



Canadian Mental
Health Association
Mental health for all

Closing the Distance

Mental Health in Rural and Remote Canada



Closing the Distance: Mental Health in Rural and Remote Canada

This report was researched, written and prepared by Dr. Leyna Lowe and Dr. Alex Luther.

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We would like to acknowledge and thank CMHA's National Federation Steering Committee for their feedback and contributions to this report.

CMHA

Founded in 1918, the Canadian Mental Health Association (CMHA) is the most established, most extensive federation of community mental health organizations in Canada. Through a presence in more than 330 communities across every province and Yukon, CMHA employs 7,000 staff and engages 11,000 volunteers to provide advocacy, programs and resources that help to prevent mental health problems and mental illnesses, support recovery and resilience, and enable all Canadians to flourish and thrive.

Land acknowledgement

Located in Toronto, the Canadian Mental Health Association National office acknowledges that we are on the traditional territory of many nations including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee and the Wendat peoples and is now home to many diverse First Nations, Inuit and Métis peoples. We also acknowledge that Toronto is covered by Treaty 13 signed with the Mississaugas of the Credit, and the Williams Treaties signed with multiple Mississaugas and Chippewa bands.

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01. Executive Summary

Many of Canada's rural and remote communities understand what it means to go the distance. Residents must persevere in the face of many challenges and, more literally, often have to go long distances to get their needs met.

This report examines national-level data on mental health, substance use health and health service use to explore rural/remote and urban experiences and illuminates where, how and for whom disparities arise. It also explores the prevalence of mental disorders, perceived mental health, rates of substance use, quality of life, and hospital service use data collected by Statistics Canada and the Canadian Institute for Health Information (CIHI). By comparing results across rural/remote and urban regions, and by gender, income, and, when possible, by Indigenous identities, the report finds trends in who is doing well, what systemic inequities exist, and where better healthcare infrastructure, access, and supports are needed.

The data show that rural populations are doing better than in urban areas on some well-being measures and worse on others.

- A larger percentage of people in rural and remote communities report good mental health and higher rates of well-being. They have higher rates of belonging to community and feelings of purpose and meaning in life, and lower rates of loneliness. However, rates of self-reported “fair” or “poor” mental health and of feeling lonely “always” or “most of the time,” are as high in rural and remote communities as in urban areas.
- Across all regions, the rates of mental well-being are significantly lower and the rates of mood disorders and anxiety disorders are higher for Indigenous and low-income populations, although the rates are slightly more favourable in rural and remote populations overall.
- Rural and remote residents are less likely to access mental health services than urban residents, and are also less likely to consult with psychiatrists, psychologists and social workers.
- The rates of violent crime (including domestic violence) are higher in rural and remote areas, and the rates of higher-risk substance use (drinking alcohol and smoking) are greater than in urban areas, and in particular for men.
- In all areas (rural/remote and urban), more women have mood disorders and anxiety disorders than men but are more willing to seek treatment. The rates of substance use disorders (SUDs) are higher in rural and remote areas overall and more men than women engage in riskier substance use, with rural and remote men reporting the highest rates of drinking (alcohol) and smoking (tobacco).

- While hospital use for mental health and substance use health concerns is very similar for rural/remote and urban areas, mental health services are both less available and accessible to rural and remote residents. The travel burden for psychiatric care in hospital is very high for rural and remote communities.

Based on these findings, CMHA presents the following recommendations.

Address the structural, social and cultural barriers that limit access to mental health care in rural and remote communities.

Invest in community-based mental health and substance use health supports to ensure that rural and remote communities have access to a broader continuum of care.

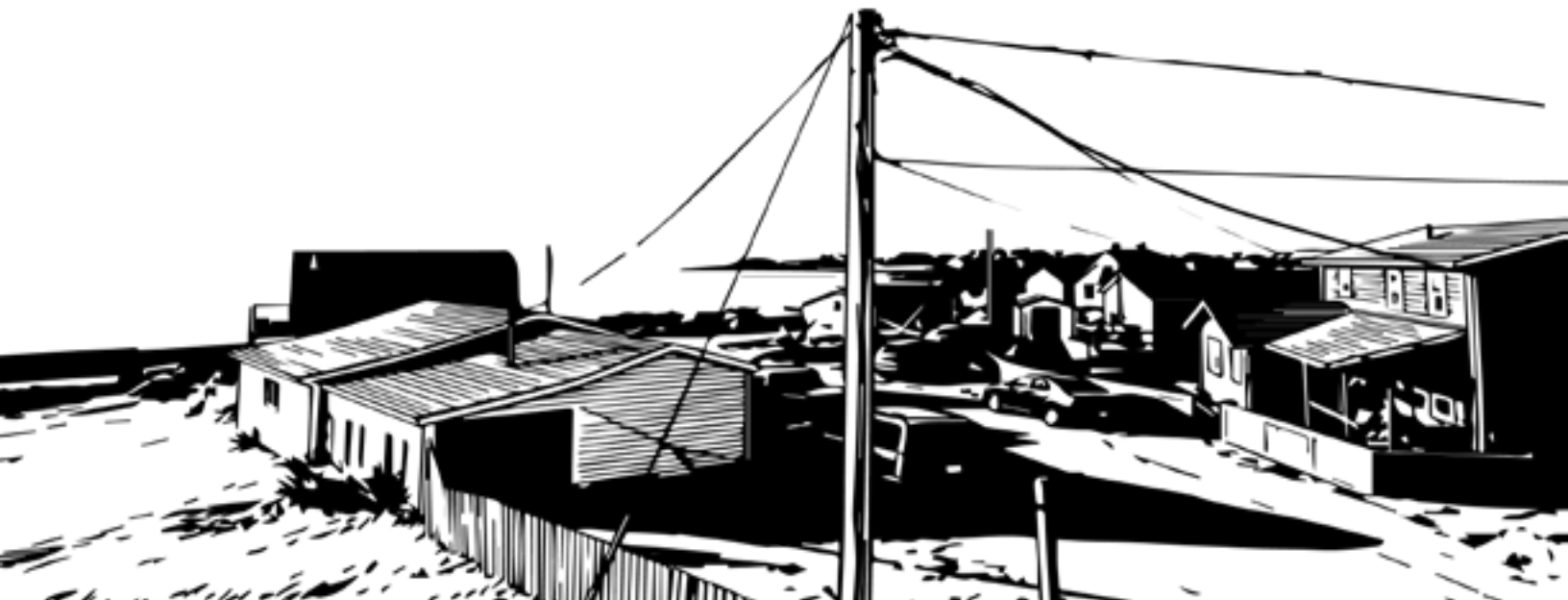
Increase social spending and enhance social supports in consultation with Indigenous Peoples and people with lived experiences of mental illnesses and addictions.

Tackle the stigma related to mental health and substance use problems in rural and remote communities.

The Government of Canada must improve data collection and reporting practices so that rural and remote population health and service utilization data are captured more completely and with greater accuracy.

The data presented here draw an important picture of the mental health and substance use health of rural and remote populations, but it is incomplete. Closing the distance between rural/remote and urban areas will require improving data collection and reporting practices so that health and service utilization data are captured more completely and with more accuracy.

Many of Canada's rural and remote communities understand what it means to go the distance. Too often, that distance is felt not just in kilometres, but in time, cost, safety, and access to care. But distance is not only geographic; it is also shaped by social relationships and inequalities. Longer travel, greater exposure to violence, and barriers to culturally appropriate services create inequities that shape people's ability to get the support they need. Closing that distance is ultimately about equity: ensuring that care is available, accessible, and within reach, so that no one is required to overcome more because of where they live, the communities that they belong to or the social conditions that shape their lives.



02. Introduction

Many of Canada's rural and remote communities understand what it means to *go the distance*. Residents must persevere in the face of many challenges and, more literally, often have to go long distances to get their needs met.

Communities that are more sparsely populated, isolated, or northerly often face more barriers and pressures than their densely populated and more southerly neighbours due to social, political, and geographic factors. In rural and remote areas, health care and other services and supports may be harder to access or lacking altogether. Weather, terrain and climate change can pose significant challenges to daily living and livelihoods, particularly for those whose way of life includes agriculture and livestock production or for whom hunting, trapping, fishing, and harvesting have cultural, spiritual and economic importance. Rural and remote community members often struggle to meet basic needs: the cost of living can be higher, housing may be in short supply, and health disparities are greater. Limited internet connectivity can make communicating and accessing information, education and employment more difficult. These challenges can impact health and well-being.

Many Indigenous communities are located in rural and remote areas and continue to experience colonial violence and intergenerational trauma caused by Canadian colonial policies. These include but are not limited to the *Indian Act*,

residential schools, cultural genocide and forced relocations, which have created systemic inequities that shape communities today and across generations. Many northerly and rural/remote Indigenous communities experience human rights violations related to environmental hazards caused by resource extraction and manufacturing. They are 90 times more likely than non-Indigenous communities to face water insecurity due to waterway contamination from industrial activity. Indigenous communities in rural and remote areas continue to advocate for action on these issues to protect land and community.¹

Given these realities, this report asks: how are rural and remote populations faring when it comes to mental health and well-being, and how do their experiences compare to urban populations?

Using national-level data on mental health, substance use health and health service use, this report explores rural/remote and urban experiences and illuminates where, how and for whom disparities arise. It also explores the prevalence of mental disorders, perceived mental health, rates of substance use, quality of life, and hospital service use data collected by Statistics Canada and the Canadian Institute for Health Information (CIHI). By comparing results across rural/remote and urban regions, and by gender, income, and, when possible, by Indigenous identities, the report finds trends in who is doing well and where better healthcare infrastructure, access, and supports are needed.

The data show that rural and remote populations are doing better than urban populations on some well-being measures and worse on others.

- A larger percentage of people in rural and remote communities report good mental health and higher rates of well-being. They have higher rates of belonging to community and feelings of purpose and meaning in life, and lower rates of loneliness. However, rates of self-reported “fair” or “poor” mental health and of feeling lonely “always” or “most of the time,” are as high in rural and remote communities as in urban areas.
- The rates of mental well-being are significantly lower and the rates of mood disorders and anxiety disorders are higher for Indigenous and low-income populations across all regions, although the rates are slightly more favourable in rural and remote populations overall.
- Rural and remote residents are less likely to access mental health services than urban residents. Rural and remote residents are also less likely to consult with psychiatrists, psychologists and social workers.
- The rates of violent crime (including domestic violence) are higher in rural and remote areas, and the rates of higher-risk substance use (drinking alcohol and smoking) are greater than in urban areas, and in particular for men.

- In all areas (rural/remote and urban), more women have mood disorders and anxiety disorders than men but are more willing to seek treatment. The rates of substance use disorders (SUDs) are higher in rural and remote areas overall and more men than women engage in riskier substance use, with rural and remote men reporting the highest rates of drinking (alcohol) and smoking (tobacco).
- While hospital use for mental health and substance use health concerns is very similar for rural/remote and urban areas, mental health services are both less available and accessible to rural and remote residents. The travel burden for psychiatric care in hospital is very high for rural and remote communities.

Disaggregation by rural/remote area was not possible for a significant portion of the publicly available data on national mental health and substance use health. The data presented in this report therefore do not paint a complete picture of the state of rural/remote mental health. As such, this report examines only a portion of mental health and substance use health data and, because it is national in scope, does not examine regional differences or differences in subpopulations except where data were available. However, the data do provide insight into rural and remote population mental health and service use. This research can help assess need, plan for services that meet the need, and track population health changes and service use patterns.



CMHA and rural and remote communities

This report stems from the Canadian Mental Health Association's (CMHA) focus on the health and well-being of rural and remote communities. The oldest and most established federation of community mental health organizations in Canada, CMHA has Divisions in all ten provinces and Yukon, and operates in dozens of rural and remote communities. CMHA frontline providers are well acquainted with the challenges their rural and remote clients face. CMHA provides a full continuum of mental health services, including housing and employment supports, food security programs, drop-in programs, educational programs, case management, counseling, crisis supports, service navigation, and many others.

Over the last two years, CMHA National, with the support of West Fraser, a forest products company operating in four Canadian provinces, has supported both the expansion of programs and services in rural and remote areas, and the development of evidence-based research about them. For more information about this work, visit CMHA's [Rural Mental Health page](#).

How rural and remote is Canada?

18%

of the population is rural or remote.



1 in 9 Canadians live in a remote municipality.²

74.6%

of Canada's landmass is considered remote.

Canada has over

400

diverse rural communities.

Rural and remote communities contribute more than

25%

of our country's GDP.



Median incomes are lower.

A high proportion of Indigenous populations live in rural and remote areas.³

03. Methodology

To locate relevant data, we scanned holdings of the three primary agencies that conduct national census and health systems surveillance on mental health, addictions and substance use health: Statistics Canada, the Public Health Agency of Canada (PHAC) and Canadian Institute for Health Information (CIHI). Statistics Canada and CIHI make some data publicly available on their websites as Public Use Microdata Files (PUMF). We downloaded .CSV files and formatted them in Excel. Statistics Canada and CIHI data were not consistently available for every data cycle or reporting year and did not necessarily allow for urban/rural stratification. We submitted requests to both Statistics Canada and CIHI for custom data tables stratified by rural/urban geography. Statistics Canada fulfilled this request.

The data in this report met the following criteria: 1) they were relevant for understanding mental health and substance use in Canada; 2) it was possible to stratify by community size (rural/remote vs. urban); 3) they were good quality; 4) and they were recent (since 2018). We excluded data where the suppression did not allow for meaningful analysis. Data were cleaned and analyzed using SAS and Excel.

The Statistics Canada data in this report come from three surveys: the Canadian Community Health Survey, the Mental Health and Access to Care Survey, and the Canadian Vital Statistics Death Database. CIHI's data were collected directly from hospitals, participating health agencies, health authorities, and ministries of health

through several databases, including the Discharge Abstract Database (DAD), the National Ambulatory Care Reporting System (NACRS) and the Hospital Morbidity Database (HMDB).⁴

Defining “rural” and “remote”

Statistics Canada's Statistical Area Classification Type categorizes communities as either rural (includes remote) or urban and it uses the concept of population centres to determine which areas are considered rural. Population centres are classified into three groups: small (1,000–29,999), medium (30,000–99,999), and large (100,000+) populations. All communities outside population centres that have a population of less than 1,000 or fewer than 400 inhabitants per square kilometre, are considered rural.⁵

Statistics Canada notes that population densities and living conditions can vary greatly in rural (includes remote) areas. Rural areas include:⁶

- small towns, villages and other places with less than 1,000 population
- rural areas of census metropolitan areas and census agglomerations that may contain estate lots, as well as agricultural, undeveloped and nondevelopable lands, and
- remote and wilderness areas.

Statistics Canada also recognizes that some areas that might be considered rural are in close proximity to urban centres

and therefore enjoy some urban benefits, while others are far from urban population centres – that is, they are remote – and do not have access to urban amenities. Statistics Canada has developed a separate methodology to account for remoteness (the Remoteness Index) but that methodology does not use the population centres methodology described above. As such, while the data accessed for this report were stratified according to the rural/urban split, “rural areas” include communities on the continuum of remoteness, from those that are not remote at all (those situated outside of urban areas) to those that are highly remote and for which access to services is very low.⁷

In several Statistics Canada datasets, the available urban data were stratified by small, medium and large population centres. To allow for a simpler comparison between rural/remote and urban areas, we pooled the urban data by aggregating estimates for small, medium, and large urban population centres. Standard errors were approximated from the 95% confidence intervals calculated and provided by Statistics Canada and pooled assuming independence between subgroup estimates and then applied to calculate pooled confidence intervals. Because these estimates originate from the same survey sample, the resulting confidence intervals are often wider, may slightly underestimate uncertainty, and should be interpreted as approximate. While the estimates should be interpreted with caution, the purpose of this report is to descriptively examine urban-rural/remote differences, for which this methodological approach is generally acceptable.

Because this report focuses on national data, comparisons among rural/remote communities across provinces and

territories are largely absent. This means that the heterogeneity of rural and remote communities across Canada is not captured or discussed here. This is an important limitation given that rural and remote communities can vary significantly from one region to another in their population groups, economies, industries, cost of living, access to health care, infrastructure and housing stock and affordability, all of which can impact health and well-being differently. Furthermore, there are differences within communities. Experiences of health and access to health care and social supports are shaped by systemic inequalities, including racism, colonialism, gender inequality and sexism, homophobia, income inequality and discrimination on the basis of health/disability. The analysis of different subgroups (that is, stratification by race, Indigenous identity, sexual orientation, income and disability) was not always possible because data may not have been collected or publicly reported, or the sample sizes were too small. In addition, subgroup analysis by profession – e.g., those working in agriculture or resource extraction – were also not available in these datasets, which is an important gap given that other published research shows higher rates of poor mental health and substance use health for these groups.⁷ We note that more research and data are needed to fully represent the heterogeneity of rural and remote populations, recognizing that mental health and well-being are deeply shaped by regional differences, political contexts and social inequities.

