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# CONTEXTUAL STUDY OF MENTAL HEALTH SERVICES IN NUNAVIK

INSTITUT NATIONAL DE SANTÉ PUBLIQUE DU QUÉBEC



CONTEXTUAL STUDY OF MENTAL HEALTH  
SERVICES IN NUNAVIK

DIRECTION RECHERCHE, FORMATION ET DÉVELOPPEMENT

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Louise, Lily et Malijaï



## HIGHLIGHTS

This section summarizes the information gathered from research participants as well as the documentation review.

1. Mental health is identified as an intervention priority in the region for the past several years.
2. Few statistics are available on the state of mental health of Nunavik Inuit. Most participants however agreed that mental health problems are on the rise.
3. Several factors appear to affect or aggravate Inuit mental health problems, including the cultural discontinuity, lack of housing, drug and alcohol use, lack of population knowledge about mental health problems, chronic socio-economic difficulties and unemployment.
4. Key targets identified for an eventual mental health program are youth and men. Individuals suffering from serious mental health problems would also benefit from better follow-up aimed at social reintegration. To this date, few initiatives have been undertaken in Nunavik to help individuals who suffer from common mental health problems such as depression or anxiety disorders.
5. The different population distribution between Hudson and Ungava partially explains the differences in services organization between the two coasts. In Ungava, services tend to be grouped around Kuujuaq, while in Hudson, services are spread geographically towards the communities.
6. The agreement between Nunavik and the CHUM (Notre-Dame Hospital), the Reintegration Centre of Inukjuak and the Crisis Centre of Puvirnituk constitute the most important mental health developments in Nunavik over the past 15 years.
7. Factors leading to hesitation by individuals in calling upon the services offered in the communities include: lack of adequate services to meet needs, mistrust regarding the efficacy of psychosocial interventions and risk of being labeled in these small communities.
8. In general, crisis situations require the involvement of health and social services staff. These situations mobilize numerous resources and drain local teams. Implementing mental health prevention activities and better clientele follow-up could contribute to a decrease in the number of such situations. However, reliance for these services on primary health and social services staff remains problematic, since their responsibility is first and foremost to respond to emergencies and ensure the day to day running of the clinic.
9. The collaboration between programs should be maximized in order to intervene with individuals who have a combination of dependence problems (drug, gaming, alcohol) and mental health or intellectual impairment and to enable the transition between youth and adult programs.
10. Local staff are at times called on to intervene with relatives. Some employees may also be dealing with personal difficult situations. There is little personal support for health and social services staff in Nunavik in this regard.

11. Participants agree that interdisciplinary collaboration is an essential attribute to offering quality services in mental health. Collaboration is however compromised by several factors: resource instability, an absence of structured communication channels between health, social services and community resources staff and holders of traditional knowledge, confusion in the exercise of leadership, mutual lack of knowledge of roles and mistrust from all sides.
12. The integration of traditional resources is aimed at diversifying the services offering. There is an urgent need to document the knowledge before their holders disappear. Together, the non-Inuit health and social services staff must learn better mastery of the cultural issues and become better informed about community initiatives and resources. That it would be useful to integrate a cultural counsellor into the healthcare teams.
13. Group approaches are particularly effective in terms of intervention aimed at improving self-esteem or dealing with collective trauma. These approaches are, however, less suitable to a mental health clientele where an individual approach is more appropriate.
14. There is a significant need for training in mental health among local health and social services teams, especially with regards to screening and mental health problems, treatment, traditional and culturally adapted approaches, follow-up, readaptation, and social reintegration of individuals with mental health problems. Specifically, the intermittent presence of psychologists and psychiatrists in the territory appears to diminish the support of local teams.
15. Collaboration between Nunavik and the CHUM (Notre-Dame Hospital) for adult psychiatric services is at times compromised by an absence of standardized admission procedures, difficulty in reaching the psychiatrist on call and lack of knowledge of the northern context by some social services staff in Montréal. Furthermore, the fact that the CHUM offers no structure for the transition from Montréal hospital setting to Northern residence increases the risk of relapse. The number of beds in psychiatry (2) available at the CHUM is judged insufficient for the needs of Nunavik.
16. Several promising programs of mental health problems prevention and mental health promotion have been abandoned over the years due to lack of financing, turnover of personnel and changes in priorities. Anchoring these programs within the community would encourage Inuit empowerment and correspond more to their collective values.

## TABLE OF CONTENTS

<b>LIST OF ABBREVIATIONS.....</b>	<b>VII</b>
<b>1 PROJET DIALOGUE .....</b>	<b>1</b>
<b>2 CONTEXTUAL STUDY IN NUNAVIK .....</b>	<b>3</b>
<b>3 CARVING UP THE TERRITORY FOR HEALTHCARE SERVICES.....</b>	<b>5</b>
<b>4 MENTAL HEALTH IN NUNAVIK .....</b>	<b>9</b>
<b>5 NUNAVIK’S MENTAL HEALTH PLAN OF ACTION .....</b>	<b>11</b>
<b>6 NUNAVIK’S MENTAL HEALTH RESOURCES.....</b>	<b>13</b>
6.1 Primary care mental health services .....	13
6.2 Psychological services .....	15
6.3 Psychiatric services .....	15
6.3.1 Psychiatry in the Nunavik settlements .....	15
6.3.2 Visiting psychiatrists.....	16
6.3.3 Hospitalization in Montréal.....	17
6.3.4 Telepsychiatry .....	19
6.4 Readaptation services .....	19
6.4.1 Anaraaluk Reintegration Centre (Inukjuak) .....	19
6.4.2 Aaniavituqarq Crisis Centre (Puvirnituuq) .....	20
6.4.3 Supervised apartments and host families .....	21
6.4.4 Detoxication services .....	21
6.5 Tertiary care services .....	22
6.6 Prevention and promotion programs in mental health.....	22
6.7 Self-help groups and community services.....	23
6.8 Traditional and religious approaches.....	24
6.9 Degree of integration of primary care services.....	25
6.10 Degree of integration between primary, secondary and tertiary care.....	26
6.10.1 Integration between primary and secondary care in Nunavik .....	26
6.10.2 Integration between Nunavik and the CHUM.....	27
<b>7 PROJET DIALOGUE : FUTURE STEPS .....</b>	<b>29</b>
<b>REFERENCES.....</b>	<b>31</b>



## LIST OF ABBREVIATIONS

<b>Abbreviation</b>	<b>Definition</b>
CBHSSJB	Cree Board of Health and Social Services of James Bay
CHUM	Centre hospitalier de l'Université de Montréal (Université de Montréal's Hospital Center)
CLSC	Centre local de services communautaires (Local community services centre)
CSSS	Centre de santé et des services sociaux (Health and social services center)
INSPQ	Institut national de santé publique du Québec
ISP	Individualized Service Plan
JBNQA	James Bay and Northern Québec Agreement
KRBHSS	Kativik Regional Board of Health and Social Services
MSSS	Ministère de la Santé et des Services sociaux (Minister of Health and Social Services)
NNADAP	National Native Alcohol and Drug Abuse Program
NRBHSS	Nunavik Regional Board of Health and Social Services
RAMQ	Régie d'assurance maladie du Québec (Québec healthcare insurance system)
RUIS	Réseau universitaire intégré de services (Integrated University Health Networks)



# 1 PROJET DIALOGUE

Projet Dialogue research program focuses on the organizational and contextual factors that influence the quality of primary care mental healthcare services delivered by teams of professionals working in Centre de santé et des services sociaux (CSSS). Specifically, this four-year project is designed to assess the impact of the effects of the Québec's mental health action plan (*Plan d'action en santé mentale 2005-2010: La force des liens*), developed by the Ministère de la Santé et des Services sociaux (MSSS) that suggests that the changes brought about in mental health services are firmly rooted in the heart of the reforms that led to the creation of the CSSS and the establishment of local services networks. This research program is jointly under the direction of the INSPQ's D<sup>r</sup>. Louise Fournier, PhD, in the capacity of principal researcher, and the MSSS's D<sup>r</sup>. André Delorme, M.D., in the capacity of principal decision-maker. Many other researchers are also contributing to the completion of this program.

