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Understanding Manitoba Inuit's Social Programs Utilization and Needs: Methodological Innovations

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Résumé de l'article

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Understanding Manitoba Inuit's Social Programs Utilization and Needs: Methodological Innovations

Abstract
Manitoba is home to approximately 1,500 Inuit, and sees 16,000 consults yearly from the Kivalliq region of Nunavut to access services. The purpose of our study was to develop detailed profiles of Inuit accessing services in Manitoba, by using administrative data routinely collected by Manitoban agencies, to support the development of Inuit-centric services. This study was conducted in partnership with the Manitoba Inuit Association, and Inuit Elders from Nunavut and Manitoba. Findings shows that the Inuit community living in Manitoba is fairly stable, with only approximately 5 percent of Inuit moving in and out of Manitoba on any given year. Inuit settle primarily in Winnipeg, and a significant proportion depend on social programs such as Income Assistance and housing support. A significant number of Inuit children have contact with the Child Welfare System. Our results support the need for more Inuit-centric programming, including family support and language programs.

Keywords
Indigenous, arctic, urban, social programs, children, Manitoba Inuit

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Understanding Manitoba Inuit's Social Programs Utilization and Needs: Methodological Innovations

It is widely accepted that Indigenous people in Canada are becoming more urbanized (Statistics Canada, 2017a). Inuit are also represented in these trends (Morris, 2016). For example, the Inuit Tapiriit Kanatami (ITK), the organization politically representing Inuit in Canada, reported that in 2016, 65,030 Inuit lived in Canada and 17,690 (37.4 percent) lived outside of Nunangat (Inuit Tapiriit Kanatami, 2018). Nunangat, Inuit's traditional territory, includes four northern Canadian regions: the Inuvialuit Settlement Region (in the northern portion of the Northwest Territories), Nunavut, Nunavik in northern Quebec and Nunatsiavut in Labrador (which is part of the province of Newfoundland and Labrador).

Whether in Nunangat or elsewhere, representations of Inuit which rely on a dichotomy of urban versus home communities are problematic. Increases in the urban Indigenous population have been reported for decades (Statistics Canada, 2017a). This increase is, however, due to many factors, including demographic growth, mobility, and changing patterns of self-reported identity (Statistics Canada, 2017a).

Further, the word urbanization conveys an assumption of a one-way move from a home community to an urban environment. While this may be true for some, a study conducted by Lavoie and colleagues with Manitoba First Nations documented that First Nations often moved between their home community, an urban centre, and a rural locale based on availability of services:

> medical "relocation" is a misnomer because the need to balance personal, family and community commitments with the need for specialized health services results in multilocality, where individuals move back and forth between an urban centre (to access care in the diagnosis phase and during acute episodes) to a regional centre (for episodes of lower acuity), to the home community (to attend to personal, family, community and cultural obligations). This "circuit," rather than being time limited, becomes a permanent feature of peoples' lives. (Lavoie et al., 2015, p. 296)

This pattern was prevalent and recurrent. Discussions with Inuit Elders involved in our project suggest that this also resonates for Kivalliq/Manitoba Inuit (McDonnell et al., 2020).

Inuit living outside of their traditional territory have been demanding access to Inuit-centric or at least Inuit-informed services for themselves and for Inuit traveling to provincial urban centres to access care (Morris, 2016; Rotondi et al., 2017; Smylie et al., 2018; Watson, 2017). For Nunavut residents, north-south corridors of care parallel airline routes that exist between the Kitikmeot Nunavut and Edmonton Alberta, the Kivalliq Nunavut and Winnipeg Manitoba, and the Qikiqtaaluk region of Nunavut and Ottawa Ontario. Inuit access specialized care not available in Nunavut in those southern locations, where they generally constitute a small proportion of patients (Marchildon & Torgenson, 2013).

Research conducted with the Ottawa Inuit community documented that many Inuit arrive in Ottawa to receive medical treatment, and some end up staying once treatment is complete. Others relocate for

post-secondary education. Some move to pursue employment, or to be with family members (Tomiak & Patrick, 2010). The extent to which this can be generalized to other urban Inuit communities (St. John's, Montreal, Winnipeg, and Edmonton, for example) is unknown.

A considerable body of literature exists, documenting inequities experienced by Inuit (Pollock et al., 2018; Statistics Canada, 2012, for examples). These inequities are the result of a variety of factors including, but not limited to,

- colonization and resultant policies that repressed and undermined Inuit society and culture,
- the marginalization of local economies as result of globalization and increased pressures to depend on waged economic activities which are scarce in the north and operate in the context of racialized and discriminatory hiring practices in the south,
- increased requirements for Western educational credentials which northern schools are underfunded and disadvantaged to deliver,
- underdeveloped northern infrastructure that places unbearable pressures on a limited housing stock. (Inuit Tapiriit Kanatami, 2014)

