Understanding the Experiences of Fly-in/Fly-out Mental Health Service Providers in the Inuit Nunangat region

By

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Abstract

My Master's thesis examined the experiences of fly-in and fly-out (FIFO) mental health service providers in Inuit Nunangat. Through participatory action research and semi-structured interviews with eight FIFO mental health service providers who deliver services to various Inuit communities across Inuit Nunangat, I assessed barriers and enablers to FIFO counselling, and I co-developed recommendations to ensure optimal delivery of services with my partner organization. I examined the factors that influence experiences of vicarious trauma for providers and gained insight into ways that FIFO practices may mitigate the effects of vicarious trauma. Additionally, I explored the impacts of the COVID-19 pandemic on FIFO mental health service delivery. The findings enabled us to reconceptualize mental health service delivery with considerations to mitigate pandemic risks. Together, these two papers are a novel contribution to understanding the experiences of FIFO mental health service providers in northern Canada.

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Chapter One: Introduction

Research and information on the practice and experience of delivering mental health services in northern Canada is limited (O'Neill et al., 2013a). Mental health service provision is challenging due to geographical isolation and the remoteness of northern Indigenous communities (O'Neill et al., 2013a). Numerous factors impact the recruitment of service providers including small community populations, transportation difficulty, as well as physical, personal and professional isolation issues (O'Neill et al., 2013a). Studies have shown consistent problems of access to mental health services in rural and remote areas in comparison to urban regions (Lutfiyya et al., 2012) due to geographical isolation and availability of services (Barbopoulos & Clark, 2013; O'Neill et al., 2013a). These issues serve as major challenges to providing mental health and psychiatric services to rural and remote patients (Zayed et al., 2016). Though these barriers are well documented, research on the situation of formal (and informal) practitioners who provide mental health support in northern communities is scarce (O'Neill, 2010).

For my thesis research, I aimed to address this gap in the academic literature, with the ultimate goal of seeking a nuanced perspective of fly-in and fly-out (FIFO) mental health providers' experiences of delivering services to Inuit Nunangat. Through this research, which I present in the format of an introductory chapter, two-publishable papers, and conclusion, I sought to explore the question, "What are the experiences of mental health practitioners who fly-in and fly-out of communities to provide mental health services in Inuit Nunangat?" Specifically, I drew upon the experiences of fly-in and fly-out providers contracted by Northern Counselling and Therapeutic Services (NCTS), a company that provides counselling services across northern regions. To complete this thesis, I undertook a participatory action research (PAR) methodology in partnership with NCTS. To engage in PAR, an advisory board was formed to guide all aspects

of the research process. The priorities of NCTS were to understand the impacts of vicarious trauma for providers and to enhance strategies/policies to enhance supports to FIFO providers. This research was initiated in September 2019; as such, the priorities shifted in March 2020 in response to the COVID-19 pandemic. The advisory board identified the importance of understanding the ways in which the provision of services changed due to a forced shift to telemental health services and what lessons could be learned. This work is particularly timely given the rapid and significant changes in working conditions as a result of the COVID-19 pandemic. The results of these research questions were the focus of my two-publishable papers.

Despite the high demand for mental health services in Inuit communities, there exists limited literature regarding the experiences of FIFO mental health providers who service these remote areas in a Canadian context. To our knowledge, no previous studies have examined the experience of FIFO providers in Inuit communities in Canada. There is a growing need to understand the perspectives of these providers given the forced shift to telemental health services due to the pandemic. It is crucial to understand these perspectives within the context of the ongoing impacts of colonialism that persist today and continue to affect the Inuit population.

This introductory chapter includes two sections. First, I review the literature relevant to my area of study, including Inuit history and health, the impacts of colonialism, vicarious trauma, and FIFO providers. This summary provides essential contextual information that situates my study within the literature. Second, I provide detailed explorations of the constructivist self-development theory (CSDT) framework, PAR methodologies, semi-structured methods, and thematic analysis of data that I engaged with.

Literature Review

Inuit History

Inuit are Indigenous peoples who primarily live in Inuit Nunangat, which is composed of four regions in northern Canada (Inuit Tapiriit Kanatami [ITK], 2018). These regions include Nunavut, Nunavik (Northern Québec), Nunatsiavut (Northern Labrador), and the Inuvialuit Settlement Region (Northwest Territories; ITK, 2018b). Archaeologists have suggested that the Inuit and their ancestors have been living in the arctic dating back to approximately 12,000 years ago (Bonesteel, 2006). Inuit were able to maintain their traditional subsistence practices, which included primarily whaling and hunting, into the twentieth century. These procured items were bartered in exchange for European goods such as metal knives, tobacco, cloth, and food; however, with the growth in the fur trade and increased European contact, the focus shifted from subsistence hunting to commercial trapping by the late nineteenth century (Bonesteel, 2006). Eventually the overhunting by European whalers and traders led to the collapse of the fur trade and subsequent lack of employment for Inuit (Bonesteel, 2006).

In response to the loss of employment opportunities, the Government of Canada encouraged settlements, thereby eliminating the Inuit's nomadic way of life. This act began the effort to assimilate Inuit to southern Canadian culture through forced programming (Bonesteel, 2006). Between the years of 1953 to 1955, the Government of Canada relocated Inuit families from Northern Quebec to the High Arctic, which is known today as the Resolute Bay and Grise Ford area (Crawford, 2014). Inuit found themselves in a harsh environment that had little in common with the region in which they had grown up in, and had fewer opportunities to hunt (Crawford, 2014). Further, promises made by the government to allow them to return home if they were unsatisfied with the High Arctic were not kept, resulting in the separation of families over generations (Crawford, 2014). Other examples of colonialism that impacted Inuit include changes in settlement, residential schooling, loss of traditional belief system, loss of traditional

relationship with the land, and language (Crawford, 2014). These economic, political, and religious influences have led to the displacement and oppression of many Inuit communities, which has subsequently resulted in adverse health problems and high-risk behaviours (ITK, 2014; Kirmayer at al., 2000). To address the disparities in health and health outcomes for Indigenous populations, it is crucial to understand the impacts of colonization.

Impacts of Colonization on Health

Indigenous health has been linked to the legacy of colonization throughout the literature (Kirmayer et al., 2000; Nelson & Wilson, 2017). Indigenous peoples in Canada have experienced historical trauma and a loss of cultural cohesion through social and cultural assimilation policies such as residential school programs (Brascoupé & Waters, 2009). These efforts of forced assimilation have resulted in a disproportionate burden of disease and inequalities in healthcare services for this population (Kirmayer et al., 2011; Nelson & Wilson, 2017). The chronic exposure to trauma has manifested in health-risk behaviours and negative symptoms like anxiety and depression, which have reverberated throughout generations (Bellany & Hardy, 2015; Bombay et al., 2009). In a scoping review looking at the mental health of Indigenous peoples, Nelson and Wilson (2017) found that the higher rate of mental health concerns in Indigenous populations was universally linked to historical trauma.

Any discussions around the health status of the Inuit population must be grounded in recognition of the historical and ongoing impacts of colonization. While epidemiological data can further stigmatize marginalized populations, presenting health statistics demonstrates the ongoing effects of colonialism that Inuit face. Decisions made by the Canadian government dramatically affected Inuit culture, economy, and their way of life through traumatic incidents such as forced relocations, tuberculosis treatment in the South, killing of sled dogs, residential

schools, and federal day schools among others (Crawford, 2014). Maintaining awareness of the impacts of colonization and ongoing marginalization is fundamental to conceptualizing the health disparities that Inuit face.

Inuit Health and Wellbeing

In a report describing the health status of the Inuit population, the national representational organization of Inuit, Inuit Tapiriit Kanatami (ITK, 2018) outlined health indicators currently impacting the health of Inuit in Canada. Low life expectancy as well as other poor health indicators such as suicide, chronic illnesses, and infectious diseases highlight the many challenges that Inuit in Canada face (ITK, 2014). In a 2006 survey on Inuit health and social conditions, Inuit adults were found to be less likely than non-Inuit adults to report excellent or very good health (Tait, 2008). These poor health outcomes are a symptom of colonialism, racism, and marginalization amongst other challenges that result in persistent inequality (ITK, 2014; Kirmayer et al., 2011).

