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Collaborating to improve child and youth mental health in Nunavik
Collaborer afin d'améliorer la santé mentale des enfants et des jeunes au Nunavik

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Résumé de l'article

Suite à la publication de plusieurs rapports soulignant le manque de services en santé mentale de la jeunesse au Nunavik (Québec, Canada), les hauts taux de placement sous la protection de la jeunesse, de même que les lacunes dans la coordination des services, le Comité de partenariat régional du Nunavik a décidé de prioriser des approches collaboratives et communautaires pour la prévention et le bien-être des enfants, des jeunes et de leurs familles. C'est dans ce contexte que le projet régional *Ilagiinut* (« Pour les familles ») a été mis en place à Kuujjuaraapik. Alors que les pratiques en collaboration sont de plus en plus valorisées en santé mentale, de telles approches ne sont pas toujours faciles à mettre en place et requièrent nombre d'ingrédients, dont la confiance, de solides partenariats, des rôles clairement définis, ainsi que des dynamiques de pouvoir propices, le tout étant marqué par la culture et le contexte du Nunavik. Dans cette étude, nous avons mené un total de 54 entrevues avec des administrateurs, cliniciens et membres de familles inuit afin de déterminer leurs attentes et leurs expériences quotidiennes en ce qui a trait aux soins offerts en santé mentale de la jeunesse et à la collaboration entre les différents acteurs impliqués. Dans notre analyse, nous explorons comment le contexte influe sur les attentes, croyances et expériences, et comment celles-ci ont des impacts sur la nature des services offerts aux enfants et aux familles. Le but est de mettre en lumière tant les obstacles que les facilitateurs de la collaboration en santé mentale de la jeunesse au Nunavik afin d'informer les individus, communautés et organisations souhaitant des changements dans les politiques et les pratiques.

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RÉSUMÉ

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Suite à la publication de plusieurs rapports soulignant le manque de services en santé mentale de la jeunesse au Nunavik (Québec, Canada), les hauts taux de placement sous la protection de la jeunesse, de même que les lacunes dans la coordination des services, le Comité de partenariat régional du Nunavik a décidé de prioriser des approches collaboratives et communautaires pour la prévention et le bien-être des enfants, des jeunes et de leurs familles. C'est dans ce contexte que le projet régional *Ilagiinut* («Pour les familles») a été mis en place à Kuujjuaraapik. Alors que les pratiques en collaboration sont de plus en plus valorisées en santé mentale, de telles approches ne sont pas toujours faciles à mettre en place et requièrent nombre d'ingrédients, dont la confiance, de solides partenariats, des rôles clairement définis, ainsi que des dynamiques de pouvoir propices, le tout étant marqué par la culture et le contexte du Nunavik. Dans cette étude, nous avons mené un total de 54 entrevues avec des administrateurs, cliniciens et membres de familles inuit afin de déterminer leurs attentes et leurs expériences quotidiennes en ce qui a trait aux soins offerts en santé mentale de la jeunesse et à la collaboration entre les différents acteurs impliqués. Dans notre analyse, nous explorons comment le contexte influe sur les attentes, croyances et expériences, et comment celles-ci ont des impacts sur la nature des services offerts aux enfants et aux familles. Le but est de mettre en lumière tant les obstacles que les facilitateurs de la collaboration en santé mentale de la jeunesse au Nunavik afin d'informer les individus, communautés et organisations souhaitant des changements dans les politiques et les pratiques.

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ABSTRACT

Collaborating to improve child and youth mental health in Nunavik

Following various reports highlighting the lack of mental health services for children and youth in Nunavik (Quebec, Canada), high rates of child placements under youth protection, and gaps in the coordination of services, the Regional Partnership Committee of Nunavik decided to prioritize collaborative, community-based approaches to the health and wellbeing of children, youth, and their families. It is in this context that the regional project *Ilagiinut* ('For families') was initiated and is being piloted in Kuujjuaraapik. In mental health care, collaborative practices are highly valued, and various models are flourishing. However, collaborative care models are not necessarily easy to implement and involve a variety of ingredients, including trust, strong partnerships, clarity of roles, and power dynamics, all of which are influenced by culture and context. In this study, we conducted a total of 54 interviews with administrators, clinicians, and Inuit family members to explore their everyday expectations for and experiences with child and youth mental health services and collaboration between people involved in care. In our analysis we explore how context influences expectations, beliefs, and experiences, and ultimately how these factors impact the nature of services offered to children, youth, and families. The aim is to shed light on obstacles to and facilitators of collaboration in child and youth mental health in order to inform individuals, communities, and organizations that are trying to change policy and practice.

