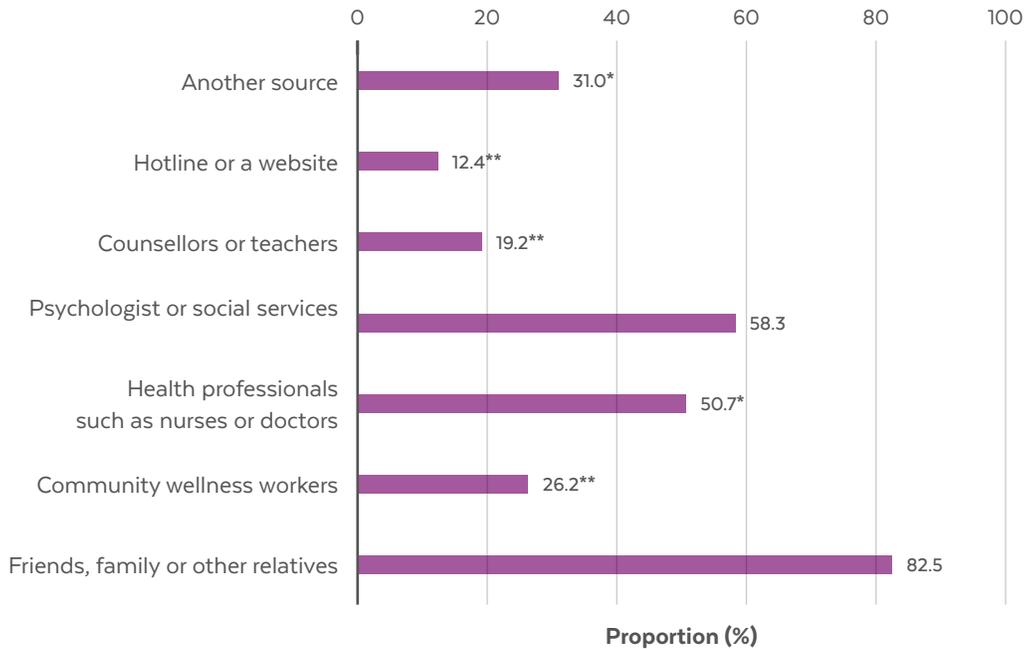
* The coefficient of variation is greater than 15% and lower than or equal to 25%. The proportion should be interpreted carefully.

4.2.4 Emotional support at the time of attempted suicide

Among Nunavimmiut who reported having attempted suicide in the previous year, 65% declared having received emotional support at that time.

People turned mostly towards friends, family or other relatives for help (83%). Psychologists or social services (58%) and health professionals such as nurses or doctors (51%) were also significant sources of emotional support, as shown by the fact that they were reported by half of the people who had reported a suicide attempt in the previous year (Figure 8).

Figure 8 Proportion of the population who reported attempting suicide in the past 12 months according to the source of emotional support they received at that time (%), population aged 16 years and over, Nunavik, 2017



NOTES

* The coefficient of variation is greater than 15% and lower than or equal to 25%. The proportion should be interpreted carefully.

** The coefficient of variation is greater than 25%. The proportion is shown for information only.

5 DISCUSSION

Eight out of ten Nunavimmiut (81%) reported being satisfied or very satisfied with their life in general. This proportion has increased by 8% from the 73% observed in *Qanuippitaa?* 2004. However, it is lower than the proportion of 93% observed in 2016 in the general Canadian population aged 12 and older (Statistics Canada, 2019a). Three out of ten Nunavimmiut (28%) considered their health as excellent or very good. This proportion increased from 22% in 2004 to 28% in 2017, but it is below that of 61% noted in 2017 for the general Canadian population aged 12 and older (Statistics Canada, 2019b).

Three out of ten Nunavimmiut (30%) responded “Mostly” or “Completely” to the question about having enough money to meet their needs. It is well known that employment is limited and the cost of living is high in Nunavik (Inuit Tapiriit Kanatami, 2014). Moreover, the high cost of food has been well documented (Duhaime et al., 2015). According to Ready, being married or in a common law household where both adults work seems to offer considerable economic advantages when it comes to purchasing necessities; furthermore, people in married or common law households participate to a greater extent in traditional food harvesting (Ready, 2018).

