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Current Issues in Mental Health in Canada: The Mental Health of First Nations and Inuit Communities

**Publication No. 2014-02-E
6 January 2014**

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(In Brief)*

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Ce document est également publié en français.

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CURRENT ISSUES IN MENTAL HEALTH IN CANADA: THE MENTAL HEALTH OF FIRST NATIONS AND INUIT COMMUNITIES

1 INTRODUCTION

On 17 April 2013, the remote, fly-in community of Neskantaga First Nation in Northern Ontario declared a state of emergency following two suicides in less than a week and 20 suicide attempts over the previous year.¹ This situation is not unique. First Nations² and Inuit³ communities experience mental health⁴ problems and their consequences – such as depression, anxiety and suicide – at significantly higher rates than the general population, and young people are the most dramatically affected. The disproportionately high prevalence of mental health problems in Aboriginal communities can be linked, in part, to a history of cultural disruption, oppression and marginalization.

This paper provides a brief overview of the unique contextual factors underlying the mental health challenges experienced by First Nations and Inuit communities, it presents recent research in the area of First Nations and Inuit mental health, and it describes health services available for these communities. The paper also explores the concept of “cultural continuity,” as well as local control over community institutions as possible protective measures that may contribute to better mental health outcomes for First Nations people and Inuit.⁵

2 CONTEXT

To be properly understood, the elevated rate of mental health issues in First Nations and Inuit communities must be considered against the unique historical experiences of these communities. The collective trauma and cultural disruption experienced by First Nations and Inuit people resulting from colonization, in particular, have been profound.⁶ Past government policies, including the systemic dispossession of land, the weakening of social and political institutions, and racial discrimination have all had lasting effects on the collective sense of identity and belonging of Aboriginal people.⁷ The cumulative effects of these policies have had a particularly detrimental effect on youth, and according to leading experts in the field, have complicated the “efforts of Aboriginal youth to forge their identities and find their ways in the world.”⁸

The implications of colonization are most notably seen in the multi-generational effects of the residential school system. Residential schools operated in Canada from the late 1800s through to the late 1960s, though a few remained in operation until the 1990s. During this period, more than 150,000 First Nations, Inuit and Métis children were taken to residential schools and isolated from their families, with the purpose of assimilating them into the dominant culture.⁹ The resulting loss of culture and language meant that many children were unable to participate in traditional activities, finding themselves “in a marginalized position as neither fully Aboriginal nor part of the ‘mainstream.’”¹⁰ Moreover, many children in the residential school system were victims of emotional, physical and sexual abuse. These children often

internalized these abuses, repeating the behaviour with other community members upon their return to their communities.¹¹

The legacy of colonization is just one of the factors that influence the mental health of First Nations people and Inuit. According to Health Canada, health, including mental health, is “determined by complex interactions between social and economic factors, the physical environment and individual behaviour.”¹² Known as the “determinants of health,” this concept refers to a spectrum of contextual factors that influence health outcomes and help to determine an individual’s overall health status. In this way, mental health in First Nations and Inuit communities is equally influenced by political context, community infrastructure and resources, and the social environment in which the people live.¹³

3 SELECTED DATA ON MENTAL HEALTH IN FIRST NATIONS AND INUIT COMMUNITIES

3.1 INUIT COMMUNITIES

Inuit communities experience suicide at a rate that is estimated to be as much as 11 times higher than the rest of the Canadian population.¹⁴ The rate of suicide varies significantly among the four Inuit regions,¹⁵ and is most dramatic among Inuit youth. A 2012 study completed by Statistics Canada¹⁶ reported that the suicide rate in the Inuit Nunangat¹⁷ between 2004 and 2008 was roughly 40 deaths per 100,000 individuals¹⁸ among young females and 102 deaths per 100,000 individuals among young males. Comparatively, the suicide rate in the general population during that same period was 2 deaths per 100,000 young females and 4.2 deaths per 100,000 young males. Overall, this study found that, in the Inuit Nunangat, children and teenagers were “30 times as likely to die from suicide as were those in the rest of Canada.”¹⁹ Suicide represented approximately 50% of all deaths of young Inuit, compared to 10% of deaths of young people in the general population.²⁰

In order to determine the possible underlying factors that contribute to the elevated rate of suicide in Inuit communities, a recent study of suicides in Nunavut found a number of correlated risk factors. These risk factors included unemployment, exposure to violence and sexual abuse, diagnosis of major depressive disorders, and substance abuse.²¹ These results support previous findings that increased suicide rates, particularly among young people, are related to changes in the intensity of the determinants of health.²² Further, these findings suggest that increased rates of mental health problems correspond with changes in the determinants of health, as difficult life experiences can trigger the onset of mental issues.²³