The Manitoba Inuit Association (MIA) was created in 2008 with a mandate to be the representative organization for Inuit living in Manitoba with a vision of "enhancing the lives of Inuit in Manitoba by promoting Inuit values, community and culture while connecting to services that meet our evolving needs" (Manitoba Inuit Association, 2019). MIA recognizes its obligation as extending to Inuit in Manitoba, whether they are residents of Manitoba, or residents of Nunavut accessing services in Manitoba. To support this vision, Inuit associated with MIA approached researchers at the University of Manitoba to enlist their assistance in creating profiles of health services utilization and needs for Inuit accessing services in Manitoba. Winnipeg is home to the largest urban Indigenous population in Canada, with 92,810 (representing 12.1% of the city's population) Indigenous people recording Winnipeg as their home during the 2016 census (Anderson, 2019). In addition, Inuit from the Kivalliq region have been accessing services in Manitoba for over five decades. MIA reported 16,000 medical trips alone in 2014/15 (Manitoba Inuit Association, 2015). Despite this, Inuit have remained largely unacknowledged in Manitoba, as if invisible. To date, most research conducted with Inuit living in an urban setting has been conducted in Ottawa (McShane et al., 2009; McShane et al., 2006; McShane et al., 2013; Smylie et al., 2018).

The *Qanuinngitsiarutiksait: Developing Population-Based Health and Well-Being Strategies for Inuit in Manitoba* project is a Canadian Institutes for Health Research-funded five-year partnership between university-based researchers from the University of Manitoba and MIA. The word *Qanuinngitsiarutiksait* means tools for the well-being/safety of Inuit/people. This study set out to document the experience and needs of Inuit accessing health and other services in Manitoba and to develop strategies to enhance these experiences and facilitate transitions to and from Nunavut. Specific objectives included, 1) developing detailed profiles of Inuit accessing services including length of residence (permanent, short-term, or long-term relocation), types of services accessed, unmet needs,

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costs and challenges associated with relocating to and accessing services in Manitoba; and 2) exploring solution-oriented options with impacted families, MIA, and allied health agencies presently serving Inuit in Manitoba.

Throughout this study, we engaged MIA and a group of Nunavut and Manitoba Inuit Elders to ensure that analyses and interpretations resonate with their experience and that the results and development of strategies to address unmet needs were grounded in *Inuit Qaujimajatuqangit* (Inuit ways of knowing) (Henderson, 2007). This engagement process was guided by a protocol and developed by the Elders and members of our team (McDonnell et al., 2020). We have described our process in more detail elsewhere (McDonnell et al., in press).

In this paper, we assess Manitoba's administrative data to identify Inuit service utilization. We hope that this approach might provide a pathway for other regions to follow. We also report on social program utilization and contacts with the justice system.

Methods

This work builds on the seminal work of Dr. Janet Smylie (Rotondi et al., 2017; Smylie et al., 2018). These researchers partnered with Tungasuvvingat Inuit, an Inuit organization located in Ottawa. Their focus was to document the needs of Inuit living in Ottawa. They used responder-driven sampling (RDS) and a comprehensive health assessment survey to collect primary data regarding health determinants, status, and service access. This data was then linked with datasets held by the Institute for Clinical Evaluative Sciences (ICES), including hospitalization, emergency room, and health screening records. Their final cohort included 341 Inuit living in Ottawa, an estimated 10 percent of the Inuit living in Ottawa (Smylie et al., 2018).

In contrast, we wanted to extend our study to all Inuit accessing services in Manitoba, whether residents of Manitoba or residents of the Kivalliq region. This choice was informed by priorities set by MIA, but also by the concept of multilocality discussed above.

Data Source and Scope

We initially hoped to include administrative data housed in the Manitoba Population Research Data Repository from 1984 to 2016. However, the provision of services to Nunavut Inuit changed jurisdictional responsibility three times during this period: between 1984-88, Inuit received services from the federal government, which provided services with apparently no single identifier. Services were devolved to the Northwest Territories (NWT) in 1988 (O'Neil, 1990). The transfer of service delivery from the NWT to Nunavut occurred in 1999. Since 1999, Nunavut residents who use Manitoba services have their Nunavut Health Care Number (NHCN) collected and documented on all Manitoba administrative records for billing purposes. Before 1999, the same process was in place, but Nunavut residents were then considered residents of the NWT, where they had NWT Healthcare Numbers. Although we initially assumed that linking NWT and Nunavut data using these healthcare numbers would be feasible, this proved prohibitively complex. Our study includes data from 1999 to 2016. To identify Inuit in the health administrative datasets, we used two interrelated approaches.

Identifying Inuit from the Kivalliq Accessing Services in Manitoba

This required Manitoba Health identifying all Inuit using their Nunavut Health Care Number (NHCN) card to access services. This number is routinely recorded at the point of care for the purpose of Manitoba billing back services to Nunavut. Manitoba Health flagged those services in the data transferred to the Manitoba Centre for Health Policy (MCHP). To determine the denominator, we used Statistics Canada Kivalliq populations and inferred population figures in between census years.