Furthermore, two of the surveys used in this analysis – the MHACS and Canadian Social Survey – do not account for persons living on reserves and only cover Canada’s ten provinces, leaving out the three territories, Yukon, Northwest Territories and Nunavut.⁹ This is a considerable gap given the higher

number of First Nations, Métis and Inuit living in the territories and on reserve, some of the most remote areas of the country.

We also recognize that data collected in Canada, including those discussed in this report, exist within a colonial history and system of governance. The ways in which populations are accounted for in statistical methodologies reflect colonial geographical boundaries, policies and Western assumptions and worldviews. These are inherent limitations and point to the need for governments to better support Indigenous data sovereignty.¹⁰

Disaggregation by gender was available for a significant portion of the datasets. Statistics Canada organizes the gender variables as “women+” and “men+” indicating that these categories include “women (and/or girls), as well as some non-binary persons” and “men (and/or boys), as well as some non-binary persons.” Gender diversity within the category “women+” includes cisgender women, transgender women, and non-binary persons, and

gender diversity within “men+” includes cisgender men, transgender men and non-binary persons.¹¹

Finally, this report presents a range of comparisons between urban and rural/remote mental health data. However, in many cases, formal statistical testing was not possible. As the data are drawn from multiple surveys, consistent denominators, variance estimates, or access to microdata were not equally available. This limits the ability to calculate true statistical significance and so, caution is warranted in interpreting differences as definitive or causal, and findings should be understood as descriptive rather than inferential. Nevertheless, many of the measures presented are standardized rates (e.g., per 100,000 population, per 1,000 visits, or averaged indicators), which permit meaningful descriptive comparisons of magnitude and direction across regions. These descriptive comparisons are valuable for identifying patterns, highlighting potential disparities, and informing future analytic work.



04. Rural and Remote Mental Health and Well-being

Mental health is central to our lives and is intrinsically tied to other aspects of our well-being, including physical health.¹² Policy decisions, funding and service delivery can be informed by examining the distribution of illness, well-being and psychiatric disorders.¹³

National-level data show that while rural/remote populations generally rate their mental health and well-being higher than urban ones, not everyone is doing equally well. Systemic barriers stemming from gender inequality, income inequality and colonialism affect the well-being of women, those who are low income, as well as Indigenous peoples.¹⁴

How people in urban and rural/remote Canada rate their mental health (“perceived mental health”)



Rural/remote

“Good,” “very good,” or “excellent”

87.4%

“Fair” or “poor”

15.1%



Urban

“Good,” “very good,” or “excellent”

84.5%

“Fair” or “poor”

15.5%

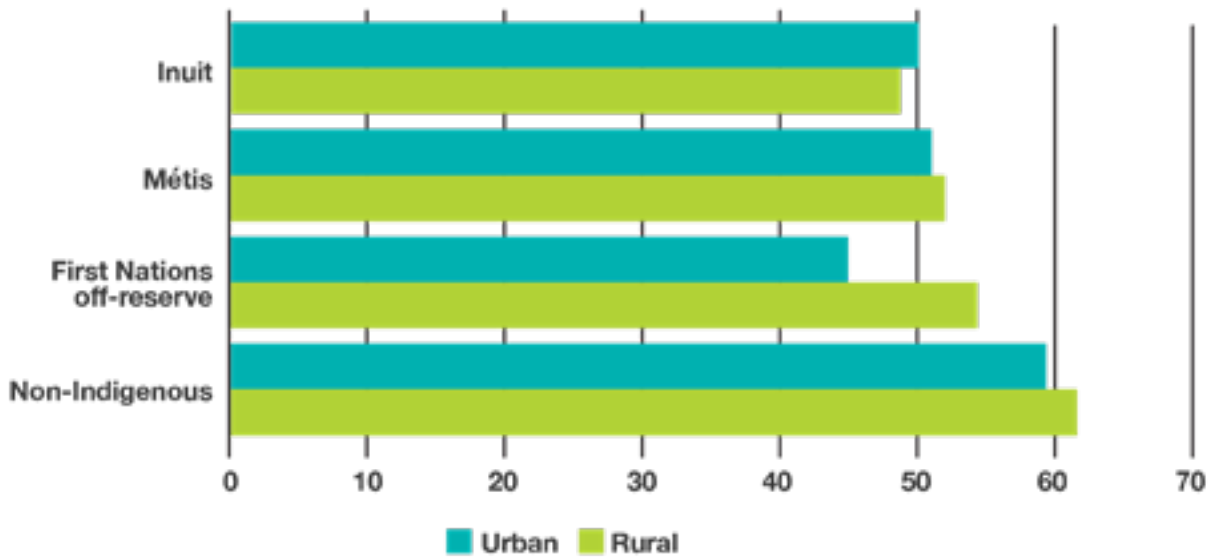
Rural and remote populations have the highest rates of well-being, with 87.4% reporting “good,” “very good,” or “excellent”

mental health. Urban areas are close behind with around 84.5%. However, the percentage of people that rate their mental health as “poor” or “fair” is similar across regions: 15.7% in urban and 15.1% in rural and remote communities.

The perceived mental health of Indigenous Peoples

Across rural/remote and urban communities, Indigenous Peoples in Canada report lower rates of well-being than non-Indigenous Canadians. In 2020–2022, 61.7% of rural/remote non-Indigenous people reported “very good” or “excellent” mental health, compared to 54.4% of rural/remote First Nations off reserve, 52.1% of Métis, and 48.5% of Inuit (Chart 1). Urban Indigenous populations report slightly lower well-being than their rural/remote counterparts: 59.4% of non-Indigenous people report “very good” or “excellent” mental health, compared to 45% of First Nations off reserve and 51.0% of Métis. Inuit populations are the exception, as the rates of perceived mental health are higher among those living in urban areas (49.5%) compared to rural and remote ones (48.5%), and that gap was as wide as 10% in 2017–2019. Urban First Nations (off reserve) report well-being at a rate that is 9.4% lower than rural and remote First Nations off reserve, representing the greatest urban-rural and remote gap within a single Indigenous identity group. All Canadians have experienced an overall decline in well-being, but Indigenous peoples continue to experience lower mental health and well-being than the non-Indigenous population.¹⁵

Chart 1. Perceived Mental Health by Indigenous and Non-Indigenous Populations, "Very good" or "Excellent" Rating, 2020-2022



Perceived mental health by income

When it comes to self-rated mental health, income matters. People with higher incomes report better mental health than those with lower incomes (according to the Low-Income Cut-Off or LICO)¹⁶ in all regions, although the rates of good mental health in rural and remote areas are higher overall across both income groups.

Perceived mental health, "good" to "excellent," by income



Rural/remote

80.4%

Lower income
(below LICO)

90.7%

Higher income
(above LICO)



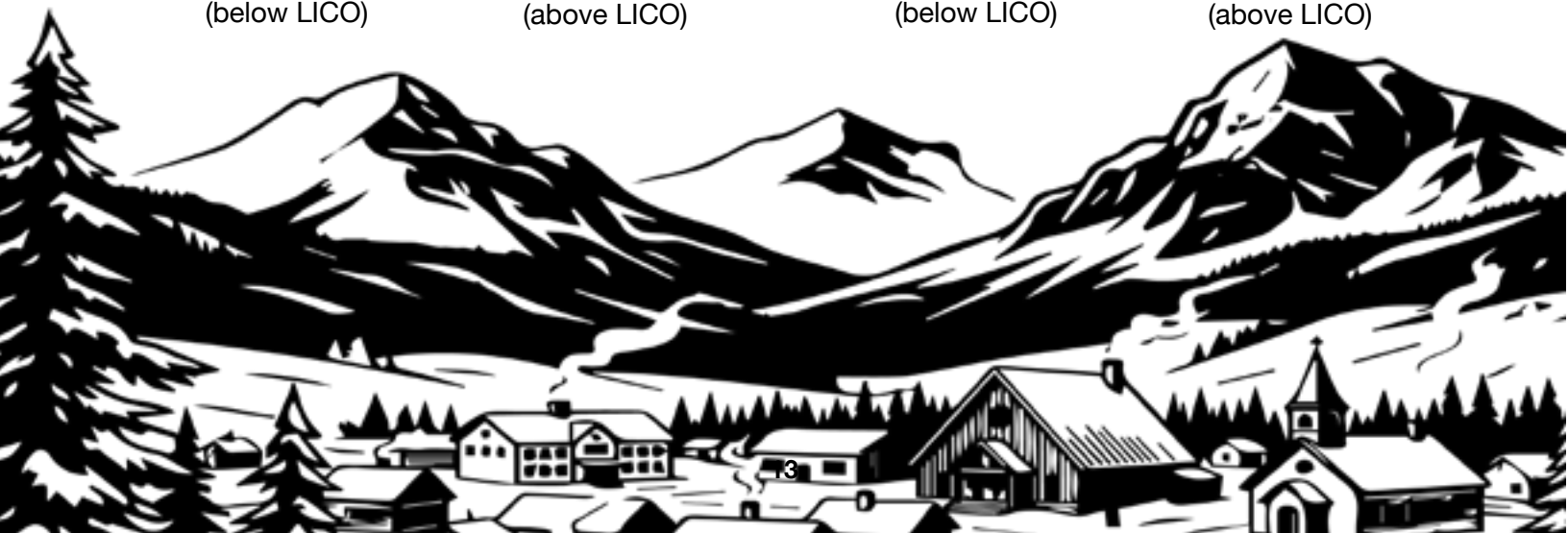
Urban

77.3%

Lower income
(below LICO)

98.3%

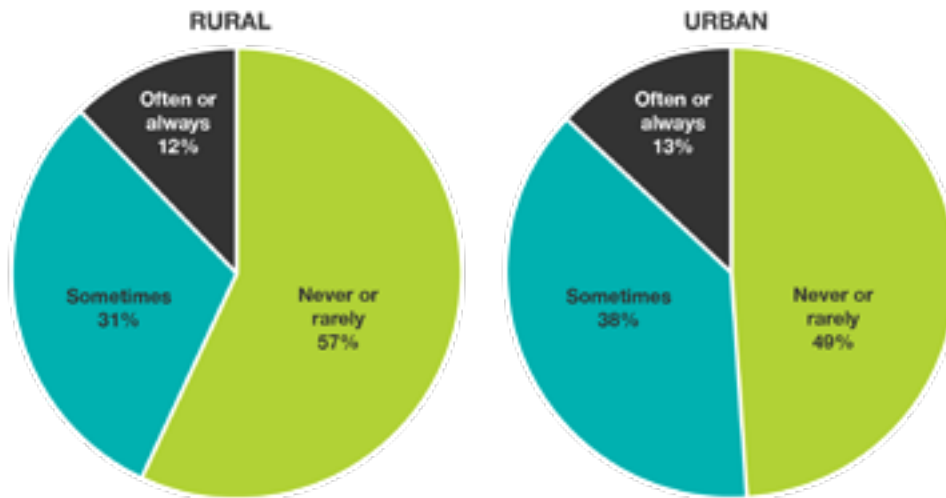
Higher income
(above LICO)



Loneliness

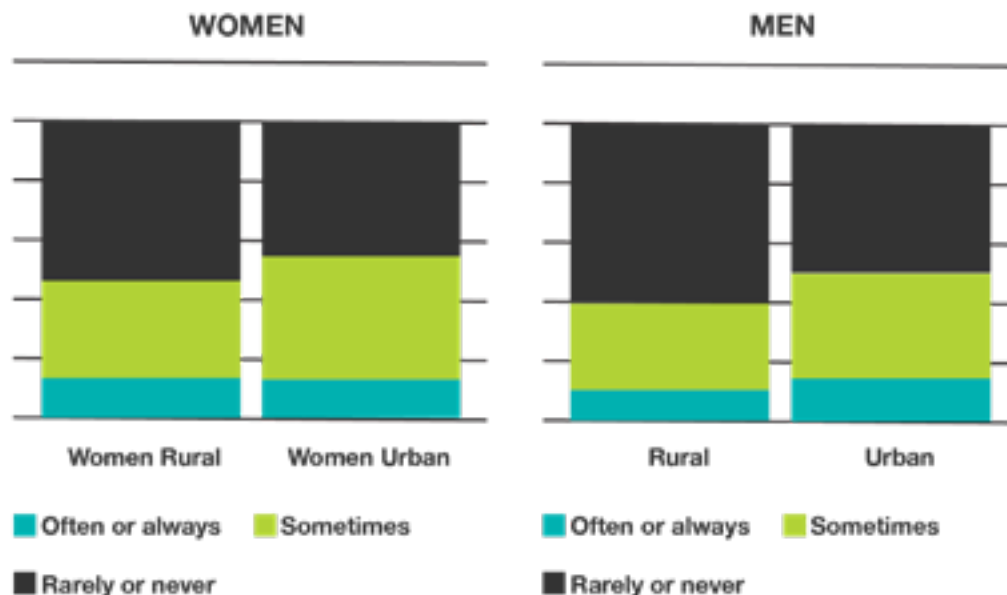
People in urban centres report feeling lonelier than people in rural/remote places. In 2024, 56.9% of rural and remote residents reported that they “rarely” or “never” feel lonely compared to 48.6% in urban areas. However, the percentage of rural/remote and urban populations that feel lonely “often” or “always,” is very similar: 12% and 13.6%, respectively (Chart 2).

Chart 2. Percentage of rural/remote vs. urban residents who report feeling lonely, 2024



Women report higher rates of loneliness than men across all geographic areas. More men (rural/remote: 60.5% and urban: 51.9%) than women (rural/remote: 53.4% and urban: 45.3%) say that they are “never” or “rarely” lonely. In rural and remote places, more women than men (14.3% vs 9.7%) say they are “often” or “always” lonely, but the gap between women (13.9%) and men (13.3%) is smaller in urban settings.

Chart 3. Percentage of women+ vs. men+ who report feeling lonely, by rural/remote and urban region, 2024



Sense of belonging

Rural and remote populations report stronger ties to their local communities than urban ones. In 2024, about 62.2% of rural and remote residents responded that they had a very “strong” or “somewhat strong” sense of belonging to their local community, compared to 52.3% in urban areas. Between 2021-2023, rural and remote rates of belonging declined from 56.6% to 52.1%, which may be due to challenges related to the COVID-19 pandemic. These rates more than rebounded in 2024 (62.2%).

Strong Sense of Belonging



Rural/remote

62.2%



Urban

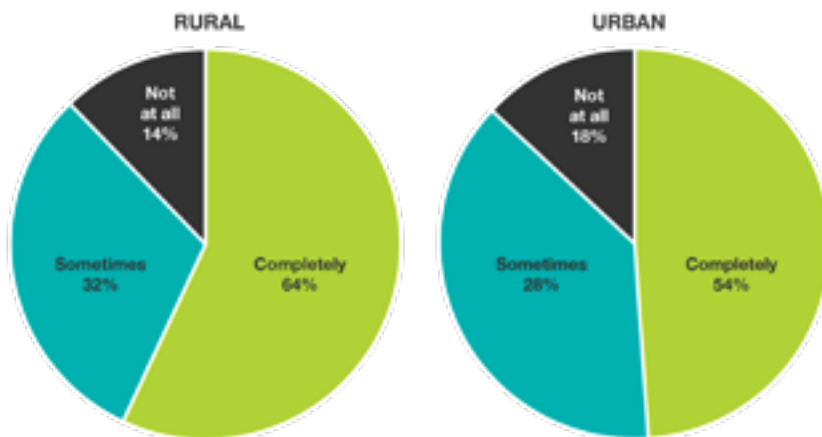
52.3%

Compared to rural/remote men, rural/remote women are slightly less likely to report that they feel a strong sense of belonging to their communities (60.1% women vs. 64.2% men), while urban men and women report nearly identical rates in sense of belonging.

Purpose and meaning

Feelings of purpose and meaning in life were rated higher in rural and remote communities than in urban ones. In 2025, 64.5% of rural and remote residents reported a high sense of purpose and meaning compared to 54.5% of residents in urban areas. The gap is consistent across reporting years.

Chart 4. Percentage of rural/remote vs. urban residents who report having a strong sense of purpose and meaning, 2024.