Disparities in the provision of care negatively impact those living in the Canadian North (Mendez et al., 2013). Although many of the barriers are associated with geographic location (Friesen, 2019), other factors affecting accessibility include social, economic, and cultural access barriers, emphasizing that healthcare services in rural and northern communities is a complex, multifactorial issue (Caxaj, 2016; Dyck & Hardy, 2013; Friesen, 2019). These complexities are exacerbated in Indigenous populations who have been impacted by colonialism and continue to face inequitable access to health care (Nelson & Wilson, 2017). Even when Indigenous peoples do access services, Nelson and Wilson (2018) found that they experience racism and discrimination. Perhaps the most significant barrier for Inuit is the limited access to health services, which is reflected in the health disparities that exist (ITK, 2014). Challenges related to

geography, culture, language, and human resourcing have resulted in poor availability of health services that have contributed to poor health outcomes for this population (ITK, 2014). Due to the reduced number of local health professionals, many Inuit are required to leave their communities to access care (ITK, 2014; Tait, 2008) or rely on health professionals who fly into and out of communities (Oosterveer & Young, 2015). The limited health care in these regions not only affects treatment, but it also impacts the overall health and wellbeing for this population (Huot et al., 2019).

Service Provision in Inuit Nunangat

The substantial need for mental health providers in rural and remote areas is often paired with a shortage of mental health services (Barbopoulos & Clark, 2003). This is especially true for communities in Inuit Nunangat, who have limited access to facilities and infrastructure to support a comprehensive continuum of mental wellness programs (ITK, 2014). None of the communities in this region have year-round road access, and only a few have hospitals (Tait, 2008). In 2008, it was reported that adult Inuit living in Inuit Nunangat were 49% less likely to come in contact with a doctor in the past year compared to 79% of the total Canadian population (Tait, 2008). Physical geography is frequently reported as a barrier to access of healthcare services in the North (Huot et al., 2019; ITK, 2014). In fact, in a study looking at primary health care service delivery in remote Indigenous communities in the Northwest Territories, both service providers and service users recognized that equal and equitable access to primary health services was unrealistic to the geographical characteristics of the communities analyzed (Oosterveer & Young, 2015).

The remoteness of communities combined with small Inuit populations creates difficulty for the recruitment and retainment of permanent health professionals, which can hinder care

(ITK, 2014; Oosterveer & Young, 2015). When services are not available locally, Inuit often must leave their homes for extended periods of time to access specialized care in regional "hubs," or travel outside of Inuit Nunangat to urban and southern-based hospitals in Happy Valley-Goose Bay, Ottawa, Montreal, Winnipeg, or Edmonton (ITK, 2014; NCCAH, 2011; Tait, 2008). Being away from community and support has significant collateral impacts (ITK, 2014), highlighting the importance of local service provision. For services available within their communities, many Inuit regions rely on transient healthcare professionals to provide services (ITK, 2021). The healthcare professionals who deliver these services often do not reside in Inuit communities, and hence rotate in and out of Inuit regions from southern Canada (ITK, 2021). This engenders its own set of problems as healthcare professionals travelling to these communities may not be familiar with Inuit culture or language (ITK, 2014). Although this approach is complex, FIFO services to these regions are currently necessary for Inuit to obtain health services.

Fly-in and Fly-out Service Provision

As a result of the low retention and recruitment of permanent health workforce, Inuit regions rely on transient staff (ITK, 2021) who fly-in and fly-out of northern communities. Wakerman et al. (2012) categorized FIFO or drive-in and drive-out (DIDO) services in five different ways:

1. Specialist or outreach services.
2. Hub-and-spoke models for allied health professionals and specialists which consists of an establishment (hub) providing services to multiple secondary establishments (spokes)

3. ‘Orbiting staff’ who spend 12 months or more in specific communities, who may work elsewhere but return to the same communities.
4. Long-term shared positions where the same practitioners visit the same communities, for example using a month-on/month-off schedule.
5. Short-term or agency staff who visit communities as a one-off, and move from place to place.

Hanley (2012) argued that these outreach models make significant contributions in the health sector as they represent a necessary compromise between equitable access of care and the “tyranny of distance” (p. 1).

Researchers in Australia have highlighted some of the advantages and disadvantages of FIFO models of care (Gardner et al., 2018; Hanley, 2012; Hussain et al., 2015; Sutherland et al., 2017; Wakerman et al., 2012). Hanley (2012) recognized the potential benefits for the individual practitioner to develop broader professional experience without having to move entirely from their home, commitments, and social and professional networks. Hussain et al. (2015) posited that FIFO services offer a great alternative for community members who would otherwise need to travel long distances. There are, however, inherent challenges to these practices. Some disadvantages of these models cited in the literature include the high cost of travel to rural communities, increased demands on local infrastructure, and wasted time travelling to communities for providers (Hanley, 2012; Hussain et al., 2015). These challenges are consistent with the barriers of recruiting and retaining permanent local staff, which include poor access to personal and professional supports, lack of anonymity and privacy, and poor work-life balance (Hussain et al., 2015; O’Neill, 2010). Researchers in Australia found that FIFO mental health service delivery is particularly challenging in a FIFO context given the nature of therapeutic

work (Sutherland et al., 2017). Psychologists in the aforementioned study described the difficulties associated with having to work within short time frames to efficiently conduct psychological assessments, while also having to reinforce therapy skills and maintain rapport with their clients (Sutherland et al., 2017).

Interruptions to FIFO Service Delivery

Recently, the challenges of delivering FIFO services have been exacerbated by the onset of the COVID-19 pandemic. In March 2020, the World Health Organization (WHO) declared the outbreak of the novel coronavirus a pandemic (WHO, n.d.). The virus impacted the ability for service providers to deliver care to Inuit Nunangat due to travel restrictions and quarantine recommendations by community leaders, governments, and organizations in Inuit Nunangat (Penny & Johnson-Castle, 2020). In response to the strict preventative restrictions guidelines that made traveling to communities difficult, many FIFO service providers shifted their practices to include telemental health services. Although telemental health services is not a new strategy, there are still many challenges associated with the delivery of online services to remote Indigenous communities. In a study looking at the experiences of delivering telemental health services to Inuit and Cree communities in Northern Quebec outside of the COVID-19 context, mental health service providers acknowledged the benefits of telemental health strategies for individuals living in remote communities (Shang et al., 2021). It was, however, emphasized that these online services should be provided in conjunction with in-person visits (Shang et al., 2021), thereby highlighting the need to have providers within the community, either through permanently residence or through FIFO models of care. Furthermore, providers in the study noted the technological limitations of offering online services, which is unsurprising considering the significant infrastructure gaps in Inuit Nunangat (ITK, 2018a).

In a position paper titled *Development and Implementation of the Arctic Policy Framework,* ITK (2018) acknowledged the gap in infrastructure as a contributor to the social, economic, and health disparities between Inuit and non-Inuit. Noted in this report was the extreme digital divide that separates this region from the rest of Canada, which impedes healthcare access. Due to the remoteness of Inuit communities, internet connectivity is necessary for the delivery of telemental health services, especially when entering the community is not possible. A Nunavut Land Claims organization, Nunavut Tunngavik, also indicated the gaps in health care infrastructure in their report, highlighting the shortage of basic mental health care and addictions infrastructure as problematic (Nunavut Tunngavik, 2020). Difficulties in telecommunications and health care infrastructure have been highlighted during the COVID-19 pandemic as FIFO services have shifted to online services.

Risks to Northern Practice

Mental health service providers face inherent risks when working with traumatized patients. Quitangon (2019) proposed that mental health providers are vulnerable to developing *vicarious trauma*, a concept that has been defined as the inner transition of a trauma provider as a result of empathetic engagement with the traumatic experiences described by clients (Pearlman & Mac Ian, 1995). Despite not being exposed directly to trauma, overly engaging empathetically with traumatized clients can result in vicarious traumatization (Finklestein et al., 2015). Changes that occur through the process of vicarious traumatization include changes of worldview, psychological beliefs and needs, as well as changes in self-capacities and abilities (Pearlman & Mac Ian, 1995). Certain factors contribute to the increased risk of developing vicarious trauma, such as a greater caseload and more time spent with patients (Finklestein et al., 2015). O'Neill (2010) noted the increased risk of northern practice for providers, and how aspects of working in

an isolated community can increase risk of exposure to various constructs of secondary trauma. Working in isolation away from personal and professional supports, with limited training opportunities and clinical supervision, may leave providers vulnerable to vicarious trauma (O'Neill, 2010). The researchers highlighted the complexities of providing isolated mental health services to northern communities because of the interactions between mental health support, secondary trauma, and histories of historical and intergenerational trauma.

Below, I outline the approach that I used in my research, which included a social constructionist epistemology, a constructivist self-development theoretical framework, participatory action research methodologies, semi-structured interviews, and thematic analysis.