3.2 FIRST NATIONS COMMUNITIES

Though not as high as in Inuit communities, the national rate of suicide among First Nations communities (approximately 24 deaths per 100,000 individuals) is roughly double that of the general public (approximately 12 deaths per 100,000 individuals). The suicide rate among First Nations youth is roughly five to seven times higher than that of the general population.²⁴ However, this national rate of

suicide is far from uniform, as suicide rates vary greatly among communities. For example, according to a 1998 study of First Nations in British Columbia, some communities experienced virtually no suicides, while others experienced suicide at a rate that was nearly 800 times the national average.²⁵

The 2008–2010 First Nations Regional Health Survey (RHS) found that approximately half of on-reserve First Nations people experience moderate to high levels of psychological distress, a term used to measure an individual's level of anxiety and depression.²⁶ Comparatively, one third of the general population experiences similar levels of psychological distress. The results of the RHS indicated that factors such as socio-economic status, exposure to aggression and racism, and attendance in the residential school system were risk factors for psychological distress. Though the RHS did not determine the prevalence of psychological disorders on reserve, the elevated rate of psychological distress was suggestive of a corresponding elevated rate of psychological disorders in First Nations communities.²⁷

4 MENTAL HEALTH CARE SERVICES

Health services and prevention programs are crucial in preventing and treating serious mental health issues. Numerous governmental and Aboriginal organizations are working to improve mental health services and address mental health disparities in First Nations and Inuit communities. Through the First Nations and Inuit Health Branch of Health Canada, the federal government provides certain health services and programs to eligible First Nations communities and Inuit living in their traditional territories. These services are either delivered directly by Health Canada, or by First Nations and Inuit communities that have had this responsibility transferred to them.²⁸ Primary health care services, such as physician and hospital care, are generally provided by provincial and territorial health authorities.²⁹

In terms of federal measures, Health Canada provides community-based mental health and substance abuse programs, as well as mental health services and supports to former students of residential schools and their families.³⁰ Together with the Assembly of First Nations and the Inuit Tapiriit Kanatami, Health Canada has established a First Nations and Inuit Mental Wellness Advisory Committee and is working collaboratively with these organizations on mental health, addictions and youth suicide prevention strategies. In addition, the Canadian Institutes of Health Research recently launched a research initiative to better understand Aboriginal health inequities and health programming needs in the area of suicide prevention.³¹

Equitable access to mental health services for First Nations people and Inuit is complicated by the multiple authorities involved in the delivery of health services. The complexity of the current framework governing the delivery of health care services has made it challenging to coordinate efforts among health authorities to ensure First Nations and Inuit receive a continuum of care. Notably, these coordination problems have created service gaps in areas such as aftercare, detoxification services and psychiatric care.³²

Further, the complexity of the current framework has led to unequal provision of mental health services among provinces and territories, and among First Nations and Inuit communities themselves. As a result, First Nations people and Inuit, particularly those living off reserve or outside their traditional territories, can face challenges in accessing comprehensive and culturally responsive health services.³³ Northern and remote communities experience additional challenges related to the high cost of delivery, shortages in health care providers, limited offering of health services (i.e., typically only basic health services) and lack of appropriate health infrastructure.³⁴

The need to address the challenges resulting from the lack of intergovernmental coordination of health services, including those related to mental health, was recognized by Parliament in 2007. Following the death of Jordan River Anderson, the House of Commons unanimously supported a private member's motion (M-296) stating that "the government should immediately adopt a child first principle, based on Jordan's Principle, to resolve jurisdictional disputes involving the care of First Nations children."³⁵

5 COMMUNITY PROTECTIVE FACTORS: CULTURAL CONTINUITY

At the individual level, mental health is influenced by both protective factors, such as family cohesion and positive interpersonal relationships that reduce the likelihood of developing mental health problems, and risk factors, such as unemployment and substance abuse. Recent research supports the idea that broader community-wide protective factors, such as local control of community institutions and "cultural continuity," may contribute to better mental health outcomes. Having established that suicide rates are not uniform across all First Nations communities, the research demonstrates that there is a strong correlation between community protective factors, called "cultural continuity factors," and the incidence of suicide. Communities involved in or that have control over some or all of the cultural continuity factors listed below experience lower rates of suicide:

- land claims;
- self-government;
- education services;
- police and fire services;
- health services; and
- cultural facilities.³⁶

Additional markers of cultural continuity include involvement of women in band councils, community control over child welfare services,³⁷ and knowledge of Aboriginal languages.³⁸ The concept of cultural continuity suggests that communities that have control over local institutions and are grounded in a collective sense of history and culture are better able to shield their vulnerable members, such as youth, from identity crises that can lead to psychological distress and suicide.³⁹