Project Dialogue was initially designed to target 15 CSSSs and their local service networks. In the summer of 2006, the Aboriginal Health Unit of the INSPQ, in partnership with the Nunavik Regional Board of Health and Social Services (NRBHSS) and the Cree Board of Health and Social Services of James Bay (CBHSSJB), requested that the research program be broadened to include the northern regions referred to as Nunavik and Iiyiyiu Aschii (Terres-Cries-de-la-Baie-James). This initiative was motivated by concerns formulated by the partners in these regions and documented in the scientific literature regarding the suboptimal conditions of access to healthcare and the continuity of care provided to individuals with mental illness living in remote First Nations and Inuit communities due to a combination of geographic, cultural and organizational variables. The objective therefore of the northern part of Projet Dialogue is to identify the approaches and organizational structures best suited to promoting access to mental healthcare services and continuity of the care for individuals living with mental health problems in the regions of Nunavik and Iiyiyiu Aschii.

This research program features three phases: a contextual study (conducted in 2006-2009); an organizational review (2008-2009) and a clientele study (2009-2010) as well as knowledge transfer component (2007-2010). This report presents the findings of the contextual study in Nunavik based on a series of focus groups conducted during January 2007. The information will be updated during future visits by the research team to the North. The findings of the results for Iiyiyiu Aschii appear under separate cover in a report that is available on the INSPQ website and on the Projet Dialogue website : [www.inspq.gc.ca/dialogue](http://www.inspq.gc.ca/dialogue) [1].



## 2 CONTEXTUAL STUDY IN NUNAVIK

This report describes the evolution of mental health services offered to adults in Nunavik over the course of the past 15 years. A knowledge of the context is essential to an understanding of the current organization of mental health services and its impact on clientele. This report is intended primarily to be descriptive rather than analytical with regard to the context of the mental health services. We begin with an overview of the health services' territorial divisions, followed by a brief description of the Nunavimmiuts<sup>1</sup> mental health situation. We then offer a description of the various mental health services, resources and level of integration.

The many sources of information for this report include the following : communications with the responsible for the mental health program of the NRBHSS, who act as the local Projet Dialogue respondent in Nunavik, plus a documentation review of the many reports, articles and other documents produced by the various Nunavik and provincial organizations. Invaluable information was also collected from interviews with some twenty participants from the Inuulitsivik Health Centre (Hudson's Bay) and the Tulattavik Health Centre (Ungava Bay) and their respective CLSC services points during two focus groups. Participants were identified and recruited by the local Projet Dialogue respondent in Nunavik at that time (Mrs Maureen Cooney) and by local authorities in each of the communities. The focus groups were held in Kuujjuaq on January 25 (Tulattavik), 2007 and in Puvirnituaq on January 27, 2007 (Inuulitsivik)<sup>2</sup>. The information was completed with some local key informants. In view of the richness and the complementary nature of the information brought to the discussion by both groups of participants, we have elected to produce a conjoint report. We have nonetheless clearly identified quotes and specific situations for each coast.

In August 2007, the information compiled from the focus groups was recorded and returned to participants for validation. This document also takes their comments into consideration.

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<sup>1</sup> Inhabitants of Nunavik.

<sup>2</sup> Other Nunavik communities will be visited (interviewed) in subsequent research phases.



### 3 CARVING UP THE TERRITORY FOR HEALTHCARE SERVICES

The portrait of the Nunavik Inuit communities has changed profoundly during the past century. At the turn of the 20<sup>th</sup> century, the Inuit people were still essentially nomadic and living in family clans. These family groups gradually came to settle around the missionary camps and the Hudson's Bay Company outlets, until during the 1950's and 1960's, the sedentarization was concretized as federal social and economic development programs for the arctic regions were put into place. These programs were intended to provide the Inuit with the benefits of the same services offered to the rest of the Canadian population. Schools and dispensaries (nursing station) were built gradually at that time in each village.

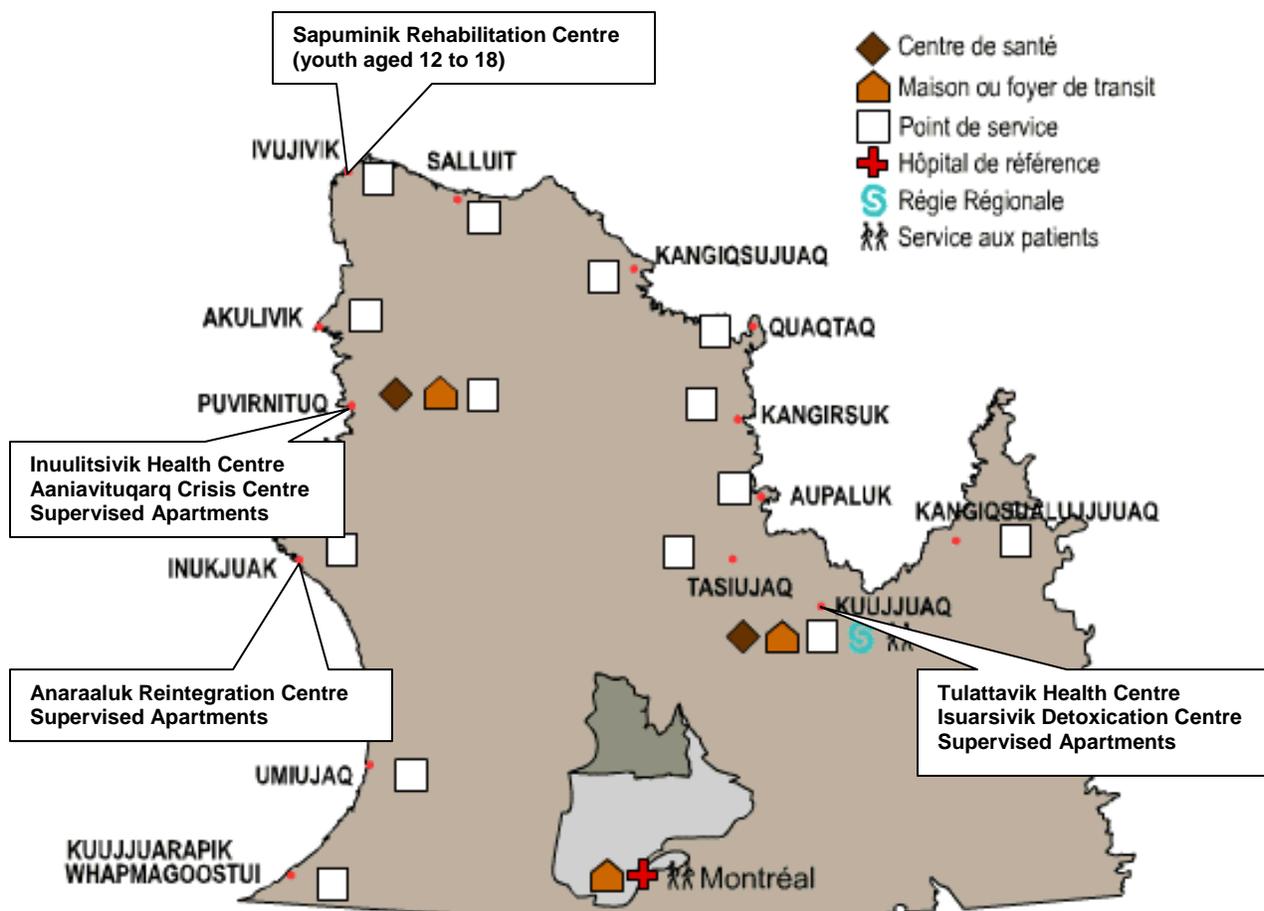
In 1975, the governments of Canada and Québec, Hydro-Québec, the Société de développement de la Baie-James (James Bay Development Corporation) and the Société d'énergie de la Baie-James (James Bay Energy Corporation) signed the James Bay and Northern Québec Agreement (JBNQA) with the Cree and Inuit peoples. This Agreement provided for a grant amount totalling \$225 million dollars in indemnities for the use of their territories [2]. It enabled the signing native peoples to exercise political, economic and social control over their territories. In 1978, the Kativik Board of Health and Social Services (KBHSS) was created in Nunavik with a mandate to improve public health in the region and to supervise the organization of health services and social services offered to the Nunavimmiuts. In 1996, the healthcare and social services functions of the KBHSS were transferred to the new NRBHSS [3, 4]. The healthcare services in Nunavik are presently therefore under the jurisdiction of the MSSS, although contribution agreements exist with Health Canada for the funding of specific programs. Nunavik is the 17<sup>th</sup> socio-sanitary region of Québec.