Introduction

For child and youth mental health in general, collaborative mental health models are seen as the most promising strategies to improve the health and wellbeing of individuals and communities (Gagné 2005; Kates et al. 2011; Nadeau et al. 2012, 2014). The different models share one main objective: integrate specialized (often called second- or third-line) psychiatric services into primary care settings (also called first- or front-line and including schools and CLSCs[1]) to make mental health services more accessible and efficient and to ensure continuity of care for all. When successful, collaborative mental health care has increased access to care and service uptake, improved clinical outcomes for patients, and brought services more into line with the expressed needs of users (Cheminais 2009; Haggarty et al. 2010; Kates et al. 2011; Quinn and Biggs 2010).

In the field of Aboriginal mental health, promising strategies are community-based and collaborative and integrate informal, traditional, and formal approaches (Auclair and Sappa 2012; Blackstock and Trocmé 2005; Cotton et al. 2014; Kirmayer et al. 2009; Rae 2011). Indeed, there is some indication that, for smaller communities, it is not so much the specific type of intervention program as the degree of community initiative, organization, and involvement that results in the greatest mental health benefits (Kirmayer et al. 2009). The above-cited publications on collaborative care and on Aboriginal health have a shared emphasis on the

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1. CLSC (Centre local de services communautaires) are public community health centres that exist throughout Quebec.

importance of "working together," coordinating, communicating, and ensuring continuity and empowerment. Also, while Aboriginal mental health care focuses primarily on community-oriented approaches, collaborative care focuses on service-level collaboration with patients (and/or communities) at its core.

In June 2014, the first and last authors of this paper, along with Jennifer Hunter, the coordinator of the Regional Partnership Committee of Nunavik, were sitting around a large table in a beautifully decorated office in Kuujjuaq. The leaders of all Nunavik organizations were there, curious to hear the first results of community mobilization in Kuujjuaraapik, a process that this same group of people mandated us to initiate and document. The aim of the regional initiative, named *Ilagiinut* ('For families'), was to develop community-led prevention, promote children, youth, and family wellbeing, and enhance connections between communities and services. The vision of local and regional leaders was one of community decision-making, having a hub in the centre of town that could provide families with activities and services to reconnect and to support each other, to reconnect to their culture, and to create trusting links with existing resources and services. In essence this initiative would make possible the development of a community-based, culturally-adapted model of collaboration for child, youth, and family wellbeing with various people in the community and in services.

At this meeting, we talked about the strengths and challenges of community members working together. We spoke of ruptures in communication, issues of trust, feelings of isolation, and community perceptions of services. The leaders, Inuit men and women, listened attentively, with their bodies leaning towards the table and their eyes staring at our measly drawings on a small white board. They connected to what was being discussed, since they had experienced it themselves. When the marker pen was put down and when the drawings seemed somehow complete, there was a moment of silence. Someone asked, "Why is it so hard for us to work together, to trust each other?" The leaders expressed their sense of disarray and urgency. "We are working in silos, we must work together." "We must act quickly for our children." The leaders were referring to the identified gaps in child and youth mental health services, to the lack of prevention-oriented and community-based services, to the incredibly high rates of reporting to the Director of Youth Protection (DYP), and to placements of children with child protection services (Sirois 2007, 2010). In the past decade, various reports have pointed to a serious lack of child and youth mental health services in Nunavik and to the consequences (e.g., Lessard et al. 2008: IV). Sirois and her team (2007: 59) suggest that the "lack of cooperation between services" negatively impacts "both the quality and effectiveness of the services offered." Lack of cooperation and gaps between services are not uncommon in health and social services in general (Demers et al. 2002; Gauthier and St-Pierre 2009; Glouberman and Mintzberg 2001). Researchers suggest that in order to reduce these gaps we must better understand the existing tensions and junctions within and between organizations (Gauthier and St-Pierre 2009).

The leaders at the meeting were also referring to incredibly high rates of completed suicides, suicidal ideation, and attempted suicides (Fraser et al. 2015; Hicks 2007a, 2007b; Kirmayer et al. 1996, 1997, 1998), to documented psychological distress, to alcohol and substance abuse (Kirmayer et al. 1997, Muckle et al. 2007), and to psychological trauma (Haggarty et al. 2000; Lavoie et al. 2008a, 2008b). Child and youth mental health has become a major health priority for many First Nation and Inuit communities across Canada, and more specifically for the regional representatives of Nunavik (Makivik Corporation 2010). Children and youth are not only the future of Nunavik's communities but also a large percentage of its population, with 39% being under the age of 14 (Rodon and Grey 2009).