Self-esteem, referred to as self-worth or self-respect, can be an important part of well-being, and too little self-esteem can leave people feeling defeated or depressed. People with good self-esteem exhibit confidence and the ability to recognize their overall strengths and weaknesses and accept them. They are also able to express their needs. In this survey, self-esteem was documented as an individual characteristic related to positive health. About one out of four Nunavimmiut (26%) had a high level of self-esteem and the proportion was similar to that reported in *Qanuippitaa?* 2004. Comparisons with results from the 2003 Canadian Community Health Survey (Statistics Canada 2012) are imperfect due to the use of a different version of the Rosenberg scale. Nevertheless, self-esteem scores seem to be similar among Nunavimmiut and the general Canadian population (mean scores of 20 and 21 for the Canadian and the Nunavik populations, respectively).

Another characteristic likely to be related to greater adaptation when coping with life difficulties is resilience, which was assessed for the first time in Nunavik in the framework of the *Qanuillirpita?* 2017 Health Survey. Resilience refers to the process of adapting well when facing adversity, trauma or stressors such as relationship problems, serious health problems or financial stressors. It means “bouncing back” from difficult experiences and does not mean that a person doesn’t experience difficulty or distress. Resilience is not a trait that people either have or do not have. It involves behaviours, thoughts and actions that can be learned and developed (American Psychological Association, 2019). In the Inuit culture, it originates within interactions between people, their communities and the social and ecological systems in which they take part (Kirmayer, Dandeneau, Marshall, Phillips, & Williamson, 2011).

The results of *Qanuillirpita?* 2017 indicate that 18% of Nunavimmiut have a high level of resilience and that the proportion is higher among people aged 55 and over. These results should be interpreted with caution due to the difficulty encountered in answering certain questions, the limited internal consistency of the instruments employed, and the fact that this is the first time this measure has ever been used in Nunavik. Furthermore, the terms “hard times”, “stressful events”, “something bad” and “set-backs” are not defined in the questions aiming to measure resilience and can be interpreted differently by different people and by people from different cultures. Nevertheless, in comparison, 37% of the Canadian general population aged 15 or older reported in 2016 that they always tend to bounce back quickly after hard times (Statistics Canada, 2016b). Using the same instrument, the proportion was 26% for Nunavimmiut aged 16 or over.

Psychological distress was documented using 1) the CES-D-10 depression scale and 2) questions on suicidal thoughts and attempts that were included in previous health surveys conducted in Nunavik (1992 and 2004). Results from the *Qanuillirpita?* 2017 survey revealed that about four out of ten Nunavimmiut (39%) reached the cut-off value on the CES-D-10 that is indicative of clinically relevant depressive symptoms during the week prior to the

interview. Comparisons with results from the *Qanuippitaa?* 2004 survey are very imperfect due to the use of a different self-reported questionnaire to assess psychological distress: the K-6 scale, which is used to assess depression and other mental disorders during the previous month (Kessler et al., 2003). In 2004, 13% of the Nunavik population was identified as presenting symptoms of depression or other common mental disorders using the K-6 scale instrument. Although the surveys conducted in 2004 and 2017 used different scales to assess psychological distress, the trends observed were similar to those obtained in 2004, i.e., greater distress among women, younger Nunavimmiut (15–29 years of age), single individuals and people with lower income (Kirmayer & Paul, 2007). With regard to the higher level of distress among youth, nearly half (48%) of Nunavimmiut aged 16 to 30 reached the cut-off for clinically relevant depressive symptoms in 2017. This proportion is higher than the 28% obtained using the same scale in a non-representative sample of adolescents aged 16 to 21, who participated to the Nunavik Child Development Study (Pepin, Muckle, Moisan, Forget-Dubois, & Riva, 2018). Taken together, the results of these studies clearly indicate that young Nunavimmiut are at high risk of experiencing psychological distress.