Inuit Living in Manitoba

We assumed that all of those who ever had an NCHN were Inuit. Upon moving to Manitoba and after a lapse of 3 months, Inuit are expected to change their healthcare card to a Manitoba card. The two numbers are independent, and Manitoba does not keep a record of the previous NCHN. Since deterministic data linkage was not possible, Manitoba Health used probabilistic data linkage (using the name, date of birth, and sex of NCHN card holder to link to the Manitoba Personal Health Identification number, or PHIN) to identify Inuit living in Manitoba. As with the first method, Manitoba Health flagged them in the resultant de-identified dataset before transferring them to the MCHP.

We created cohorts of the Inuit in Manitoba for each year between 1966 and 2016. We factored in attrition due to Inuit moving out of Manitoba and death to finalize the cohort.

Once cohorts were created, we linked these cohorts to administrative data housed in the Manitoba Population Research Data Repository at MCHP. We were able to link these cohorts to a long list of administrative datasets, including the Manitoba Registry, Manitoba Housing & Community Development (Tenant Management System, Rent Assist Shelter benefit), Manitoba Family Services (Child and Family Services Application and Intake, Social Allowances Management Information Network), Manitoba Education (Enrollment, Marks, and Assessments), and Justice data (Prosecutions Information and Scheduling Management [PRISM]). We also linked our cohort to multiple health services databases which are reported elsewhere. Our data linkage spanned 2001 to 2016.

Analysis

In this manuscript, we provide a description of the cohorts and report on analyses describing Inuit health and social program utilization and contact with the justice system in Manitoba. We present health utilization data in more detail elsewhere. In this manuscript, we present hospitalization data only to show where services are primarily accessed.

Results

Cohort Descriptions

Table 1, Inuit from the Kivalliq accessing services in Manitoba, describes our cohort of Inuit from the Kivalliq, who may from time to time come to Manitoba to access services.

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Table 1. Cohort Description: Inuit from the Kivalliq Region Who May Access Services in Manitoba (Statistics Canada, 2006, 2011, 2017c)

	2001 (%)		2006 (%)		2011 (%)		2016 (%)	
Age groups	Male	Female	Male	Female	Male	Female	Male	Female
0 to 4 years	575 (7.0)	570 (6.9)	525 (6.3)	535 (6.4)	620 (6.9)	585 (6.5)	650 (6.2)	590 (5.7)
5 to 14 years	1115 (13.5)	1055 (12.8)	1000 (12.0)	1005 (12.0)	1005 (11.2)	970 (10.8)	1170 (11.2)	1135 (10.9)
15 to 19 years	385 (4.7)	380 (4.6)	490 (5.9)	460 (5.5)	455 (5.1)	445 (5.0)	520 (5.0)	505 (4.8)
20 to 24 years	330 (4.0)	315 (3.8)	325 (3.9)	345 (4.1)	455 (5.1)	430 (4.8)	470 (4.5)	470 (4.5)
25 to 44 years	1200 (14.5)	1160 (14.1)	1185 (14.2)	1140 (13.7)	1210 (13.5)	1180 (13.2)	1460 (14.0)	1390 (13.3)
45 to 54 years	290 (3.5)	305 (3.7)	330 (4.0)	330 (4.0)	445 (5.0)	385 (4.3)	560 (5.4)	545 (5.2)
55 to 64 years	190 (2.3)	185 (2.2)	220 (2.6)	210 (2.5)	235 (2.6)	220 (2.5)	300 (2.9)	275 (2.6)
65 to 74 years	80 (1.0)	55 (0.7)	95 (1.1)	90 (1.1)	110 (1.2)	95 (1.1)	140 (1.3)	135 (1.3)
75 to 84 years	30 (0.4)	15 (0.2)	30 (0.4)	25 (0.3)	45 (0.5)	45 (0.5)	55 (0.5)	45 (0.4)
85 years and over	10 (0.1)	10 (0.1)	5 (0.1)	5 (0.1)	5 (0.1)	15 (0.2)	20 (0.2)	5 (0.0)
Total	4205	4050	4205	4145	4585	4370	5345	5095
Median age of the population	19.8	19.8	20.8	20.7	19.1	19.6	22.3	22.9

Figure 1 shows that the vast majority of Inuit from the Kivalliq are accessing hospitalization services in Winnipeg, as opposed to other sites in Manitoba.