The leaders ended the meeting in agreement that the next step to community mobilization should be to figure out how to work together: the community members with each other; the community with services; and the organizations with each other. What does collaboration look like in child and youth mental health services? What are the gaps and how can a community fill some of them to improve care? In the previous year we had focussed our attention on community needs and visions for such collaborations. Our action research made us soon realize that we also needed to explore the experiences of service providers. This article thus aims to sketch the collaborations among service providers and between services and the community, as perceived and experienced by various stakeholders: medical and social professionals; administrative staff of local services; and institutional representatives of Nunavik. First, we will briefly present our conceptual framework and method. After describing the context in which Nunavik children and youth with social and mental health difficulties enter the realm of health and social services, we will present the results of our interviews in terms of the models of collaboration and the challenges to overcome. We will conclude with a discussion of our results.

Conceptual framework

This research is framed around collaborative mental health models, all the while placing community collaboration and mobilization at the heart of research concerns. While examining the literature on collaborative care, Boon and her colleagues (2004) suggest that collaborative care, or "teamwork," can be best described as a continuum between seven models. Table 1 briefly describes this continuum.

The models differ in the amount of organizational structure for collaboration, the degree of formality of exchanges between collaborators, the degree of communication that takes place between practitioners, and the nature of the communication (ibid.). With less "collaborative" approaches, practitioners will share information. With more collaborative approaches, they will share decision-making and ensure integration of roles into patient monitoring and follow-up.

TABLE 1. Models of teamwork (Boon et al: 2004).

Parallel: independent health care practitioners work in a common setting.
Consultative: expert advice is given from one professional to another.
Collaborative: practitioners normally practice independently of each other and share information concerning a particular patient who has been (or is being) treated by each of them. This teamwork is often done informally.
Coordinated: patient records are shared and forwarded among professionals who are members of a team intentionally formed to provide treatment. The case coordinator is responsible for ensuring information is transferred.
Multidisciplinary: teams are managed by a leader (usually not a physician) who plans patient care. Individual team members each make their own decisions and recommendations, which may be integrated by the team leader.
Interdisciplinary: practitioners begin to make group decisions (usually based on a consensus model) about patient care. Decisions are facilitated by regular, face-to-face meetings.
Integrative: there is interdisciplinary, non-hierarchical blending of conventional medicine with complementary and alternative health care. This model provides a seamless continuum of decision-making and patient-centred care and support.

Moreover, the more integrative the approach is, the more cohesive and less hierarchical the services will be, and the more involved the patients will be in the various stages of care (ibid.). These concepts guided development of our research protocol and will be referred to throughout the article. We adopted qualitative methods in order to gather a rich, complex, and in-depth description of the multi-layered interactions and contexts around collaborative mental health care and collaboration (Patton 1990). We also used qualitative research to explore the subject of interest within its natural setting with an intent to "make sense of, or to interpret, phenomena in terms of the meanings people bring to them" (Denzin and Lincoln 2005: 3).

Method

The project proposal that led to this article was initially submitted to the Nunavik Regional Board of Health and Social Services (NRBHSS), the Kativik School Board (KSB), and the ethics board of the first author's affiliated university for approval. Two research assistants worked with agents from the health board and the KSB to prepare a list of service providers who represented all "levels" (front-line workers, specialists/consultants, administrators, directors) of multiple organizations. The agents sent out letters to all service directors and school principals, explaining the project and inviting their staff to participate. Then, a snowball sampling method (Bernard 1995: 97) was used to recruit participants in Kuujjuaraapik, Kuujjuaq, Puvirnituq, and Montreal. We conducted a total of

54 interviews with 58 participants. Four interviews were conducted with two participants at the same time, as decided by the participants. Participants included psychiatrists, general practitioners, nurses, social workers, school principals, teachers, student counsellors, representatives of local committees (education committee, health committee), and police officers. At the time of the interview, 14 participants were living in Kuujjuaraapik, 17 in Puvirnituq, 20 in Kuujjuaq, and 7 in Montreal (who were working for Inuit organizations based in that city or as consultants in the North). Of the 58 participants, 39 were non-Inuit and 19 were Inuit.

Interviews were in English or in French, approximately 90 minutes long, and on three broad themes. First, the participant's current and past positions/roles were ascertained. Then, we explored their perceptions of the clientele they served and their understanding of and experience with the collaboration within and between services (who works with whom). All interviews were audio-recorded, transcribed, and subsequently analyzed using QDA Miner, a qualitative data software.