Epistemology

The epistemology that directed my research is social constructionist. As described by Crotty (1998), social constructionists argue that all knowledge is based on human practices and is constructed by interactions between humans and the world, which is then transmitted within a social context. Given (2008) referred to the term social construction as "the tradition of scholarship that traces the origin of knowledge and meaning and the nature of reality to processes generated within human relationships" (p. 816). Crotty (1998) emphasized the cultural and institutional role in how we make sense of the world, as social constructionists use critical thought to acknowledge and challenge dominant social thought. The use of social constructionism provided me with an understanding of how FIFO service providers collectively construct the different factors that impact the delivery of mental health services within the context of Inuit communities. Taking this approach allows for diverse perspectives that contributes in equal ways to the construction of meaning which is important as different people may construct meaning of the same phenomenon in different ways.

Theoretical Framework

To better understand the experiences of vicarious trauma in FIFO mental health providers, the theoretical framework that informed this research was the constructivist self-development theory (CSDT). CSDT was an appropriate framework for this research as it enabled us to be able to describe and understand how and why traumatic work can profoundly impact a trauma therapist. McCann and Pearlman (1990) conceptualized vicarious trauma from the theoretical position of cognitive development and constructivism by blending object relations, self-psychology, and social cognition theories (Pearlman and Saakvitne, 1995). The authors suggested that vicarious trauma can result in changes to cognitive systems and schemas, which include beliefs, assumptions, and expectations of the self and world.

McCann and Pearlman (1990) identified five components of the self that can be affected by exposure to traumatic material: frame of reference; self-capacities; ego resources; psychological needs; and cognitive schemas, memory, and perception. Frame of reference refers to an individual's sense of identity and views of the self, the world, and relationships. Self-capacities include a person's ability to manage emotions and feelings related to love and inner connection with others. Ego resources refers to self-awareness and interpersonal skills that would include maintaining healthy boundaries. Psychological needs are an individual's feelings for safety, intimacy, control, trust, and esteem. Finally, cognitive schemas, memory and perception refer to the disruption of the imagery system that are often impacted by a traumatic event. It is within these five components that therapists' distorted beliefs and vicarious traumatization reactions may occur (Trippany et al., 2004).

Understanding CSDT can assist mental health service providers in identifying symptoms of vicarious trauma. This theoretical framework describes how exposure to traumatic material

can affect the trauma therapist. According to CSDT, individuals actively construct their realities through cognitive schemas and perceptions, which help to understand the world and life experiences (Trippany et al., 2004). Changes to schemas can occur as a result of interaction among clients' stories and the personal characteristics of the provider (Saakvitne & Pearlman, 1996; Trippany et al., 2004). Through the CSDT lens, adaption occurs through interpersonal, intrapsychic, familial, cultural, and social frameworks (Trippany et al., 2004). Researchers who adopt a CSDT framework propose that vicarious trauma symptoms are a normal adaption to a client's traumatic experience. When a therapist encounters events outside of their current perceptions, irrational beliefs develop as a form of self-protection against the emotionally traumatic experiences (Trippany et al., 2004). These changes are pervasive and cumulative, which impact every aspect of a therapist's life and cumulate with each exposure to traumatic material that reinforces the altered beliefs and schemas (Trippany et al., 2004).

The CSDT framework was suitable for this research project given the focus on factors that influence the experience of vicarious trauma for FIFO mental health providers. I used this theory to understand the risk and protective for the development of traumatization for providers in the first publishable paper, and the opportunities to manage the risk of vicarious trauma through a combination of in-person and remote counselling as a result of COVID-19 in the second publishable paper.

Methodology

To guide this qualitative research study, participatory action research (PAR) was chosen as the methodology. To address the research questions outlined in this thesis, a partnership was formed with Northern Therapeutic Counselling Services (NCTS). Thus, it was crucial to engage

with a methodology that would prioritize the organization's representatives' research needs and goals.

Action research has become increasingly popular in health research, as action researchers seek to study as well as change practice (Green & Thorogood, 2009). The term *action research* first appeared in the work of Kurt Lewin, a psychologist who attempted to methodically address social problems by developing a scientific approach to studying social groups (Lewin, 1947). Lewin found that people who experience the need to change (unfreezing) will move to a new standard of behaviour (moving) and stabilize the change (refreezing) (Coghlan & Jacobs, 2005; Lewin 1947). Since its origins, Lewin's theories continue to influence researchers today who organize their work in cycles of steps including observing, reflecting, acting, evaluating, and modifying (McNiff & Whitehead, 2006). Hart and Bond (1995) noted the potential of participatory action approaches for health professionals who are interested in improving their practice or organization as these strategies combine both processes of knowledge production and practice changes in the short term. This allows for the research, action, and evaluation to occur in one process. The sharing of findings with participants allows for the discussion to inform subsequent stages of the research, and leads to cyclical research design–including planning, observing, acting, and reflecting–which can inform future research and may generate new questions (Green & Thorogood, 2009).

The roots of PAR are often traced back to the Brazilian educator Paolo Freire, who believed in an emancipatory approach to educating, in which education should be liberating rather than a passive process (Freire, 2000). Reason (1998) described PAR as an approach that liberates communities by shifting the balance of knowledge from the researcher through engagement in research activities. Researchers have applied this concept when working with

communities through understanding that knowledge is "an outcome of a process of sharing, reflection, and experience rather than a process of experts either inserting or extracting information" (Green & Thorogood, 2009, p. 21). Overall, PAR is a collaborative methodology that creates a reflexive awareness within organizations and emphasizes a conscious approach to action (Green & Thorogood, 2009). In this section, I highlight the strengths and weaknesses of the PAR approach, and I demonstrate how the key principles of PAR guided this research to align with the priorities of the partner organization.

Strengths

A key feature of the PAR approach is the emphasis on collaboration with the participants to improve conditions. Researchers conduct studies "with" a group of people rather than "on" a group of people by incorporating participants' perspectives in all phases of the research process (Olshansky et al., 2005). Power is another critical concept of PAR, with the goal to empower all of those involved in the research process (Baum et al., 2006). By seeking to be active in research, individuals and community members are increasing their capacity as powerful agents (Baum et al., 2006), which should promote trust and their active involvement in ongoing work (Olshansky et al., 2005). The dynamic relationship between researcher and participant will increase the likelihood of obtaining the ultimate goal of PAR, which is to create social change (Olshansky et al., 2005).

Researchers have highlighted the appropriateness of the application of PAR in the realm of health research (Baum et al., 2006; Olshansky et al., 2005). Using a PAR approach includes both studying a problem, as well as creating action towards solving such problems (Olshansky et al., 2005). Health disparities among particular groups is an example of social injustice that must be addressed (Olshansky et al., 2006). Baum et al. (2006) argued that PAR could be particularly

useful in mental health research as it allows participants, in this case, mental health professionals, to have a voice in service development and implementation that encourages choice for delivery of services in a manner that considers service provider health and wellbeing.

Weaknesses

Although PAR has numerous strengths, it is not utilized without challenges. The term PAR and its meaning lack consistency and are sometimes used interchangeability with "action research" (MacDonald, 2012). This may be confusing for beginner researchers and others who are not familiar with employing this type of approach (MacDonald, 2012). Other factors that make it hard to engage in this approach include unwillingness for community or organization to participate (Cornwall & Jewkes, 1995). Cornwall and Jewkes (1995) noted that not everyone will be motivated to be involved nor want to commit time and resources to involvement. This makes participant involvement unpredictable and not always continuous (Cornwall & Jewkes, 1995). Furthermore, researchers must use this methodology carefully so that they do not homogenize groups of peoples or communities (Bennett, 2004). Within groups, there can be numerous interconnected axes of difference including gender, age, wealth, religion, ethnicity, and–as a result–power (Cornwall & Jewkes, 1995). Thus, the researcher needs to be aware of competing or changing versions of community members' needs and/or values (Cornwall & Jewkes, 1995).

Indeed, the strengths of PAR outweigh the limitations of this approach, which was an important factor in achieving the goals of this research. Below, I explain the process in which I engaged with in PAR with Northern Counselling and Therapeutic Services.