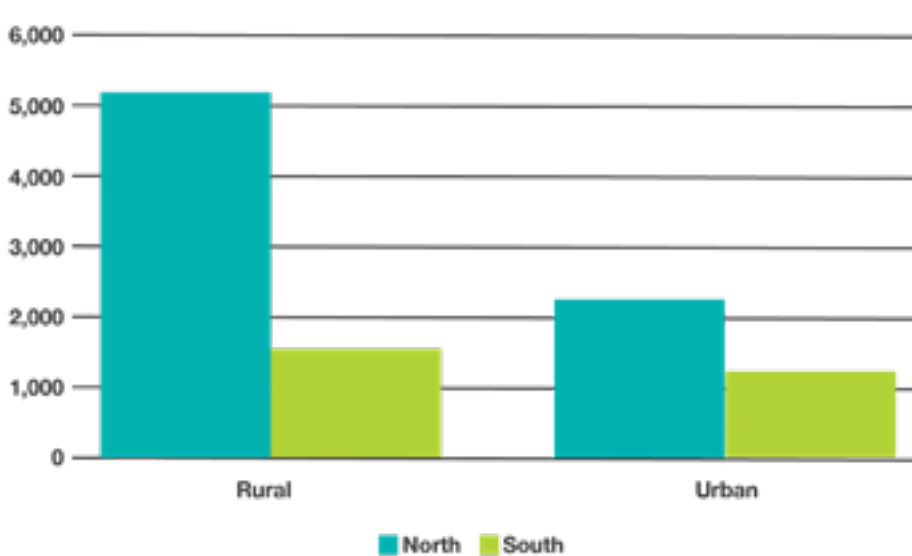


Rural/remote and urban women report a slightly higher sense of purpose and meaning than men (66.0% vs. 63.0%; 55.4% vs. 53.6%), which may point to gender differences in experiences related to life purpose (Chart 4).

Rates of Violence

Experiences of violence in childhood and adulthood – including child abuse and neglect, intimate partner violence and community violence – have a significant impact on physical and mental health. Research shows that both direct exposure to violence and perceiving one’s community as dangerous and unsafe are linked to poorer mental health, including higher rates of anxiety and depression.¹⁷ Although perceived mental health and quality of life rank higher in rural/remote areas, national data show that rural/remote areas have higher rates of violent crime.¹⁸

Chart 5. Violent Crime Rate by Rural/remote (North and South) and Urban (North and South) areas, 2023



When analyzing by the north-south divide, rates of violence are higher in northern areas (Chart 5), suggesting that living in a northern community is a significant risk factor for experiencing violence. It is striking to note that the rate of victimization of girls and younger women is significantly higher in rural and remote areas (1,963 per 100,000 population) compared to

urban areas (1,137 per 100,000) in Canada. The rates for girls and women are highest – almost double that of boys and young men – in the 12-17 and 18-24 age categories.¹⁹ Still, rural and remote boys and men face victimization more often than their urban counterparts.

The rates of intimate partner violence are also higher in rural and remote (29%) than in urban areas (24%). In rural and remote areas, the perpetrator of violence is much more likely to be a family member (rural/remote 22% vs urban 12%), or a friend/casual acquaintance (rural/remote 26% vs urban 19%), whereas in urban areas, stranger-perpetrated violence is much higher (rural/remote 13% vs urban: 30%).

The higher rate of violence in these regions is a social justice concern that stems from colonial policy. The Government of Canada reported in 2019 that Indigenous Peoples in Canada are far more likely to be victimized by violent crimes (177 per 100,000) than non-Indigenous people (80 per 100,000). A significant number of Indigenous women and girls are also reported missing and murdered each year. While the exact number is unknown, crime statistics show that the rate of homicide against First Nations, Métis and Inuit women and girls was six times higher than among non-Indigenous women.²⁰ These high rates of violence reflect deep systemic inequalities and intergenerational trauma produced by colonial government policies that continue to impact communities today. The findings regarding gender-based and family violence in the North underline the need to increase social supports that sustain healthy families and address underlying systemic inequalities.

Mood Disorders and Anxiety Disorders

Mood disorders and anxiety disorders change our moods and patterns of thinking in ways that disrupt our daily functioning and well-being. In mood disorders, this can include feelings of depression, anger and irritability. Anxiety disorders are often experienced as excessive fear and worry that can impact daily functioning. Together, along with substance use disorders, they are among the most common mental illnesses in Canada, representing about 70% of all mental disorders and affecting about 15-18% of the population.²¹ However, the rates of mood and anxiety disorders vary by community size and among populations.



Mood disorders

include major depressive disorder, bipolar disorder, or persistent depressive disorder.



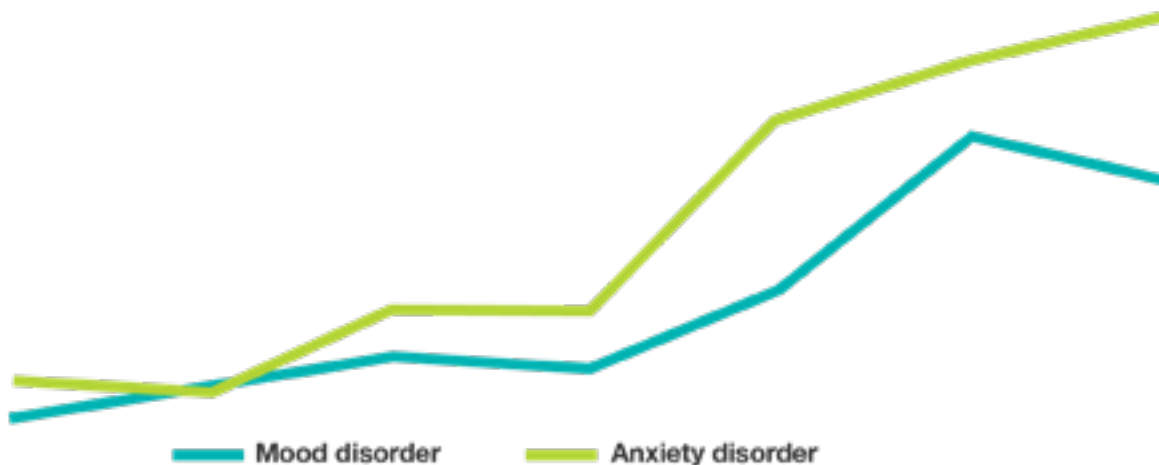
Anxiety disorders

include phobias, panic disorder, post-traumatic stress disorder and obsessive-compulsive disorder.

Rural and remote areas in Canada report slightly lower rates of both mood and anxiety disorders. In 2024, rural and remote communities reported a rate of 12.4% for mood disorders and 15.4% for anxiety disorders while the rates in urban areas were 13.2% and 16.2%, respectively.

In all regions, the overall rates of mood and anxiety disorders have been climbing, mirroring a global increase and signalling a decline in the mental health of the Canadian population.

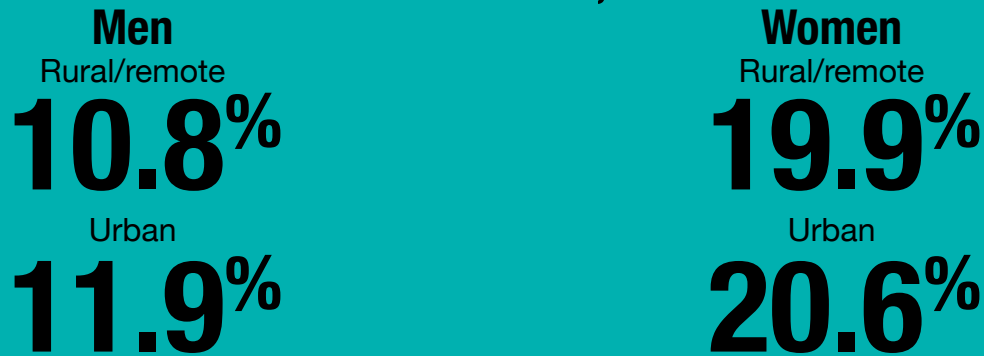
Rural rates of mood and anxiety disorders



Mood disorders and anxiety disorders among women

Women in all regions report higher rates of both mood disorders and anxiety disorders than men. The differences are significant: the rates of mood and anxiety disorders are up to 2x higher for women, depending on the size of their community. In 2024, women in urban communities reported the highest rates of mood disorders (15.8%) and anxiety disorders (20.6%), rates that were much higher than men's: 10.5% and 11.9%, respectively. Rural and remote women have a slightly lower incidence of these disorders than urban women.

Rate of anxiety disorders among rural/remote and urban men and women, 2024



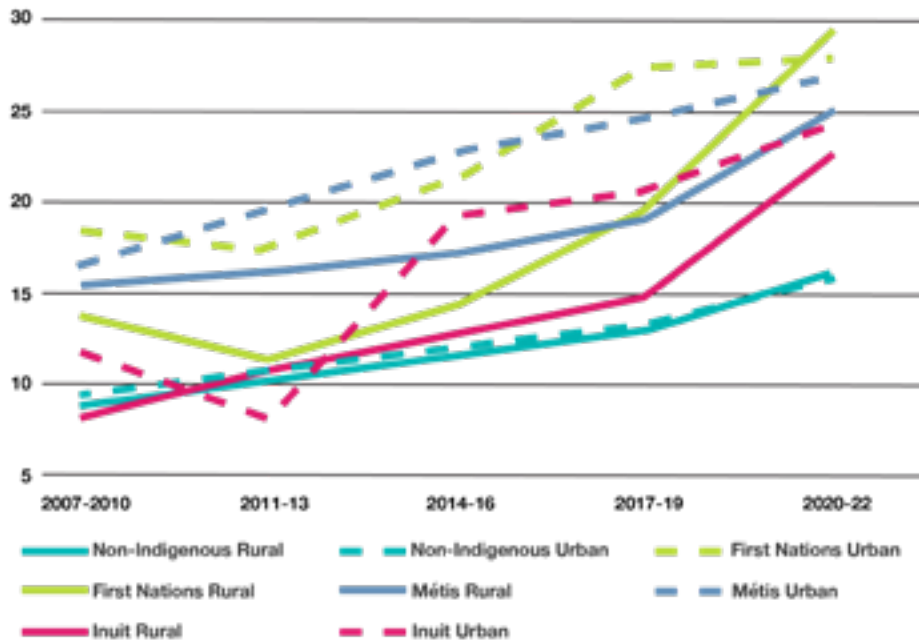
Mood disorders and anxiety disorders among Indigenous Peoples

The rates of mood and anxiety disorders are much higher for Indigenous Peoples. In 2020–2022, the combined rate of mood and anxiety disorders was 29.3% for rural/remote First Nations (off reserve), 25.0% for rural/remote Métis, and 22.6% for rural/remote Inuit, compared to 16.0% for rural/remote non-Indigenous populations. This difference is similar across populations in urban areas where the rate was 27.8% (First Nations off reserve), 26.8% (Métis), and 24.2% (Inuit), compared to 15.8% of non-Indigenous people.

Historically, rates of mood and anxiety disorders among First Nations, Métis and Inuit have differed from non-Indigenous people, depending on where they live. The rate for urban First Nations (off reserve), for instance, was nearly 1.5 x higher than for First Nations in rural/remote areas (off reserve) in 2014-16 and 2017-19 (Chart 6). In addition, while the rates of mood and anxiety disorders have increased in the Canadian population since 2007, the increase has been much higher among Indigenous groups.²²



Chart 6. Changes in rates of mood/anxiety disorders (combined) for First Nations, Métis, Inuit and non-Indigenous populations, 2007-2022.



Mood and anxiety disorders by income

In both rural/remote and urban areas, people with lower incomes report higher rates of mood and anxiety disorders compared to those with higher incomes. However, income-related differences tend to be greater in urban areas.

Rural/remote rates of mood and anxiety disorders (2021)



Mood Disorders

16.2% **8.6%**

Anxiety Disorders

14% **9.8%**

Lower income
(below LICO)

Higher income
(above LICO)

Urban rates of mood and anxiety disorders (2021)



Mood Disorders

18.2% **9.4%**

Anxiety Disorders

17.7% **10.2%**

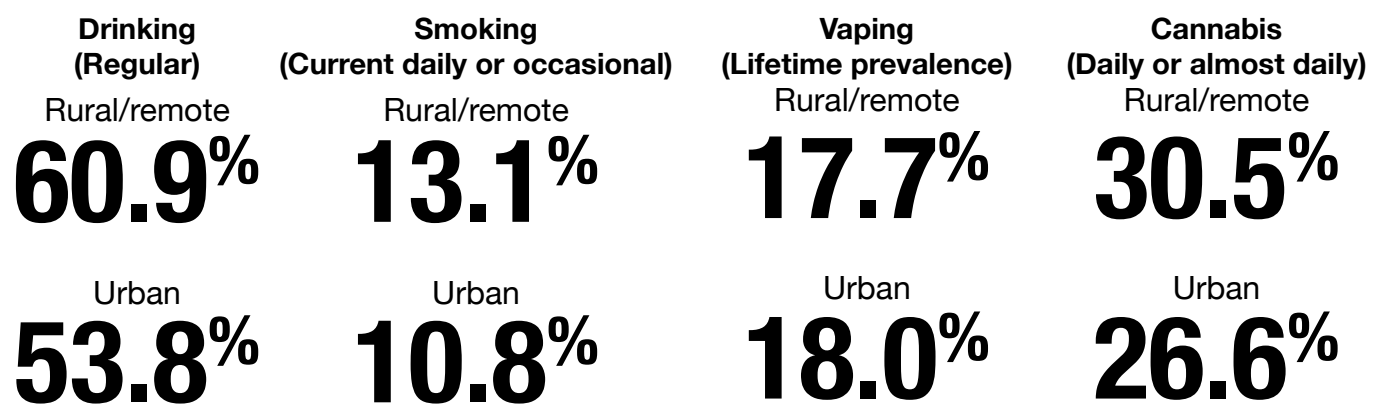
Lower income
(below LICO)

Higher income
(above LICO)

05. Substance Use Health in Rural and Remote Areas

A person can have good mental or physical health even if they use substances. Substance use falls on a continuum, from beneficial use to substance use disorder (SUD). Substance use is problematic when it has negative consequences for individuals, families, and health.²³ For many substances, including alcohol and tobacco (cigarettes), the risk of harm increases with frequency of use.²⁴ As such, this report examines the rates of regular and daily use of alcohol, smoking (tobacco), vaping, and cannabis use in rural/remote and urban populations. Data show that rural and remote populations report higher rates of riskier substance use and substance use disorders (SUDs) and that rates of substance use are higher among men.

Overview: Higher risk substance use among adults by rural/remote and urban region.



Rural and remote populations report drinking alcohol and smoking cigarettes more often: 60.9% of rural and remote residents report regular drinking compared to 53.8% of urban residents, and 13.1% in rural/remote areas report smoking daily or occasionally compared to 10.8% in urban areas. The smoking rate has since dropped in rural/remote areas, as 15.4% of rural/remote adults reported smoking daily or occasionally in 2022. Daily cannabis use²⁵ in rural and remote areas (30.5%) is considerably higher than in urban places.

In 2022, the rates of substance use disorders were also higher in rural and remote areas, with 24.4% of rural and remote residents reporting that they are experiencing problems with substance use compared to 19.9% of urban residents. However, as we were only able to access data for one reporting year, we must interpret this finding with caution, recognizing that year-over-year comparisons are needed to better understand whether rural/remote-urban differences persist over time.



Substance use disorders

Rural/remote

24.4%

Urban

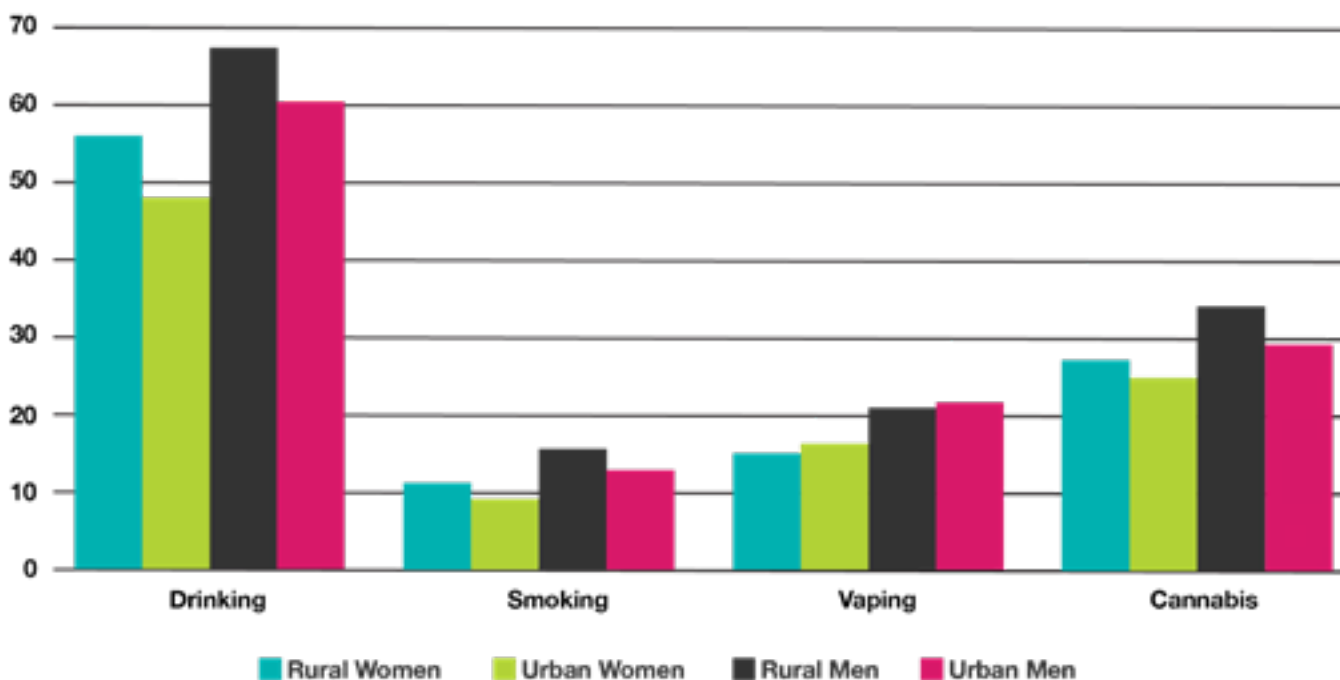
19.9%



Men and Substance Use

Men report using substances more often than women across regions and the rates for rural/remote men are the highest. In 2024, 66.6% of rural/remote men and 59.9% of men in urban areas reported regular drinking. Women’s rates are lower: 55.4% in rural/remote areas and 47.7% in urban areas. Women report occasional drinking more often than men.