While research suggests that the preservation or promotion of cultural continuity could help lower suicide rates, further work is needed to determine how cultural continuity can be translated into community programming options.⁴⁰ In addition, more work is needed to demonstrate a causal relationship between cultural continuity and improved mental health, and determine the degree to which suicide and mental health could be influenced by other co-varying factors, such as community empowerment⁴¹ and social cohesion.⁴²

The concept of cultural continuity and self-determination in the delivery of health care services has been embraced by Aboriginal organizations such as Inuit Tapiriit Kanatami.⁴³ It has also been reflected in the recent establishment of the First Nations Health Authority in British Columbia: On 1 October 2013, responsibility for the delivery of health services to First Nations in British Columbia was transferred from Health Canada to the First Nations Health Authority in order to provide British Columbia First Nations with greater control over the design and delivery of health programs. This transfer is part of a broader health reform process between Health Canada, the British Columbia Ministry of Health and British Columbia First Nations. It is argued that self-determination in this area will enable communities to create integrated and culturally appropriate health services that are more effective.⁴⁴

6 CONCLUSION

First Nations and Inuit communities experience significantly higher rates of mental health problems than the general population. This disparity can be explained, in part, by unique contextual factors that influence mental health in those communities, such as the effects of colonialism and more difficult access to health services.

Given the variance in mental health among First Nations communities, the concept of cultural continuity shows promise in providing some of the community-wide protective factors that could improve mental health outcomes. Though more research is needed to determine how best to incorporate cultural continuity into health service options, the concept provides a potential framework for aiding communities in the development of mental health programs and services. Exploring the possible beneficial effects of integrating cultural continuity in First Nations and Inuit communities becomes more relevant as organizations, such as the First Nations Health Authority in British Columbia, move toward increased control over the design and provision of health services.

NOTES

1. Neskantaga First Nation, "[Neskantaga First Nation Declares a State-of-Emergency Following Recent Suicides](#)," News release, 17 April 2013.
2. The term "First Nations" refers to "Status and Non-Status 'Indian' peoples in Canada." (Aboriginal Affairs and Northern Development Canada, [First Nations](#).)
3. The Inuit are the Aboriginal peoples living in four Arctic regions: Nunatsiavut (Labrador); Nunavik (Quebec); Nunavut; and the Inuvialuit Settlement Region (Northwest Territories and Yukon). (Aboriginal Affairs and Northern Development Canada, [Inuit](#).)

4. Mental health is defined by the Public Health Agency of Canada 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. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity.

(Public Health Agency of Canada, [Mental Health Promotion](#).)
5. There is limited epidemiological data regarding the prevalence of specific mental illnesses in First Nations and Inuit populations. Further, because each survey and research project on this topic relies on different methodologies, it is difficult to compare results or provide a comprehensive profile of mental health in these communities. Even less information is available for Métis people and for non-Status Indians. (Laurence Kirmayer et al., “The Mental Health of Aboriginal Peoples in Canada: Transformations of Identity and Community,” in *Healing Traditions: The Mental Health of Aboriginal Peoples in Canada*, ed. Laurence Kirmayer and Gail Guthrie, UBC Press, 2009.) Given the limitations of current data, this paper focuses on the available information regarding Inuit and on-reserve First Nations populations.
6. Laurence Kirmayer et al., [“Suicide Among Aboriginal People in Canada,”](#) Aboriginal Healing Foundation, 2007.
7. Ibid.
8. Laurence Kirmayer et al., “Healing Traditions: Culture, Community and Mental Health Promotion with Canadian Aboriginal Peoples,” *Australian Psychiatry*, Vol. 11 (Supplement), 2003, p. 20.
9. Aboriginal Affairs and Northern Development Canada, [“Prime Minister Harper offers full apology on behalf of Canadians for the Indian Residential Schools system,”](#) *Statement of Apology*, 11 June 2008.
10. Kirmayer et al. (2007), p.69.
11. Kirmayer et al. (2003), p. 18; and Kirmayer et al. (2007), p.70.
12. Health Canada, [A Statistical Profile on the Health of First Nations in Canada: Determinants of Health, 1999 to 2003](#), 2009.
13. Charlotte Loppie Reading and Fred Wien, [Health Inequalities and Social Determinants of Aboriginal Peoples’ Health](#), National Collaborating Centre for Aboriginal Health, 2009.
14. Inuit Tapiriit Kanatami, [Inuit Approaches to Suicide Prevention](#).
15. The rate of suicide is estimated to be 181 deaths per 100,000 individuals in Nunavik, 239 deaths per 100,000 individuals in Nunatsiavut, 120 deaths per 100,000 individuals in Nunavut, and 61 deaths per 100,000 individuals in the Inuvialuit Settlement Region. (Inuit Tapiriit Kanatami, [Inuit Approaches to Suicide Prevention](#).)
16. Lisa N. Oliver, Paul A. Peters and Dafna E. Kohen, [Mortality rates among children and teenagers living in Inuit Nunangat, 1994 to 2008](#), Statistics Canada, Catalogue no. 82-003-X, Vol. 23, No. 3, July 2012.
17. The term “Inuit Nunangat” refers to the collective Inuit land claims regions: Nunatsiavut (northern coastal Labrador), Nunavik (northern Quebec), the territory of Nunavut, and the Inuvialuit Settlement Region (western edge of the Northwest Territories and northern Yukon).
18. The suicide rates in the Inuit Nunangat reported by Statistics Canada were calculated using age standardized mortality rates for person-years at risk (deaths per 100,000 person-years at risk).
19. Oliver, Peters and Kohen (2012), p. 4.