The rate of death by suicide began to rise in the 1970s in Inuit Nunangat (Inuit Tapiriit Kanatami, 2016) and has remained very high especially among youth, making suicide a major public health concern. According to the most recent data published by INSPQ, the rate of death by suicide in Nunavik was 10 times higher for men and 6 times higher for women compared to the population of the province of Quebec during the 2015–2017 period (Levesque et al. 2020). Among Nunavimmiut who reported suicidal thoughts in their lifetime, the proportion who declared a suicidal attempt during the year prior to the *Qanuilirpitaa?* 2017 survey was 5%, a value similar to the ones observed in 2004 (7%) and 1992 (6%) (Santé Québec Health Survey 1992). The proportion of the population who reported suicidal thoughts and declared a suicidal attempt during their lifetime was 13% in 1992, 20% in 2004 and 23% in 2017. When considering everyone and not only people who declared having had suicidal thoughts in their lifetime, 30% of Nunavimmiut reported a suicide attempt in their lifetime. In comparison, 12% of First Nations adults living on-reserve reported a lifetime suicide attempt in the 2008–2010 First Nations Regional Health Survey (McQuaid et al., 2017). As reported for depression, the *Qanuilirpitaa?* 2017 results clearly indicate that 16 to 30 year olds, especially women, were more likely to report suicidal attempts, with prevalences for the previous year and lifetime reaching 12% and 43%, respectively. Again, however the proportion of Nunavimmiut declaring suicidal attempts during the previous year needs to be interpreted with caution based on the high coefficients of variation.

With regard to serious suicidal thoughts during the year prior to the survey, similar prevalences were observed in three Nunavik health surveys: 12% in 1992, 13% in 2004 and 13% in 2017. It is noteworthy, however, that in *Qanuilirpitaa?* 2017, 21% of the 16 to 30 year old age group had thought seriously about suicide in the year preceding the survey, making it the age group for whom suicidal thoughts are the most prevalent. This rate is similar to the 18% found in the non-representative sample of the Nunavik Child Development Study involving adolescents aged 16 to 21 years old (Pepin et al., 2018).

Suicide ideations in one's lifetime were experienced by 24% of Nunavimmiut in 1992, 34% in 2004 (Kirmayer & Paul, 2007) and 41% in 2017. In comparison, 14% of Canadians aged 15 to 24 years reported having had suicidal thoughts in their lifetime (Findlay, 2017).

The most prevalent situations that Nunavimmiut were in just before attempting suicide involved feeling bored, tired of life or very depressed, feeling very angry, being under a lot of pressure or stressed out and having a conflict with their partner, family member, friends or other close ones. In the Monitoring Suicide in Europe project, involving 4 683 suicide attempters from nine countries, interpersonal conflicts and mental health problems were identified with increased risk of suicide attempts and the repetition of suicide attempts (Burón et al., 2016), which is consistent with the *Qanuilirpitaa?* 2017 results. Similarly, negative social interactions and lower perceived ability to deal with stress were associated with suicide ideation for 15 to 24 year old Canadians (Findlay, 2017).

In *Qanuippitaa?* 2004, participants who reported suicide ideations in the past 12 months were asked about the emotional support they had received at that time. In the 2017 survey, those same questions on emotional support were asked only to participants who reported having made a suicide attempt in the preceding year. To offer a comparison, however imperfect, 66% of Nunavimmiut in the 2004 survey answered affirmatively about seeing or talking to someone about their suicide attempt. In 2017, 65% of Nunavimmiut stated that they had received emotional support at the time of the attempt. In both surveys, friends and family members were by far the most common source of help sought. It should also be noted that it is difficult as for adolescents and young adults to seek help related to mental health from professionals. Stigma, embarrassment, difficulty recognizing symptoms, and a preference for self-reliance are frequently named as barriers (Gulliver, Griffiths, & Christensen, 2010).

Several initiatives have been implemented to help fight psychological distress and suicide, such as the National Inuit Suicide Prevention Strategy (Inuit Tapiriit Kanatami, 2016), Suicide Prevention Liaison Workers, and Applied Suicide Intervention Skills Training by different organizations.

The results presented in this thematic report include cross-tabulations of mental health indicators by several sociodemographic and sociocultural characteristics. These bivariate analyses cannot be interpreted as providing definitive information on risk factors of well-being and distress since the transversal nature of the survey precludes the inference of causality (e.g., does high satisfaction with the ability to go on the land predispose to greater satisfaction in life, or does the feeling of being very satisfied with life influence the assessment of one's own abilities?). Multivariate analyses are required to determine whether an association between a sociodemographic or sociocultural characteristic and a mental health outcome will persist after simultaneous consideration of other characteristics.