PAR and Northern Counselling and Therapeutic Services

Due to my interest in mental health service delivery in northern Indigenous communities, my supervisor and I approached the owners of NCTS to understand the experiences of FIFO

mental health service delivery in Inuit communities. After meeting with the founders of the organization, a partnership and advisory board was formed for my research. In the initial meeting with the advisory board, I was able to understand the needs of NCTS. The advisory board was comprised of two FIFO mental health service providers, two researchers, and one representative from our partner organization, NCTS. Guided by the insights from this meeting, I began to develop a research project. Throughout this study, the advisory board guided each phase of this project, which was refined and changed to reflect the needs of the organization. Communication was maintained through emails and virtual meetings where advisory board members provided feedback and advice. Based on their recommendations, I chose to conduct semi-structured interviews with mental health service providers, who were contracted by NCTS, to adequately capture their experiences. Through an iterative research process, we co-constructed an interview guide, reviewed the results of the interview data, and discussed findings with the community advisory board. A representative from the organization closely supported data analysis and was a co-author on the first and second publishable paper. A final report with the findings was created and distributed to participants, advisory board members and the partner organization. I outline these methods below.

Methods

According to Crotty (1998), methods are a comprehensive strategy that uses specific approaches that relate to the anticipated outcome. Within qualitative research, interviewing is the most common format of data collection (Jamshed, 2014). Qualitative research interviews are employed to understand the world from the point of view of the subject (DeJonckheere & Vaughn, 2019). Thus, the method used to collect data for my thesis was semi-structured interviews.

Participant Recruitment and Procedure

Through my research, I sought to explore the perspectives of FIFO mental health service providers who delivered services in Inuit Nunangat. Selection criteria included that participants were proficient in English; considered themselves to be mental health service providers; and provided these services to communities in Inuit Nunangat.

To recruit participants, emails were shared through our partner organization. Once a few participants were successfully recruited, I used snowball sampling (Ghaljaie et al., 2017) and other interested participants contacted me through email. When providers expressed interest in participating, study information was forwarded over email. Once participants agreed to take part in the study, I sent a copy of the participant consent form and arranged an interview time that was scheduled to be conducted either online via Zoom or over the phone. I interviewed a total of eight mental health service providers (See Table 1: Service Providers), all of which identified as Caucasian who currently reside outside of Inuit Nunangat. All participants provided written consent prior to participating in the study. To understand the experiences of mental health service providers in Inuit Nunangat, I used semi-structured interviews.

Table 1: Service Providers

Name		**Years of Service Provision to Inuit Nunangat**
Susan	Female	10 years
James	Male	10 years
Diane	Female	1 year
Tanya	Female	2 years
Carol	Female	7 years
Rebecca	Female	5 years
David	Male	2 years

Rachel	Female	3 years

Note. The data presented reflects the years of experience with NCTS. Prior to being hired with the partner organization, all employees had a minimum of ten years of counselling experience.

Semi-Structured Interviews

Interviews are an excellent way of gaining insights into the experiences of participants (Fontana & Frey, 2005). Fontana and Frey (2005) described three types of interviews in qualitative research: structured, semi-structured, and unstructured interviews. Structured interviews are typically conducted in a very standardized and straightforward manner (Fontana & Frey, 2005). There is a predetermined set of questions that are asked, with little variation in response from participants (Fontana & Frey, 2005). In contrast, unstructured interviews provide opportunities for a larger range of topics to be covered due to the open-ended nature of the questions (Fontana & Frey, 2005). Semi-structured interviews combine strategies from both structured and unstructured interviews that allows researchers to ask participants preestablished, but open-ended questions (Given, 2008).

There are many strengths associated with semi-structured interviewing that have established it to be an effective method to collecting open-ended data from participants (DeJonckheere & Vaughn, 2019). This method follows a flexible interview protocol, with supplemental probes and comments to explore participants' feelings, thoughts, and beliefs about a particular topic (DeJonckheere & Vaughn, 2019). DeJonckheere and Vaughn (2019) recognized the use of semi-structured interviews as a useful tool for collecting qualitative data in health services research. Semi-structured interviewers have the ability to gather information from key informants who have personal attitudes, experiences, and perceptions related to the topic of interest (DeJonckheere & Vaughn, 2019). Many researchers use this form of interview to

understand providers' perspectives on health behaviours (Chang et al., 2013; Croxson et al., 2018).

Though semi-structured interviews give researchers the ability to effectively collect open-ended data, there are disadvantages to this type of interviewing. Not all interviewees participate at the same level, and some individuals are harder to engage with in this type of questioning (DeJonckheere & Vaughn, 2019). Moreover, some participants may not want to discuss sensitive topics (DeJonckheere & Vaughn, 2019). Other weaknesses of this method include the potential for an interviewer to miss important opportunities for asking appropriate follow-up questions, or underestimating the amount of time and resources that this type of interviewing can take (DeJonckheere & Vaughn, 2019).

Engaging with semi-structured interview method allowed me to obtain rich data in a way that felt comfortable for participants. I accomplished this through guided questions about the types of services the NCTS mental health service providers offer, and the different challenges they face as FIFO providers (see Appendix A). Some of the interview questions in this study were modeled after a Northern Mental Health and Wellness survey developed by O'Neill et al. (2013b) to understand the experience of northern mental health practitioners providing formal and informal mental health support in northern British Colombia, northern Alberta, Yukon, the Northwest Territories and Nunavut. Based on the survey generated by O'Neill et al. (2013b), and information provided by Peterson (2000) on how to construct effective questionnaires, we developed a moderator guide to address my research question. This guide included specific questions that pertained to fly-in and fly-out mental health services in Inuit Nunangat, and the impacts of the novel COVID-19 virus on service delivery (see Appendix A). At the time of interviews, there were minimal to no cases of COVID-19 in the communities serviced.

Considering the rapidly changing COVID-19 situation, a follow-up email was sent to all participants to gain insight into if/how their situation prior to our analysis. The questions in the follow-up email were: *How has the recent increase of COVID-19 cases changed the demand for your services? As a result of the uptake in COVID-19 cases, have you experienced any different/new challenges with remote counselling?*

To adhere to public health guidelines in place as a result of the COVID-19 pandemic, all interviews had to be conducted via Zoom or on the phone. Conducting online interviews presents its own challenges that may not be present in face-to-face interviews (Mirick & Wladkowski, 2019). Technological issues such as connectivity problems, indistinct audio, and lags in video and sound can arise (Mirick & Wladkowski, 2019), which may distract interviewers and participants and affect the quality of the interview and audio recording (Irani, 2019). Other issues such as the inability to see the full range of body language and non-verbal cues may also be observed (Irani, 2019). Despite these limitations, online interviewing does allow for flexible scheduling in a relaxed, familiar environment (Irani, 2019). This approach allows for a researcher to preserve many benefits of in-person interviews while adding an element of convenience for both researchers and participants (Irani, 2019).

Data Analysis

Thematic Analysis

Thematic analysis is a robust, systematic approach to data analysis that allows the researcher to identify, analyse, and report patterns of meaning within the data (Braun & Clarke, 2006; Crowe et al., 2015). Researchers who utilize this approach to their analysis have the ability to describe their data in rich detail, and to organize and interpret qualitative data to further understand participant descriptions of their experiences through the identification of common

themes and categories (Braun & Clarke, 2006; Crowe et al., 2015). Green and Thorogood (2009) recognized thematic analysis as a comparative process, where the accounts gathered are compared to one another to classify reoccurring themes. It is, however, more than merely categorizing and coding data (Green & Thorogood, 2009). Other important aspects to consider are the relationships between themes that have emerged, and the context from which the themes have appeared (Green & Thorogood, 2009). Crowe et al. (2015) recommended the use of thematic analysis as a technique of analysis to look at the skills of mental health providers to understand the complexity of their works. This research technique allows the researcher to look at multiple descriptions of each participant's experience to develop a broader sense of the general experience itself (Crowe et al., 2015). Crowe et al. (2015) emphasized the use of thematic analysis in research to provide a greater interpretation of the meaning in participant responses.

Although thematic analysis is not explicitly bounded to a theory or epistemological position (Braun & Clarke, 2006), it offers a flexible approach that I feel complements my epistemological position and is well-tailored to the use of social constructionism in this work. This method of analysis was appropriate for this research study as I required an approach that was flexible enough to reflect the research needs and priorities of the participants. Engaging in thematic analysis allowed me to conduct a theoretically driven form of analysis that was reflective of participant views.