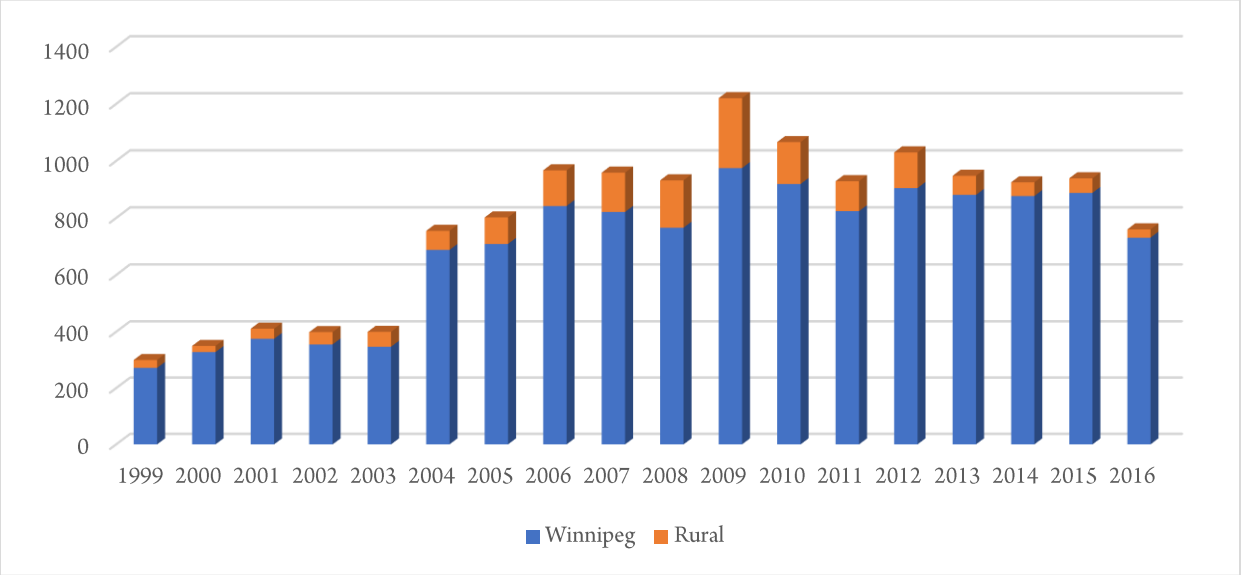

Figure 1. Number of Kivalliq Patient Hospitalizations, Winnipeg vs. Manitoba rural settings, 1999-16

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Our cohort of Inuit living in Manitoba is shown in Table 2. We aligned timelines to reflect more dependable data and sex/age breakdown (1999-2016). Our data shows 785 Inuit moving to Manitoba between 1999 and 2016.

Table 2. Cohort Description: Inuit living in Manitoba

	Men			Women			Total numbers	% increase
	Number	Average age	Standard dev	Number	Average age	Standard dev		
1999	166	29.5	15.9	187	28.8	15.5	353	
2000	176	29.8	15.4	212	28.1	15.7	388	9.92
2001	202	30.4	16	226	28.3	16.1	428	11.33
2002	236	30	16.5	251	28.4	15.7	487	16.71
2003	259	30.4	16.8	262	29.4	15.9	521	9.63
2004	290	32.1	17.6	300	30.7	16.4	590	19.55
2005	284	33.8	17.7	317	31.7	16.4	601	3.12
2006	286	34.5	17.8	332	32.4	16.9	618	4.82
2007	304	34.9	18.3	348	33.4	17.2	652	9.63
2008	313	35.2	18.3	379	33.4	17.7	692	11.33
2009	311	36.5	18.6	392	33.5	17.9	703	3.12
2010	327	37	18.9	402	34.1	17.8	729	7.37
2011	336	37.5	18.8	405	34.8	17.8	741	3.4
2012	340	37.7	19.1	405	35.6	18.0	745	1.13
2013	361	38.2	19.2	422	35.4	18.2	783	10.76
2014	370	39.2	19.3	430	36.7	18.4	800	4.82
2015	381	39.9	19.5	433	37.2	18.5	814	3.97
2016	369	41.2	19.5	416	38.5	18.6	785	-8.22

While the number of Inuit women progressively increased from one year to the next, the number of Inuit men has been slightly more variable. Our cohort of Inuit living in Manitoba is older than the cohort of Kivalliq Inuit accessing care in Manitoba and is also ageing faster.

Table 3 reports the stability of the Manitoba Inuit population. Our results show that between 0.8 to 13.3% of the Manitoba Inuit population had relocated to Manitoba per year. This represents an average of 7.2% in the 18 years analyzed, although mobility seems to be slowing down. We did not document the length of stay in Manitoba.

Table 3. Cohort Description: Percentage of Inuit Moving to Manitoba (within the last 12 months)

	Number of Inuit living in Manitoba	Number of Inuit moving to Manitoba*	Yearly % of Inuit newly arrived in Manitoba
1999	353	24	6.8%
2000	388	37	9.5%
2001	428	44	10.3%
2002	487	65	13.3%
2003	521	51	9.8%
2004	590	59	10.0%
2005	601	48	8.0%
2006	618	48	7.8%
2007	652	49	7.5%
2008	692	65	9.4%
2009	703	46	6.5%
2010	729	32	4.4%
2011	741	39	5.3%
2012	745	30	4.0%
2013	783	50	6.4%
2014	800	38	4.8%
2015	814	43	5.3%
2016	785	6	0.8%

*The number of movers is included in the total number of Inuit in Manitoba in the same year. Variations are due to deaths.