Chart 7. Percentage of rural/remote and urban populations that report regular drinking, smoking, vaping, and cannabis use by gender, 2024.



Men also smoke cigarettes more often than women across all regions: in 2024, 15.4% of rural/remote men reported smoking cigarettes, compared to 10.9% of rural/remote women, and the rate for rural/remote men exceeded that of urban men (12.7%). More men than women vape across all regions.

Men (rural/remote: 24% and urban: 22.1%) consistently report higher rates of frequent, and especially daily cannabis use than women across regions (rural/remote:19.6% and urban: 16.9%).

Substance use and Income

While people with low incomes in all regions are more likely to smoke cigarettes, patterns of alcohol use show the opposite trend: regular drinking is more common among higher-income adults, particularly in rural and remote areas. In rural and remote communities, 62.8% of higher-income adults reported regular drinking in 2021 compared to 46.7% of people with lower incomes. Urban communities show a similar pattern (56.6% above LICO vs 41.8% below LICO) but the rates are lower than in rural/remote areas.

In rural and remote communities, 20.4% of lower income adults were smokers compared to 14.1% of those with higher incomes (2021), and this difference is repeated in urban communities (18.4% below LICO vs 10.9% above LICO).

Suicide

Tragically, more than 4,000 lives are lost to suicide in Canada each year.²⁶ Measuring suicide rates is critical to making health system, clinical, and policy changes that will prevent these deaths and ensure people have the supports they need to be well.

The rate of death by suicide is an important metric for understanding population health. Other measures include having thoughts of suicide (suicidal ideation), and suicide attempts, which may involve self-harm and lead to hospitalization. Data on suicidal thoughts and behaviours can help guide strategies for health promotion, early identification, improved access to mental health supports, and the development of community-based suicide prevention initiatives.

Self-harm and suicide rates vary by geographic region, with rurality and remoteness having been identified as risk

factors.²⁷ However, it is difficult to make national-level rural/remote and urban comparisons because suicide rates by population size are not reported publicly. Some studies using sub-provincial data have compared rural/remote and urban rates, but findings are mixed, with some noting elevated rates of suicide in rural/remote areas and others reporting no difference. When a difference was reported, rates of suicide deaths among rural/remote men was higher, as was the rate of hospitalization due to self-harm among rural/remote women.²⁸

For this report, we accessed national data on suicidal ideation²⁹ by rural/remote and urban population size. Data showed slightly lower levels of suicidal ideation in rural/remote populations (6.9%) compared to urban ones (7.7%). However, these figures must be interpreted with caution as data were only available for one reporting year (2022) and do not include Canada's three territories or Indigenous Peoples living on reserve.³⁰

The rates of suicide mortality by province and territory (not disaggregated by rural/remote and urban split) also provide some important insights into regional and population differences. Nunavut and the Northwest Territories, which are the most remote areas of Canada, report the highest rates of suicide deaths in the country year over year. In 2024, the rates were 76.5 and 21.8 per 100,000 population, respectively, which is between 2-7x higher than the national average (10.6 per 100,000 population). This is significant because a large proportion of Canada's North and Arctic regions are First Nations, Inuit and Métis. One study that examines Labrador, for instance, reports that the majority of suicide deaths were in Inuit (50%) and Innu (21.9%) communities.³¹

Although suicide is a leading cause of death among Indigenous peoples in Canada, population-specific data are not widely available, obscuring the full extent of the public health impact.³² Some Indigenous communities have developed their own suicide prevention strategies and declared suicide a public health emergency.³³ Governments in Canada continue to fail to measure critical health equity gaps among Indigenous and non-Indigenous populations, falling short on national commitments to deliver on the *Truth and Reconciliation Commission of Canada: Calls to Action* (2015).

Even at the national level, it is difficult to assess the full extent of suicide's public health impact, as provinces and territories are responsible for the investigation of unexplained or unnatural deaths through their own Office of the Chief Medical Officer or Coroner, and attendant reporting systems. A lack of consistency contributes to misclassification and underreporting.³⁴

The statistics cannot capture the deep impact of suicide in rural and remote communities. Communities' smaller sizes, greater interconnectedness, and the political and social relationships, including colonial relations, have shaped lives there and are important factors. Sub-provincial data may show that the number of suicide deaths are higher in many urban areas, congruent with their larger population sizes, but the loss of life in tight-knit rural and remote communities can cast a very long shadow, particularly when youth are involved. The grief of suicide in rural and remote places reverberates across the whole community and the loss of life is often linked to ongoing colonial violence in Indigenous communities.³⁵



06. Health Service Access and Use in Rural and Remote Areas

Data on mental health and substance use (MHSU) health service use provide critical insights into population health needs and how people access services. They also uncover broader challenges in accessing and delivering effective, coordinated community-based care. Here, we report on the use of hospital and other health services and the extent to which people's mental healthcare needs are being met. The national-level data show that while there is little difference between how often rural/remote and urban populations use hospital services, rural/remote populations face very high travel burdens to access psychiatric care in hospital, and they are less likely to consult with a professional about their mental health needs. In addition, a high proportion of Indigenous populations in Canada report needing to travel outside their communities to access health care and their rates of unmet need for mental health care are higher than those of non-Indigenous people.

Hospital use for MHSU



30-day readmission rate: the proportion of individuals who return to inpatient care within 30 days after being discharged.



Repeat hospital stays: the percentage of the population that experiences three or more inpatient hospitalizations in a year.



Frequent ER visits: the percentage of individuals who had four or more visits to an emergency department within a year for help with mental health or substance use problems.

The year-over-year data on hospital use for MHSU show very small differences between people in rural/remote and urban areas. In 2023-2024, the 30-day readmission rates to hospital were slightly higher in urban (12.6%) than rural/remote (11.8%) areas. People in urban areas are also slightly more likely to return to inpatient care (repeat hospital stays) (12.2 per 100,000) for a mental health or substance use problem than people in rural/remote areas (11.3 per 100,000).

People in rural/remote areas are slightly more likely than those in urban areas to return frequently to the emergency department for a mental health or substance use problem. In 2023-2024, the rate of frequent ER use was 10.1% in rural and remote areas compared to 8.9% in urban areas.

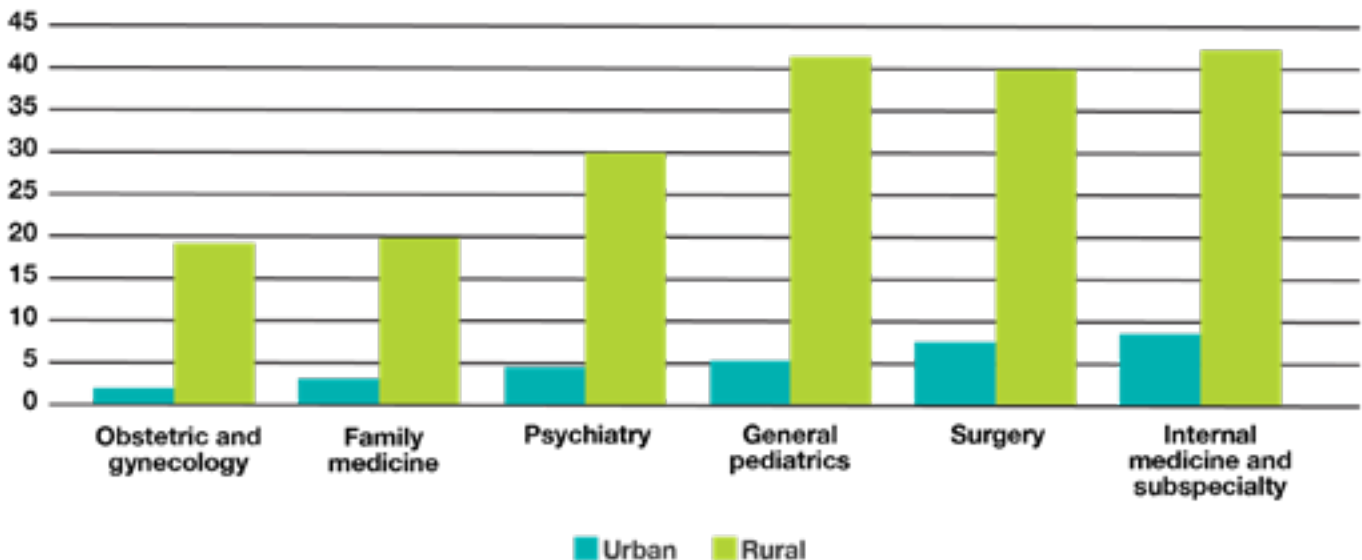
Across Canada, Yukon consistently reported the highest frequent emergency department visits for mental health and substance use in both rural/remote and urban areas, with 2023–2024 rates reaching 14.4 and 17.7 per 100,000 respectively, well above the national averages of 10.1 (rural/remote) and 8.9 (urban). In contrast, Nova Scotia had the lowest rates in 2023–2024, with both rural/remote and urban communities reporting about 5.7 per 100,000. Alberta and Ontario are the only provinces that show higher rates of emergency department visits in rural/remote areas year-over-year compared to urban ones.



Travel burden for psychiatric care assesses the estimated travel distance/time from a person’s community to the site of inpatient psychiatric care.

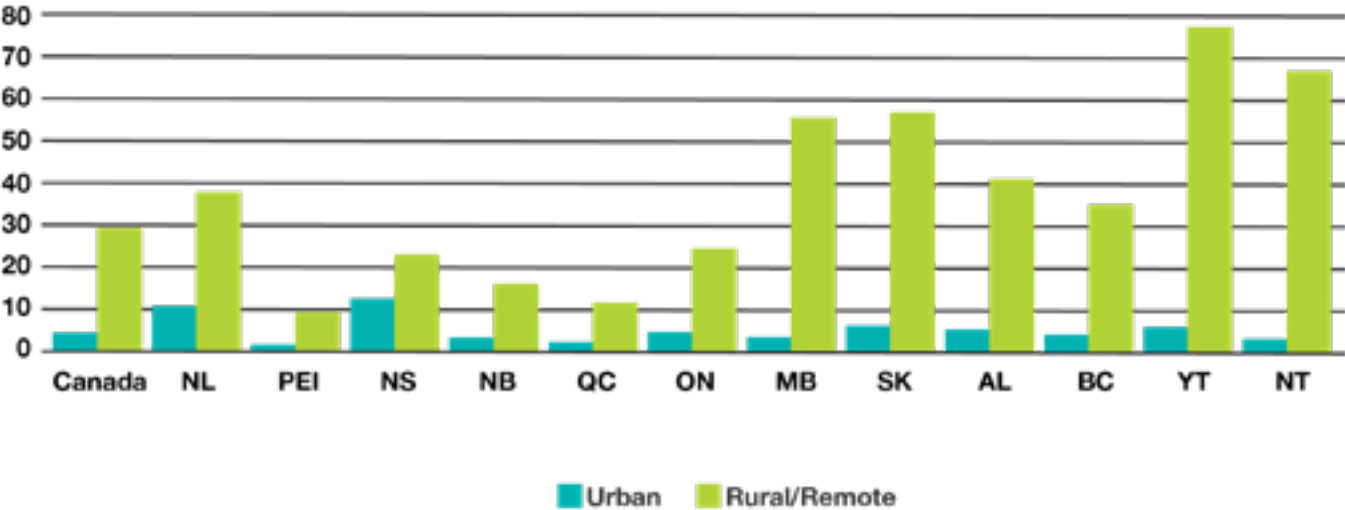
The data also show that people in rural and remote communities in Canada experience greater travel burdens in accessing hospital care than urban ones. Rural and remote communities experience a higher burden of travel across all types of hospital care (see Chart 8), with 29.4% of rural/remote patients reporting a high or very high travel burden for psychiatric care. In contrast, only 4.3% of urban patients report a “high” or “very high” travel burden to access psychiatric care in hospital.

Chart 8. Percentage of urban and rural/remote patients with high and very high travel burden to hospital care by provider service group, 2018-2019 to 2022-2023



The high travel burden rates in rural and remote areas vary across provinces and territories. Manitoba (56%), Saskatchewan (57.2%), Yukon (77.2%) and Nunavut (67.5%) stand out with exceptionally high rates. Prince Edward Island and Nova Scotia showed a mixed pattern, with the travel burden distributed more evenly across rural/remote and urban regions.

Chart 9. Percentage of rural/remote and urban populations reporting high/very high travel burden for psychiatric services, by province and territory, 2018-2019 and 2022-2023



Furthermore, national-level data from the Survey Series on First Nations People, Métis and Inuit show that many Indigenous Peoples must travel to access health care. Eighteen per cent of First Nations people living off reserve, 16% of Métis and 40% of Inuit travel outside their communities for care. Among Inuit who travel for care, 51.8% report travelling significant distances of 1,500 km or more.³⁶

Access to MHSU Health Services

People living in rural and remote areas are slightly less likely to consult with a professional for their mental health needs than their urban counterparts. In 2024, 18.2% of people in rural and remote areas reported that they consulted a professional compared to 19.7% of those in urban areas. This gap is wider in other reporting years: in 2020, for instance, the rates were 12.8% for rural/remote versus 15.6% for urban populations and in 2023, they were 15.2% for rural/remote versus 19% for urban. Men across all regions (13.9%) are much less likely to consult with a professional for their mental health than women (24.9%), and the rates of access for rural and remote men are among the lowest (rural/remote men: 12.7% versus urban men:14.2%).

People in all communities consult family doctors most often for mental health concerns and rates of access are similar across all regions (around 7.5%). In contrast, rural and remote residents report seeing psychiatrists less often (rural/remote: 1.4% vs urban: 2.5%) and psychologists (rural/remote: 2.6% vs urban: 4.3%), which likely reflects the concentration of these specialized service providers in urban areas. Access to social workers is similar, with urban residents (4.3%) reporting more consultations than those in rural/remote (3.2%)

regions. Consulting with a nurse is less common overall, with virtually no difference between rural/remote and urban settings. From 2018-2020, visits to all types of providers increased significantly, which may suggest growing engagement with mental health care.

Data on met mental health care needs were available for 2022 only. Just over three-quarters of rural/remote populations (77.1%) who needed and accessed care reported that their needs were met compared to 75.5% of urban residents. Given these data are for one year only, data from additional reporting years are needed to understand if differences persist over time. However, experiences of having mental healthcare needs met vary within populations. National-level data on Indigenous Peoples' experiences of met need, across both rural/remote and urban areas, show that of those who accessed care, only 28% of First Nations people living off reserve, 23% of Métis and 22% of Inuit reported that their needs were fully met. This means nearly three-quarters reported partially met or unmet mental health care needs, a far higher proportion than that reported for the entire rural/remote and urban population.³⁷



07. What needs to happen next

Recommendations

1. Address the structural, social and cultural barriers that limit access to mental health care in rural and remote communities.

- Provide a full range of virtual services and supports.
- Provide financial assistance to cover travel and accommodations for those who must travel outside their community to access mental health and addictions treatment.

2. Invest in community-based mental health and substance use health supports to ensure that rural and remote communities have access to a broader continuum of care.

- Invest in mobile clinics that provide outreach, primary care and mental health and substance use health supports.
- Invest in land-based and culturally safe healing programs.
- Invest in men's and women's peer support groups.
- Establish and invest in "homegrown" mental health training programs to develop a workforce of peer supporters, counselors, healers, and paraprofessionals.
- Increase the number of Indigenous health providers in the workforce and train health providers to deliver culturally appropriate and trauma-informed care.