As a regional entity, the NRBHSS is responsible for the organization of services and the evaluation of the effectiveness of programs developed by the MSSS and the quality of services offered to the population of the 14 Nunavik communities: Kuujjuarapik, Umiujaq, Inukjuak, Puvirnituk, Akulivik, Ivujivik, Salluit, Kangiqsujuaq, Quaqaq, Kangirsuk, Aupaluk, Tasiujaq, Kuujuaq and Kangiqsuallujuaq. The NRBHSS must collaborate closely with the MSSS and the representatives from the two regional health centres, the Tulattavik Health Centre in Kuujuaq and the Inuulitsivik Health Centre in Puvirnituk, in order to develop the healthcare and social services for the populations of Nunavik [3]. The NRBHSS also has the responsibility for allocating budgets for the two centres and their CLSC services points.

The two Health Centres (Tulattavik and Inuulitsivik) are intended to provide short and long term hospital services. They are also responsible for the administration of the readaptation centres for youth with adaptation difficulties (Group Home) in Kuujuaq, Puvirnituk and Salluit. Given the communities' geographic isolation, each is provided with a CLSC services point that offers its population primary health and social services of a curative and preventative nature as well as youth protection services [5]. Figure 1 illustrates the healthcare installation locations of the region. The administration of the Ungava CLSC services points (from Kangiqsujuaq to Kangiqsuallujuaq) is the responsibility of the Tulattavik Health Centre in Kuujuaq while the Hudson CLSC service points (from Kuujjuarapik to

Salluit) fall under the responsibility of the Inuulitsivik Health Centre in Puvirnituaq. In addition to the two Health Centres and the 14 CLSC service points, three other regional infrastructures serve the entire population of Nunavik: the Anaraaluk Reintegration Centre in Inukjuak, the Aaniavituqarq Crisis Centre in Puvirnituaq and the Sapuminik Rehabilitation Centre in Salluit for young offenders aged 12 to 18.

Figure 1. **Nunavik healthcare installations**



Source : <http://www.rrss17.gouv.qc.ca/fr/services/>.

On the Ungava coast, the Tulattavik Health Centre serves 4,675 individuals, of which almost half live in Kuujjuaq [6]. On the Hudson coast, where Puvirnituaq, Salluit and Inukjuak are the most populated communities, Inuulitsivik serves 6,169 individuals. This unequal population division between Hudson and Ungava explains in part the differences in the services organization between the two coasts. Ungava services tend to be centralized around Kuujjuaq, whereas Hudson services are more decentralized towards the communities [7, 8]. The Nunavik population distribution for each community is presented in Table 1.

**Table 1. Population of the Nunavik communities**

	<b>Communities</b>	<b>Population in 2006</b>
HUDSON	Kuujjuarapik	568
	Umiujaq	390
	Inukjuak	1,597
	Puvirnituq	1,457
	Akulivik	507
	Ivujivik	349
	Salluit	1,241
UNGAVA	Kangiqsujuaq	605
	Quataq	315
	Kangirsuk	466
	Aupaluk	174
	Tasiujaq	248
	Kuujjuaq	2,132
	Kangiqsualujjuaq	735
	<b>TOTAL Nunavik:</b>	<b>10,784</b>

Source: 2006 Census data, Statistics Canada [6].



## 4 MENTAL HEALTH IN NUNAVIK

It is difficult to know the incidence of mental health problems in Nunavik due to the paucity of standardized statistical reporting in the area of primary healthcare and social services [7, 9, 10]. Nonetheless, the participants of both discussion groups had observed an increase in cases over the past ten years. In their opinion, the prevalence of mental health problems is also greater on the Hudson coast than on the Ungava coast. Individuals suffering from these kinds of problems are also of an increasingly young age. The mental health problems reported are mainly schizophrenia, bipolar disorder, depression, anxiety and panic disorders, disorders stemming from substance abuse, post-traumatic stress disorder, foetal alcohol syndrome, learning difficulties and problems due to organic causes [4, 9]. The incidence of suicide, often considered a symptom of mental health, is worrisome in Nunavik. The suicide rate is the highest in Québec and represents up to 24% of deaths, roughly 10 times greater than elsewhere in the province [12]. Suicide also touches four times more young men than women. On the Hudson coast, the number of suicides is three times greater than on the Ungava coast [11, 12].

According to the individuals we met with, mental health is a regional intervention priority. The groups mainly targeted are youth, especially young men, who are more affected by suicide, families, the older age group, and the handicapped [3, 12]. According to group discussion participants and the documents consulted, several factors contribute to the aggravation of mental health problems in Nunavik. First, rapid cultural changes constitute major collective stressors. Many individuals, in particular the older age group, are still troubled by the years spent in residential schools, the epidemics of Spanish influenza and the forced relocations of Grise Fjord and Resolute Bay [9]. Furthermore, according to the group discussion participants, geographic isolation, lack of future prospects, such as employment or postsecondary studies, may also contribute to disorientation and depression for certain individuals.

“There is nothing for these young adults. If they aren’t working, they have nothing much else to do, other than watch satellite TV or maybe gamble.”

Tulattavik Participant

Another risk factor for the mental health of the Nunavimmiuts is alcohol, drug and solvent abuse. These behaviours also contribute to the emergence of social problems such as conjugal violence, parental negligence, absenteeism from work and school and poverty [10, 13]. Foetal alcohol syndrome also is a concern due to the developmental problems that it causes. There is however little data on the prevalence of this problem in Nunavik [4].

“There are a lot of drugs in the houses and the situation is getting worse. The children see their parents doing drugs and do the same, and it’s the same with cigarettes and alcohol. What happens when people just want to do that and stay in their homes?”

Tulattavik Participant

According to participants in both discussion groups, the social integration of individuals living with these types of problems is hindered by the population's lack of knowledge concerning mental health and by the taboos surrounding the subjects of mental health and suicide [9, 11]. Some participants in the Tulattavik group discussion mentioned that doctors and specialists should be careful when formulating their diagnosis since some individuals, especially young people, may suffer when given this label. A lack of support is also identified as a risk factor since it is associated with specific criminal acts and social problems [14]. Recent data show that assault, sexual abuse, driving under the influence of substance use and break and enter infractions increased between 2001 and 2005 [15]. Other risk factors hindering the Nunavimmiuts' mental health are identified by participants of both groups and the documentation : a lack of knowledge by the population about mental health services offered, mistrust on the part of some individuals regarding the quality of these services, and insufficient culturally adapted tools that primary care healthcare and social services intervention staff have access to which allow them to screen, follow and treat individuals with mental health problems [10]. Finally, several participants affirm that the organization of current health and social services takes for granted that the families play an active role in the responsibility for individuals with mental health problems. However, the family does not always offer the necessary structure and security in the context of overpopulated housing, disruption of traditional roles of family members and the widening intergenerational gaps [3, 7, 9, 13, 14, 16].

## 5 NUNAVIK'S MENTAL HEALTH PLAN OF ACTION

Since 1989, a series of mental health plans of action have proposed solutions to meet the needs of the population and attempted to adapt the goals of the MSSS to the Nordic context. The reach of the action plans seems however to have been somewhat restricted, for several reasons including: a lack of financing related to the accumulated deficits of both health centres, non-renewal of budgets, instability due to the high turnover of personnel, the high cost of hiring new staff and a glaring lack of housing for health and social services staff and their families. Added to this is the absence of quantitative data on the loss of life and morbidity associated with mental health problems and the combination of mental health problems and addiction [17]. Applying the ministerial recommendations for adapting the plan is still problematic.

“The risks of misunderstandings and non-relevance are considerable when you borrow a model of services adapted to a given society and transfer them to a completely different cultural context.”