That being said, this is the first health survey in Nunavik to provide so much data on potentially protective sociocultural factors of mental health. People reporting strong cultural identity, who are highly satisfied with their

ability to do traditional activities, who report higher emotional and family support and higher family and community cohesion, and who are actively involved in their community were also more likely to obtain high scores on life satisfaction, general health and self-esteem, and were less likely to reach clinically significant levels of depressive symptoms. With regard to the sociodemographic characteristics associated with mental health indicators, the results of this survey are similar to those of the 2004 health survey. Generally speaking, Nunavimmiut men, as well as people who are in a relationship, have more schooling, are working or earn an annual income above \$20 000 feel better.

Overall, the prevalence of psychological distress is higher among Nunavimmiut aged 16 to 30 years old, which is a subgroup representing nowadays about 28% of the Nunavik population (Duhaimé et al., 2015). This illustrates the substantial need for prevention and intervention in mental health in the region, as well as the burden being placed on the regional health system. Further analyses that consider simultaneously multiple variables such as education and working history, lifetime experience of interpersonal trauma and substance use are required to better understand the variables associated with mental health outcomes.

6 CONCLUSION

The burden of psychological distress among Nunavimmiut in 2017 remains alarming. The results reported in this thematic report must be understood from the perspective that many Nunavimmiut themselves, or their family, have experienced collective traumas resulting from assimilatory, discriminatory and colonialist policies such as residential schools, which still influence the well-being and mental health of the population. Substantial efforts are still necessary to overcome systemic discrimination and ensure

cultural safety in public services. The inclusion of sociocultural indicators for the first time in a health survey conducted in Nunavik, under the leadership of Nunavik stakeholders, has shed light on many potential risk and protective factors which, pending additional analyses, have considerable potential to guide culturally responsive interventions and programs aimed at improving the mental health and well-being of the population.

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APPENDIX B

SUPPLEMENTARY RESULTS

WELL-BEING INDICATORS

Table A Proportion of the population according to well-being indicators (%), by sex, age group, coastal region, community size, marital status, education, employment, and income, population aged 16 years and over, Nunavik, 2017

	Life satisfaction (very satisfied or satisfied)	Having enough money to meet needs			Perception of health (excellent or very good)	Self-esteem (high)	Resilience (high)
		Mostly or completely	A little or moderately	Not at all			
Sex							
Men	85.7 ¹	25.8 ¹	48.6	25.6 ¹	31.7 ¹	30.0 ¹	18.2
Women	77.0	34.0	48.0	18.0	23.7	22.0	17.4
Age group							
16-30 years	77.0 ¹	28.4	51.1	20.5	31.4	19.1 ¹	15.0
31-54 years	83.5	30.3	50.0	19.7	26.3	28.1	15.1
55 years and over	87.8	32.4	37.2 ¹	30.4 ¹	21.6 ²	38.6	31.6 ¹
Coastal region							
Hudson	79.8	28.6	48.2	23.1	26.9	22.6 ¹	17.7
Ungava	83.5	31.4	48.4	20.2	28.9	30.5	17.9
Community size							
Large	79.6	28.3	48.7	23.0	27.5	27.9	16.5
Small	83.9	31.9	47.8	20.3	28.0	23.4	19.7
Marital status							
Single	72.6 ³	23.0 ³	52.2	24.7	29.1	19.0 ^{3,4}	17.0
Married or in a common law relationship	88.2	35.3	46.0	18.7 ¹	27.4	30.6	17.8
Separated, divorced or widowed	83.3	28.7 [*]	41.1 [*]	30.2 [*]	20.4 [*]	33.3 [*]	24.1 [*]



Table A Proportion of the population according to well-being indicators (%), by sex, age group, coastal region, community size, marital status, education, employment, and income, population aged 16 years and over, Nunavik, 2017 (continued)

	Life satisfaction (very satisfied or satisfied)	Having enough money to meet needs			Perception of health (excellent or very good)	Self-esteem (high)	Resilience (high)
		Mostly or completely	A little or moderately	Not at all			
Education							
Elementary school or less	84.7	23.7*	41.5	34.8 ¹	24.7*	23.3*	24.6*
Secondary school not completed	80.7	24.5	52.1 ⁵	23.4 ⁵	26.2	21.3	15.8
Secondary school or higher	81.2	42.9 ¹	43.6	13.5*	32.5	37.3 ¹	17.8
Employment							
Employed	83.3	34.7 ¹	47.8	17.5 ¹	29.8 ¹	29.2 ¹	16.3
Not employed ^a	77.6	19.7	50.0	30.3	23.6	20.2	20.7
Annual personal income							
Less than \$20 000	78.2 ¹	18.5 ¹	53.3 ¹	28.2 ¹	28.4	18.8 ¹	18.0
\$20 000 or more	85.1	41.1	43.2	15.8	29.6	36.6	18.4

NOTES

Coloured cells indicate statistically significant comparisons.