3. Increase social spending and enhance social supports in consultation with Indigenous Peoples and people with lived experiences of mental illnesses and addictions.

- Work in partnership with Indigenous communities to close health and social equity gaps and make progress on the *Truth and Reconciliation Commission of Canada: Calls to Action* (2015).
- Strengthen income supports, including disability income supports, across all levels of government to address poverty.
- Invest in social supports to address and curb gender-based and family violence, particularly in northern regions. This includes more community supports for women and children, more healthy family programs, financial supports, education, and employment programs (including upskilling and retraining) for women, and women's housing programs.

4. Tackle the stigma related to mental health and substance use problems in rural and remote communities.

- Increase investment in mental health promotion, including in anti-stigma initiatives and Social and Emotional Learning (SEL) in schools.
- Fund the development and implementation of a National Suicide Prevention Strategy.
- Develop local initiatives that encourage help seeking among men.

5. The Government of Canada must improve data collection and reporting practices so that rural and remote population health and service utilization data are captured more completely and with greater accuracy.

- Work with the provinces and territories to strengthen capacity for consistent data collection across a comprehensive set of performance indicators, including establishing a common death certificate to improve national reporting of suicide rates.
- Address gaps in data collection and public reporting on mental health and substance use health data for Canada's northernmost areas (including sub-provincial regions and the three territories), and for rural and remote First Nations, Inuit and Métis Peoples, ensuring that this process is Indigenous-led.
- Collect and report data on mental health and substance use health stratified by occupation in rural and remote areas.



08. Conclusion

The data in this report suggest important rural/remote-urban differences in mental health and substance use health as well as unmet need for services and social supports in rural and remote Canada.

On one hand, people in rural and remote areas report higher well-being than people in urban areas. They have a stronger sense of belonging, meaning and purpose, and lower rates of mood and anxiety disorders.

On the other hand, this is not true for all populations. Indigenous Peoples, low-income residents and women report having poorer mental health and higher rates of mood and anxiety disorders. These data also show that women have unmet needs and underscore the importance of increased social investment for people in rural and remote areas who are struggling, including low-income earners and those living in poverty. The data also point to the need for action by the Government of Canada, in partnership with the provincial and territorial governments and Indigenous communities and governments, to support Indigenous-led solutions and close the equity gaps in mental health between Indigenous Peoples and the non-Indigenous population. This is critical for advancing the *Truth and Reconciliation Commission of Canada: Calls to Action* (2015) and for honouring our national commitment to dismantling the legacies of colonialism that continue to profoundly affect the health and well-being of Indigenous Peoples.

Violence in rural and remote communities, particularly those that are northerly, is of significant concern. Rural and remote girls and young women disproportionately experience violence that is perpetrated by someone the victim knows, such as a family member or friend. Efforts to address this violence must not replicate past and ongoing harms of colonialism, such as those associated with the child welfare system.

This report also shows that the rates of drinking, smoking and substance use disorders (SUDs) are higher in rural and remote areas, particularly among men. This finding suggests a service gap for rural and remote men with respect to substance use health and problematic substance use. Stigma related to seeking help may play a role here, as men are less likely than women to seek help for a mental health concern.

Finally, more work is needed to ensure that rural and remote residents, in general, are supported to seek help when they need it and receive care without hardship. Rural and remote populations, and particularly those in the territories, experience very high travel burdens to psychiatric care in hospital. The travel burden to access any type of health care is also higher overall for Indigenous peoples and especially so for Inuit. Rural and remote populations overall are also less likely to access services and consult with mental health professionals. While the data in this report cannot explain this gap, research suggests that stigma, a scarcity of services, and lack of culturally appropriate services in rural and remote areas are important factors. As such, reducing stigma associated with help seeking and

ensuring that services, including community-based services and peer support, are accessible in rural and remote communities may go a long way toward closing the gap.

The data presented here provide an important picture of the mental health and substance use health of rural and remote populations, but it is incomplete. Closing the distance between rural/remote and urban areas will require improving data collection and reporting practices so that health and service utilization data are captured more completely and with more accuracy. In addition, more data on rural and remote poverty, core housing need, rates of mental health-related disabilities, experiences of discrimination related to mental health status, and healthcare utilization, should be explored.

Many of Canada's rural and remote communities understand what it means to go the distance. Too often, that distance is felt not just in kilometres, but in time, cost, safety, and access to care. But distance is not only geographic; it is also shaped by social relationships and inequalities. Longer travel, greater exposure to violence, and barriers to culturally appropriate services create inequities that shape people's ability to get the support they need. Closing that distance is ultimately about equity: ensuring that care is available, accessible, and within reach, so that no one is required to overcome more because of where they live, the communities that they belong to or the social conditions that shape their lives.



09. Appendix

A1. Perceived Mental Health

Response	Region Type	Gender	2024	2023	2022	Region Type	2021	2020	2019	2018	
Adults											
Good, Very Good or Excellent	Rural/remote	Total	87.4 (86.4, 88.4)	87.1 (86.2, 88.1)	88.4 (87.5, 89.2)	Rural/remote	89.9	90.0	93.0	93.3	
		Men+	87.9 (86.5, 89.3)	88.5 (87.1, 89.8)	89.9 (88.7, 91.1)		---	---	---	---	
		Women+	86.9 (85.6, 88.3)	85.8 (84.5, 87.2)	86.9 (85.6, 88.1)		---	---	---	---	
	Urban	Total	84.5 (79.9, 89.0)	84.5 (80.1, 88.9)	85.0 (80.3, 89.6)	Urban	87.9	90.3	91.7	92.8	
		Men+	85.5 (79.6, 91.4)	86.5 (80.9, 92.0)	86.8 (81.0, 92.6)		---	---	---	---	
		Women+	83.5 (78.3, 88.6)	82.7 (77.7, 87.7)	83.3 (78.2, 88.4)		---	---	---	---	
	Total	Total	84.9 (84.3, 85.5)	85.0 (84.4, 85.5)	85.6 (85.1, 86.1)	Total	88.2	90.3	91.9	92.9	
		Men+	85.9 (85.0, 86.7)	86.8 (86.0, 87.5)	87.3 (86.6, 88.1)		---	---	---	---	
		Women+	84.0 (83.2, 84.8)	83.2 (82.4, 84.0)	83.9 (83.2, 84.6)		---	---	---	---	
	Fair or Poor	Rural	Total	15.1 (14.5, 15.7)	15.0 (14.5, 15.6)	14.4 (13.9, 14.9)	Rural	10.1	10.0	7.0	6.7
			Men+	14.1 (13.3, 15.0)	13.2 (12.5, 14.0)	12.7 (11.9, 13.4)		---	---	---	---
			Women+	16.0 (15.2, 16.8)	16.8 (16.0, 17.6)	16.1 (15.4, 16.8)		---	---	---	---
Urban		Total	15.5 (12.9, 18.2)	15.5 (13.1, 17.8)	15.0 (12.6, 17.5)	Urban	12.1	9.7	8.3	7.2	
		Men+	14.5 (10.6, 18.4)	13.5 (10.3, 16.8)	13.2 (10.0, 16.4)		---	---	---	---	
		Women+	16.5 (13.1, 19.9)	17.3 (13.9, 20.7)	16.7 (13.3, 20.1)		---	---	---	---	
Total		Total	15.3 (14.5, 16.2)	15.6 (14.8, 16.3)	14.9 (14.1, 15.6)	Total	11.8	9.7	8.1	7.1	
		Men+	14.2 (13.0, 15.4)	13.6 (12.6, 14.6)	13.1 (12.1, 14.1)		---	---	---	---	
		Women+	16.4 (15.3, 17.6)	17.5 (16.4, 18.6)	16.6 (15.5, 17.6)		---	---	---	---	

Note: Data source: CCHS (adult).

A2. Perceived Mental Health, Life Satisfaction, and Mood/Anxiety Disorders by Indigenous Identity

Variable	Response	Region Type	Identity	2020-2022	2017-2019	2014-2016	2011-2013	2007-2010	2009-2010	
Perceived Mental Health	Very Good or Excellent	Rural	Non-Indigenous	61.7 (60.8, 62.7)	69.9 (69.1, 70.6)	72.9 (72.2, 73.7)	73.0 (72.2, 73.7)	74.2 (73.6, 74.7)		
			First Nations (off-reserve)	54.4 (49.2, 59.6)	60.0 (56.2, 63.8)	60.1 (56.4, 63.7)	57.9 (53.5, 62.3)	64.1 (60.5, 67.8)		
			Métis	52.1 (47.2, 57.0)	62.8 (59.0, 66.6)	64.9 (61.1, 68.7)	65.2 (60.8, 69.5)	65.3 (61.7, 68.9)		
			Inuit	48.5 (37.5, 59.5)	43.5 (33.7, 53.2)	54.8 (48.2, 61.4)	49.9 (41.5, 58.2)	60.4 (52.5, 68.3)		
			Urban	Non-Indigenous	59.4 (58.8, 60.0)	69.0 (68.5, 69.4)	71.7 (71.2, 72.1)	71.9 (71.4, 72.4)	74.5 (74.1, 74.8)	
				First Nations (off-reserve)	45.0 (41.4, 48.6)	56.0 (52.6, 59.4)	61.7 (58.3, 65.1)	61.8 (58.6, 65.0)	63.1 (60.2, 66.0)	
		Métis		51.0 (47.5, 54.6)	60.4 (57.3, 63.5)	61.4 (57.9, 64.9)	61.7 (58.5, 64.9)	64.0 (61.0, 67.0)		
		Total	Non-Indigenous	49.5 (39.1, 60.0)	52.3 (44.5, 60.0)	54.3 (48.2, 60.4)	61.2 (52.5, 69.9)	63.8 (58.1, 69.5)		
			First Nations (off-reserve)	8.0 (8.0, 8.1)	8.3 (8.3, 8.3)	8.3 (8.3, 8.3)	7.9 (7.6, 8.1)	8.2 (8.2, 8.2)	8.2 (8.2, 8.2)	
			Métis	7.9 (7.7, 8.2)	8.1 (8.0, 8.3)	8.0 (7.8, 8.1)	8.0 (7.9, 8.0)	7.9 (7.8, 8.1)	7.8 (7.6, 8.0)	
			Inuit	7.8 (7.4, 8.2)	8.0 (7.9, 8.2)	8.1 (7.9, 8.3)	8.2 (8.0, 8.3)	7.8 (7.3, 8.3)	8.2 (8.2, 8.2)	
			Urban	Non-Indigenous	7.8 (7.4, 8.2)	7.8 (7.4, 8.2)	8.0 (7.5, 8.6)	7.8 (7.3, 8.3)	8.0 (7.9, 8.1)	8.0 (7.9, 8.0)
First Nations (off-reserve)	7.8 (7.8, 7.8)			8.1 (8.1, 8.1)	8.1 (8.0, 8.1)	7.8 (7.7, 7.9)	8.0 (7.9, 8.1)	7.7 (7.6, 7.9)		
Métis	7.4 (7.3, 7.6)	7.8 (7.7, 7.9)		7.9 (7.7, 8.0)	8.2 (8.2, 8.2)	7.9 (7.6, 7.9)	7.9 (7.8, 8.1)			
Total	Non-Indigenous	7.6 (7.5, 7.7)	7.8 (7.7, 7.9)	7.7 (7.6, 7.9)	7.8 (7.6, 7.9)	7.8 (7.6, 7.9)	7.8 (7.6, 7.9)			
	Métis	7.8 (7.5, 8.1)	7.8 (7.5, 8.2)	7.7 (7.3, 8.1)	7.8 (7.4, 8.2)	7.8 (7.4, 8.2)	7.8 (7.2, 8.4)			
	Inuit	22.6 (16.4, 28.8)	14.8 (8.0, 21.7)	12.6 (8.3, 17.0)	10.8 (5.7, 15.9)	8.3 (2.9, 13.6)				
	Urban	Non-Indigenous	16.0 (15.5, 16.5)	13.0 (12.4, 13.5)	11.5 (11.0, 12.0)	9.7 (9.3, 10.2)	8.7 (8.4, 9.1)			
		First Nations (off-reserve)	29.3 (26.1, 32.6)	19.5 (16.5, 22.5)	14.4 (11.9, 16.9)	11.4 (9.0, 13.9)	13.7 (11.2, 16.2)			
		Métis	25.0 (20.3, 29.8)	19.1 (16.1, 22.1)	17.2 (14.3, 20.1)	16.2 (12.6, 19.7)	15.5 (12.7, 18.4)			
Total	Non-Indigenous	22.6 (16.4, 28.8)	14.8 (8.0, 21.7)	12.6 (8.3, 17.0)	10.8 (5.7, 15.9)	8.3 (2.9, 13.6)				
	First Nations (off-reserve)	15.8 (15.1, 16.6)	13.3 (12.9, 13.6)	11.9 (11.6, 12.2)	10.8 (10.4, 11.1)	9.5 (9.2, 9.7)				
	Métis	27.8 (23.4, 32.3)	27.4 (24.5, 30.4)	21.3 (19.0, 23.6)	17.4 (15.0, 19.7)	18.4 (16, 20.8)				
	Inuit	26.8 (23.6, 30.0)	24.6 (22.1, 27.0)	22.7 (20.0, 25.4)	19.6 (17.1, 22.1)	16.5 (14.2, 18.8)				
	Total	Non-Indigenous	24.2 (15.7, 32.8)	20.6 (14.0, 27.3)	19.3 (12.9, 25.8)	8.2 (4.5, 11.9)	11.7 (7.5, 16.0)			
		First Nations (off-reserve)								
Métis										

Note: Data source: Canadian Community Health Survey (CCHS), population 12 years and older

A3. Perceived Mental Health, Mood and Anxiety Disorders, and Depression by Household Income

Variable	Response	Region Type	Identity	2021	2020	2019	2018
Perceived Mental Health	Good to Excellent	Rural	Below LICO	80.4	82.6	86.2	85.2
			Above LICO	90.7	90.6	93.3	93.7
			Total	89.9	90.3	92.9	93.3
		Urban	Below LICO	77.3	78.6	81.7	83.1
			Above LICO	88.4	90.7	92.2	92.7
			Total	87.9	90.3	91.7	92.1
Mood Disorders	Yes	Rural	Below LICO	16.2	18.0	13.3	16.5
			Above LICO	8.6	8.7	8.4	7.5
			Total	8.9	9.1	8.6	8.0
		Urban	Below LICO	18.2	20.0	19.3	18.2
			Above LICO	9.4	8.6	8.6	8.5
			Total	9.8	9.0	9.1	9.2
Anxiety Disorders	Yes	Rural	Below LICO	14.0	18.0	16.6	16.4
			Above LICO	9.8	9.7	8.2	8.4
			Total	10.0	10.0	8.6	8.7
		Urban	Below LICO	17.7	17.4	18.6	17.2
			Above LICO	10.2	9.9	9.4	8.6
			Total	10.5	10.1	9.8	9.2

Note: Data source: CCHS.

A4. Loneliness

Response	Region Type	Gender	2024	2023	2022	2021	2020	2019	2018
Rarely or Never Feels Lonely	Rural	Total	56.9	63.4	54.1	59.0	---	---	---
		Men*	60.5	70.4	58.3	63.6	---	---	---
		Women*	53.4	57.2	50.4	55.1	---	---	---
	Urban	Total	48.6	53.6	49.6	51.9	---	---	---
		Men*	51.9	56.4	55.1	57.2	---	---	---
		Women*	45.3	50.8	44.0	46.6	---	---	---
	Total	Total	49.7	54.9	50.3	52.9	---	---	---
		Men*	53.0	58.2	55.6	58.0	---	---	---
		Women*	46.4	51.7	45.1	47.9	---	---	---
Sometimes Feels Lonely	Rural	Total	31.0	25.5	31.9	29.9	---	---	---
		Men*	29.8	20.3	25.4	27.8	---	---	---
		Women*	32.3	30.1	37.4	31.7	---	---	---
	Urban	Total	37.8	33.2	35.9	33.8	---	---	---
		Men*	34.8	31.4	31.7	30.0	---	---	---
		Women*	40.7	35.1	40.2	37.7	---	---	---
	Total	Total	36.9	32.2	35.3	33.3	---	---	---
		Men*	34.1	29.9	30.8	29.7	---	---	---
		Women*	39.7	34.4	39.7	36.8	---	---	---
Always or Often Feels Lonely	Rural	Total	12.0	11.1	14.0	11.1	---	---	---
		Men*	9.7	9.3	16.3	8.6	---	---	---
		Women*	14.3	12.7	12.1	13.2	---	---	---
	Urban	Total	13.6	13.1	14.5	14.3	---	---	---
		Men*	13.3	12.2	13.2	12.9	---	---	---
		Women*	13.9	14.0	15.8	15.7	---	---	---
	Total	Total	13.4	12.9	14.4	13.8	---	---	---
		Men*	12.9	11.9	13.6	12.3	---	---	---
		Women*	14.0	13.9	15.2	15.3	---	---	---

Note: Data source: CSS.