Braun and Clarke (2006) described a six-phased process to guide thematic analysis of the data. In the first phase, the researcher must immerse themselves in the data to familiarize themselves with the depth and breadth of content. During phase two, the researcher is focused on generating initial codes and organizing data into meaningful groups. The third phase is to search for themes by examining codes and organizing the data into potential themes. Phase four

involves reviewing and refining themes to determine if they accurately represent the data and address the research question. In the fifth phase the researcher is required to define and name the themes while further developing the analysis to determine what aspect of the data is being captured by each theme; Braun and Clarke (2006) refer to this as identifying the "essence" of each theme. In the sixth and final phase of analysis, the findings are written up to provide an analytic narrative that situates the results within existing literature. While following these steps of analysis, I also engaged in Braun and Clarke's (2019) update to this approach which emphasizes reflexivity. To achieve reflexivity, I challenged my own assumptions on FIFO mental health service provision as someone who received FIFO care for much of my childhood. This reflection helped me recognize how my perspectives may differ from those delivering the services, which added a level of reflexivity to my analysis. Through this updated approach I was able to reflect on how the themes found relate to the literature on service provision to the North and what conclusions may be drawn based on the data found.

To begin data analysis, all transcripts were uploaded to NVivo[10], a qualitative data analysis software package. All interviews were digitally recorded, transcribed verbatim, and returned to participants for review. Two participants made revisions to some potentially identifying information, while one participant added a brief clarification related to physical wellness. Each transcript was reviewed and initial codes were generated. I organized the codes and recognized patterns in NVivo software, which were then reviewed with my supervisor to generate preliminary themes. These findings were shared with the non-research members of the advisory board to ensure we accurately reflected the perspectives of the service providers. Once the themes were reviewed and confirmed, I then proceeded to writing publishable papers and a

final report for all participants and NCTS. By rigorously following these steps of thematic analysis, I was able to produce insightful analysis to address my research question.

Ethics

This research was approved by the Carleton University Research Ethics Board. This study was first approved on 11 May, 2020, and underwent two revisions that were approved on 23 June, 2020 and 20 July, 2020. The most recent renewal was received on 11 May 2021 (see Appendix B). As the interviews were all conducted with individuals who were not in the Northwest Territories or Nunavut at the time, I did not have to obtain a research licence.

Thesis Format

In this chapter, I introduced the literature addressing the complexities of providing FIFO services to communities in Inuit Nunangat, as well as the epistemology, theoretical framework, methodology, methods, and analysis I used in two of my publishable papers. In the chapters that follow, I present two publishable papers. In Chapter two, I examine the factors that influence mental health service providers' experiences of vicarious trauma who FIFO of Inuit communities. In Chapter three, I illustrate the impact of COVID-19 on FIFO mental health service providers who typically deliver in-person services to regions in Inuit Nunangat, but who have had to rapidly shift their services to be offered online. In these papers, you will notice that "I" and "we" are used interchangeably. "I" reflects my direct contributions to these papers, while "we" reflects the contributions of the advisory board, and/or Drs. Darroch and Giles. The findings presented in these Chapter two and three make an important contribution to address the gap in the literature surrounding FIFO practices in Canada. To my knowledge, these are the first papers that address the experiences of FIFO providers with a focus on mental health and the northern, Inuit context, and the first to consider the impacts of COVID-19 on service delivery

from the perspective of the service provider. I hope that this research can inform future policies and practices to enhance support to providers travelling to remote Inuit communities.

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Chapter Two: You're Carrying so Many People's Stories: Vicarious Trauma Among Fly-in Fly-Out Service Providers in Canada

Abstract

The purpose of this article is to examine the factors that influence fly-in and fly-out (FIFO) mental health service providers' experiences of vicarious trauma as they deliver services to communities in Inuit Nunangat through a constructivist self-development theory (CSDT) lens. Using semi-structured interviews, we explored eight providers' perspectives on the risk of developing vicarious trauma and potential strategies to mitigate the risk of vicarious traumatization. Using a participatory action research methodology, we identified three themes through thematic analysis: 1) vicarious trauma is an "occupational hazard" when entering communities with high rates of trauma; 2) self-care, boundaries, and external supports are crucial to FIFO providers' well-being and career longevity; 3) FIFO models of care may reduce the risk of vicarious trauma for service providers. We conclude that FIFO models of care may help mental health service providers to manage the risk of vicarious trauma through reduced caseload and less time spent in community.

Keywords: vicarious trauma, fly-in/fly-out, mental health, mental health service provider, rural and remote, Inuit

Mental health service delivery to rural and remote regions of Canada is complex as community members face barriers to mental health care (Mental Health Commission of Canada (MHCC), n.d.). Individuals in residing in communities in Inuit Nunangat, which comprises four regions which include the Inuvialuit Settlement Region, Nunavut, Nunavik, and Nunatsiavut, are often forced to travel to obtain mental health services or rely on transient and fly-in fly-out (FIFO) healthcare professionals and who do not reside in their community (Inuit Tapiriit Kanatami [ITK], 2014; ITK, 2021; Oosterveer & Young, 2015). The recruitment and retention of permanent health professionals is challenging due to the remoteness of Inuit communities (ITK, 2014; Oosterveer & Young, 2015). This is especially problematic for Inuit who reside in Inuit Nunangat and experience poor health outcomes related to mental health (ITK, 2014), which are symptoms of colonialism, racism, and marginalization amongst other challenges that result in persistent inequality (ITK, 2014; Kirmayer et al., 2011). For mental health service providers to provide continuity in services to Inuit, there must be considerations for the practitioners' mental health and well-being. Constant turnover of mental health providers is a challenge for clients who need continuity of care (ITK, 2014). Although there is limited literature that examines the experience of vicarious trauma in FIFO service providers, there is an overwhelming amount of evidence that experiences of trauma can be shared between provider and client (Finklestein et al., 2015; McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Quitangon, 2019). While researchers have examined the effects of vicarious trauma on therapists globally (Cohen & Collens, 2013; Finklestein et al., 2015; Harrison & Westwood, 2009), to my knowledge, there is limited peer-reviewed research on the impact for FIFO mental health service providers who deliver services to Inuit communities in Canada.

Literature Review

Vicarious Traumatization

Secondary exposures to trauma can negatively affect the well-being of mental health providers and the quality of care they are able to provide (Quitangon, 2019). Three frequently used constructs that have been used interchangeably to describe the impact of providing trauma therapy on mental health providers are: compassion fatigue, secondary traumatic stress syndrome, and vicarious trauma (Devilly et al., 2009; Quitangon, 2019; Voss Horrell et al., 2011). These three constructs are interrelated and complex, with some arguing that they measure the same phenomenon (Devilly et al., 2009), while others argue that they in fact relate to different phenomena (Jenkins & Baird, 2002; Quitangon, 2019). Quitangon (2019) described compassion fatigue, which was originally referred to as secondary trauma stress syndrome, as empathic strain and exhaustion from caring for people in distress, which present as PTSD-like symptoms. Burnout is mentioned frequently in the literature as a persistent state of exhaustion that is a result of prolonged exposure to occupational stress (Quitangon, 2019). Although both constructs describe manifestations of exhaustion, unlike vicarious trauma, neither compassion fatigue nor burnout are specific to working with clients who have experienced trauma (Quitangon, 2019). There is a body of research that supports vicarious trauma as the only concept that describes a change in world views that are similar to the changes that occur in the traumatized client and that emphasizes cognitive symptomatology (Jenkins & Baird, 2002; Pearlman & Mac Ian, 1995; Quitangon, 2019).

Pearlman and Mac Ian (1995) defined vicarious trauma as the inner transformation of a trauma provider due to a cumulative and empathetic engagement with the client's traumatic experiences (Pearlman & Mac Ian, 1995). Clemans (2005) described vicarious trauma in a

broader manner and conceptualized it as emotional, physical, and spiritual transformations that may occur when working with members of populations that have experienced trauma. Documented symptoms of vicarious trauma include changes in one's identity, worldview, interpersonal relationships, sense of oneself in the world, cognitive schemas or a person's beliefs and assumptions about the world (Pearlman & Saakvitne, 1995), and post-traumatic stress disorder (PTSD)-like symptoms such as intrusive imagery, painful experiences of images, and emotions that are parallel to the traumatic memories of clients (Jenkins & Baird, 2002). For the purposes of this paper, aligning with the definitions provided by Jenkins & Baird (2002), Pearlman & Mac Ian (1995), and Quitangon (2019), we will consider vicarious trauma as a separate construct that occurs as a result of interactions with clients who have experienced trauma.