KBHSS, 1991 [13]

In 1991, a first mental health plan of action was developed in Nunavik by the NRBHSS in response to the mental health policy adopted by the Québec government two years earlier [13]. This plan highlighted the importance of developing and offering services based on an overall approach and anchored in the community. Its main orientations were centered around the integration of mental health services to form a coherent system of services adapted to the needs of the population. These services were meant to respond to the increase in psychosocial problems, promote health and well-being and foster community development and participation. A consultative committee – *Isumannaanirmut Katimajitt* – was created at the time with the purpose of evaluating mental health needs and developing recommendations on the establishment of regional services [13]. In 2000, a new plan that focused on the challenge of physical and mental handicaps was tabled. In 2003, a report proposed a series of measures and actions to facilitate interventions with individuals with intellectual or physical deficiencies. In 2005, a new mental health plan of action responded to the goals of the MSSS plan of action of 1998 that was designed to consolidate the community interventions. More recently, in 2006, a committee for the organization of services was set up by the NRBHSS to develop a preliminary version of an overall regional plan of action and to propose a model of organization of services. This committee compiled a descriptive list of primary, secondary and tertiary care services and community organizations as well as service agreements based on information catalogued in Québec government documents. All of the information collected was assembled in a document entitled *NRBHSS 2006 Offer of services*. A section devoted to mental health outlined the prevention and promotion activities, the primary, secondary, and tertiary care services of the mental health program for specific population targets (children, youth, adults) for each coast [18].



## 6 NUNAVIK'S MENTAL HEALTH RESOURCES

Mental health services are offered by resources in primary care (general practitioners, nurses and social services staff) and supported by resources in the fields of psychology, psychiatry, readaptation, mental health prevention and promotion, and resources using traditional healing approaches. Overall, participants of both discussion groups agreed that the services in Nunavik have improved over the past ten years. A number of factors have contributed to these improvements: the advent of renewable financing for the Anaraaluk Reintegration Centre created in 2000, the agreements signed for the pediatric psychiatry with Montréal Children's Hospital and with the CHUM (Pavillon Notre-Dame) for adult psychiatry, the renovation of the isolation rooms in the Hudson Bay CLSC services points, the creation of the Puvirnituk Crisis Centre in 2005, as well as specific training offered to the health and social services intervention staff in Nunavik by the Douglas Hospital few years ago. Despite the recent improvements, mental health resources are still inadequate to meet the needs of the population [14]. Only the intervention staff from the reintegration centres, crisis centre and visiting psychiatrists are specifically dedicated to mental health. Furthermore, the documents consulted and focus group participants deplored the lack of services for individuals suffering from common mental health problems, young people and individuals with suicidal tendencies [10].

### 6.1 PRIMARY CARE MENTAL HEALTH SERVICES

Primary care nursing and social services are offered in each of the 14 Nunavik communities and include health services prevention and promotion, community health programs, general healthcare services, supervision of chronic health problems, homecare services and around-the-clock emergency services [18]. In some communities, pre-hospitalization emergency services, administered by the municipalities, are also available. The integration of the municipalities' first responder teams and the CLSC service points teams is in the process of being developed [7, 8]. Where pre-hospitalization teams are absent, primary healthcare teams ensure services delivery.

The organization of healthcare services in Nunavik plans for taking in charge of individuals suffering from common mental health problems by the health and social services intervention staff. They are called on for screening, evaluating individuals with mental health problems and ensuring follow-up. When needed, clients are referred to the general practitioners. General practitioners are generally on site in the more populated communities of Kuujuaq, Salluit, Puvirnituk, Inukjuak and Kuujuarapik. In the other communities, a general practitioner visits a few days per month and the local intervention staff have access to non-local medical coverage during his absence through contact by telephone with general practitioners situated in other communities. In some communities, the nurses and social services staff can refer an individual directly to the psychiatrists when they visit the north.

The development of social services and the department of youth protection on both coasts was begun during the 1990's. The organization of social services differs between the two coasts. On the Ungava coast, a social worker and a human relations agent are available full-time in each community, working in collaboration with an Inuit social assistant who receives

professional support. All three individuals can offer youth protection services and CLSC social services [18]. On the Hudson coast, youth protection services and social services are separate and distinct and offered through a social worker or a human relations agent. The Inuit who work for these services are called *community workers* [18]. Public curator services, generally offered by the social services staff, were initiated by the two hospital centres in 2002 to facilitate better support for individuals suffering from severe mental health problems in the communities [10].

“The nurses and doctors try to refer people to social services, but something in local culture makes people come into social services and say: “Do something!” They want action that is concrete and fast. It’s often difficult to get them involved in any follow-up. I don’t know why it is this way, but that is what social services offer. Maybe the Inuit don’t like that.”

Inuulitsivik Participant

The participants also emphasized the difficulties primary care intervention staff encountered in coming to the assistance of clients with mental health problems. Questions were raised by participants in the focus groups as to whether these services were in fact adapted to the realities facing the Nunavik inhabitants. Many lack adequate knowledge and show little interest in mental health [10]. Furthermore, from the perspective of health and social services, a lack of resources, personnel turnover, lack of support and access to training, and absenteeism among local intervention staff, plus a difficult and expensive recruiting process, weak organizational structures and scarce housing for staff all affect the delivery of health services [3], particularly in the areas requiring great continuity of healthcare services, as is the case with the mental health. Health and social services intervention staff often feel overwhelmed by the severe mental health problems, and cases of violence, sexual abuse and suicide. A further difficulty facing primary care intervention is related to the small size of the communities. This reality creates a situation where local intervention staff are often confronted by patients whom they cross paths with daily or to whom they are related [10]. This then makes it difficult to dissociate the social person from the intervention worker. The Inuit intervention staff may also be confronted by his or her own history [14] and own issues, so much so that sometimes it is difficult to establish boundaries with the clientele [8].

Despite the importance given to primary care services in Nunavik, both literature review and group participants reveal that these services, from the point of view of both health and social services, are seldom consulted by clients for common mental health problems. Furthermore, regardless of the fact that they are generally well developed throughout the territory for other health problems, home care services for mental health cases are still inadequate. Primary care intervention in mental health could be fairly summarized as short term assistance as required in situations of crisis [4, 5]. Focus group participants identified the development of primary healthcare services in mental health as a priority [11].

“We are conscious that in primary health and social care, an acknowledgement of the need for population mental health services must be much more emphasized.”

Inuulitsivik Participant

Although the formation of mental health teams was identified as a priority by the administration of the Planning and Programming section of the NRBHSS [7], it was nonexistent at the time of our structured team visit regarding mental healthcare in Nunavik. Ad hoc intervention teams, composed of general practitioners, nurses, social workers, community workers and other resource staff from both health centres are formed to deal with crisis. There is nonetheless a plan underway to put such a team into place at the Tulattavik Health Centre in order “*to improve the taking charge, follow-up, and support of patients and their social milieu in order to diminish and prevent frequent relapses or crises in our communities.*” [19]

## **6.2 PSYCHOLOGICAL SERVICES**

Currently, psychological resources in Nunavik are few, although in 2003 there were four psychologist positions in Nunavik, two for the Hudson and two for the Ungava communities [3]. Initially, their role consisted of sustaining local teams and devoting time to the application of programs for mental health promotion. Their role however was gradually transformed until they mainly were conducting evaluation and follow-up of individuals referred to them by primary care health and social services.

In 2006, both psychologist positions were abolished in the Hudson Bay region. The reasons cited officially were of an administrative and budgetary nature, but remained obscure for several Inuulitsivik focus group participants. While some participants thought that the psychology services were possibly inadequate to meet the real needs of the population, they admitted to being worried about the absence of psychologists in the region. Currently, in the Ungava Bay region, a sole psychologist based in Kuujjuaq offers adult consultation services on referral weekdays and some evenings. According to some participants, these services were mostly used by non-Inuit from Kuujjuaq or residents from neighbouring communities. In some villages, visiting psychologists made occasional visits. Also in 2006, the Kativik School Board hired its own psychologist and made plans to hire a second to meet the needs of the Hudson Bay region to evaluate young people from primary and secondary schools. Nonetheless, this one resource staff member is hard pressed to meet demands, and is thus restricted to evaluating young people. The Tulattavik focus group participants added that evaluations all too often remain without follow-up since local resources are insufficient and inadequately trained either to ensure follow-up or undertake psychotherapy. The work of the Kativik School Board psychologist is furthermore poorly integrated into the other community resources or social services.

## **6.3 PSYCHIATRIC SERVICES**

### **6.3.1 Psychiatry in the Nunavik settlements**

In Nunavik, general practitioners are responsible for primary care psychiatric services in collaboration with the nurses and the local social services staff. According to the literature review and comments from participants, the health centres are ill-equipped to receive psychiatric patients, especially since there are no beds specifically attributed to psychiatry. Hospitalizations are therefore generally of short duration. In 2002, there were twice as many psychiatric hospitalizations on the Hudson Bay coast, for a total of 38, compared to 17 on the

Ungava coast. The average length of stay was 6.3 days for both coasts [7]. While the Inuulitsivik Health Centre and its CLSC services points have functional isolation rooms, such is not the case on the Ungava coast, although efforts currently are underway to narrow the gap in facilities. Consequently, patients who are a danger to themselves or to others are sometimes temporarily isolated in a police station cell. A recent report on suicide prevention deplores this situation, maintaining that police stations are inadequate for a suicidal patient and may provoke a passage to the act itself [7].