A5. Sense of Belonging to Local Community

Response	Region Type	Gender	2024	2023	2022	2021	2020	2019	2018
Very Strong or Somewhat Strong Sense of Belonging to Local Community	Rural	Total	62.2	54.9	52.1	56.6	---	---	---
		Men+	64.2	55.0	50.2	57.5	---	---	---
		Women+	60.1	54.8	53.7	55.8	---	---	---
	Urban	Total	52.3	44.7	44.5	43.6	---	---	---
		Men+	52.3	43.9	44.0	43.4	---	---	---
		Women+	52.3	45.5	45.0	43.7	---	---	---
	Total	Total	53.5	46.1	45.6	45.4	---	---	---
		Men+	53.8	45.4	44.8	45.3	---	---	---
		Women+	53.3	46.8	46.4	45.6	---	---	---
Somewhat Weak or Very Weak Sense of Belonging to Local Community	Rural	Total	23.5	29.8	35.4	29.7	---	---	---
		Men+	20.5	28.0	35.4	29.6	---	---	---
		Women+	26.5	31.4	35.5	29.7	---	---	---
	Urban	Total	34.9	38.3	41.4	40.0	---	---	---
		Men+	35.4	39.6	42.5	40.6	---	---	---
		Women+	34.5	37.1	40.3	39.4	---	---	---
	Total	Total	33.5	37.2	40.5	38.6	---	---	---
		Men+	33.5	38.1	41.5	39.2	---	---	---
		Women+	33.5	36.3	39.5	37.9	---	---	---
No Opinion on Sense of Belonging to Local Community	Rural	Total	14.3	15.3	12.5	13.7	---	---	---
		Men+	15.3	17.0	14.5	12.9	---	---	---
		Women+	13.3	13.8	10.8	14.4	---	---	---
	Urban	Total	12.8	17.0	14.1	16.4	---	---	---
		Men+	12.3	16.5	13.5	15.9	---	---	---
		Women+	13.3	17.4	14.7	16.9	---	---	---
	Total	Total	13.0	16.7	13.9	16.0	---	---	---
		Men+	12.7	16.6	13.6	15.9	---	---	---
		Women+	13.3	16.9	14.1	16.9	---	---	---

Note: Data source: Canadian Social Survey.

A6. Sense of Purpose and Meaning

Response	Region Type	Gender	2025	2024	2023	2022	2021	2020	2019
Rating of 8, 9, or 10	Rural	Total	64.5	59.1	68.7	64.9	---	---	---
		Men+	63.0	59.4	66.7	63.6	---	---	---
		Women+	66.0	58.8	70.5	66.0	---	---	---
	Urban	Total	54.5	49.9	56.7	55.4	---	---	---
		Men+	53.6	48.9	54.1	53.8	---	---	---
		Women+	55.4	50.8	59.3	57.0	---	---	---
	Total	Total	55.7	51.1	58.3	56.8	---	---	---
		Men+	54.7	50.4	55.7	55.2	---	---	---
		Women+	56.7	51.8	60.9	58.4	---	---	---
Rating of 6 or 7	Rural	Total	22.0	24.7	21.2	21.0	---	---	---
		Men+	22.0	23.6	22.7	20.8	---	---	---
		Women+	22.1	26.1	20.0	21.2	---	---	---
	Urban	Total	27.7	28.3	26.9	27.7	---	---	---
		Men+	27.5	28.9	28.5	28.6	---	---	---
		Women+	28.0	27.7	25.4	26.9	---	---	---
	Total	Total	27.0	27.8	26.2	26.7	---	---	---
		Men+	26.8	28.2	27.7	27.5	---	---	---
		Women+	27.3	27.5	24.6	26.0	---	---	---
Rating between 0 and 5	Rural	Total	13.5	16.1	10.0	14.2	---	---	---
		Men+	15.1	17.1	10.7	15.6	---	---	---
		Women+	11.9	15.1	9.5	12.8	---	---	---
	Urban	Total	17.8	21.8	16.4	16.9	---	---	---
		Men+	19.0	22.1	17.5	17.6	---	---	---
		Women+	16.6	21.5	15.4	16.2	---	---	---
	Total	Total	17.2	21.1	15.6	16.5	---	---	---
		Men+	18.5	21.4	16.6	17.3	---	---	---
		Women+	16.0	20.7	14.5	15.6	---	---	---

Note: Data source: CSS.

A7. Police-reported crime and Crime Severity Index by Province

Variable	Region Type	CA	NL	PEI	NS	NB	QC	ON	MB	SK	AL	BC	YT	NT	NU
Police-reported Crime Rate	Rural	7,317	5,392	6,278	6,689	3,585	4,120	14,846	18,010	11,190	7,546	8,054	---	---	---
	Urban	5,440	6,559	5,781	6,527	3,738	4,491	8,987	10,699	7,268	7,389	6,437	---	---	---
Crime Severity Index	Rural	99	92	67	78	92	67	60	184	204	145	106	---	---	---
	Urban	76	82	76	72	83	61	61	131	142	94	104	---	---	---

Note: Data source: Uniform Crime Reporting Survey. Rate is per 100,000 population.

A8. Crime and Social Dynamics by Region, 2023

Variable Type	Variable	Rural North	Rural South	Rural Total	Urban North	Urban South	Urban Total
Police-reported Crime Rates	Total Crime Rate	17,546	5,379	7,317	8,815	5,310	5,440
	Total Violent Crime Rate	5,193	1,545	2,126	2,244	1,237	1,274
	Total Property Crime Rate	8,221	2,834	3,692	4,691	3,207	3,262
Accused-victim relationship	Weapon present in the incident	845	182	268	299	179	184
	Intimate partner	30	28	29	27	24	24
	Other family member	23	20	22	13	12	12
	Friend or casual acquaintance	26	26	26	23	19	19
	Other person known to the victim	8	12	11	13	14	14
	Stranger	12	14	13	23	31	30
Gender of victim	Women and girls	4,974	1,416	1,963	2,067	1,101	1,137
	Men and boys	3,459	1,131	1,494	1,740	1,065	1,091

Note: Data source: Uniform Crime Reporting Survey. Accused-victim relationship: data reported is a percentage of total. Gender of victim: rate is per 100,000 population.

A9. Mood Disorders

Response	Region Type	Gender	2024	2023	2022	Region Type	2021	2020	2019	2018
Yes	Rural	Total	12.4 (11.5, 13.3)	13.2 (12.2, 14.2)	10.4 (9.6, 11.2)	Rural	8.9	9.1	8.6	8.0
		Men+	9.8 (8.6, 11.0)	10.1 (8.7, 11.5)	7.9 (6.9, 8.9)		---	---	---	---
		Women+	14.9 (13.6, 16.3)	16.3 (14.8, 17.8)	12.9 (11.7, 14.2)		---	---	---	---
	Urban	Total	13.2 (10.9, 15.5)	12.9 (10.8, 15.0)	12.0 (9.9, 14.0)	Urban	9.8	9.0	9.1	9.2
		Men+	10.5 (7.3, 13.8)	9.8 (7.2, 12.3)	9.2 (6.7, 11.7)		---	---	---	---
		Women+	15.8 (12.7, 18.9)	16.0 (12.9, 19.2)	14.6 (11.7, 17.5)		---	---	---	---
	Total	Total	13.1 (12.6, 13.6)	13 (12.5, 13.5)	11.7 (11.2, 12.1)	Total	9.7	9.1	9.0	8.9
		Men+	10.4 (9.7, 11.2)	9.8 (9.3, 10.4)	9.0 (8.4, 9.6)		---	---	---	---
		Women+	15.7 (15.0, 16.4)	16.1 (15.3, 16.8)	14.3 (13.6, 15)		---	---	---	---

Note: Data source: CCHS (adult).

A10. Moderate to Severe Depression

Response	Region Type	Gender	2024	2023	2022	Region Type	2021	2020	2019	2018
Yes	Rural	Total	10 (8.7, 11.3)	9.6 (8.2, 11.1)	---	Rural	11.9	---	---	---
		Men+	9.2 (7.3, 11.1)	7.8 (5.8, 9.8)	---		---	---	---	
		Women+	10.7 (8.9, 12.6)	11.4 (9.2, 13.6)	---		---	---	---	
	Urban	Total	12.7 (9.1, 16.3)	11.6 (8.4, 14.8)	---	Urban	14.0	---	---	---
		Men+	11.0 (6.0, 16.1)	9.6 (5.4, 13.8)	---		---	---	---	
		Women+	14.2 (9.5, 18.9)	13.5 (8.9, 18.1)	---		---	---	---	
	Total	Total	12.3 (11.5, 13.1)	11.3 (10.6, 12.1)	12.3 (11.5, 13.1)	Total	13.7	---	---	---
		Men+	10.8 (9.6, 12)	9.4 (8.4, 10.3)	10.8 (9.6, 12)		---	---	---	
		Women+	13.7 (12.6, 14.8)	13.3 (12.2, 14.3)	13.7 (12.6, 14.8)		---	---	---	

Note: Data source: CCHS.

A11. Anxiety Disorder

Response	Region Type	Gender	2024	2023	2022	Region Type	2021	2020	2019	2018
Yes	Rural	Total	15.4 (14.3, 16.4)	14.8 (13.4, 15.9)	13.5 (12.6, 14.3)	Rural	10.0	10.0	8.6	8.7
		Men+	10.8 (9.5, 12.1)	11.1 (9.4, 12.7)	9.3 (8.3, 10.3)		---	---	---	---
		Women+	19.9 (18.3, 21.5)	18.3 (16.5, 20.2)	17.7 (16.3, 19.0)		---	---	---	---
	Urban	Total	16.2 (13.6, 18.8)	15.5 (12.5, 18.4)	15.1 (12.8, 17.4)	Urban	10.5	10.1	9.8	9.2
		Men+	11.9 (8.5, 15.2)	10.5 (7.1, 13.9)	10.7 (8.0, 13.3)		---	---	---	---
		Women+	20.6 (18.9, 24.2)	20.3 (15.8, 24.7)	19.4 (15.9, 22.8)		---	---	---	---
	Total	Total	16.1 (15.5, 16.7)	15.3 (14.7, 16.0)	14.8 (14.3, 15.3)	Total	10.4	10.1	9.6	9.1
		Men+	11.7 (11.0, 12.5)	10.6 (9.8, 11.4)	10.5 (9.9, 11.0)		---	---	---	---
		Women+	20.5 (19.6, 21.3)	20.0 (18.9, 21.0)	19.1 (18.3, 19.9)		---	---	---	---

Note: Data source: CCHS (adult).

A12. Drinking Status

Response	Region Type	Gender	2024	2023	2022	Region Type	2021	2020	2019	2018	
Adults											
Regular	Rural	Total	60.9 (59.5, 62.4)	63.9 (62.6, 65.2)	63.0 (61.8, 64.2)	Rural	62.2	60.5	60.8	61.5	
		Men+	66.6 (64.6, 68.5)	70.3 (68.5, 72.0)	69.1 (67.4, 70.7)		---	---	---	---	
		Women+	55.4 (53.5, 57.3)	57.5 (55.7, 59.4)	56.9 (55.0, 58.9)		---	---	---	---	
	Urban	Total	53.8 (49.4, 58.1)	56.4 (52.1, 60.6)	56.1 (51.9, 60.4)	Urban	55.9	58.3	57.1	58.1	
		Men+	59.9 (53.8, 65.8)	61.2 (55.4, 67.0)	61.5 (55.9, 67.1)		---	---	---	---	
		Women+	47.7 (42.7, 52.7)	51.7 (46.9, 56.4)	50.9 (46.0, 55.8)		---	---	---	---	
	Total	Total	54.9 (54.1, 55.7)	57.6 (56.8, 58.3)	57.3 (56.6, 58.0)	Total	57.0	58.7	57.7	58.7	
		Men+	60.9 (59.8, 62.0)	62.7 (61.8, 63.8)	62.9 (61.9, 63.9)		---	---	---	---	
		Women+	49.0 (47.9, 50.1)	52.6 (51.5, 53.6)	51.9 (51.0, 52.9)		---	---	---	---	
	Occasional	Rural	Total	18.5 (17.4, 19.6)	17.0 (16.0, 18.0)	17.6 (16.7, 18.6)	Rural	15.2	16.4	16.6	17.0
			Men+	14.5 (13.0, 16.0)	11.9 (10.8, 13.1)	13.9 (12.6, 15.3)		---	---	---	---
			Women+	22.4 (20.8, 24.0)	22.1 (20.8, 23.7)	21.3 (19.8, 22.7)		---	---	---	---
Urban		Total	20.9 (18.0, 23.8)	19.3 (16.6, 21.9)	19.1 (16.6, 21.6)	Urban	16.4	15.5	17.3	16.8	
		Men+	16.8 (12.8, 20.8)	16.2 (12.4, 19.9)	15.9 (12.5, 19.2)		---	---	---	---	
		Women+	25.1 (21.0, 29.2)	22.3 (18.7, 25.8)	22.2 (18.6, 25.6)		---	---	---	---	
Total		Total	20.6 (19.9, 21.2)	18.9 (18.3, 19.5)	18.8 (18.3, 19.3)	Total	16.2	15.6	17.2	16.9	
		Men+	16.4 (15.5, 17.3)	15.5 (14.7, 16.3)	15.5 (14.8, 16.3)		---	---	---	---	
		Women+	24.7 (23.8, 25.6)	22.2 (21.4, 23.0)	22.0 (21.2, 22.8)		---	---	---	---	

Note: Data source: CCHS (adult).

A13. Smoking Status

Response	Region Type	Gender	2024	2023	2022	Region Type	2021	2020	2019	2018	
Adults											
Current Daily or Occasional	Rural	Total	13.1 (12.2, 14.1)	13.7 (12.7, 14.6)	15.4 (14.5, 16.3)	Rural	14.3	14.2	16.3	17.7	
		Men+	15.4 (13.9, 16.9)	15.0 (13.5, 16.5)	17.3 (15.9, 18.7)		---	---	---	---	
		Women+	10.9 (9.7, 12.1)	12.4 (11.2, 13.6)	13.5 (12.3, 14.7)		---	---	---	---	
	Urban	Total	10.8 (8.5, 12.9)	11.0 (9.0, 12.9)	11.9 (9.8, 13.8)	Urban	11.3	12.7	14.4	15.4	
		Men+	12.7 (9.1, 16.2)	13.0 (9.8, 16.1)	13.8 (10.7, 16.9)		---	---	---	---	
		Women+	8.8 (6.5, 11.1)	9.0 (6.8, 11.2)	10.0 (7.7, 12.2)		---	---	---	---	
	Total	Total	11.1 (10.6, 11.6)	11.4 (11, 11.9)	12.5 (12.0, 12.9)	Total	11.8	12.9	14.8	15.8	
		Men+	13.1 (12.3, 13.9)	13.3 (12.6, 14)	14.4 (13.7, 15.1)		---	---	---	---	
		Women+	9.2 (8.6, 9.8)	9.6 (9.0, 10.1)	10.6 (10.0, 11.1)		---	---	---	---	
	Experimental	Rural	Total	11.0 (10.2, 11.9)	10.8 (9.9, 11.7)	12.6 (11.8, 13.5)	Rural	11.7	12.0	13.1	12.4
			Men+	10.8 (9.5, 12.1)	11.5 (10.1, 12.9)	11.8 (10.7, 12.9)		---	---	---	---
			Women+	11.2 (10.0, 12.4)	10.1 (9.0, 11.2)	13.5 (12.3, 14.7)		---	---	---	---
Urban		Total	21.5 (18.8, 24.1)	21.9 (19.5, 24.2)	22.0 (19.6, 24.5)	Urban	11.4	12.7	12.9	12.8	
		Men+	23.7 (19.7, 27.6)	23.4 (19.9, 26.8)	24.2 (20.6, 27.7)		---	---	---	---	
		Women+	19.3 (16.2, 22.4)	20.4 (17.5, 23.3)	19.9 (17.0, 22.8)		---	---	---	---	
Total		Total	10.1 (9.6, 10.5)	10.1 (9.7, 10.6)	12.4 (11.9, 12.9)	Total	11.5	12.6	13.0	12.8	
		Men+	10.1 (9.4, 10.7)	10.8 (10.2, 11.5)	12.9 (12.2, 13.6)		---	---	---	---	
		Women+	10.0 (9.5, 10.6)	9.5 (8.9, 10.1)	11.8 (11.2, 12.5)		---	---	---	---	

Note: Data source: CCHS (adult).