We primarily conducted applied thematic analyses on the data to explore emerging issues and experiences rather than pre-determined hypotheses (Tuckett 2005). The initial data analysis was therefore iterative, inductive, and co-constructed. Interviewers were asked to jot down thoughts after interviews. The first author held brainstorming sessions with the interviewers as well as with the last author. The health board agent and two community members also participated in discussions on the emerging themes. Once these themes had been described, we returned to the coded interviews to extract verbatim examples on the various themes. The verbatim texts were translated when in French and edited to improve readability.

It is important to note that the objective of the sampling method and analyses was to obtain a broad picture of existing services in the field of child and youth mental health and hence to gather experiences from a variety of people. We do not assume that the voices of those interviewed represented the experiences of all service providers and all families. They offer an image of collaboration and services, and material to reflect upon when discussing these complex issues. To understand collaborations in the field of child and youth mental health we will briefly describe the institutions providing health and social services in Nunavik and the way their staff is organized.

Context of health services in Nunavik

A number of provincial, territorial, and municipal public organizations and agencies are involved in delivery of mental health services. Health and social services are under the responsibility of the Board of Health and Social Services (NRBHSS). Regional programs are developed by the NRBHSS. In recent years the NRBHSS has engaged in extensive community consultations on four broad subjects: mental health; youth in difficulty; addictions; and physical health

(Ilusiliriniqmi Pigutjiutini Qimirruniq n.d.). In light of these consultations, the NRBHSS brought together a mental health team as well as a suicide prevention team. It also organised the first Nunavik-based *Dialogue for Life* conference, and started adapting and implementing the SIPPE (Prevention Oriented Services and Activities for Young Families) program.

Clinical activities are coordinated through the Tulattavik and Inuulitsivik health and social services centres, in Kuujjuaq and Puvirnituq respectively. Each hospital coordinates medical, nursing, social, and youth protection services for the seven communities on each coast of Nunavik. They also coordinate community workers and representatives who are hired to liaise between communities and services. On the Hudson Coast, each service (nursing, social services, youth protection, and wellness workers) has its own clinical director in charge of supervising and coordinating the services delivered within the communities. On the Ungava Coast, social services and nursing operate under the same administrative director. Each community has a CLSC, often referred to as the clinic or the nursing station. Smaller community clinics are run by nurses, and a general practitioner (GP) flies in on a regular basis. In larger communities GPs reside in the community. Each community also has a social services unit, which is either within the CLSC or in an independent building, and a youth protection facility, often referred to as the DYP (Department of Youth Protection). The CLSC hires local interpreters and community workers. Pediatricians and child psychiatrists travel to most communities. At the time of the study, two pediatricians came to Nunavik, with each of them usually visiting one or two communities per trip. Two child psychiatrists come to Nunavik. The psychiatrist assigned to the Hudson Coast makes six trips per year, with each trip lasting 5 to 10 days, somewhat more often than the psychiatrist on the Ungava Coast. There is also one psychologist stationed at Tulattavik Health Centre in Kuujjuaq, who serves the Ungava population, and a psychologist under the KSB who serves the various schools throughout the region. When children or youth need to be hospitalized for mental health reasons, they may go to the sub-regional health centres (Inuulitsivik or Tulattavik) or be sent to Montreal to a specialized child psychiatry unit. There are regional rehabilitative services in some Nunavik communities: Salluit, Inukjuaq, Kuujjuaq, and Kuujjuaraapik.

The Kativik School Board coordinates the school programs and the services offered in the 14 Inuit communities of Nunavik. Schools generally have "shadows" (school facilitators) and behavioural technicians for children with learning or behavioural difficulties, as well as a student counsellor. Shadows are often, but not always community members, and are hired to accompany a child or youth on a one-to-one basis. A psychoeducator has been hired by the school board. She offers assessments and follow-up on the school's premises in Kuujjuaq. Depending on each community, the social worker (who works for the hospital under the community social services) may work a day or two a week within the school to offer assessments and follow-ups. Some schools have

adopted the "compassionate school approach," which has three aims: enhance school staff awareness of historical and current traumas affecting students; improve their ability to develop plans to support positive behaviour in schools; and establish a physically and psychologically safe and predictable student environment (Kativik School Board n.d.). Such programs are still being implemented. Some schools have "nurturing classes," which are classrooms where children or youth who have special needs or are exhibiting distress can go take a break in a structured, warm, and accepting environment with diverse creative and educational activities and individualized support. The KSB has also been very active in implementing the Good Touch / Bad Touch program, a regional initiative to prevent sexual abuse, and the Baby Book program, where Inuit parents come together to discuss parenting and family wellbeing.