* The coefficient of variation is greater than 15% and lower than or equal to 25%. The proportion should be interpreted carefully.

a. Not employed: hunter support program, housework, retired or on pension, employment insurance, parental leave, income support, student or other.

1. Statistically significant difference observed using the 5% threshold compared to the other group or groups.

2. Statistically significant difference observed using the 5% threshold compared to Nunavimmiut aged 16 to 30 years old.

3. Statistically significant difference observed using the 5% threshold compared to Nunavimmiut who are married or common law.

4. Statistically significant difference observed using the 5% threshold compared to Nunavimmiut who are separated, divorced or widowed.

5. Statistically significant difference observed using the 5% threshold compared to Nunavimmiut who have completed secondary school or higher.

Table B Prevalence of well-being indicators (%), by cultural identity, spirituality, and cultural identity satisfaction, population aged 16 years and over, Nunavik, 2017

	Life satisfaction (very satisfied or satisfied)	Having enough money to meet needs			Perception of health (excellent or very good)	Self-esteem (high)	Resilience (high)
		Mostly or completely	A little or moderately	Not at all			
Perception of cultural identity							
High	90.5 ¹	30.2	43.3	26.6	34.6 ¹	33.8 ¹	32.8 ¹
Low	77.5	29.1	50.9	20.0	24.7	22.5	11.5
Spiritual values play an important role in life							
Yes	81.5	28.0	49.3	22.6	26.7	25.9	18.4
No	82.0	36.6	44.6	18.8*	33.5	28.1	16.2*
Participation in religious activities excluding weddings and funerals							
At least monthly	83.4	29.9	48.7	21.4	28.0	25.6	20.8 ¹
Other	80.0	29.4	48.4	22.3	27.5	26.3	15.8
Going on the land							
Often	85.5 ¹	33.1	44.7	22.2	29.7	30.0 ¹	18.2
Occasionally or never	78.0	27.3	51.0	21.7	26.2	23.1	17.4
Sedentary time							
> 7 hours	79.6	31.7	50.0	18.3	24.6	26.7	18.5
≤ 7 hours	82.6	28.4	47.9	23.7	29.8	25.8	17.0
Your ability to go out on the land, hunting, fishing and berry picking							
Very satisfied	88.9 ¹	33.1 ¹	43.0 ¹	23.9	33.7 ¹	31.9 ¹	21.3 ¹
Other	73.7	25.5	54.5	20.0	21.5	19.8	14.4
Your ability to satisfy country food cravings							
Very satisfied	85.7 ¹	31.6	45.7	22.7	30.0 ¹	27.5	21.2 ¹
Other	77.4	27.3	51.4	21.3	25.5	24.7	14.5



Table B Prevalence of well-being indicators (%), by cultural identity, spirituality, and cultural identity satisfaction, population aged 16 years and over, Nunavik, 2017 (continued)

	Life satisfaction (very satisfied or satisfied)	Having enough money to meet needs			Perception of health (excellent or very good)	Self-esteem (high)	Resilience (high)
		Mostly or completely	A little or moderately	Not at all			
Your ability to communicate with others in Inuktitut							
Very satisfied	86.8 ¹	32.0	45.5	22.6	31.0 ¹	33.2 ¹	20.7 ¹
Other	75.1	26.5	52.2	21.2	23.8	17.5	14.1
Your knowledge and skills of cultural and traditional activities, games, and arts							
Very satisfied	88.9 ¹	30.8	41.4 ¹	27.9 ¹	37.1 ¹	34.0 ¹	27.2 ¹
Other	78.5	28.9	51.4	19.7	24.2	23.2	14.4

NOTES

Coloured cells indicate statistically significant comparisons.

* The coefficient of variation is greater than 15% and lower than or equal to 25%. The proportion should be interpreted carefully.