Table 3 above suggests that the Manitoba Inuit population is relatively stable, with an average of 43 new arrivals every year. It is noteworthy that since 2010, nearly 95 percent of Inuit living in Manitoba had been in the province for at least one year.

Figure 2 shows where Inuit relocating to Manitoba settle. The vast majority came to Winnipeg. As with the previous cohort, we note a shift away from the Northern Health Region, possibly related to a reduction of services offered in Churchill in the 2003–07 timespan. Overall, two thirds of Inuit who move to Manitoba move to the Winnipeg Health Region.

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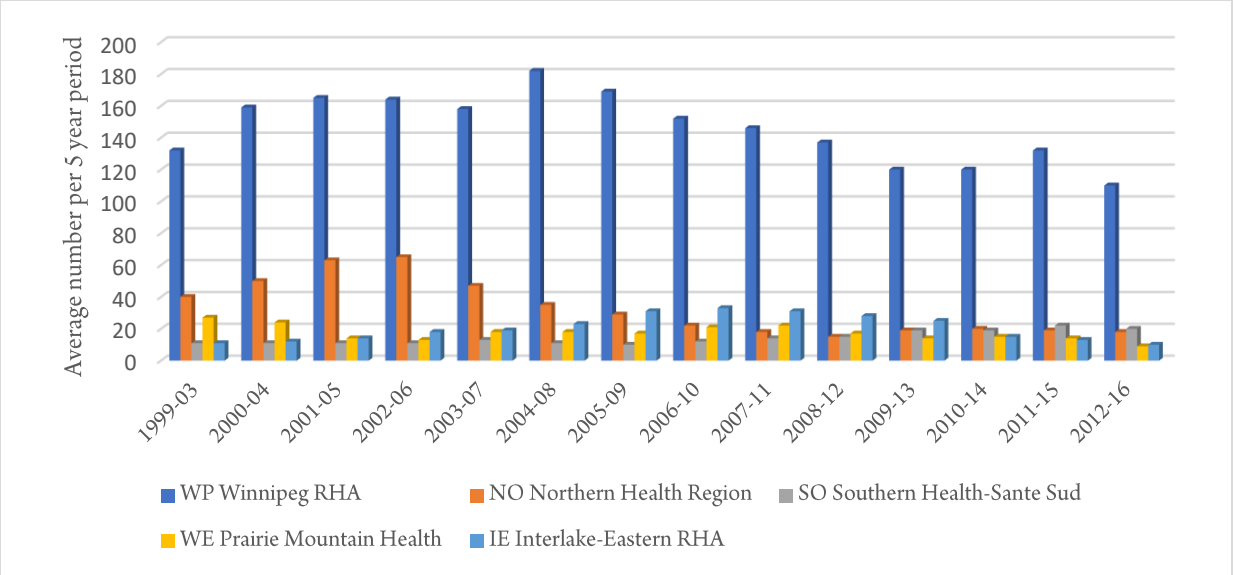

Figure 2. Number of Inuit living in MB by Regional Health Authority, yearly average (5 years roll-up)

Social Program Utilization

Table 4 reflects Inuit's access to three key programs:

- Inuit who have relocated to Manitoba become eligible to the Manitoba Income Assistance program after having completed 3 months of residence.
- The Manitoba Rent Assist program is a financial benefit provided by the Government of Manitoba for people who receive Income Assistance and have housing costs to cover. It is also available to other low-income private renters.
- The Manitoba Social Housing program provides subsidized rental housing for low-income individuals, seniors, and families.

We present the number of Inuit accessing these services in 5-year periods to address issues associated with small sample size.

Our results show that, on average, nearly one in four Inuit (aged over 18 years of age) depend on Manitoba Income Assistance (with a range of 15.5 to 32.2 percent). Trends suggest that this percentage has been dropping over time. On average, 4.9% of Inuit use the Manitoba Rent Assist program. Recent trends are however closer to 9%. Overall, an average of 12.2% of Inuit are housed in Manitoba's social housing.

Table 4. Social Program Utilization of Inuit Living in Manitoba

	Inuit accessing MB Income Assistance		Inuit accessing MB Rent Assist		Inuit in MB Social Housing	
Year	# by 5-year period	% of the MB Inuit popn	# by 5-year period	% of the MB Inuit popn	# by 5-year period	% of the MB Inuit popn
1995-1999	48	15.5	N/A	N/A	32	10.3
1996-2000	60	19.3	N/A	N/A	38	12.2
1997-2001	67	21.1	N/A	N/A	34	10.6
1998-2002	93	27.7	N/A	N/A	55	16.3
1999-2003	104	28.5	N/A	N/A	54	14.7
2000-2004	126	31.6	N/A	N/A	65	16.1
2001-2005	141	32.2	N/A	N/A	71	16.0
2002-2006	142	30.0	11	2.3	77	16.0
2003-2007	139	27.7	15	2.9	77	15.0
2004-2008	139	26.3	33	6.1	84	15.5
2005-2009	132	23.7	42	7.3	77	13.4
2006-2010	125	21.3	52	8.6	71	11.7
2007-2011	128	21.0	63	9.9	67	10.5
2008-2012	129	20.6	71	10.7	63	9.5
2009-2013	138	21.4	75	10.9	71	10.3
2010-2014	133	20.2	65	9.2	64	9.1
2011-2015	141	21.2	65	9.0	62	8.6
2012-2016	129	19.2	62	8.5	56	7.6
2013-2017	137	20.3	63	8.5	62	8.4
Average		23.6		4.9		12.2