Finally, it is important to note that the Kativik Regional Government is also responsible for its own police force. In our research, the police were often mentioned as key partners whose presence was deemed crucial in interventions with patients experiencing mental health issues. In some communities police may hold education workshops in school. They work closely with youth protection agents and, because of their role in crisis intervention, they liaise between families and health and social services.

Models of collaboration

In Nunavik, many Inuit families deal with the behavioural and mental health issues of children and youth. Bullying, suicidal ideation, delinquent or antisocial behaviours, and prolonged sadness are some of the difficulties children, youth, and parents may experience. According to our participants, parents themselves do not commonly initiate referrals to psychosocial services. Yet some will request services directly. A number of other institutions may become involved in screening and referring children and youth to health and social services.

Schools are one such front-line setting where psychosocial difficulties can be observed first-hand. Indeed, teachers spend multiple hours a week with children or youths and have a privileged position to observe them in a social context. When difficulties are encountered, the teacher will often refer the case to the student counsellor and the principal. The student can be sent to the nurturing room for short periods of time. In cases of behavioural outbursts the student may be returned home for the day or longer. In cases where school staff are particularly concerned about a child or youth, the principal or school counsellor will generally call or send out a letter to the parents requesting their collaboration. With or without parental involvement, school staff may develop an action plan for the student, sometimes with the involvement of the teacher, the principal, a behavioural technician, and/or a school counsellor. The education committee (elected community representatives) can also be asked by the principal to work with the school when dealing with a situation or a student.

Some schools develop a partnership with the community social worker where the latter might work directly from the school so that students have direct access to these services. In such cases, the social worker can offer follow-up; however, this requires parental consent for children under 14, and such consent is not necessarily easy to obtain. In fact, many participants mentioned that a rupture between the school and the parents is making collaboration at this level quite difficult. The school principal can also submit a request to the school board for a psychological evaluation of a child or youth. A psychologist from the Kativik School Board visits the communities for such evaluations. This being said, many participants spoke of a serious lack of resources in this area and frequent frustrations due to the impracticality of the specialist's recommendations and the disconnect between the recommendations and a northern context.

In cases where school/parent collaboration has not been established, and where the student's behaviours are becoming worrisome or problematic, the school might report the situation to the Department of Youth Protection (DYP). An officer (in Kuujjuaq or Puvirnituq) will assess whether the report is to be acted upon and whether the local DYP worker should conduct the assessment. Stakeholders working for the DYP say that the schools report such cases much too often and beyond the purview of the DYP mandate, the outcome being over-reporting and overloading of the DYP system. In cases where parent/school collaboration is positive, school staff may be able to offer an intervention, or encourage parents to bring their child or teen to the community social worker or nursing clinic for further assessment. However, many participants say that these follow-ups are extremely difficult to carry out because appointments are continually cancelled.

Another context where mental health or psychosocial difficulties of children or youth may be identified is during follow-ups at the nursing clinic. A nurse or doctor may suspect developmental or psychosocial challenges and perform a clinical assessment. A nurse suggested that families "will rarely come in with a psychological complaint. So from the physical you have to kind of deduct, work your way around." Nurses and doctors may work with the CLSC interpreter or a community worker. A few also mentioned working with the community wellness worker for consultative purposes to better understand the needs of the child or youth and the family. Finally, children and youth may be screened during crisis situations following delinquent acts, suicidal crises, or family crises. In such cases, police are the primary point of contact, and they work directly with youth protection, social services, and nursing, depending on the needs and the individuals involved in the crisis.

When attempting to determine which professional services should be taking charge of a situation, service providers may enter into contact with their clinical supervisors in Puvirnituq or Kuujjuaq for guidance. Many participants explained that, due to the lack of community services in most communities, children or youth with behavioural or mental health issues are often referred to youth

protection services, whereas parents are referred to social services. Social service workers, nurses, and youth protection workers generally hold weekly inter-organizational meetings to exchange information on certain cases. A nurse described such meetings:

> We have a meeting once a week with […] Nursing, DYP and social services, where we actually help with action plans. Once we know we have, for example a teen sexual abuse victim and we don't know who, for example, the perpetrator was, DYP is working on the case for example 'cause they might or might not be in the family, we're working on it because there's no psychotherapy, there's no psy [psychiatrist], so often what we need to do with the patient is a nurse would see him once a week to […]. I can't really call it a therapy session […].