Risk Factors for Mental Health Service Providers

Mental health providers are particularly vulnerable to vicarious trauma as a result of repeated exposure to details of clients' trauma experiences (Quitangon, 2019). Researchers have found that the more time mental health professionals spend with their traumatized clients and the heavier the workload, the higher the providers' risk of developing vicarious trauma (Finklestein et al., 2015; Pearlman & Mac Ian, 1995). Additional influences on vicarious trauma include stressful client behaviours, the nature of the clientele, work setting, and social-cultural context, as well as provider characteristics such as personal history of trauma, professional development, and current stressors and supports (Pearlman & Mac Ian, 1995). In a study that examined the predictors of vicarious trauma in non-victims, Lerias and Byrne (2003) reported that young age, being female, low socioeconomic status, high levels of stress, and low levels of social support may predict vulnerability to vicarious trauma.

Mitigation of Vicarious Trauma

To mitigate the risks of vicarious trauma for mental health service providers, it is essential to understand the protective and supportive factors. Cohen and Collens (2013) conducted a metasynthesis to examine the impact of trauma work on trauma workers, and they posited that personal factors such as optimism and spirituality can be considered resilience factors due to their impact on practitioners' ability to cope with work-related distress. Optimism was found to not only function as a coping strategy, but also as an aspect of posttraumatic growth. Other researchers have suggested that personal strategies such as the balancing of personal and work life can moderate the negative impact of trauma work (Pearlman & Mac Ian, 1995). These findings contrast with findings from a study conducted by Bober and Regehr (2006), who found that although clinicians who work with victims of violence reported the usefulness of engaging with coping strategies such as self-care and leisure activities, there was no association found between self-care and lower traumatic stress scores.

Bober and Regehr (2006) proposed that the most significant predictor of high trauma scores for mental health service providers was the number of hours worked per week with clients who experience clients; organizations should thus consider the ways in which they distribute workload to providers to limit their traumatic exposure (Bober & Regehr, 2006). Cohen and Collens (2013) found that organizations can play instrumental roles in managing the distress of mental health workers, and these authors recommended that organizations foster a systematic approach to managing the impact of trauma work by providing institutional support and encouraging individual coping strategies.

Finally, numerous professional variables have been identified as affecting the development of vicarious trauma such as mental health provider training and professional

support (Finklestein et al., 2015; Michalopoulos & Aparicio, 2012; Trippany et al., 2004). In a study looking at the development of vicarious trauma among social workers, Michalopoulos and Aparicio (2012) determined that more professional experience and increased support predicted a decrease in vicarious trauma symptoms. Having access to peer support systems, specialized trauma education, and training to support professional self-efficacy can strengthen provider resources and help to manage their risk of developing vicarious trauma (Finklestein et al., 2015; Trippany et al., 2004).

Mental Health Service Delivery in Rural and Remote Canada

Members of communities in rural and northern regions of Canada face significant difficulties when accessing mental health care (Dyck & Hardy, 2013). Although rural and remote communities are often categorized by geographic isolation, they can also be defined by their organizational, social, and cultural arrangements (Bourke et al., 2013). Pitblado (2005) found that northern is also frequently used in the context of rural health research in Canada. Most often, the terms rural and remote are used under the same umbrella (Bourke et al., 2013). Barriers that affect access to services for these residents include limited local mental health care services and clinicians, high travelling costs, and long wait times, among others (Boydell et al., 2006; Dyck & Hardy, 2013). Due to these challenges, many communities in the Circumpolar North rely on short-term locum providers who travel from outside the region to provide healthcare services (Huot et al., 2019). Wakerman et al. (2012) described FIFO services in a healthcare setting in a variety of ways: specialist outreach services; “hub-and-spoke” or outreach arrangements for allied health and specialists, which consists of an establishment (hub) providing services to multiple secondary establishments (spokes); “orbiting staff” who spend 12 months or more in one or two specific communities; long-term shared positions in which practitioners service the

same communities (e.g., one month on/one month off); and short-term locums who service numerous rural locations on a short-term basis. In Canada, little is known about FIFO mental health services to Inuit communities, although mental health service delivery is particularly important for Inuit peoples, who have complex histories of colonization, trauma, marginalization, and racism (Kirmayer et al., 2011). For FIFO mental health professionals working with Inuit, managing and monitoring symptoms of vicarious trauma is essential given the magnitude of historical and intergenerational traumatic issues experienced by this population.

Research and available information on the practice and experience of delivering mental health services in northern Canada is limited (O'Neill et al., 2013). Furthermore, the literature surrounding the transmission of trauma and coping strategies for mental health providers in the North is scant (O'Neill, 2010). In a review looking at secondary trauma in mental health practitioners in northern communities, O'Neill (2010) demonstrated the connection between isolated mental health practice and secondary trauma. In their review, secondary trauma was defined under the constructs of vicarious trauma, burnout, compassion fatigue, and secondary trauma stress. The author highlighted the vulnerability of providers to the various constructs of secondary trauma by describing the potential impact of professional and personal isolation combined with the requirements of empathic engagement with clients (O'Neill, 2010). In a study looking at the experiences of rural and remote nurses in Canada, Jahner et al. (2020) detailed the risks of encountering distressing incidents that affect the psychological health and physical safety. Participants in their study reported concern over limited protective strategies and a lack of supportive action from organizations, which put providers' psychosocial health and safety (Jahner at al., 2020).

Factors specific to northern mental health practice may contribute to the development of secondary trauma. O'Neill (2010) listed several contributing factors: prolonged interaction with traumatic material, lack of clinical supervision, high visibility in small communities, and complex overlapping relationships. Although, as noted above, researchers have identified protective practices to prevent vicarious traumatization of mental health providers such as access to supervision (Finklestein et al., 2015; Pearlman & Mac Ian, 1995), organizational support (Cohen and Collens, 2013), and training (Finklestein et al., 2015; Harrison & Westwood, 2009; Pearlman & Mac Ian, 1995), O'Neill (2010) acknowledged that these practices are not always possible in northern communities. Although outside of a FIFO context, O'Neill recognized the difficulties in developing supportive social networks in isolated or rural communities in combination with a lack of clinical supervision, leaving providers vulnerable to personal and professional isolation. Indeed, this is problematic given the extensive number of scholars who have noted how support can reduce the risk of vicarious trauma. The purpose of the current study was to extend the literature to include experiences of vicarious trauma among FIFO mental health providers who deliver services to Inuit communities in Inuit Nunangat. Through our participatory action research (PAR) with Northern Counselling and Therapeutic Services (NCTS), we aimed to co-identify and recommend strategies to reduce the risk of traumatization for FIFO mental health service providers.

Theoretical Framework

Vicarious trauma has its theoretical basis in the constructivist self-development theory (CSDT), which allows researchers to conceptualize an individual's adaptation to trauma through interaction between a traumatic event, personal history, and the social and cultural context (Pearlman & Mac Ian, 1995). The underpinning of this theory is that individuals construct their

realities through cognitive schemas or perceptions (Trippany et al., 2004). Trippany et al. (2004) noted that the CSDT framework proposes that changes in perceptions or cognitive schemas can occur as a result of interacting with clients' traumatic material and personal characteristics. The new information and experiences presented by clients are incorporated into the beliefs and systems of meaning for trauma therapists, which encourages change within the provider. There are five components of the self that are affected by exposure to trauma: frame of reference; self-capacities; ego resources; psychological needs; and cognitive schemas, memory, and perception. According to CSDT scholars, vicarious trauma reactions and distorted beliefs occur within the five components (Trippany et al., 2004). By using a CSDT lens, we sought to better understand how FIFO mental health service providers experience vicarious trauma. To my knowledge, this theoretical framework has not been explicitly discussed in the context of FIFO practitioners who serve Inuit Nunangat.

Methodology

The research was approved by Carleton University's Research Ethics Board (CUREB-B 112643). This study was conducted using a PAR approach in partnership with NCTS. When engaging in a PAR approach, action is achieved through collecting and analyzing data alongside those who stand to benefit from the action taken (Baum et al., 2006). An advisory board, which consisted of two FIFO mental health service providers, two researchers, and one representative from my partner organization, guided all phases of the research. In accordance with a PAR approach, the aim of this research was to co-create action and change with participants, specifically through changes to existing policy, procedures, and practice guidelines within the partner organization to optimize their service provision in the North (Baum et al., 2006). NCTS

offers a variety of services across the North including in-person counselling services, crisis response, clinical staff fill in, among others.