1. Statistically significant difference observed using the 5% threshold compared to the other group or groups.

Table C Proportion of the population according to well-being indicators (%), by social support, family cohesion, and community wellness and participation, population aged 16 years and over, Nunavik, 2017

	Life satisfaction (very satisfied or satisfied)	Having enough money to meet needs			Perception of health (excellent or very good)	Self-esteem (high)	Resilience (high)
		Mostly or completely	A little or moderately	Not at all			
Emotional support							
High	85.4 ¹	40.1 ¹	43.8 ¹	16.1 ¹	32.7 ¹	41.0 ¹	18.8
Low	79.7	24.6	50.8	24.5	25.4	19.2	17.1
Tangible support for transportation to health services							
High	83.8	33.2	46.6	20.3	30.3	33.2 ¹	19.7
Low	80.3	27.3	49.8	22.9	26.4	20.6	15.9
Positive interactions							
High	84.6 ¹	30.4	49.3	20.3	32.5 ¹	28.3 ¹	19.6 ¹
Low	74.9	27.9	46.9	25.2	17.7	21.4	14.1
Love and affection							
High	84.4 ¹	32.7 ¹	47.2	20.1 ¹	29.1	29.5 ¹	18.1
Low	73.7	20.4	53.0	26.7	23.6	16.1	16.6
Family cohesion							
Top 30 percentile	93.6 ¹	34.2 ¹	41.6 ¹	24.2	36.3 ¹	39.4 ¹	26.5 ¹
Other	76.0	27.4	51.7	20.9	23.9	20.1	14.0
Community cohesion							
Top 30 percentile	88.7 ¹	29.0	47.0	24.0	33.3 ¹	31.1 ¹	22.3 ¹
Other	77.1	29.7	49.6	20.7	24.3	23.0	15.2
Participation in cultural or community events (festivals, dances or feasts)							
Always or often	85.5 ¹	35.3 ¹	46.2	18.6 ¹	32.0 ¹	32.9 ¹	23.0
Other	78.7	25.7	50.2	24.1	24.8	21.3	14.3
Volunteering in a group, organization, rescue team, or church group							
Always or often	88.0 ¹	34.5	44.7	20.8	33.2	32.2 ¹	24.6 ¹
Other	78.4	27.4	50.3	22.3	25.2	23.2	14.8

NOTES

Coloured cells indicate statistically significant comparisons.

1. Statistically significant difference observed using the 5% threshold compared to the other group or groups.

Table D Proportion of the population according to well-being indicators (%), by healing and wellness participation, and positive perception of health services, population aged 16 years and over, Nunavik, 2017

	Life satisfaction (very satisfied or satisfied)	Having enough money to meet needs			Perception of health (excellent or very good)	Self-esteem (high)	Resilience (high)
		Mostly or completely	A little or moderately	Not at all			
Participation in activities promoting healing and wellness							
Yes	82.6	34.1	47.7	18.2	34.3 ¹	28.2	16.9
No	81.0	27.6	48.9	23.5	25.0	25.1	18.2
Positive perception of health services							
Top 30 percentile	85.7	29.1	45.2	25.7	30.7	27.6	32.3 ¹
Other	80.5	29.1	50.1	20.9	27.0	25.2	14.5

NOTES

Coloured cells indicate statistically significant comparisons.

1. Statistically significant difference observed using the 5% threshold compared to the other group.

PSYCHOLOGICAL DISTRESS INDICATORS

Table E Prevalence of psychological distress indicators (%), by sex, age group, coastal region, community size, marital status, education, employment, and income, population aged 16 years and over, Nunavik, 2017

	Depressive symptoms ^a (clinical level)	Suicide ideation in lifetime	Suicide attempts in lifetime	Suicide ideation in past 12 months	Suicide attempts in past 12 months
Sex					
Men	34.6 ¹	35.4 ¹	26.5 ¹	11.2*	3.9** ¹
Women	43.8	47.0	33.4	14.7	7.2
Age group					
16-30 years	48.3 ¹	48.7 ¹	36.1	21.1 ¹	9.6
31-54 years	35.7 ²	40.8 ²	29.8	8.8* ²	3.3**
55 years and over	23.4	22.7	14.3* ¹	1.7**	NP
Coastal region					
Hudson	39.2	38.8	30.9	10.4 ¹	4.5*
Ungava	39.2	44.3	28.7	16.3	6.9*



Table E Prevalence of psychological distress indicators (%), by sex, age group, coastal region, community size, marital status, education, employment, and income, population aged 16 years and over, Nunavik, 2017 (*continued*)