“The main problem of the two Nunavik hospitals (Tulattavik Health Centre in Kuujuaq and Inuulitsivik in Puvirnituk) lies in their reception of psychiatric patients in crisis. Their hospitalization is difficult and potentially dangerous for other hospitalized patients due to the organization of the space (open area, hence no closed unit; scarcity of rooms), the general nature of the health centres (no psychiatric bed) and the lack of specialized personnel.”

Streit, 2003 [7]

Some participants from the Inuulitsivik Health Centre mentioned that the needs were so great in Nunavik that a psychiatrist could work there full time. Furthermore, a proposal for setting up a psychiatric department in Tulattavik and creating a permanent psychiatrist position was tabled by the NRBHSS in 2000. In 2003, a first meeting between psychiatrists from the CHUM prepared the ground. However, difficulties encountered in recruiting visiting psychiatrists have delayed the project from becoming a reality. Despite these difficulties, a report on Nunavik psychiatric services in 2004 recommended keeping this option open due to the increasing heavy case load [8]. Some participants proposed that the MSSS authorizes the right of limited practice in order to facilitate recruiting of foreign psychiatrists. In 2007, the goal of developing a psychiatric unit in Tulattavik was still evident, notably with the addition of two observation beds and a proper isolation room. However, the unit should be able to count on the support of a mental health team, and not only rely on the general practitioners on call.

Moreover, with regard to psychiatric approaches, focus groups participants claimed that prescribing medication and antidepressants was frequently criticized by users of the services and their families. According to popular opinion, medication aggravates the condition of the person who is ill. Several participants felt that the general practitioners and psychiatrists needed therefore to review their practice relative to the prescribing of medication. However, participants also maintained that medication was a response to the scarcity of cognitive and behavioral therapies given the lack of psychological resources. Finally, participants mentioned that the Inuit tended to have more confidence in older rather than younger physicians for mental health problems.

### **6.3.2 Visiting psychiatrists**

Psychiatric consultations are offered in Nunavik through the intermediary of visiting psychiatrists. When the visiting psychiatrist is referred a patient for secondary care, his role is one of consultant and not of treating physician [8]. The two health centres organize and coordinate the psychiatrists' visits. The patients who require their care have to travel from their community to where the psychiatrist is. Some psychiatrists came to Nunavik (Ungava) all the same on a voluntary and individual basis, without contracts. This situation created

coordination problems with the visiting psychiatrists. On the Ungava coast, one psychiatrist made an unnecessary trip because another psychiatrist had arrived before him and had already met with all the clients.

“Without efficient coordination or collaboration, the intervention of traveling psychiatrists who were attached to different Montréal or Sherbrooke hospitals was added to the existing resources of Nunavik, on an irregular basis.”

Streit, 2004 [8]

Initially, Nunavik had five medical specialist positions, including one in psychiatry. Difficulties in recruiting for the North, however, led regional health authorities to conclude agreements with the hospital centres of the South in order to offer psychiatric and other specialized medical services. Major constraints limiting the recruiting of visiting psychiatrists were however revealed by group participants and the documentation consulted. They included the unwieldy administrative procedures of the Régie d'assurance maladie du Québec (RAMQ) related to the psychiatrists' remuneration, the difficulties in obtaining travel expense reimbursement and a limitation on hours worked all of which greatly diminished the profitability of the specialists' stays in the North [7]. Additionally, it seems that most of the associations of medical specialists in Québec did not make life easy for the specialists to work or travel in the North. In this regard, group participants suggested creating an association of Nordic specialists to facilitate negotiations with the Nunavik settlements [17]. Recruiting was also limited by family and professional constraints. Finally, factors like the occurrence of tragic events in the past, such as the hostage taking in Kangirsuk, discouraged some candidates from staying in Nunavik.

The psychiatrists' contribution to the mental health services offered in Nunavik was further hampered by the lack of local qualified resource staff to conduct client follow-up [7]. Furthermore, some group participants mentioned that the interpreters encountered difficulties in adequately translating what the clients were saying or the recommendations made by the psychiatrist. Some group participants on the Ungava Bay coast thought that the Inuit social services staff would have been in a better position to accompany the psychiatrists on their visits. Their presence would have allowed the visiting psychiatrists to be aware of the family and social context of the individuals they were treating. Visiting psychiatrists, however, had few contacts with the Inuit social services staff.

*“We have two psychiatrists in Ungava. They rarely consult the Inuit workers.”*

Tulattavik Participant

### 6.3.3 Hospitalization in Montréal

Patients who require psychiatric hospitalization are generally transferred to one of the two Nunavik health centres. When necessary, the general practitioner may request hospitalization in Montréal. In 1991, the Douglas Hospital was the main resource available for Nunavimmiuts who needed psychiatric care or hospitalization [10]. The relationship was severed with the adult psychiatric services of the Douglas Hospital during 1995-1996 for reasons said to be administrative. The Régie régionale de la santé et des services sociaux de Montréal at the time directed the Nunavik health centres towards Pavillon Notre-Dame at

the CHUM for adult psychiatric care. The other specialties, including pediatric psychiatry, remained under the RUIS McGill. In October 2001, an agreement with the CHUM – Notre-Dame resulted in the setting up of a pilot project and the opening of two positions for psychiatrists to offer services to Nunavik. The CHUM agreed to ensure 120 days of consultation services and psychiatric follow-up in Nunavik and to dedicate two psychiatric beds at the CHUM. These beds were located on the same floor to reduce the isolation of the Inuit clientele who were sometimes hesitant to mix with the other patients. The two-year pilot project has since been renewed. The transfer to the CHUM was the subject of an evaluation in 2003-2004 [7, 8].

The group participants considered the transfer from the Douglas to the CHUM to be a significant change over the past ten years. In 2003, the Nunavik doctors pointed out that the absence of a senior staff member who could propose clinical criteria to justify hospitalization complicated the client referral process to the CHUM. They then had to negotiate the hospitalizations with the psychiatrists or psychiatric residents who, in some cases, had little knowledge of the Nordic medical practice conditions [7, 8]. Responding to the criticism, the CHUM set up a team that was specifically dedicated to the responsibility for the Nunavik patients hospitalized in Montréal. This team, that meets on a weekly basis, is composed of the coordinating Nunavik psychiatrist, a social worker, and a coordinating nurse, both familiar with the Nordic context, plus a nurse and occupational therapist. Despite everything, participants pointed out that the Montréal hospital setting encountered more difficulties in answering the needs of the Inuit patients due to the lack of knowledge of the Nordic context and the lack of interpreters qualified to work with mental health patients [7]. Added to this is the fact that the CHUM is a francophone milieu, whereas the Inuit express themselves mainly in Inuktitut or English. Some group participants also criticized the maximum length of stay that was fixed at six weeks. They felt that some individuals returned to their communities after this period of time without being completely stabilized. The absence of a transition resource person in Montréal who was dedicated to the psychiatric hospitalized Inuit patients increased the risks of relapse.

“The need for a place for transition and readaptation before returning Inuit patients to Nunavik after psychiatric hospitalization – where, when stabilized, the patients need physical health care – has existed in a more or less critical way for some time. Such a resource person would make it possible to prevent having to keep patients in the hospital while they are waiting for the arrival of an escort or for an available seat on a plane.”

Streit, 2004 [8]

The participants and the documents also reveal that the two beds available at the CHUM are insufficient for the needs of Nunavik [7]. In their opinion, there should be immediate access in response to an immediate need. It should be noted that from the viewpoint of pediatric psychiatry with the RUIS McGill, there is no limit on the number of beds attributed to the Nunavik children. Lastly, follow-up with patients is at times complicated by the fact that the responsibility for ensuring liaison with the CHUM team lies with the general physicians in charge. Unlike the nurses who are there in Nunavik full-time, they are not always present in the communities.