Using an interview guide co-created with the advisory board, the first author conducted eight semi-structured interviews with FIFO mental health service providers who work with Northern Counselling and Therapeutic Services and deliver services to communities in Inuit Nunangat to understand the experiences of vicarious trauma among FIFO mental health providers (see Table 2: Service Providers). We recruited participants who met the following eligibility criteria: spoke English and had a minimum of one year of experience with FIFO delivery of mental health services to residents of communities in Inuit Nunangat. We recruited participants through an email that was circulated within the partner organization and snowball sampling (Ghaljaie et al., 2017). Before conducting interviews, each participant provided written informed consent. In total, there were six female participants and two male participants, all of whom identify as Caucasian and reside outside of Inuit Nunangat. While participants all reported a minimum of ten years of counselling experience, their work in the FIFO capacity ranged from one to ten years. Time spent in Inuit communities was described as dependent on the type of contract, which differed among providers, varying from a few weeks for crisis response and short-term staff fill in, to multiple months for school settings and longer-term staff fill in. Participants received a $25 gift card to thank them for their involvement in the research.

Table 2: Service Providers

Pseudonym	**Years of FIFO Service Provision to Inuit Nunangat**
Susan	10 years
James	10 years
Diane	1 year

Tanya	2 years
Carol	7 years
Rebecca	5 years
David	2 years
Rachel	3 years

All interviews were digitally recorded and lasted between 45 and 90 minutes. Questions guiding the semi-structured interviews included questions, *What do you or your colleagues do to mitigate the risk of vicarious trauma? What supports are available for practitioners who experience vicarious trauma? What motivates you to return to northern communities to provide mental health services?* I transcribed the interview data verbatim and checked the transcription accuracy before sending the transcripts to participants for verification. Participants made few changes: two participants changed their transcripts were to remove identifying information, and one participant added additional information for clarification. I then uploaded the transcripts into a qualitative software data analysis program, NVivo[10], for coding and analysis.

Analysis

The first author and Darroch conducted a thematic analysis. Using Braun and Clarke's (2006) six-step approach to thematic analysis. We also engaged in reflexivity while following Braun and Clarke's (2019) update to this approach. First, we familiarized ourselves with the data, and we proceeded to generate initial codes and organize the data to develop potential themes. Potential themes were reviewed to determine if they were relevant to the extracted data. To ensure the themes captured the experiences of FIFO service providers, we shared the findings with the board members who agreed with the results. In the final step, as advised by Braun and Clarke's (2006) approach, we constructed three themes: 1) Vicarious trauma is an "occupational hazard" when entering communities with high rates of trauma; 2) Self-care, boundaries, and

external supports are crucial to FIFO well-being and career longevity; and 3) FIFO models of care may reduce the risk of vicarious trauma. To achieve reflexivity, we reflected on our positionally as it relates to the research, such as how our own experiences of trauma and our professional work may impact how we perceive the experience of vicarious trauma. For example, all authors have undergraduate or graduate level training in psychology, and thus may have preconceived ideas of risk and protective factors for the development of vicarious traumatization.

Results

THEME 1: Vicarious trauma is an "occupational hazard" when entering communities with high rates of trauma

In the first theme, mental health providers identified exposure to trauma as an "occupational hazard of their work as counsellors in Inuit Nunangat. Many participants described the risks associated with providing counselling services in small Inuit communities where members have experienced trauma. Rebecca stated,

> Just the constant exposure to trauma, right? It's an occupational hazard… it's a small community. You have to manage being discreet and neutral in the community because you're carrying so many people's stories. You're at high risk [of developing vicarious trauma] for sure.

Rebecca described the impacts of working in a community on a longer-term FIFO contract:

> I feel quite exhausted at the end of the week because of the concentration of pain and the energy that it takes me to show up professionally and interact with a number of different professionals that I don't have a history with.

In comparison, Susan shared her experience of working in a crisis response role and the challenges that this short-term position entailed. Susan recognized the potential of being triggered by the trauma that has cumulated from the lack of mental health care in some communities despite the overwhelming need for counselling services. Susan explained:

> We know some of these deployments can be triggering … we had a couple of counsellors come in to respond to a suicide and while they were there, someone else committed suicide, and then there was an [type of accident] accident and [number of people] people died. The whole community was just completely overwhelmed with everything, and it's really hard not to get overwhelmed yourself because you're in the middle of that. People just offload on you, and it's sometimes people who haven't had the opportunity for this kind of counseling when there's no crisis, so they also have a lot of pent up trauma or emotion or courage or other experiences that all get triggered and come out, so it's huge what comes to our counsellors.

Whether service providers were in the community for short- or long-term contracts, all participants agreed that there is a risk for the development of vicarious trauma.

THEME 2: Self-care, external supports, and boundaries are crucial to FIFO providers' well-being and career longevity

While mental health service providers recognized the risk of developing vicarious trauma, they also identified supports and boundaries that they believe are required to promote personal well-being and career longevity. Carol explained her personal strategies when she is working in northern communities:

> You have to be really self-aware and [have] excellent self-care. I always find a place that I can work-out in a community. And having the debriefing, open honest debriefing with

> one of the associates [within NCTS] to work through that, is really important. Because sometimes you can't just say sorry, I can't work with you. That's not always an option.

Rachel also stated that debriefing with counsellors is essential:

> I think it's [debriefing with other counsellors] part of the job. It's really, really important, because otherwise it [trauma] can be carried in their bodies and it's just important to keep clear and keep healing and be present. We're not immune. Counsellors are not immune to this.

Rebecca also emphasized the importance of self-care and identified physical activity as one of her strategies. Rebecca remarked, "I'd ride my bike to the hospital in the summer in [the community], you know so exercise was great." Beyond physical activity, Rebecca also engaged in other self-care strategies such as massage therapy with a "massage therapist who did trauma massage therapy."

James concurred with the other providers' remarks regarding self-care and extended the discussion to include the significance of providers having their own therapist. He asserted,

> Make sure that you are caring for yourself in healthy ways as opposed to unhealthy ways that includes alcohol and drugs. Exercise, and having your support network so friends and family but also your own counselor that you can call whenever you're stressed to get specific strategies for the specific symptoms of PTSD that you may be facing, feeling or thinking.

Diane agreed that a strong support system is essential, and she emphasized the role that organizational support can play as a crucial aspect of self-care:

> Having that support to process, debrief, release and knowing how to do that for yourself. At NCTS there's strong support to be well within your work as a counselor and so that

> might mean that I need to talk to my own supervisor and just say I'm really struggling with the situation that I'm in front of right now and I feel like the organization supports that well, but also, I need to take that up as a counselor and be aware that this is a real thing that happens. Overtime you can, if you don't take care and process continuously, fall into vicarious trauma, and compassion fatigue or burn out. I guess it's the awareness that it definitely can happen. I guess as counselors we always need to have a supervisor…who we check in with about our role as the counselor and…when [you're] beginning to feel signs of burnout or anything like that, it kind of keeps you in check.

In addition to self-care, personal and/or personnel support, participants discussed the importance of boundaries related to caseload management. Rachel described a strategy she employs in which she manages her caseload and sets boundaries for the type of cases she takes on while engaging in other previously mentioned self-care approaches: "I sort of titrate my involvement with the traumatic situations and so I don't load myself up too much. I basically make sure that I pace myself in terms of taking those types of cases." Tanya found that limiting time within communities is a boundary that is essential. She remarked, "I don't stay there too long, like, I usually like not to stay more than 10 days or 14 days, the most." The importance of engaging in self-care strategies and setting boundaries was highlighted by all participants as crucial aspects of their practice that reduce the impact of vicarious trauma.

THEME 3: FIFO models of care may reduce the risk of vicarious trauma

Many providers credited the FIFO model of care as a potential protective factor against their own traumatization. David explained,

> Honestly, I think that we are lucky in a sense, if we're doing this kind of work, where we're fly-in and fly-out. We have the opportunity to debrief with Northern Counselling

> support people and admin people. And then of course once we're back in the South, we have the opportunity to access our own mental health services and our own support networks. And so, I think there's lots of it [support] available once you're out of those communities. When you're in those communities, I don't think there is much available at all. But again, we're not there for a long period of time. So, in a way, it makes a huge difference when you know you're leaving.

David described the benefits of having the ability to leave communities so that he can decompress, a strategy that he associated with mitigating the risk of vicarious trauma. Rachel echoed this statement and suggested that FIFO work offers health service providers who live in communities an opportunity to recover:

> I think there's certainly a danger of those things [vicarious trauma] happening, but I think in some ways it's mitigated a little bit by the fly-in fly-out model. Because we're in there, we deal with it for a while, and then we're gone. And we get a period of time to recover.