Once DYP workers, nurses, or general practitioners suspect a mental health problem, the child or youth can be placed on a list for psychological, pediatric, or child psychiatric assessment. He or she might be seen during the specialist's next visit to the community or be flown out to a neighbouring community. The medical specialists offer consultations at the nursing station, while also favouring more integrative community-oriented approaches. Indeed, some pediatricians have been offering consultations at community "family houses" and daycares. Child psychiatrists and pediatricians generally try to work with a variety of professionals during their short stay in the community, including other doctors, nurses, youth protection workers, social workers, interpreters, community workers, school staff, family members, and the child or youth. However, multiple factors make it difficult to meet all of these people simultaneously. As a doctor explained, some will use more coordinated approaches to the evaluation process:

> At first, I would have liked to do something more akin to what is done in the South, that is, consultations where partners are present so that we reflect on the situation together. In the North, people tend to be placed in emergency situations, making them less available. Therefore, I am doing more "step by step" collaborations. I see a family or a youth, then I discuss with the social services, the DYP, the physician, and then with the nurses who play a really important role.

Following their stay, child psychiatrists are often available for phone consultations or telehealth consultations (a resource still in development) and are pro-active in their follow-up by calling community professionals to ensure coordination of care. A nurse shared her experience of working with psychiatrists and general practitioners, "Work relations are pretty good here because when they [the general practitioners and specialists] are here, we work closely with the teams. When they are not here, they talk over the phone. I must say we, the nurses, are privileged here because we are highly respected by doctors, since we are both their eyes and ears. We were thus able to develop such good collaborative relations."

When a child or youth experiences behavioural or psychiatric crises, he or she may be sent to Montreal either for an outpatient consultation with a child psychiatrist or for hospitalization. When sent to Montreal for these reasons, hospitalization is frequent. Following the stay, an assessment and action plan will be sent to the community nursing station. However, as described by a nurse, often times the action plan involves services and resources that are unavailable in the community, and the care is offered by people who feel under-trained:

> It is because A, we don't necessarily have the training for it. We don't have the time for it either. […] Like someone who is shut down and doesn't speak, who walks into your office and plays on her iPhone for half an hour and then doesn't want to open up, then when you don't have tools and the training […]. We have, I don't know […] 10, 12 patients in the waiting room, waiting for whichever reason. And we can't take more than that half an hour (with a patient). So basically you're putting them back in the street with no improvement.

A medical professional similarly pointed to lack of follow-up after a psychiatric assessment, especially for teens. "You send them down [to Montreal] to the external clinic but you don't know what kinds of services they received, it's vague […]. The child psychiatrist who comes here makes suggestions, but you don't know if it was followed. Are there people to put all of that in place? No, nothing at all." A nurse offered similar thoughts: "The problem we have with these plans, it's nice we meet but there's rarely action plans that are being followed, because once we discuss the issues, we know they're there, we know who's responsibility it is, but after that there is no infrastructure that allows us to work on the issues."

Too often, because human resources and prevention services are lacking, overextended staff must go beyond their mandates and schedules to offer services they are not trained for to reduce the risks of families going through such crises. Unfortunately, lack of resources also means less prevention and more intervention in crisis situations. In communities where people have neither a specific mandate nor the training for follow-up or mental health intervention, youth mental health or psychosocial difficulties may be "controlled" rather than treated. As a mental health nurse remarked, "In villages where there are no isolation rooms, suicidal patients end up in prison, with policemen dealing with them. It's like a ball game, with patients thrown from one side to the other." A social worker shared her frustration with the current situation, feeling unable to offer the type of service she would like to provide, "Because I'm alone, I must deal more with the clients who are judiciarized and who must come to us because of a court order. They have to come to the social services each week. It ends up being like we are serving the court but we're not a customer's service. As a result, because of that, it's like a punishment to come to social services."

Challenges to collaboration

Many participants described a major challenge to collaboration: ruptures in communication of information and a feeling that other organizations did not understand one's job duties. Many spoke of lacking relevant information for clinical decision-making. These ruptures in information were often linked to issues around "confidentiality." A teacher spoke of how little information teachers can get on the psychosocial needs and history of children in their class:

> I took the time to open the files of all my 20 students to look at their school experience. I have their marks and all, but when it comes to their behaviour, I don't know if there were interventions. Were there plans? What worked and what didn't? No trace was kept. Since I found nothing at school concerning some students, I asked the social worker as well as Youth Protection in order to have access to information, but I was told it's confidential.