### 6.3.4 Telepsychiatry

A telepsychiatry project was put forward in Inuulitsivik Health Centre in 2004. This technology aims to encourage access to training activities, facilitate court orders for the confinement of dangerous patients and support consultation between the intervention staff members from North and South [10]. The project would also contribute to the continuity of services and psychiatric follow-up. Telepsychiatry was however still not operational during our visit in 2007. Several obstacles explain the delays in setting up this technology. First, the questions of remuneration and legal protection of the psychiatrists being consulted at a distance are not resolved. Furthermore, it would seem that computer support in the North is insufficient. Inuulitsivik participants suggested that in each health centre, one person be designated to take charge of the leadership for developing the distance psychiatry. This person would also be responsible for training the local intervention staff to use the technology.

## 6.4 READAPTATION SERVICES

According to participants, the setting up of the Anaraaluk Reintegration Centre in Inukjuak in 2000 and the Aaniavituqarq Crisis Centre in Puvirnituk in 2005 are major milestones in regional development over the course of the past ten years to improve the mental health services offering. Other resources were added to these two centres to encourage the integration of adults with mental health problems in the Nunavik communities. Among other things, these resources include supervised apartments, networks of host families and detoxication centres in Kuujuaq and Inukjuak.

### 6.4.1 Anaraaluk Reintegration Centre (Inukjuak)

Opened in 2000, the Anaraaluk Reintegration Centre in Inukjuak is a regional resource offering short and long term accommodations services, a day centre and centre for medication supervision for adults living with severe and persistent mental health problems. The objectives of the Anaraaluk Centre are to develop the necessary skills for integration into the community of individuals who visit the centre, to improve their quality of life and the quality of life of their families, and on a wider scale, to sensitize the Nunavimmiuts to the challenges faced by individuals with mental health problems [7]. The accommodation capacity of the Anaraaluk Centre is 21 adults. There are ten beds, of which five are on a regular basis and one is for emergency, as well as 11 day centre spaces [7]. The personnel is comprised of two full-time psycho-educators, four part-time educators, six educators on call, two night supervisors and a coordinator.

The Inuulitsivik participants mentioned that ten years ago, severe mental health problems occupied the Inukjuak community social services almost full time. The two social intervention staff devoted all their energy to finding refuge for individuals with mental health problems who had been thrown out by their extended families. This clientele was also a very heavy burden for the local nursing and medical staff.

“The portrait changed dramatically in 2000 when the Reintegration Centre opened. Suddenly, there was a refuge for the most difficult clients and someone to look after them.”

Inuulitsivik Participant

The Anaraaluk Reintegration Centre welcomes individuals with a diverse diagnostic profile: schizophrenia, borderline personality disorder, depression and mentally handicapped. An evaluation conducted in 2003 of the services offered to individuals with mental impairments highlighted that their needs were not being met within a structure offering generalized mental health services [4]. The reasons cited are notably a lack of experience and training among the personnel to intervene and care for this group of clientele [3, 10]. Also, the Anaraaluk Centre's activities are often restricted by the difficult recruitment of Inuit employees, personnel turnover, a lack of training for the intervention staff in the area of mental health, and the high prevalence among this clientele of behavioural problems [4]. Added to this are the difficulties of conducting follow-up at a distance when the individuals leave the Centre and return to their community [10]. Finally, some group participants criticized the fact that admission to the Anaraaluk Centre required a medical diagnosis of a mental health problem. The formulation of a diagnosis was sometimes complicated in certain communities that did not have permanent physicians and where the psychiatric resource personnel are in short supply.

Despite everything, the Inuulitsivik group participants mentioned that the Anaraaluk Centre contributed to improving the mental health services offering in Nunavik. They also expressed the hope – that was also reflected in the documents reviewed – that the services would be extended to a pediatric clientele [5]. The opinions of the Tulattavik group participants appeared, for their part, more divided with regard to the contribution of this resource, which was used less by their clientele. In 2002, of the 40 individuals admitted to the Centre, only 7 were from Ungava, while the other 33 came from the Hudson Coast.

#### **6.4.2 Aaniavituqarq Crisis Centre (Puvirnituuq)**

Opened on December 1<sup>st</sup> 2005, the Aaniavituqarq Crisis Centre is a regional resource with a mission of temporarily stabilizing psychiatric clients in crisis. Short term, highly structured accommodation services are offered for individuals in a situation of crisis. The Aaniavituqarq Centre also allows mid- to long-term placement of individuals who are either unable to reintegrate into their community following hospitalization in the South or who cannot be admitted to the Anaraaluk Reintegration Centre. The Aaniavituqarq Centre also ensures continuity of follow-up for clients returning to their community by developing a personalized care plan as well as offering respite for families, communities and local teams. The services offered by the Centre are meant complement those dispensed by the Inuulitsivik and the Tulattavik Health Centres and by the Anaraaluk Reintegration Centre [20]. Five beds are available of which two are for Ungava and three for Hudson. The Aaniavituqarq Centre targets adults in crisis situation, but who are able to communicate, understand and participate in resolving their crisis. The mental or emotional state must be considered serious enough to cause problems of family or social dysfunction and to justify constant supervision. All the same, such individuals must not require acute psychiatric or medical care nor long term care [20]. Individuals who meet the criteria of Bill 39 and who must be confined in preventive isolation may also be admitted to the Aaniavituqarq Centre for 30 days.

### 6.4.3 Supervised apartments and host families

Supervised apartments for adults under age 65 and without dependent children have been available since 2004 in Inukjuak and since 2007, in Puvirnituk and Kuujuaq [8]. These resources respond to the goals of the MSSS to offer supervised residential services for individuals with mental health problems. Furthermore, they help to foster the social integration and better compliance with treatment [14]. These services are targeted to individuals in transition towards their complete reintegration in the community and to individuals whose conditions require long term placement. The individuals who live in these apartments are encouraged to socialize with their housemates and to take on daily domestic chores with the support of the members of their family, health and social services professionals and the community. By housing this clientele, supervised apartments also give the families respite [14]. Generally, long term adult residents experience difficulties looking after themselves, holding down a job and carrying out daily life activities. They may have been hospitalized repetitively for mental health problems, show evidence of severe and recurring symptoms, have problems of alcoholism for at least 6 months, be facing the law or needing more targeted treatment than that offered by the ambulatory care [14]. Individuals with mental health problems without a fixed residence have priority. In Kuujuaq, community residents have priority over the other residents of Ungava.

Moreover, a network of host families has been put into place on the Hudson coast by a regional liaison team composed of a social worker and a community worker. Financial compensation is granted to the families who house individuals with mental health problems. These families receive support and training to help them care for the individuals they house [7]. Despite everything, recruiting these families remains difficult [3].

### 6.4.4 Detoxication services

The Isuarsivik Detoxication Centre in Kuujuaq offers 28 days rehab for adult clients, while the Aanarraapik Treatment Centre in Inukjuak offers treatment for a clientele of minor age. Agreements with the two health centres does not allow the Isuarsivik Centre to accept individuals with mental health problems. However, two out of three individuals with mental health problems also have addiction problems. The documents consulted mention that inter-program collaboration should be maximized in order to intervene with individuals who have a combination of dependence problems (drug, gaming, alcohol) and mental health or intellectual impairment [14]. More coordination between youth and adult programs is also desirable. At the time of our visit in January 2007, the Isuarsivik Centre was not optimally functioning due to the reorganization of services. This reorganization is planning on hiring and training personnel. The management of the centre is also working on adapting the approaches to make them culturally meaningful for the Inuit. During the reorganization, adults requiring this type of help are referred to detox centres in the South. Moreover, some communities offer Alcoholics Anonymous meetings in addition to a sponsorship system to support individuals who have stayed in a detoxication centre. Prevention programs are also offered to all the communities, thanks to a grant from Health Canada to the *Nunalituqait Ikajuqatigiitut* (help between communities) association. Finally, workers from the National Native Alcohol and Drug Abuse Program (NNADAP) are present in Nunavik.

## 6.5 TERTIARY CARE SERVICES

Tertiary care services in legal psychiatry are offered in collaboration with the Institut Philippe-Pinel in Montréal. Hospitalizations are made at the Centre hospitalier de soins psychiatriques d'Abitibi-Témiscamingue situated in Malartic. According to participants, relationships are much improved with these institutions.