In comparison, 38.6 percent of Kivalliq Inuit were accessing Income Support Assistance from the Government of Nunavut in 2013 (Nunavut, 2016). According to Statistics Canada, Nunavut had 9,820 households in 2016, with 7,860 (80%) considered public housing (Statistics Canada, 2017c). Of these, 37% are reportedly in need of major repair, inappropriate in size or unaffordable (Riva et al., 2020).

Contacts with the Justice System

We explored contacts with the justice system for Inuit living in Manitoba. Results are shown in Table 5. We included all charges: laid, stayed, dropped, disposed, or convicted. On average, 12.6% of Inuit living in Manitoba had contacts with the justice system for a crime alleged, stayed, dropped or that resulted in a conviction. On average, 6.5% of Inuit living in Manitoba were victim of a crime on a given year. Both statistics appear to be following a modest downward trend.

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Table 5. Contacts with the Justice System for Inuit Living in Manitoba

	# of Inuit aged 12+ charged with a crime		# of Inuit victim of a crime	
Year	Number	%	Number victims of a crime	%
2002-2006	51	12.5	44	9.1
2003-2007	58	13.2	43	8.4
2004-2008	54	11.4	37	6.8
2005-2009	65	12.9	37	6.4
2006-2010	64	12.0	38	6.3
2007-2011	74	13.1	40	6.3
2008-2012	78	13.3	42	6.3
2009-2013	80	13.1	43	6.3
2010-2014	85	13.5	43	6.1
2011-2015	88	13.6	41	5.7
2012-2016	79	11.9	42	5.7
2013-2017	72	10.7	36	4.9
Average		12.6		6.5

Contacts with the Manitoba Child and Family Services System

Inuit children may have contacts with the Manitoba Child Welfare System for a number of reasons. Child protection services are provided to children 0–17 years of age. According to Section 17 of Manitoba Child and Family Services Act, a child is considered in need of protection if that child experiences physical injury, emotional disability of a permanent nature, or sexual exploitation because of an action or failure to act by any person. Services provided include counselling, guidance, educational support, investigation, emergency shelter services, out-of-home placement, permanency planning, adoption, and post-adoption services (Milne et al., 2014).

Table 6. Inuit Children Having Contacts with the Manitoba Child Welfare System

	Inuit children having contacts with MB Child Family Services		Inuit children in care	
Year	Number*	% of overall Inuit children population in MB	Number	% of overall Inuit children population in MB
1992-1996	14	11.7	Suppressed	Suppressed
1993-1997	16	13.8	Suppressed	Suppressed
1994-1998	19	17.2	Suppressed	Suppressed
1995-1999	22	21.2	Suppressed	Suppressed
1996-2000	22	22.1	Suppressed	Suppressed
1997-2001	24	24.3	Suppressed	Suppressed
1998-2002	33	32.3	6	5.9
1999-2003	38	34.1	Suppressed	Suppressed
2000-2004	39	32.0	7	5.7
2001-2005	39	29.4	14	10.5
2002-2006	39	27.1	19	13.2
2003-2007	40	26.2	22	14.4
2004-2008	40	25.0	23	14.4
2005-2009	38	22.2	25	14.6
2006-2010	41	22.2	30	16.3
2007-2011	40	20.4	31	15.8
2008-2012	35	17.3	32	15.8
2009-2013	31	14.8	32	15.3
2010-2014	28	13.2	32	15.1
2011-2015	30	14.2	30	14.2
2012-2016	32	15.2	30	14.3
2013-2017	32	15.1	29	13.7
Average		21.4		13.3

*Numbers when observations are less than 5 have to be suppressed to ensure that privacy and confidentiality is protected.

Discussion

This study is a first attempt at documenting Inuit's utilization of social services in Manitoba. The attempt breaks new methodological ground. Still, we note some limitations. We report on challenges associated with each cohort separately. For the **cohort of Inuit from the Kivalliq region** accessing care in Manitoba, we considered all of those with a Nunavut Health Care Card as being Inuit. First, we are aware that the population of Nunavut is 84.8% Inuit. This goes up to 89.1% for the Kivalliq region (Nunavut, 2016). We used this method because Manitoba data lacks an Inuit identifier. Thus, assuming that all Kivalliq residents utilize Manitoba services equally, we could assume that nearly one consult for every 10 is from a non-Inuit person. Yet, we also know that a majority of non-Inuit residents of Nunavut

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moved to Nunavut for employment and are likely to have higher socio-economic status. In contrast, Inuit are known to shoulder a significantly higher burden of chronic diseases and to experience higher mortality rates (Macaulay et al., 2004). Consequently, we anticipate that Manitoba service utilization by non-Inuit may be considerably less than one in 10. We are however unable to assert the percentage of consults with non-Inuit Nunavut residents.