Similarly a nurse reported, "There are also people who keep information to themselves. They say: 'listen, it's my patient I don't have to tell you about him/her.' They use confidentiality, but […] not very well. They're gonna give you information and then tell you, 'I actually didn't tell you that.' It's really bizarre." Another nurse explained that medical care, social services, and youth protection services keep separate patient charts. This is because each professional has a different role and is bound by patient confidentiality. Non-circulation of information is a major challenge to delivery of quality care. As an example a doctor said:

> Youth Protection can't give us information. We're obliged to give them information at a certain level. But they can't share information. So basically it cuts collaboration. It would be nice though when they place a child in another village, they communicated with the healthcare system to find out the health needs for the children and to make sure that the appropriate follow-up is put in place. Because they do place children whose medication stopped when they put a child in the next home.

A doctor also explained that parents work around the lack of coordination between mental health services: "[…] for coordinating and also for speaking for the child. Like 'You sent me for that specialist but that wasn't the one I needed. What I needed was this.' So when there's that kind of empowerment and ability, then those people really do best."

Because of ongoing frustrations with ruptures in communication, consultants and clinical directors have attempted to bring service providers to sit around the same table and discuss various issues and inform everyone about their respective job duties. These discussions have been viewed as being quite positive and will hopefully enhance collaboration. Many participants believed in principle that ideal collaborations are integrative (i.e., characterized by inter-disciplinarity),

have less of a hierarchy between service providers who make decisions together, and take a more patient-centred approach (see Boon et al. 2004). They agreed that various attempts were being made to ensure greater coordination and integration of services. However, in practice, as participants observed, these initiatives face a variety of challenges to their sustainability: their dependence on specific individuals; high staff turnover; busy schedules; frequent crisis situations requiring the few available service providers to be on clinical duty; and frequent and long vacations by staff. Moreover, having everyone sit around the same table can increase existing tensions. Such tensions have a variety of causes: repeated differences in perspectives on what to do with certain situations; conflicts over roles and mandates of different services; personality clashes; power differentials related to the perceived status of patients' needs, race and language. Sharing a table with people with whom tension already exists can also worsen and aggravate interpersonal problems, increase mistrust, and cause communication breakdowns. These problems were mentioned primarily by front-line workers and teachers. A teacher described the dynamic in a school:

> There are a lot of people. You can notice the dynamic as well. Often, you'll have a more Francophone corner, another one which is more Anglophone, and then one where the Inuit sit. Sometimes, it's a bit more mixed, but you still feel the existence of such divisions during the meetings. There are a lot of tensions and it affects our interactions. I think we've reached a point where there often are things we'd like to say, but we don't know to whom we should tell them or if we would dare to say them. […] when things become more interactive, most of the time things turn a little aggressive.

Participants spoke of a major impediment to collaboration: "problematic people" with whom it would be difficult, if not impossible to collaborate. These tensions led to gaps in communication and gaps in services for children. Such interpersonal or inter-organizational problems led to a widespread feeling of disempowerment and frustration. A doctor explained:

> You know, you start feeling a lack of power at a certain point in time when you are in front of people who have been around for 20-25 years. […] and there is a proverb that says that collaboration happens between people, collaboration beyond individuals […] well some people are going to have to be put in their place so that this [collaboration] can start happening.

Another doctor said that the problem with integrative collaboration was that once plans had been made, very little could rectify the situation if people did not put the plans into action. This is partly because many practitioners must operate within separate clinical administrations and because management must comply with legal considerations. Hence when problems arise in community collaboration there rarely is an individual in the community with the mandate

or the legitimacy to address, resolve, or mediate them. Practitioners can only refer to their immediate superior who is often times outside the community and has no say in the actions of other practitioners.

Participants felt that community representatives, or some broad form of "community" could potentially help orient decision-making, as noted by a general practitioner, "In an ideal world it would be good to have the community mobilized. Because we are really powerless when facing problems of mental health which are often more related to psychosocial problems than to anything else." Such an opinion also clearly appeared in a school principal's words, "If you put the services at the periphery of the community, each person will stay on their territory and defend it. All services should be at the centre of the community. We all serve the community. (Interviewer: But are they at the centre of the community)? No (Interviewer: So what is in the centre?) Emptiness. It is empty."

Some participants referred to the lack of power that community representatives or committees might face when attempting to create change. During our interviews, community members were generally not included in inter-organizational meetings. For example, a clinical director remarked, "At our meetings, it's often only White people meeting. We'd have to integrate local workers in our collaboration. We think we understand, that we're going in the right direction, but we don't always have a good understanding of the local issues [...]. We have to integrate culture in our collaborations."