A14. Past Year Cannabis Use

Response	Region Type	Gender	2024	2023	2022	Region Type	2021	2020	2019	2018	
Adults											
Weekly or Almost Weekly	Rural	Total	22.1 (19.4, 24.7)	21.6 (19.1, 24.2)	21.5 (19.3, 23.8)	Rural	---	---	---	---	
		Men+	24.0 (20.2, 27.8)	21.9 (18.5, 25.3)	23.8 (20.6, 26.9)		---	---	---	---	
		Women+	19.8 (16.2, 23.1)	21.3 (17.8, 25.1)	18.8 (15.7, 21.6)		---	---	---	---	
	Urban	Total	19.9 (13.3, 26.4)	20.3 (14.4, 26.3)	20.5 (14.5, 26.5)	Urban	---	---	---	---	
		Men+	22.1 (12.6, 31.6)	21.9 (13.8, 30.0)	22.1 (14.2, 29.9)		---	---	---	---	
		Women+	16.9 (9.3, 24.4)	18.3 (10.1, 26.6)	18.5 (10.3, 26.6)		---	---	---	---	
	Total	Total	20.2 (18.9, 21.6)	20.6 (19.3, 21.8)	20.7 (19.5, 22.0)	Total	---	---	---	---	
		Men+	22.5 (20.5, 24.4)	21.9 (20.2, 23.6)	22.4 (20.7, 24.1)		---	---	---	---	
		Women+	17.3 (15.6, 19.0)	18.8 (17.0, 20.6)	18.6 (16.8, 20.3)		---	---	---	---	
	Daily or Almost Daily	Rural	Total	30.5 (27.6, 33.3)	31.7 (28.7, 34.7)	27.5 (25.0, 29.9)	Rural	---	---	---	---
			Men+	33.8 (29.6, 37.6)	34.9 (30.8, 39.1)	31.2 (27.8, 34.6)		---	---	---	---
			Women+	26.5 (22.6, 30.4)	27.2 (23.1, 31.3)	22.5 (19.0, 25.9)		---	---	---	---
Urban		Total	26.8 (19.4, 33.8)	26.3 (19.6, 32.9)	27.6 (20.6, 34.6)	Urban	---	---	---	---	
		Men+	28.4 (17.8, 38.9)	29.1 (19.0, 39.1)	30.3 (20.5, 40.1)		---	---	---	---	
		Women+	24.4 (15.2, 33.8)	22.7 (14.7, 30.6)	23.9 (14.8, 33.4)		---	---	---	---	
Total		Total	27.3 (25.8, 28.7)	27.2 (25.9, 28.5)	27.6 (26.2, 29.0)	Total	---	---	---	---	
		Men+	29.2 (27.2, 31.3)	30.1 (28.2, 32.0)	30.5 (28.5, 32.4)		---	---	---	---	
		Women+	24.7 (22.7, 26.8)	23.4 (21.6, 25.1)	23.7 (21.8, 25.7)		---	---	---	---	

Note: Data source: CCHS (adult).

A15. Past Year Cannabis Use Type

Response	2024	2023	2022	Region Type	2021	2020	2019	2018
Non-Medical	---	---	---	Rural	13.1	10.6	10.2	---
	---	---	---	Urban	13.3	12.6	12.0	---
	---	---	---	Total	13.3	12.3	11.7	---
Medical	---	---	---	Rural	4.0	4.8	3.8	---
	---	---	---	Urban	3.0	3.3	3.1	---
	---	---	---	Total	3.2	3.5	3.2	---
Both	---	---	---	Rural	5.1	4.8	5.1	---
	---	---	---	Urban	3.5	4.9	4.8	---
	---	---	---	Total	4.6	4.9	4.9	---

Note: Data source: CCHS.

A16. E-cigarette/Vape Use

Response	Region Type	Gender	2024	2023	2022	Region Type	2021	2020	2019	2018
Adults										
Yes	Rural	Total	17.7 (16.6, 18.8)	17.6 (16.5, 18.7)	18.1 (17.0, 19.1)	Rural	16.9	---	---	---
		Men+	20.4 (18.7, 22.1)	19.5 (17.7, 21.3)	21.2 (19.5, 22.8)		---	---	---	---
		Women+	15.0 (13.6, 16.4)	15.7 (14.3, 17.2)	14.9 (13.6, 16.2)		---	---	---	---
	Urban	Total	18.0 (15.2, 20.8)	17.3 (14.8, 19.9)	19.2 (16.6, 21.8)	Urban	16.7	---	---	---
		Men+	21.3 (17.0, 25.5)	19.9 (15.9, 23.8)	22.6 (18.5, 26.6)		---	---	---	---
		Women+	14.9 (11.5, 18.2)	14.8 (11.6, 18.1)	15.9 (12.9, 19.0)		---	---	---	---
	Total	Total	18.0 (17.4, 18.6)	17.4 (16.8, 17.9)	19.0 (18.4, 19.5)	Total	16.7	---	---	---
		Men+	21.1 (20.2, 22.1)	19.9 (19.0, 20.7)	22.3 (21.5, 23.1)		---	---	---	---
		Women+	14.9 (14.1, 15.6)	14.9 (14.2, 15.7)	15.8 (15.1, 16.4)		---	---	---	---

Note: Data source: CCHS.

A17. Substance Use Disorder

Response	Region Type	2024	2023	2022	Region Type	2021	2020	2019	2018
Yes	Rural	---	---	24.4 (23.5, 25.4)	Rural	---	---	---	---
	Urban	---	---	19.9 (19.4, 20.3)	Urban	---	---	---	---
		---	---		---	---			
		---	---		---	---			
Total	---	---	20.7 (20.3, 21.0)	Total	---	---	---	---	

Note: Data source: 2022 MHACS.

A18. Smoker Status and Drinker Status by Household Income

Variable	Response	Region Type	Identity	2021	2020	2019	2018
Smoker Status	Current Daily or Occasional	Rural	Below LICO	20.4	23.3	26.0	27.2
			Above LICO	14.1	13.8	15.9	17.3
			Total	14.4	14.2	16.3	17.8
		Urban	Below LICO	18.4	24.8	27.0	27.6
			Above LICO	10.9	18.2	13.8	14.5
			Total	11.3	12.7	14.4	15.3
	Former Daily or Occasional	Rural	Below LICO	32.4	29.3	28.8	29.1
			Above LICO	29.0	30.2	29.1	28.9
			Total	29.2	30.2	29.1	28.9
		Urban	Below LICO	20.6	21.4	20.9	19.0
			Above LICO	23.4	23.1	23.1	23.5
			Total	23.3	23.1	23.0	23.3
	Experimental	Rural	Below LICO	9.3	7.3	9.9	7.8
			Above LICO	11.8	12.3	13.7	12.6
			Total	11.7	12.0	13.5	12.4
Urban		Below LICO	10.8	9.3	8.8	8.7	
		Above LICO	11.3	12.8	13.1	13.1	
		Total	11.4	12.7	12.9	12.8	
Drinker Status	Regular	Rural	Below LICO	46.7	45.9	47.4	41.4
			Above LICO	62.8	61.2	61.4	62.5
			Total	62.2	60.5	60.8	61.5
		Urban	Below LICO	41.8	42.7	43.6	43.2
			Above LICO	56.6	58.9	57.7	59.1
			Total	55.9	58.3	57.0	58.1
	Occasional	Rural	Below LICO	20.9	23.4	22.7	20.9
			Above LICO	15.0	16.0	16.3	16.8
			Total	15.2	16.3	16.6	17.0
		Urban	Below LICO	21.0	19.1	22.6	19.4
			Above LICO	16.2	15.4	17.0	16.6
			Total	16.4	15.5	17.3	16.8

Note: Data source: CCHS.

A19. Suicidality

Variable	Region Type	2024	2023	2022	2021	2020	2019	2018
Adults								
Suicidal Ideation	Rural	---	---	6.9 (6.3, 7.4)	---	---	---	---
	Urban	---	---	6.8 (6.5, 7.0)	---	---	---	---
		---	---		---	---		
		---	---		---	---		
Total	---	---	6.8 (6.6, 7.0)	---	---	---	---	

Note: Data source: 2022 MHACS (adult).

A20. 30-Day Mental Health or Substance Use Readmission

Year	Region Type	CA	NL	PEI	NS	NB	QC	ON	MB	SK	AL	BC	YT	NT	NU
2023-2024	Urban	12.6	10.9	14.0	9.9	11.6	12.2	13.8	9.7	11.0	10.6	13.0	—	—	—
	Rural/remote	11.8	11.7	10.7	9.4	12.9	12.2	12.4	9.7	10.9	10.6	12.6	—	—	—
	Total	13.0	11.4	12.7	9.8	12.1	12.3	13.6	9.7	11.1	10.6	13.1	—	—	—
2022-2023	Urban	13.2	11.7	13.1	9.5	12.5	13.0	14.0	10.6	11.0	11.1	14.1	—	—	—
	Rural/remote	13.1	14.3	13.8	10.0	12.2	13.5	14.5	10.2	11.3	12.3	13.4	—	—	—
	Total	13.4	12.9	13.5	9.9	12.3	13.2	14.1	10.5	11.5	11.4	14.2	—	—	—
2021-2022	Urban	14.0	13.0	15.0	11.9	14.0	13.3	15.2	11.0	11.7	12.3	14.6	—	—	—
	Rural/remote	13.8	16.1	15.9	11.0	11.8	14.2	15.3	11.7	11.2	12.6	15.5	—	—	—
	Total	13.8	14.5	15.2	11.7	13.2	13.5	15.2	11.2	11.4	12.4	14.9	—	—	—
2020-2021	Urban	15.4	17.4	16.5	11.2	14.7	15.0	16.8	13.6	12.6	12.6	15.9	—	—	—
	Rural/remote	14.3	15.8	13.5	13.4	16.1	14.6	14.1	13.1	14.5	12.4	15.4	—	—	—
	Total	14.4	16.6	15.2	11.9	15.3	14.9	16.5	13.5	13.4	12.6	15.9	—	—	—
2019-2020	Urban	12.2	13.8	10.5	11.1	11.6	11.5	13.3	10.1	10.1	9.8	13.0	—	—	—
	Rural/remote	12.3	14.0	11.9	12.2	13.5	12.6	13.2	8.9	10.6	11.0	13.2	—	—	—
	Total	12.7	14.0	11.0	11.5	12.3	11.7	13.3	9.8	10.3	10.3	13.1	—	—	—
2018-2019	Urban	12.3	12.1	11.1	11.7	11.4	12.1	13.1	8.8	10.7	9.7	13.0	—	—	—
	Rural/remote	11.8	12.3	15.7	11.7	12.5	12.5	12.1	10.3	9.2	10.2	13.0	—	—	—
	Total	12.7	12.1	12.7	11.7	11.9	12.2	13.1	9.3	10.1	10.0	13.0	—	—	—
2017-2018	Urban	12.3	12.7	13.8	10.6	12.1	12.3	13.1	9.0	10.7	9.1	13.1	—	—	—
	Rural/remote	12.2	13.6	11.9	13.5	11.7	13.0	12.5	10.5	10.4	11.0	12.5	—	—	—
	Total	12.6	13.1	13.3	11.6	12.0	12.5	13.0	9.6	10.7	9.7	13.1	—	—	—

Note: Data is risk-adjusted ratio (per 100). Risk-adjusted rate for each region = Observed number of readmissions in each region ÷ Expected number of readmissions in the region ÷ Canadian average readmission rate. Unit of Analysis: Episode of care

A21. Repeat Stays for Mental Health or Substance Use

Year	Region Type	CA	NL	PEI	NS	NB	QC	ON	MB	SK	AL	BC	YT	NT	NU
2023-2024	Urban	12.2	11.8	14.4	11.4	11.7	11.5	12.8	10.6	11.1	10.8	13.3	—	—	—
	Rural/remote	11.3	10.8	14.4	9.2	12.7	10.6	11.6	10.2	10.1	10.5	14.0	—	—	—
	Total	12.7	11.6	14.4	10.8	12.1	11.5	12.7	10.5	10.8	10.9	13.9	—	—	—
2022-2023	Urban	13.1	9.5	13.2	12.2	12.8	12.5	13.6	12.2	12.3	12.2	14.2	—	—	—
	Rural/remote	12.6	13.9	14.6	11.3	11.9	11.8	13.4	10.9	11.7	12.3	14.5	—	—	—
	Total	13.2	11.5	13.8	12.2	12.5	12.6	13.6	11.9	12.1	12.4	14.7	—	—	—
2021-2022	Urban	13.9	14.8	13.4	12.8	14.5	12.6	14.5	13.7	13.2	12.9	15.2	—	—	—
	Rural/remote	13.1	14.7	14.8	11.7	13.9	12.7	13.3	11.8	12.0	12.8	15.1	—	—	—
	Total	13.5	14.8	13.9	12.7	14.3	12.8	14.4	13.1	12.8	13.0	15.5	—	—	—
2020-2021	Urban	13.1	14.0	14.0	11.0	13.2	12.2	13.8	12.3	11.6	11.8	14.2	—	—	—
	Rural/remote	12.5	15.4	11.3	10.1	12.3	13.0	12.6	8.9	12.6	11.8	13.8	—	—	—
	Total	13.1	14.8	13.0	10.7	13.0	12.4	13.7	11.3	12.0	12.0	14.4	—	—	—
2019-2020	Urban	12.4	14.6	12.7	11.4	12.9	11.5	13.1	10.4	12.6	10.8	13.2	—	—	—
	Rural/remote	11.6	12.2	11.8	11.2	11.9	11.7	11.6	9.2	10.9	11.2	13.1	—	—	—
	Total	12.6	13.6	12.4	11.3	12.5	11.6	12.9	10.1	12.1	11.1	13.5	—	—	—
2018-2019	Urban	12.2	13.8	12.3	11.4	11.7	11.8	12.6	10.0	12.4	10.4	13.4	—	—	—
	Rural/remote	11.2	13.1	10.5	11.5	12.3	11.2	11.1	10.4	11.4	10.4	12.1	—	—	—
	Total	12.4	13.5	11.9	11.4	12.0	11.8	12.4	10.2	12.0	10.8	13.4	—	—	—
2017-2018	Urban	11.7	13.7	14.7	10.5	13.3	10.9	12.4	10.7	12.3	9.5	12.8	—	—	—
	Rural/remote	11.0	12.6	8.3	13.3	10.8	10.9	11.3	9.0	11.1	10.4	11.4	—	—	—
	Total	12.2	13.2	12.5	11.5	12.4	11.0	12.3	9.7	11.9	10.0	12.7	—	—	—

Note: Data is total number of individuals who had at least 3 episodes of care for MHSU disorders (repeat hospitalizations) in a 1-year period ÷ Total number of individuals who had at least one episode of care for MHSU disorders in a 1-year period ÷ 100. Unit of analysis: Patient

A22. Frequent Emergency Room Visits for Mental Health or Substance Use

Year	Region Type	CA	NL	PEI	NS	NB	QC	ON	MB	SK	AL	BC	YT	NT	NU
2023-2024	Urban	8.9	—	11.1	5.6	—	7.8	9.2	—	10.8	10.3	6.6	17.7	—	—
	Rural/remote	10.1	—	6.9	5.7	—	6.0	10.8	—	10.5	12.5	6.6	14.4	—	—
	Total	9.6	—	10.7	5.7	—	7.7	10.1	—	10.9	11.2	7.3	17.0	—	—
2022-2023	Urban	8.8	—	10.4	5.6	—	7.7	9.2	—	10.5	9.9	6.9	16.5	—	—
	Rural/remote	9.6	—	7.9	7.9	—	6.6	10.4	—	9.1	11.7	5.9	13.5	—	—
	Total	9.4	—	10.4	6.9	—	7.5	9.9	—	10.1	10.7	7.2	15.5	—	—
2021-2022	Urban	9.0	—	9.7	7.2	—	7.9	9.3	—	10.1	10.0	7.6	15.5	—	—
	Rural/remote	9.5	—	7.1	8.0	—	6.8	10.3	—	8.6	11.9	6.1	14.5	—	—
	Total	9.5	—	9.4	7.7	—	7.7	10.0	—	9.8	10.8	7.8	15.2	—	—
2020-2021	Urban	9.4	—	10.4	8.2	—	8.7	9.7	—	10.2	10.4	7.5	18.4	—	—
	Rural/remote	9.9	—	8.0	6.9	—	7.0	10.5	—	8.1	12.4	5.5	16.4	—	—
	Total	9.9	—	9.4	7.6	—	8.4	10.3	—	9.6	11.3	7.8	17.7	—	—
2019-2020	Urban	9.4	—	9.5	7.8	—	8.4	9.8	—	10.5	10.4	7.2	18.8	—	—
	Rural/remote	9.8	—	5.7	6.3	—	7.5	10.5	—	7.0	12.1	5.9	17.0	—	—
	Total	9.8	—	7.7	7.0	—	8.2	10.4	—	9.7	11.2	7.5	18.3	—	—
2018-2019	Urban	9.5	—	10.1	7.3	—	—	9.7	—	9.5	10.2	7.4	17.1	—	—
	Rural/remote	10.7	—	6.9	7.5	—	—	10.3	—	7.5	12.5	6.0	18.1	—	—
	Total	10.1	—	8.5	7.4	—	—	10.2	—	9.0	11.2	7.7	17.8	—	—
2017-2018	Urban	9.1	—	10.7	6.8	—	—	9.5	—	9.3	9.5	7.3	14.4	—	—
	Rural/remote	10.3	—	4.7	8.1	—	—	10.2	—	6.5	11.7	6.3	16.1	—	—
	Total	9.8	—	7.9	7.6	—	—	10.0	—	8.7	10.8	8.2	15.7	—	—