## 6.6 PREVENTION AND PROMOTION PROGRAMS IN MENTAL HEALTH

In terms of prevention and promotion of mental health, the needs are great in Nunavik. Group participants and documentation consulted identified families and young people in particular as the main targets of prevention activities related to drug addiction and promotional activities in parenting skills and leisure [7].

The Inuulitsivik participants mentioned that the risk factors of drug and alcohol abuse can exacerbate mental health problems. In addition to the suggestion of setting up activities to prevent substance abuse, they proposed developing violence prevention programs, including control of access to firearms. The Tulattavik participants highlighted the necessity of providing parents with tools to enable them to act proactively before problems occurred and recognize the signs of deteriorating mental health among their children. They furthermore maintained that the programs must advertise using popular channels such as radio. In the past, radio information capsules on mental health were presented in Kuujuaq and generated a certain amount of interest from the population. Several individuals showed themselves consequently more open to the mental health problems and services available. The Tulattavik participants suggested therefore that this initiative should be repeated and supported. One proposal was also made to integrate the mental health prevention programs into the school calendar in order to reach a younger audience.

The documentation review allowed us to retrace a certain number of preventive programs that were available at the time. Among them, were federal initiatives that funded communities to recruit resource persons, known as *wellness coordinators*, who would be responsible for organizing mental health prevention activities. However, the lack of integration between these resource staff with those from the health services and provincial jurisdiction, led to the adoption of a resolution of the NRBHSS aimed at repatriating the *wellness coordinators* into CLSC teams of each community. The *Brighter Future* program is another federal program that offers youth camps in each of the communities and finances five *Youth Homes*. Several suicide prevention programs have also been set up over the past fifteen years. In 2001, an offered psychological screening for factors leading to depression among young people, counselling for couples by specialized Inuit resource staff, and training for Inuit personnel to facilitate information sessions. Another initiative, the *Healthy School Program*, carries out promotion in schools of factors that protect against suicide, such as self-esteem, social skills, lifestyle and safe behaviours [11]. Recently, a network of watchers or sentries – the *Gatekeeper Network* – was also put into place. These are individuals who are very active in their community and recruited to inform individuals in distress about existing resources and to guide them to the appropriate services [11, 17]. Other programs offer group approaches. According to the Inuulitsivik group participants, this approach is especially effective for dealing with collective trauma. This initiative led to a kind of healing circuit being organized in

the 14 Nunavik communities between 2003-2006, funded by the *Aboriginal Healing Foundation*. Offering more traditional approaches, the *Traditional Counsellor Services* was a pilot project begun in Inukjuak in 2006. These services are offered part-time in collaboration with the care teams [11]. The *Traditional Approach in Healing Families* offers a camp and three weeks stays in the tundra for healing families [11]. Lastly, self-esteem workshops were organized to promote better understanding of collective trauma from the past that can influence the state of mental health of the Nunavimmiuts [3].

Unfortunately, several of these programs could not be renewed. Group participants recalled that the continuity of health prevention and promotion programs was often compromised by an administrative burden, a pilot project “formula” that did not ensure budget renewal, personnel instability and an absence of program managers. Participants also deplored a lack of concordance between federal programs and provincial programs that hindered the integration of services. The *Peace of Mind Committee* that was present in the 1990’s consequently proposed activities with an Inuit approach that were anchored in the community. The actual project was however never implemented. The *Building Healthy Community* program has still not started, although counselling services are offered in the two detox centres. As for the *Kajusitta Inc. – Let’s Move On – project*, a non-profit bakery in Kuujuaq where individuals with a physical or intellectual impairment work, was operational only between 1999 to 2001, due to lack of financing. The group participants and the documentation reviewed also highlighted the difficulty of adapting programs financed by the federal or the provincial governments to the realities of the region [7]. In particular, the sparse population of Nunavik complicates the establishment of government programs. Lastly, the participants also reported the low participation of the population in the various activities and programs that were in place. In their opinion, anchoring the programs in the communities encouraged the Inuit’s empowerment and was more in tune with their collective values.

## **6.7 SELF-HELP GROUPS AND COMMUNITY SERVICES**

Despite the few self-help groups in Nunavik and the precarious state of existing community services [8], Tulattavik participants noted that there was more involvement on the part of the Inuit in community work. Since the beginning of 2000, there is a youth home in each of the 14 communities [5]. Shelters for women victims of violence are accessible in Kuujuaq and Salluit. The one in Kuujuarapik has been closed for several years, despite the efforts of some individuals to reopen it. The Qajaq Network men’s group was founded in 2003 in Kuujuaq and offers consultation services for violent men. Other resources such as free telephone services of the *Baffin Help Line* or *Suicide Action Montréal* are also accessible, but there are no data available on the utilization of these services by Nunavimmiuts [10]. Referring to the community orientation proposed by the MSSS in its action plan, Inuulitsivik participants felt that the communities must play a part in looking after the care and the readaptation of individuals with mental health problems. In their opinion, there must be an end to the sole reliance on the services provided by the health centres. Participants reported that until the 1970’s, meetings with family clans were organized to discuss the different community issues. Some mentioned that they would like to see the return of these meetings in order to defuse some of the crisis situation and to resolve the collective trauma. For the communities to organize themselves, the participants maintained that funding must be made available.

## 6.8 TRADITIONAL AND RELIGIOUS APPROACHES

A document produced in 1991 stipulated that traditional counselors felt overwhelmed by the magnitude of the problems in mental health that were often complicated by social and drug addiction problems [13]. At the time, their action was still considered as relevant, but the need for setting up supplementary services was raised [13]. Mixed approaches, combining traditional know-how, cultural concepts and methods of modern medicine such as counselling and psychosocial and psychological interventions were also planned at that time [9]. However, western approaches seem to have eclipsed the traditional mental health methods over time. For one group participant from Inuulitsivik, the Anaraaluk Reintegration Centre and the Aaniavituqarq Crisis Centre were the only resources available that created a real bridge between the two cultures. The Tulattavik participants mentioned that unfortunately, several intervention non-Inuit staff were unaware of the existence of traditional resources. Some Inuit participants mentioned furthermore that these approaches were sometimes unclear to them, and they claimed that they wished to get together among themselves to discuss them. According to group participants, the Inuit tended to see the individuals exhibiting mental health problems as normal people. The Inuit approach to healing consisted of listening and showing an openness and unconditional acceptance of the individual. In the past, the depressive individuals were encouraged to distance themselves for a while from their group, either going to a neighbouring clan or into the tundra. Sometimes it happened that very severe cases threatening the stability and the survival of the group were isolated for a period of time. The group participants from Tulattavik mentioned that it would be pertinent to integrate a cultural counsellor into the healthcare teams. Similar plans seemed to already exist in education. In fact, the Kativik School Board offered its new professors from the South one week of orientation where they were partnered with an Inuk mentor. They could refer to their mentor during their first year in the North. In this respect, the non-Inuit participants said they were ready to work in concert with traditional resources or even to refer clients to these resource individuals. The Inuulitsivik groups participants pointed out the existence of self-help groups for women and men animated by religious ministers or traditional healers. The availability of these religious resources and local traditional counselors varied from one community to another [13]. The documentation reviewed also confirmed that some healing sessions were often animated by elders [8]. They also raised the fact that the holders of the knowledge were aging. It therefore becomes urgent that it was time that the young people learned the wisdom themselves and to document this knowledge.

“To help a depressive person, we took them hunting. When he was hunting, he was a completely different person. He was the one who took the leadership. He had control over his life. It is one of the Inuit approaches.”

Inuulitsivik Participant

Support from the churches, religious ministers and religious groups are also of primary importance given the place that faith occupies in Inuit society since Christianization. The Inuulitsivik group participants reported that the religious ministers are regularly consulted for mental health problems. The patients suffering from serious symptoms would furthermore be helped by methods that combined prayers and exorcism.

“I have seen people healed from chronic mental illness by Inuit traditional methods and I don't understand how from the perspective of my own (non-inuit) cultural background.”

Inuulitsivik Participant

In terms of local leadership, healing circles with a religious nature are also sporadically organized in the churches or other places deemed appropriate. Places of meeting and sharing, these circles have the goal of giving back to participants the power over their own life, by making them aware of past trauma and teaching them different means to confront it. Some Inuulitsivik participants mentioned however that the group approach may cause labeling, and some individuals hesitate to participate. The group approach nonetheless seemed to them the most appropriate in the framework of intervention aimed at improving self-esteem or countering collective trauma, than intervention in the context of mental health problems.