	Depressive symptoms ^a (clinical level)	Suicide ideation in lifetime	Suicide attempts in lifetime	Suicide ideation in past 12 months	Suicide attempts in past 12 months
Community size					
Large	34.4 ¹	42.6	30.9	12.1	4.9*
Small	45.6	39.3	28.7	14.1	6.4*
Marital status					
Single	47.6 ¹	45.1	34.0	18.3	8.3*
Married or in a common law relationship	33.3	39.1	27.3 ³	9.6 ³	3.8 ^{*3}
Separated, divorced or widowed	31.7*	29.9 ^{*3}	25.3*	NP	NP
Education					
Elementary school or less	42.3	27.6 ^{*1}	21.3*	5.9**	4.6**
Secondary school not completed	42.1 ⁴	42.1	34.3 ¹	14.4	5.7*
Secondary school or higher	33.3	45.4	25.2	12.8*	5.4*
Employment					
Employed	35.8 ¹	41.3	28.6	12.2	4.9*
Not employed ^b	45.9	40.8	32.4	14.6	6.7*
Annual personal income					
Less than \$20 000	45.3 ¹	39.8	30.6	14.5	6.0*
\$20 000 or more	31.2	43.2	29.2	10.8	4.4*

NOTES

Coloured cells indicate statistically significant comparisons.

* The coefficient of variation is greater than 15% and lower than or equal to 25%. The proportion should be interpreted carefully.

** The coefficient of variation is greater than 25%. The proportion is shown for information only.

NP: This value is not displayed since some categories have less than 5 respondents.

a. On the CES-D-10 scale, in the two weeks preceding the survey.

b. Not employed: hunter support program, housework, retired or on pension, employment insurance, parental leave, income support, student or other.

1. Statistically significant difference observed using the 5% threshold compared to the other group or groups.

2. Statistically significant difference observed using the 5% threshold compared to Nunavimmiut aged 55 years and over.

3. Statistically significant difference observed using the 5% threshold compared to Nunavimmiut who are single.

4. Statistically significant difference observed the 5% threshold compared to Nunavimmiut who have completed secondary school or higher.

Table F Proportion of the population according to psychological distress indicators (%), by cultural identity, spirituality, and cultural identity satisfaction, population aged 16 years and over, Nunavik, 2017

	Depressive symptoms ^a (clinical level)	Suicide ideation in lifetime	Suicide attempts in lifetime	Suicide ideation in past 12 months	Suicide attempts in past 12 months
Perception of cultural identity					
High	32.9 ¹	42.0	28.6	10.2*	4.0*
Low	41.9	41.0	30.6	14.2	6.2*
Spiritual values play an important role in life					
Yes	38.5	39.4 ¹	29.9	11.3 ¹	4.7*
No	40.5	48.9	29.5	20.1*	8.5**
Participation in religious activities excluding weddings and funerals					
At least monthly	34.9 ¹	37.2 ¹	29.6	11.4	11.4
Other	42.0	44.0	30.2	14.0	14.0
Going on the land					
Often	38.0	39.6	29.5	12.4	5.2*
Occasionally or never	40.0	42.4	30.2	13.5	5.8*
Sedentary time					
> 7 hours	37.9	48.0 ¹	32.0	15.4	4.8*
≤ 7 hours	39.2	37.3	28.4	11.5	6.5*
Your ability to go out on the land, hunting, fishing and berry picking					
Very satisfied	34.4 ¹	40.4	30.6	13.7	5.3*
Other	44.1	41.9	29.2	12.3	5.8*
Your ability to satisfy country food cravings					
Very satisfied	39.4	42.3	31.8	12.6	4.9*
Other	38.8	39.8	27.9	13.1	5.9*



Table F Proportion of the population according to psychological distress indicators (%), by cultural identity, spirituality, and cultural identity satisfaction, population aged 16 years and over, Nunavik, 2017 (*continued*)

	Depressive symptoms ^a (clinical level)	Suicide ideation in lifetime	Suicide attempts in lifetime	Suicide ideation in past 12 months	Suicide attempts in past 12 months
Your ability to communicate with others in Inuktitut					
Very satisfied	34.8 ¹	39.6	28.6	11.6	5.4*
Other	44.3	42.9	31.4	14.6	5.7*
Your knowledge and skills of cultural and traditional activities, games, and arts					
Very satisfied	31.3 ¹	36.5	31.8	12.9*	6.6*
Other	41.7	42.9	29.0	13.0	5.1*

NOTES

Coloured cells indicate statistically significant comparisons.

a. On the CES-D-10 scale, in the two weeks preceding the survey.