Note: Data is total number of individuals who had at least 4 ER or UCC visits for mental health and substance use in a 1-year period ÷ Total number of individuals who had at least 1 ER or UCC visit for mental health and substance use in a 1-year period ÷ 100. Unit of analysis: Patient

A23. Travel Burden for Psychiatric Hospital Care

Year	Region Type	CA	NL	PEI	NS	NB	QC	ON	MB	SK	AL	BC	YT	NT	NU
Urban	Very Low	76.2	75.0	67.9	79.5	75.4	78.5	63.4	92.3	85.8	81.0	72.3	83.8	—	—
	Low	11.6	8.8	13.4	3.0	16.1	12.8	17.1	1.7	4.6	5.3	15.0	1.4	—	—
	Moderate	7.9	5.7	17.3	4.9	5.2	6.4	14.6	2.4	3.1	8.1	8.3	8.7	—	—
	High/Very High	4.3	10.6	1.4	12.7	3.3	2.3	4.8	3.6	6.4	5.5	4.4	6.1	3.2	—
Rural/Remote	Very Low	17.7	18.8	11.6	18.6	1.5	20.5	30.4	15.1	9.2	16.3	13.6	15.6	—	30.6
	Low	17.3	6.6	28.4	16.2	15.5	29.2	14.1	6.1	5.1	8.5	18.3	0.0	—	—
	Moderate	35.6	36.6	50.6	42.2	66.9	38.3	30.6	22.7	28.5	33.8	32.8	7.2	—	—
	High/Very High	29.4	38.0	9.4	23.1	16.2	12.0	24.9	66.0	67.2	41.5	35.3	77.2	67.5	69.4

Note: Data is from years 2018-2019 to 2022-2023.

A24. Consulted with a Health Professional Regarding Mental Health

Response	Region Type	Gender	2024	2023	2022	Region Type	2021	2020	2019	2018	
Yes	Rural/remote	Total	18.2 (16.9, 19.4)	15.2 (13.9, 16.4)	18.1 (17.0, 19.1)	Rural/remote	---	12.8	14.1	---	
		Men+	12.7 (11.1, 14.2)	9.9 (8.3, 11.5)	14.9 (13.6, 16.2)		---	---	---	---	
		Women+	23.5 (21.7, 25.4)	20.5 (18.6, 22.4)	21.2 (19.5, 22.8)		---	---	---	---	
	Urban	Total	19.7 (16.6, 22.8)	19.0 (15.6, 22.4)	19.6 (16.4, 22.7)		Urban	---	15.6	16.2	---
		Men+	14.2 (10.4, 18.0)	13.5 (9.6, 17.4)	14.7 (10.9, 18.4)			---	---	---	---
		Women+	25.2 (20.6, 29.7)	24.5 (19.6, 29.5)	23.9 (18.9, 28.4)			---	---	---	---
	Total	Total	19.4 (18.8, 20.1)	18.3 (17.6, 19.0)	19.0 (18.4, 19.5)		Total	---	15.1	15.9	---
		Men+	13.9 (13.1, 14.8)	12.8 (11.9, 13.6)	22.3 (21.5, 23.1)			---	---	---	---
		Women+	24.9 (23.9, 25.9)	23.7 (22.7, 24.8)	15.8 (15.1, 16.4)			---	---	---	---

Note: Data source: CCHS.

A25. Type of Health Professional Consulted Regarding Mental Health

Response	Region Type	2024	2023	2022	2021	2020	2019	2018
Family Doctor/General Practitioner	Rural/remote	---	---	---	---	7.5	8.2	2.6
	Urban	---	---	---	---	7.6	8.7	1.8
	Total	---	---	---	---	7.6	8.6	1.9
Psychiatrist	Rural/remote	---	---	---	---	1.4	2.0	0.6
	Urban	---	---	---	---	2.5	2.8	0.5
	Total	---	---	---	---	2.3	2.6	0.6
Psychologist	Rural/remote	---	---	---	---	2.6	2.6	1.2
	Urban	---	---	---	---	4.3	4.1	1.7
	Total	---	---	---	---	4.0	3.8	1.6
Nurse	Rural/remote	---	---	---	---	0.7	0.8	0.2
	Urban	---	---	---	---	0.7	0.7	0.2
	Total	---	---	---	---	0.7	0.7	0.2
Social Worker	Rural/remote	---	---	---	---	3.2	3.6	0.6
	Urban	---	---	---	---	4.3	4.2	0.5
	Total	---	---	---	---	4.1	4.1	0.6
Other	Rural/remote	---	---	---	---	0.9	1.3	0.3
	Urban	---	---	---	---	1.2	1.3	0.2
	Total	---	---	---	---	1.1	1.3	0.2

Note: Data source: CCHS.

A26. Mental Healthcare Needs Met

Response	Region Type	2024	2023	2022	Region Type	2021	2020	2019	2018
Yes	Rural/remote	---	---	77.1 (74.9, 79.2)	Rural/remote	---	---	---	---
	Urban	---	---	75.5 (73.6, 77.1)	---	---	---	---	
		---	---		---	---			
		---	---		---	---			
Total	---	---	75.7 (74.9, 76.5)	Total	---	---	---	---	

Note: Data source: 2022 MHACS.

09. References

- ¹ Nasimi, Sorour, Mostafa Dorosti, Guangji, Hu, Zoe Li, Rehan Sadiq and Jianbing Li. “The status of water security in small, rural, and remote communities in Canada: A review,” *Environmental Reviews*, 30 (2026): 1-22.
- ² Statistics Canada. Who lives in remote communities? Government of Canada, 2023. <https://www.statcan.gc.ca/o1/en/plus/3117-who-lives-those-remote-communities>
- ³ Canadian Institute for Health Information. Indicator library: General methodology notes – clinical indicators. CIHI, 2025. <https://www.cihi.ca/sites/default/files/document/general-methodology-notes.pdf>.
- ⁴ Statistics Canada. Population centre (POPCTR). Dictionary, Census of Population, 2021. Government of Canada. <https://www12.statcan.gc.ca/census-recensement/2021/ref/dict/az/definition-eng.cfm?ID=geo049a>.
- ⁵ Statistics Canada. Rural area (RA). Dictionary, Census of Population. 2021. <https://www12.statcan.gc.ca/census-recensement/2021/ref/dict/az/definition-eng.cfm?ID=geo042>.
- ⁶ Alasia, Alessandro, Frédéric Bédard, Julie Bélanger, Eric Guimond and Christopher Penney. Measuring remoteness and accessibility: A set of indices for Canadian communities. Statistics Canada. 2017. <https://www150.statcan.gc.ca/n1/pub/18-001-x/18-001-x2017002-eng.htm>; <https://www150.statcan.gc.ca/n1/pub/11-633-x/11-633-x2020002-eng.htm>.
- ⁷ Thompson, Rochelle, Briana N. M. Hagen, Margaret N. Lumley, Charlotte B. Winder, Basem Gohar, and Andria Jones-Bitton, “Mental health and substance use of farmers in Canada during COVID-19,” *International Journal of Environmental Research and Public Health* 19, 20 (2022): 13566. <https://www.mdpi.com/1660-4601/19/20/13566>.
- ⁸ Government of Canada. Mental Health and Access to Care Survey (MHACS). 2022. <https://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&SDDS=5015>.
- ⁹ Leone, Donald. Data colonialism in Canada: Decolonizing data through Indigenous data governance. MA Thesis. Ottawa: Carleton University, 2021. <https://carleton.scholaris.ca/server/api/core/bitstreams/b559099c-7720-46e9-b4b8-fb99747395b9/content>; Govorchin, Alya, Maëve Leduc, Clifford G. Atleo, Dawn Hoogeveen, Irina Borgos and Lyana Patrick, “The right to health: indigenous data sovereignty in Canada during and beyond the COVID-19 pandemic,” *The Lancet Regional Health – Americas* 54 (2026). <https://www.sciencedirect.com/science/article/pii/S2667193X25003461>.
- ¹⁰ Government of Canada. Filling the gaps: information on gender in the 2021 Census. 2022. <https://www12.statcan.gc.ca/census-recensement/2021/ref/98-20-0001/982000012021001-eng.cfm>.
- ¹¹ OECD. Measuring population mental health. Paris: OECD, 2023. <https://doi.org/10.1787/399c6a02-en>.
- ¹² Fuhrer, Rebecca and Katherine M. Keyes, “Population Mental Health Today: Confronting the Challenge,” *American Journal of Public Health* 109,3 (2019): S149.
- ¹³ We acknowledge that these data are national level, and therefore, that they do not capture how local contexts and community strengths also play a role in shaping well-being.
- ¹⁴ A notable trend for all groups is that they show declines in well-being over time. The rate of good, very good, or excellent mental health for rural non-Indigenous people dropped from 74.2% in 2007–2010 to 61.7% in 2020–2022, while First Nations off reserve fell from 64.1% to 54.4%, and Métis from 65.3% to 52.1%. Inuit trends fluctuate but remain lowest overall, with rural Inuit decreasing from 60.4% in 2007–2010 to 48.5% in 2020–2022, and urban Inuit dropping from 63.8% to 49.5%.
- ¹⁵ Statistics Canada uses a measure referred to as “Low-income cut-off” (LICO) to understand the percentage of families considered to be low income. It indicates that a family is likely to spend a larger share of income on necessities such as food, clothing and shelter than does the average family of similar size. The LICO threshold varies by family size and by size of community.
- ¹⁶ Fowler, Patrick J., Carolyn J. Tompsett, Jordan M. Braciszewski, Angela Jacques-Tiura and Boris B. Baltes, “Community violence: a meta-analysis on the effect of exposure and mental health outcomes of children and adolescents,” *Developmental Psychopathology* 21,1 (2009):227-59.
- ¹⁷ Statistics Canada defines violent crimes as the use or threatened use of violence against a person, and include offences such as homicide, attempted murder, assault, sexual assault, and robbery. Statistics Canada. Classification of most serious offence. Government of Canada. 2019.
- ¹⁸ Cotter, Adam. Characteristics of police-reported crime in rural areas in the Canadian provinces, 2023. Statistics Canada. 2025. <https://www150.statcan.gc.ca/n1/pub/85-002-x/2025001/article/00005-eng.htm>

- ¹⁹ Burczycka, Marta and Adam Cotter. Court outcomes in homicides of Indigenous women and girls, 2009-2021. Government of Canada. 2023. <https://www150.statcan.gc.ca/n1/pub/85-002-x/2023001/article/00006-eng.htm>
- ²⁰ Stephenson, E. Mental disorders and access to mental health care. Government of Canada. 2023. <https://www150.statcan.gc.ca/n1/pub/75-006-x/2023001/article/00011-eng.htm>.
- ²¹ The historical rates among Inuit have fluctuated in ways the others have not, with urban Inuit mood disorder and anxiety disorder rates dropping below the rural rate in 2011-2013 and then far surpassing Inuit rural rates in 2014-2016, suggesting a decline in mental well-being for this group.
- ²² CAPSA. Understanding substance use health: A matter of equity. <https://capsa.ca/2023/wp-content/uploads/2023/11/CAPSA-Substance-Use-Health-EN-1.pdf>.
- ²³ Canadian Centre on Substance Use and Addiction. Canada's guidance on alcohol and health. <https://www.ccsa.ca/en/guidance-tools-resources/substance-use-and-addiction/alcohol/canadas-guidance-alcohol-and-health>.
- ²⁴ Non-medical cannabis use is much higher than medical use across all regions. In 2021, 13.3% of urban adults reported non-medical use compared to 13.1% in rural areas, while medical use was slightly higher in rural communities (4.0% vs 3.0% urban). Non-medical use increased slightly after legalization (2018). Combined medical and non-medical use is low but more common in rural areas (5.1% vs 3.5% urban).
- ²⁵ Mental Health Research Canada. Mental health support in Canada: Urban vs rural. MHRC. <https://www.mhrc.ca/blog-research-brief/mental-health-support-in-canada-urban-vs-rural>.
- ²⁶ Mahinpey, Newsha, Nathaniel J Pollock, Li Liu, Gisele Contreras and Wendy Thompson, "Self-harm and rurality in Canada: an analysis of hospitalization data from 2015 to 2019," *Journal of Social Psychiatry and Psychiatric Epidemiology* 58, 8 (2023): 1161-1170.
- ²⁷ Burrows, Stephanie, Natalie Auger, Philippe Gamache and Denis Hamel, "Leading causes of unintentional injury and suicide mortality in Canadian adults across the urban-rural continuum," *Public Health Reports* 128,6 (2013): 443-453. <https://journals.sagepub.com/doi/pdf/10.1177/003335491312800604>. Rauch, Kyrra Hunter, et al., "Suicidality in rural and remote communities: A scoping review," *Research Connection* 4,3 (2021). <Rauch-et-al.-wl-pdf.pdf>.
- ²⁸ Suicide ideation is defined as whether an individual reported seriously considering suicide or taking their own life at least once. Data retrieved from MHACS survey (2022).
- ²⁹ See methodological notes for MHACS survey: Statistics Canada. Mental Health and Access to Care Survey (MHACS). 2022. <https://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&SDDS=5015>.
- ³⁰ Pollock, Nathaniel J., Shree Mulya, James Valcour and Michael Jong. "Suicide rates in Aboriginal communities in Labrador, Canada," *American Journal of Public Health* 106,7 (2016): 1309-1315. <https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2016.303151>.
- ³¹ Pollock, Nathaniel J., Gwen K Healey, and Michael Jong, "Tracking progress in suicide prevention in Indigenous communities: a challenge for public health surveillance in Canada," *BMC Public Health* 18 (2018): 1320. <https://link.springer.com/article/10.1186/s12889-018-6224-9>.
- ³² Snowdon, W. Mikisew Cree First Nation declares state of local emergency following multiple suicides. CBC News. 2023. <https://www.cbc.ca/news/canada/edmonton/mikisew-cree-first-nation-suicide-mental-health-emergency-1.6821877>; Inuit Tapiriit Kanatami. National Inuit Suicide Prevention Strategy. 2016. <https://itk.ca/national-inuit-suicide-prevention-strategy/>.
- ³³ Stigma is also thought to be one of the biggest factors for why suicide rates are underreported. In addition, sometimes deaths that might otherwise have been ruled a suicide cannot be categorized as such due to the lack of unequivocal evidence signaling certain suicide. See Olsen, Robert. The Accuracy and reliability of suicide statistics: Why it matters. Centre for Suicide Prevention, 2025. <https://www.suicideinfo.ca/wp-content/uploads/2021/05/Suicide-stats-article-web.pdf>.
- ³⁴ See p. 36 of ITK Suicide Prevention Strategy for a discussion of intergenerational impacts. Inuit Tapiriit Kanatami. National Inuit suicide Prevention Strategy. 2016. <https://itk.ca/national-inuit-suicide-prevention-strategy/>.
- ³⁵ Government of Canada. Health care access and experiences among Indigenous people, 2024. Government of Canada, 2024. <https://www150.statcan.gc.ca/n1/daily-quotidien/241104/dq241104a-eng.htm>.
- ³⁶ Statistics Canada. Health care access and experiences among Indigenous people. Government of Canada, 2024. <https://www150.statcan.gc.ca/n1/daily-quotidien/241104/dq241104a-eng.htm>.
- ³⁷ Mental Health Research Canada. Mental Health Support in Canada: Urban vs. Rural. 2022. <https://www.mhrc.ca/blog-research-brief/mental-health-support-in-canada-urban-vs-rural>. Hagen, Briana N.M., Alex Sawatzky, Sherilee L. Harper, Terri L. O'Sullivan, Andria Jones-Bitton, "Farmers Aren't into the Emotions and Things, Right?" A Qualitative Exploration of Motivations and Barriers for Mental Health Help-Seeking among Canadian Farmers," *Journal of Agromedicine* 27 (2022): 113-123. <https://www.tandfonline.com/doi/full/10.1080/1059924X.2021.1893884>.