Second, a small proportion of Inuit accessing services in Manitoba may be from other regions of Nunavut and Nunangat. Examples provided to us by experts include Inuit children being treated for early childhood tooth decay at the hospital in Churchill. We are told that Inuit children from all of Nunavut access these specific services in Churchill. Another example includes Inuit accessing mental health services at the Selkirk Mental Health Centre. This Centre provides mental health stabilization and residential care to children in crisis and hosts Inuit from the Kivalliq and elsewhere in Nunavut. We will address these issues in subsequent manuscripts.

Finally, Inuit from the Kivalliq requiring highly specialized care may be transferred to centres others than Winnipeg (Vancouver, Toronto). The number of cases is however estimated to be low, especially in relation to access to social services, and unlikely to have a significant impact on the data reported here.

We also note some limitations to the **cohort of Inuit living in Manitoba**. First, we are aware of instances where Inuit families from the Kivalliq move to Winnipeg, return to Nunavut, and come back eventually. Our count thus might include the same individual counted separately within the same time period (1 or 5 years, depending on analyses). Second, the method we used to identify Inuit included anyone living in Manitoba who previously had a Nunavut health care number. As a result, we may have missed some Inuit families who were living in Manitoba before the creation of Nunavut. In addition, since the beginning of our project, we met Inuit from the Inuvialuit Settlement Region, Nunavik and Nunatsiavut. These were not included in our cohort. Third, our final cohort is small, and limited the number of analyses we could undertake. Despite these limitations, we believe that the methods we developed provide a novel perspective on Inuit service utilizations and needs.

Our results show 785 Inuit lived in Manitoba in 2016. This number contrasts to that of Statistics Canada, which documented 610 Inuit living in Manitoba in 2016, of which 285 only lived in Winnipeg (Statistics Canada, 2017b). It also contrasts with federal numbers of Inuit living in Manitoba, based on the federal non-insured health benefits program utilization, which totaled Inuit in Manitoba at 222 in 2018–19 (Health Canada, 2019). While our numbers are higher than other estimates, we believe that our estimate may nevertheless underrepresent Inuit living in Manitoba, because of the limitations noted above. Recent work by Manitoba Health conducted in the context of the pandemic estimates that 1,500 is closer to reality.

We were also able to document that Inuit from the Kivalliq primarily access services in Winnipeg: indeed, between 75% in 2009 (the lost point between 1999 and 2016) to 96% in 2016 of all hospitalizations occurred in Winnipeg. Likewise, Inuit moving to Manitoba primarily relocate to Winnipeg (from 57% in 1999-03 to 66% in 2012–16).

Social Program Utilization

Smylie and colleagues documented the socio-economic conditions of Inuit living in Ottawa (Smylie et al., 2018). Our approach to examining Inuit in Manitoba draws important parallels such as the reliance on social programming as an indication of poverty and social exclusion. We documented that one in five Inuit depended on Manitoba's income assistance program, suggesting that food insecurity is a likely challenge. An analysis published by Statistics Canada documented that in 2011–2012, the rate of food insecurity was more than three times higher in households where government benefits were the main source of income (21.4%) compared with households with an alternate main source of income (6.1%) (Roshanafshar & Hawkins, 2015). Other factors associated with reliance on social programming includes a lack of educational credentials, racialization, and discrimination. Further research is required to assess the main factors at play.

Justice

We documented that, on average, 12.6% of Inuit in Manitoba had been charged (but not necessarily convicted) of a crime, and that 6.5% of Inuit had been the victim of a crime. We did not itemize the types of crimes of which Inuit were accused, the percentage that led to a sentence, nor the type of sentence. Inuit experience higher rates of mental health problems than the general population (Kielland & Simeone, 2014), often associated with a context of rapid social, cultural, and economic change (Kral et al., 2011), which can be magnified by social exclusion, food insecurity, and income disadvantage. Further research is required to assess whether the contacts with the justice system, for alleged offenders and victims, are related to social exclusion, and whether culturally informed programming might mitigate issues of social exclusion and diminish the number of contacts with justice (Ferrazzi & Krupa, 2016).