* The coefficient of variation is greater than 15% and lower than or equal to 25%. The proportion should be interpreted carefully.

** The coefficient of variation is greater than 25%. The proportion is shown for information only.

1. Statistically significant difference observed using the 5% threshold compared to the other group or groups.

Table G Proportion of the population according to psychological distress indicators (%), by social support, family cohesion, and community wellness and participation, population aged 16 years and over, Nunavik, 2017

	Depressive symptoms ^a (clinical level)	Suicide ideation in lifetime	Suicide attempts in lifetime	Suicide ideation in past 12 months	Suicide attempts in past 12 months
Emotional support					
High	32.0 ¹	40.2	29.5	11.2*	4.1**
Low	42.5	41.8	30.1	13.7	6.0
Tangible support for transportation to health services					
High	36.5	42.5	30.0	12.2	4.8**
Low	40.8	40.3	29.6	13.5	6.1
Positive interactions					
High	37.0 ¹	42.2	30.3	13.9	6.4* ¹
Low	43.7	38.9	29.0	10.7*	3.5*
Love and affection					
High	36.2	41.9	28.0 ¹	12.1	4.9*
Low	47.3	39.5	35.3	15.0	6.8*
Family cohesion					
Top 30 percentile	32.4 ¹	35.7 ¹	27.8	7.0 ¹ *	2.61**
Other	42.0	43.5	30.8	15.6	6.8
Community cohesion					
Top 30 percentile	38.0	34.2 ¹	27.9	9.4 ¹ *	3.1**
Other	39.8	44.9	30.7	15.1	6.9



Table G Proportion of the population according to psychological distress indicators (%), by social support, family cohesion, and community wellness and participation, population aged 16 years and over, Nunavik, 2017 (continued)

	Depressive symptoms ^a (clinical level)	Suicide ideation in lifetime	Suicide attempts in lifetime	Suicide ideation in past 12 months	Suicide attempts in past 12 months
Participation in cultural or community events (festivals, dances, feasts or Inuit games)					
Always or often	34.7 ¹	38.4	27.0	12.8	6.5*
Other	42.2	43.1	32.0	13.1	4.9*
Volunteering in a group, organization, rescue team, church group, spring clean-up					
Always or often	37.4	39.3	28.1	13.5*	3.6* ¹
Other	40.0	42.0	30.8	12.7	6.4

NOTES

Coloured cells indicate statistically significant comparisons.

a. On the CES-D-10 scale, in the two weeks preceding the survey.

* The coefficient of variation is greater than 15% and lower than or equal to 25%. The proportion should be interpreted carefully.

** The coefficient of variation is greater than 25%. The proportion is shown for information only.

1. Statistically significant difference observed using the 5% threshold compared to the other group or groups.

Table H Proportion of the population according to psychological distress indicators (%), by healing and wellness participation, positive perception of health services, and Internet use as a source of information, population aged 16 years and over, Nunavik, 2017

	Depressive symptoms ^a (clinical level)	Suicide ideation in lifetime	Suicide attempts in lifetime	Suicide ideation in past 12 months	Suicide attempts in past 12 months
Participation in activities promoting healing and wellness					
Yes	44.4 ¹	49.9	37.4 ¹	17.6 ¹	7.6*
No	36.9	37.5	26.6	10.9	4.6*
Positive perception of health services					
Top 30 percentile	38.7	38.2	33.6	10.6*	6.6**
Other	40.2	41.6	27.9	13.6	5.3*
Internet use as a source of information about depression, anxiety, stress, or suicide					
Yes	54.3 ¹	67.5 ¹	45.5 ¹	38.2 ¹	18.5* ¹
No	37.2	37.9	28.0	9.8	3.8*

NOTES

Coloured cells indicate statistically significant comparisons.

a. On the CES-D-10 scale, in the two weeks preceding the survey.

* The coefficient of variation is greater than 15% and lower than or equal to 25%. The proportion should be interpreted carefully.

** The coefficient of variation is greater than 25%. The proportion is shown for information only.

1. Statistically significant difference observed using the 5% threshold compared to the other group.