20. Ibid.
21. Eduardo Chachamovich and Monica Tomlinson, in collaboration with Embrace Life Council, Nunavut Tunngavik Inc., and the Government of Nunavut, [Learning From Lives That Have Been Lived](#), Douglas Mental Health University Institute (McGill), n.d., p. 51.
22. The rate of suicide in Nunavut correlates to an increase in social determinants of health, such as the intergenerational effects of colonization, unemployment and violence. These social determinants weaken social ties and present risk factors for suicide. (Government of Nunavut, Nunavut Tunngavik Inc., Embrace Life Council and the Royal Canadian Mounted Police, [Nunavut Suicide Prevention Strategy](#), October 2010, p. 10.)
23. Ibid., p. 11.
24. Public Health Agency of Canada, "[The Mental Health and Well-Being of Aboriginal Peoples in Canada](#)," Chapter 12 in *The Human Face of Mental Health and Mental Illness in Canada 2006*.
25. Michael J. Chandler and Christopher Lalonde, "Cultural Continuity as a Hedge Against Suicide in Canada's First Nations," *Transcultural Psychiatry*, Vol. 35, No. 2, 1998.
26. The measure of psychological distress is used in clinical settings as a screening tool to determine if more serious psychological disorders exist. (First Nations Information Governance Centre, "[First Nations Regional Health Survey \(RHS\) 2008/10: National Report on Adults, Youth and Children living in First Nations Communities](#)," Ottawa, 2012.)
27. Ibid., p. 223.
28. Responsibility for the administration of health programs can be transferred to First Nations and Inuit communities through contribution agreements, Health Service Transfer Agreements, or settled comprehensive land claims. For more information on this topic, see National Collaborating Centre for Aboriginal Health, [The Aboriginal Health Legislation and Policy Framework in Canada](#), 2011.
29. Ibid.
30. Health Canada, [Indian Residential Schools Resolution Health Support Program](#); Health Canada, [Brighter Futures and Building Healthy Communities](#).
31. Canadian Institutes for Health Research, [About Pathways to Health Equity for Aboriginal Peoples](#).
32. Health Canada, [First Nations and Inuit Mental Health and Addictions – Cluster Evaluation 2005/06–2009/10](#), September 2012.
33. National Collaborating Centre for Aboriginal Health, [Access to Health Services as a Social Determinant of First Nations, Inuit and Métis Health](#), 2009.
34. Ibid.
35. Parliament of Canada, "[Private Members' Business](#)," *Order and Notice Paper*, 4 December 2007. Jordan's Principle was brought about after a young First Nations' boy named Jordan River Anderson died in hospital while the federal and provincial governments argued over which jurisdiction was responsible for paying for his care. Aboriginal Affairs and Northern Development Canada is currently working with provinces and First Nations to implement Jordan's Principle. (Aboriginal Affairs and Northern Development Canada, [Jordan's Principle](#).)
36. Chandler and Lalonde (1998).
37. Michael J. Chandler and Christopher Lalonde, "[Cultural Continuity as a Protective Factor against Suicide in First Nations Youth](#)," *Horizons*, Vol. 10, No. 1, 2008, p. 70.

38. Darcy Hallett et al., "[Aboriginal language knowledge and youth suicide](#)," *Cognitive Development*, Vol. 22, 2007.
39. Chandler and Lalonde (2008), p. 70.
40. Chandler and Lalonde (1998), p. 18.
41. Kirmayer et al. (2007), p. 77.
42. James B. Waldram, D. Ann Herring and T. Kue Young, *Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives*, University of Toronto Press, 2006, p. 280.
43. Inuit Tapiriit Kanatami, [Social Determinants of Inuit Health in Canada: A discussion paper](#), 22 April 2007.
44. First Nations Health Authority, "[BC First Nations Health Authority Marks Historic Transfer of Services from Health Canada](#)," News release, 1 October 2013.