Child and Family Services

Child and Family Services follow two main streams: the family enhancement stream or the child protection stream. Family enhancement services are provided on a voluntary basis to families where there is no imminent risk of harm to children but who need supports to strengthen parenting capacity or to keep children safer at home. The child protection stream pertains to children in care through voluntary placement, voluntary surrender of guardianship, apprehension, or order of guardianship. Services can also be provided based on voluntary requests for service, usually for children who are not in care (Milne et al., 2014, p. 9). In Manitoba, following the death of Phoenix Sinclair, 17 First Nations and two Métis Child and Family Services (CFS) agencies were created to oversee services, disperse funds, and ensure that culturally appropriate services are delivered. An Inuit equivalent was not created. Instead, Inuit children are under the care of Métis CFS agencies.

It is not clear why, on average, one of every 10 Inuit children is being followed by Manitoba CFS. Scholars have problematized the overrepresentation of Indigenous children in CFS, citing racial bias as a contributing cause (Duthie et al., 2019; Sinclair, 2016). The group in our analysis included Inuit children under 18 years of age who moved and became connected to the Manitoba CFS system, and children of movers who also became connected to the CFS system. A 2011 report of a study conducted

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by the Iqaluit Qaujigiartiit Health Research Centre documented the existence of 265 approved foster homes in Nunavut (Lindsay & Healey, 2012). The report cited that,

> In extenuating circumstances, for example if the child requires medical support, the child may be placed in an out-of-territory foster home in order to receive treatment. Additional special circumstances may see a child placed in a childcare facility such as a group home or treatment facility outside of the territory for behavioural and/or medical treatment. (Lindsay & Healey, 2012, p. 11)

In some cases, we are aware that Inuit children who are medically fragile live in foster care homes in Manitoba because they need to access services not available in Nunavut. We are told by families operating foster homes for medical fragile Inuit children that these children are under the Nunavut CFS system. We are planning further research on this issue.

As it exists, the Child Welfare System is a creation of a Western worldview. Reforms to the Manitoba system that resulted in the creation of First Nation and Métis CFS, created opportunities for some cultural adaptation (Milne et al., 2014). Although the Government of Nunavut has expressed a commitment to greater integration of Inuit Qaujimajatuqangit (Inuit Traditional Knowledge, or IQ) (Tagalik, 2010) into its child welfare system, this integration has proven challenging for a number of reasons (Johnston, 2014). To begin, the managerial approach to child welfare is in direct opposition to IQ and Inuit values. In addition, social workers in Nunavut remain primarily non-Inuit, and therefore are insufficiently familiar with IQ and Inuit culture. We wonder whether IQ has informed interventions with Inuit families by the Métis CFS.

Similar comments can be made of the income assistance, housing, and justice systems, which operate from a Western perspective on individual and collective responsibilities and accountability and ignore Inuit *maligait* (laws) (Oosten et al., 2017) and values (Karetak et al., 2017). While it may not be feasible or appropriate to expect all services and systems to reflect an Inuit-centric perspective, support to Inuit using these services and systems might result in better alignment between needs and service provision.

Conclusions

This study is making a unique contribution to understanding the Manitoba Inuit community's service utilization in Manitoba. Results tell us that there are about one in 10 Inuit in Manitoba who, if an adult, have had contact with the justice system; or if a child, interact with the CFS system. One out of every five are on income assistance. This alone justifies the existence of the Manitoba Inuit Association, an Inuit-led representative organization for Inuit living in Manitoba. The Manitoba Inuit Association was created by Inuit for Inuit to advocate for Inuit rights to access culturally relevant services in areas that improve their health, education, employment, income, and general wellness. Our findings underscore the importance of funding work that supports the Inuit community, and of investments in culturally informed counselling and parenting programs, as well as service navigation and advocacy.

Key gaps identified in our studies include Inuit-centric Child and Family Services, parenting programs, family supports, and language programs for Inuit children in care. Inuit living in Manitoba or traveling to

Manitoba to access care also require Inuit-specific programming to allow them to better navigate their options and meet their specific needs.

To our knowledge, the *Qanuinngitsiarutiksait* study is the first study reflecting Nunavut Inuit service utilization in Manitoba. More work is required documenting how Inuit from other Nunavut regions are accessing services in southern urban centres.

Lastly, findings from the Qanuinngitsiarutiksait study are already being used to inform policy and decision-makers in all levels of government: federal, provincial, territorial, as well as Inuit governments and their leadership (Clark et al., 2020; Lavoie et al., 2020). Decision-making around programming must be filled with Inuit-centric evidence for those living in Manitoba.

The Inuit community living outside Inuit Nunangat and those settling in the province of Manitoba can best be served by a number of Inuit-led organizations who will determine their mandates and service provision that is led by evidence provided through research, such as the Qanuinngitsiarutiksait study. We know that just in the city of Winnipeg there are numerous First Nations and Métis led organizations serving their constituencies, and this blanket of service providers has developed over decades. Inuit are at these cross-roads of weaving their own Inuit blanket of service providing organizations. We are thrilled that this collaborative research opportunity, which was pursued at the request of MIA and in partnership with Inuit Elders, generated meaningful research findings to inform the priorities and mandates of Inuit organizations and the community.

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