Discussion and conclusion

In December 2015, we were sitting at a long plastic foldable table, one of the many items donated to the Tasiurvik Family House in Kuujjuaraapik, the first of the *Ilagiinut* project's community-initiatives. Looking at the specific objectives for 2016, four objectives were prioritized, one of which being collaboration with local services. Just as service providers seem to crave community/service collaboration, community members are wishing to be heard by service providers. After reflecting on what service providers tell us, what can we learn? What can we share with community members? We see so many ideas, projects, and initiatives. Collaboration and services are very much alive. Participants do not seem to see complete silos; however, they do see gaps in services and resources, as well as obstacles to different forms of collaboration. Many collaborations depend on the good will of individuals, but this good will is weakened by interpersonal difficulties, inter-organizational disagreements, a hierarchical organizational structure, and high turnover. To address some of these obstacles, people are innovating to create strategies for communicating and thinking outside the box.

We noticed at least two major areas of discrepancies between ideal and current collaborations. First and foremost, participants seem to desire integrative collaboration where stakeholders sit around a table and share information and decision-making on youth and children. However, if we compare the participants'

descriptions of current collaboration with Boon's (2004) models of "teamwork," we see they are primarily focused on communicating basic information on clients, as well as discussing the roles and mandates of services. These exchanges seemed to be more in line with what Boon (2004) might describe as "consultative" and thus the first stages of "collaboration." Second, within these idealized models of collaboration, "community" and, more specifically, the parents of youth were at the centre, defining priorities, ensuring links with services, attending appointments, and asking for preventive support. Community was described almost as a "saviour" in a situation where service providers feel overwhelmed, overworked, and undertrained to offer the complex support required for Inuit children and youth who present behavioural and mental health problems.

There are gaps between what is hoped for and what is possible at the current time, and these gaps seem to leave traces of despair and disempowerment in many service providers. The frustrations appear to infiltrate into interpersonal and inter-organizational relationships. How can we build around the gaps and on the strengths in order to move towards the ideals of collaboration hoped for by our participants? In our own fieldwork and attempts to strengthen collaboration between services, we found that moving too quickly towards integrative care could exacerbate tensions amongst stakeholders. Interpersonal and inter-organizational relationships seem emotionally charged in a context where demand for services is high, where there is a history of colonization, and where ongoing power differentials separate Inuit from non-Inuit. Indeed, as described by participants, and as experienced in the field, when attempting to seat all stakeholders around a table, the tensions were palpable and could feel violent to those who were not used to speaking up. Exchanges had a potential for quickly falling into direct or indirect (post-meeting) blame games and attempts to defend oneself or shut things down completely. Moreover without case management and therapeutic care, service providers were burning themselves out attempting to fill the void and having to respond to crisis situations that might have been avoided with greater follow-up.

Perhaps integrative collaboration could be planned as a long-term goal with a stepwise approach that is communicated transparently to all staff within organizations. To obtain integrative mental health care services, the structure must move from being hierarchical to becoming horizontal. This can take years to do, as it requires strong local leadership, organized spaces, and mechanisms where this leadership can have a voice. It also demands greater local resources, especially prevention, and psychosocial supports. As these steps are slowly being taken, more coordinated approaches may be favoured. Indeed, in our interviews, participants who felt positive about collaboration often spoke of first trying coordinated approaches and reaching out to individuals one-by-one. A recent meta-analysis of data from rural and remote communities of Australia confirms that coordinated approaches are sometimes more realistic than integrated approaches (Wakerman et al. 2008). To enhance this first big step towards improved collaboration, truly coordinated services require a case manager—a

person whose mandate is to create links between all services and the family to put an action plan together and ensure it is carried out (Boon et al. 2004; Mueser et al. 1998). Research suggests that when clients build positive alliances with case managers, care is more effective (Howgego et al. 2003).

A first step for *Ilagiinut* will be to create spaces for communication between the services and the community where community members will meet to strengthen their collective voice and invite service providers individually in order to initiate dialogue and share a community vision of mental health care. These efforts must be accompanied by regional-level support relaying community experiences to regional representatives and then back to the community. "Collaboration coordinators" might be necessary to take charge of these local/regional communication channels. In our fieldwork, and as described by community partners, we have also noticed that such service/community collaboration requires going beyond "the invisible leash" of institutional mandates. Although examples of going beyond one's mandate were described in interviews as happening during emergency situations or when one is confronted with court-mandated deadlines, they were rarely discussed as happening to prevent problems or to engage the community. As mentioned by a local leader, moving towards ideal collaboration will require many local and regional stakeholders making sacrifices for a common vision of collaboration and community empowerment. A first step will be to ensure that the vision is shared and understood by all institutions and by all personnel who serve the communities.

Acknowledgments

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