## **6.9 DEGREE OF INTEGRATION OF PRIMARY CARE SERVICES**

According to the participants and the documentation reviewed, the integration of primary care resources is a priority mandate. Since 1975, when the JBNQA treaty was signed, the Inuit have opted for a global and multidisciplinary approach to health and social services [3]. The multidisciplinary approach and the close collaboration between health and social services are essential to answer the needs of the individuals exhibiting mental health problems and to allow them to move more easily from one service to another [4, 14]. The participants nonetheless report that this collaboration is sometimes difficult to establish. This situation entails breaks in the continuity of services, especially between social services and health services [14]. These breaks lead then to a loss of confidence of the clientele towards the services offered and significantly increase the risks of relapse.

“Formally integrated teamwork is non-existent. Teamwork exists in Akulivik, since the personnel have been there for a very long time.”

Inuulitsivik Participant

There are multiple obstacles to the integration of services and to the collaboration between the intervention staff. They include: a lack of confidence between the intervention staff of health services and social services, the use of different languages (French, English, Inuktitut), personnel turnover, confusion of roles attributed to each service and to the various intervention staff, a lack of formalization of interprofessional relationships, a lack of recognition of the varied expertise, an apparent inaction by the social services in some specific cases and the fact that social services files are not up to date [7, 14]. Furthermore, shared decision-making is limited by excessive workload, a lack of follow-up and prevention that prompts intervention staff to act only when the situation becomes urgent, long vacation time for non-Inuit resources staff and difficult access to continuing training for local employees [8]. Participants also mentioned the difficulty of identifying team leaders, which hampers integration efforts. Although until recently the nurse had taken on this role, the exercise of healthcare team leadership had become confusing because of the arrival of other professionals such as general practitioners on the scene and the desire for self-

determination by the Inuit who were looking for the appropriation of their services. As for the others, Tulattavik participants added that there was a communication problem between non-Inuit management and Inuit intervention staff. In particular, they emphasized that the taking over of management by local staff was from being assured.

“Just at the moment when we feel we are getting there, have to start over. It is difficult to implement because of the personnel turnover, and it is difficult to have leadership that is moving in this direction. Akulivik and Salluit are doing well because they are having multidisciplinary meetings religiously, on a weekly basis.”

Inuulitsivik Participant

The advent of *Individualized Service Plans (ISP)* over the past few years for individuals with physical and mental impairments was presented by participants as a means of coordinating services more effectively and making the holding of multidisciplinary meetings easier. These plans lay out the responsibility of each staff member called in to intervene with the individuals exhibiting mental health problems. They also provide timeframes for revision of the ISP's and clientele evaluation. A single key intervention staff member then becomes responsible for each ISP and coordinates the services dispensed, ensuring the relationships between the various service providers and evaluating the situation of the individual and their family. This type of plan does not currently exist for clients in mental health and no project for integrated services have been established between municipalities, organizations, Health Centres, CLSC or community health committees [9]. In 2004, the creation of an access point in Tulattavik somewhat improved the outlook for this clientele and there has been, since 2005, an admission committee for the mental health clientele in Nunavik.

## **6.10 DEGREE OF INTEGRATION BETWEEN PRIMARY, SECONDARY AND TERTIARY CARE**

Better collaboration and integration of service plans in both health centres would ensure a more effective use of resources, particularly in a context where they are few and far between [10]. To support individuals with mental health problems, it is important for all agents responsible for mental health in the *NRBHSS* to work together in partnership. These include health centre directors and coordinators, the Kativik Regional Police Force, the Kativik School Board, residential services, legal services, public curator, healthcare teams, community organizations, and various levels of government, including the Kativik Regional administration, the provincial and the federal governments [3, 10]. Despite good intentions, services remain fragmented and without coordination [4].

### **6.10.1 Integration between primary and secondary care in Nunavik**

According to the individual responsible for the mental health program at the *NRBHSS*, group participants and documentation, collaborative efforts have been made between the Anaraaluk Reintegration Centre, the Aaniavituqarq Crisis Centre and the CLSC service points. For example, the Aaniavituqarq Crisis Centre collaborates with health and social services to ensure adequate follow-up of individuals on their return to the community. The intervention staff of the Aaniavituqarq Crisis Centre have an agreed plan of intervention for each client and remain in communication with the families after the admission of a relative

[20]. This integration is facilitated by the fact that the management of the Aaniavituqarq Crisis Centre is shared between the representatives of the police services, the healthcare centres, the local liaison team, the Anaraaluk Reintegration Centre and the nursing services of the local CLSC.

“I am proud that the social services offer services to people with mental health problems in collaboration with the Reintegration Centre. We have seen a lot of improvement. The individuals, the nurses, and the social intervention staff have more interest for this type of clientele. It is not perfect, but much better than before. We have really done well with the severe cases.”

Inuulitsivik participant

The Tulattavik participants also highlighted a lack of support for families and individuals who leave the Anaraaluk Reintegration Centre to return to their community. The recruitment of a mobile psychoeducator has already been the subject of investigation in order to improve relationships between such healthcare centres and the communities [5].

### **6.10.2 Integration between Nunavik and the CHUM**

The NRBHSS has an important role to play in the integration of services between the CHUM and the communities [7]. The roles of the different organizations must furthermore be clarified and the protocols for services and information exchange must be followed. Currently, relationships are often based on informal discussions between the various professionals who have a history of working together [4]. The lack of clarity in the admission procedures to the CHUM, along with variable interpretation of admission criteria, absence of protocols and lack of availability of the coordinating psychiatrists cause major obstacles in the hospitalization of the Inuit [8].

“The only access for requests for hospitalization or consultation ends up being a pager number.”

Streit, 2004 [8]

The Tulattavik participants mentioned the frequent difficulty of reaching the psychiatrists. Once they are reached, however, they are generally very open and available to discuss the cases brought to their attention by the intervention personnel from Nunavik. According to Inuulitsivik group participants, there is a noticeable improvement in the CHUM's hospitalization procedures as well as improved adaptation of services. Better communication has made follow-up with the community easier and the coordinating psychiatrist has been reasonably available for consultations with the Nunavik communities and general practitioners.

“They have more understanding of who we are. The psychiatric services corridor is improved.”

Inuulitsivik Participant

According to participants, there are communication problems between the North and the South when the patients hospitalized in Montréal return home. After receiving their discharge from the CHUM, the patients are returned into their communities, where follow-up is sometimes difficult since the local services are not adequately organized. Furthermore, some individuals mentioned that information is not always transmitted between Kuujuaq and its service points in Ungava. According to the documentation, the promotion of a greater flow of information between the different services must take place among the numerous intermediaries [7, 8]. The creation of the Reintegration Centre and the Crisis Centre partially solved the problem by offering transition services [7, 8]. Despite all this, the responsibility for individuals with mental health problems generally falls to the families. According to the Kuujuaq participants, more information is needed on how to care for this group of clients.

“There are increasingly more cases that are diagnosed with severe mental health problems. There is little support for the families who are experiencing these situations. They do not know how to deal with this type of case. Furthermore, when they are hospitalized in the South, or when the person comes back from hospitalization, there is no support for the families. All that is done, is to send the severe cases South to stabilize them. That is all! And the families have no idea of what is being done down there.”

Tulattavik Participant

The relationships between the social services teams in the communities and the psychiatric services offered either by the visiting psychiatrists or by the Montréal hospitals are insufficient. The Tulattavik participants mentioned that the social services teams are often contacted by clients who are looking to obtain information on the reasons for a prescription, new medication, treatment or diagnosis. The social intervention teams in the North have also little information about the details regarding hospitalizations made in the South. The summaries sent by the CHUM for follow-up sometimes contain very little detail.

*“There are so many relapses that happen because of the lack of support.”*

Tulattavik Participant

## **7 PROJET DIALOGUE : FUTURE STEPS**

The information contained in this report provides an overview of the mental health services situation in Nunavik as they were at the beginning of 2007. Within the context of Projet Dialogue, more visits are planned to update the information each year.

Other steps are also planned to complete the portrait of the contextual and organizational characteristics of health services in the region. These next steps will be conducted at a local level. We hope subsequently to link the contextual and organizational characteristics to the care experience of the clientele. Our goal is to guide regional decision-makers, local authorities and community resources in setting up healthcare services that will be better adapted to the Nunavik population.



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