Rachel predicted that the prevalence of trauma among other professionals in the community was higher due to the inability to have time to recover: "The school staff that I was dealing with, the occurrence of PTSD within that school [staff], I would probably tag it around 40%. And then other simple trauma and other types of just stress, I would say was close to 90% to a 100% of the staff were experiencing that."

In line with the aforementioned comments, Tanya described the benefits of being able to go home and for minimizing the amount of time spent in the community and the exposure to traumatic experiences. She stated:

> Usually, we stay for a week or two. Sometimes, some people stay for three weeks. Myself, I don't want to stay too long, because it's also hard on ourselves, right, and we

> have lives here [in the South], as well. So – and I find for our home and for health, it's good not to stay too long. So, we can still be objective, and we can be refreshed after a while.

Rachel felt that the FIFO model of care may act as a protective factor against the development of vicarious trauma, and she expanded the discussion to include what puts FIFO providers at risk. Rebecca agreed, arguing that the FIFO model enables providers to benefit from breaks and keep returning, thus continuing to build relationships within the community:

> That's a benefit of fly-in fly-out. For a couple of months at a time, the relationship building is there. But the person who's there, you know living in the same building in which they offer services [e.g., health centre], they can make sure to get some distance [by flying out] - you know, and not let their whole consciousness be around just their work.

According to providers, the FIFO model itself may serve as a strategy to manage the risk of vicarious trauma and can alleviate stress not only for the travelling provider.

Discussion

Through this current research, we aimed to provide insight into the factors that influence the experience of vicarious trauma for FIFO mental health providers in Inuit communities and propose how FIFO models of care may affect the risk of vicarious traumatization. This study advances the current literature on vicarious trauma among mental health providers in northern Canada (O'Neill, 2010; O'Neill et al., 2016) with a focus on the Inuit Nunangat and FIFO contexts. Overall, we found that participants acknowledged the risks of developing vicarious trauma as a result of working with highly traumatized clients in Inuit communities. As a result, the providers in our study highlighted the importance of developing self-care routines,

establishing boundaries, and maintaining supports to promote well-being and career longevity. The providers acknowledged the FIFO model of care as a potential protective factor from vicarious traumatization. These research findings offer opportunities to inform future practice and policy for the delivery of mental health services to Inuit Nunangat.

Perceived Risk

In alignment with the CSDT framework, the mental health service providers in this study agreed that their engagement with trauma work makes them more vulnerable to the negative effects of vicarious trauma. Being aware of the five areas of self is important for providers who can use this model to help understand how/if they may be experiencing vicarious trauma. Providers in this study acknowledged that their self-capacities can be affected by engaging with traumatized clients, which is characteristic of CSDT as described by Pearlman and Saakvitne (1995). When self-capacities are affected, providers may have difficulty managing emotions negative emotions (Trippany et al., 2004). Similar to other research on vicarious trauma (Quitangon, 2019), providers in this study recognized the inherent risk to their mental health when working with traumatized clients and communities. The providers in this study described the potential risks of developing vicarious trauma based on the type of contract (short-term or long-term) and thus the duration of time they spent in the communities. The providers who assumed a short-term, crisis response role acknowledged the potential of risk of traumatization in the community due to the overwhelming need for mental health services for a large number of clients over a short period of time. These findings align with the work of scholars who have noted that heavier caseloads and constant exposure to trauma stories put providers at a heightened risk for developing vicarious trauma (Bober & Regehr, 2006; Pearlman & Mac Ian, 1995). Providers in this study affirmed that the prolonged exposure to trauma in a small

community setting for an extended period of time can be overwhelming for them. In an article addressing health care provider turnover in Nunavut, Cherba et al. (2019) highlighted the need for Inuit to retain short-term locum physicians. They argued that the high turnover of health care personnel impacts the quality of care for residents in Nunavut through low patient satisfaction, poorer health outcomes, and negative effects on community-provider relationships. Cherba et al. (2019) noted the specific impact that high turnover has on mental health services, citing the lack of continuity in provision of services as a potential cause of critical symptoms being missed. Although discussed in a slightly different context (i.e., primary care provision), the need to ensure the mental well-being of FIFO providers is crucial to optimizing care for community members.

Prevention Strategies

Despite being in Inuit communities for relatively short contracts, the participants in this study noted that establishing strategies to prevent negative emotional responses to trauma work is of utmost importance. Prevention approaches are well reported in the literature, which suggests that engaging in different strategies can affect manifestations of vicarious trauma (Cohen & Collens, 2013; Finklestein et al., 2015; Pearlman & Mac Ian, 1995). Engaging in self-care behaviours has been described as a way for individuals to regulate emotions and experiences, and it is required to provide high-quality services (Cohen & Collens, 2013).
All providers in this study emphasized self-care as crucial to their well-being as FIFO workers. Some of the self-care strategies the providers used included physical activity, massage therapy, and speaking with family, friends. Providers in this study also noted that access to external supports on a professional and organizational level is key, including debriefing with fellow associates and supervisors. Michalopoulos and Aparicio (2012) described increased social

support as a professional variable that could predict less severe vicarious trauma. Furthermore, O'Neill et al. (2016) reported that consistent clinical supervision could buffer the effects of trauma. In addition to these supports, providers in this study also described setting boundaries as an essential aspect of their practice such as reducing caseload and time spent in community. On an organizational level, Pearlman and Mac Ian (1995) proposed that balancing personal and work life can mitigate negative impacts of trauma, while Bober and Regeher (2006) found that distributing caseload among therapists to limit exposure to trauma can significantly reduce the impact of trauma. Participants in this study reported using both of these strategies while working FIFO contracts, and they identified them important elements for organizations to consider when distributing workload to employees. Engagement with prevention strategies is important for FIFO mental health service providers to avoid symptomatic adaptions or disruptions to previous belief systems that occur most commonly within the five components of self described by CSDT (Trippany et al., 2004) as a result of vicarious traumatization.

FIFO Model of Care as a Mitigator Vicarious Trauma

To mitigate the risk of vicarious trauma noted by providers, participants noted that in addition to the strategies they engage in, the FIFO model of care serves as an approach to reduce the risk of traumatization. Through FIFO contracts, providers are able to limit the amount of time they spend in communities and, in turn, their exposure to trauma stories. Through the CSDT framework, the FIFO model of care could be employed to manage the risk of emotional, physical, and spiritual transformations through reduced exposure to traumatic material (Clemans, 2005). Although their exposure to trauma may be heightened while in a community, being employed on a FIFO basis allows providers to exit the community after a short amount of time. This gives providers the ability to engage in self-care routines such as exercise and time spent

with friends, which, according to Harrison and Westwood (2009), contribute towards well-being. In a study looking at the experiences of FIFO and drive-in and drive-out services with remote psychologists in Australia, researchers found that working on a FIFO basis in a rural community was associated with avoidance of burnout (Sutherland et al., 2017). Although burnout is a different construct than vicarious trauma (O'Neill, 2010), the psychologists in Sutherland et al.'s (2017) study pointed to the advantage of being able to seek support outside of the affected rural community when a tragedy occurs (Sutherland et al., 2017).

The findings of this collaborative research process have identified areas for action and change. As such, the director of operations at the organization that was a partner in this research is in the process of revising policies and practices to further prioritize the mental health and well-being of its employees who are mental health service provides to clients in Inuit Nunangat to ensure continuity of care and thus better care for Inuit. Specifically, it is doing the following: 1) exploring the optimal among time spent in community that would allow for counsellors to develop relationships with community members and maintain their mental health; 2) formalize policies, procedures, and internal structures to encourage discreet and accessible pre- mid- and post- deployment debriefing with fellow associates or supervisors and other forms of self-care strategies

Study Limitations

As with all research, this study has limitations. The aim of this paper was to focus on the experience of FIFO service providers; however, we acknowledge that the most important perspectives are those of Inuit community members. Regardless of what is best for mental health service practitioners who work in Inuit Nunangat, the needs of Inuit are of utmost importance. The FIFO model presented in this study has clear benefits for providers, but its benefits for

community members may be limited. While ensuring that FIFO mental health practitioners are mentally well enough to continue FIFO work is of benefit to Inuit in terms of providing some continuity of care, permanent, resident, Inuit practitioners would likely provide the greatest benefit to Inuit (Cherba et al., 2019; ITK, 2014). Further, upstream, Inuit-led solutions to address past and current traumatic colonial practices that continue to put Inuit at heightened risk for poor mental health are urgently needed.

The scope of this study was limited as participants were all employed by one organization, Northern Counselling and Therapeutic Services. Though their experiences may be directly related to other FIFO providers, the professional and organizational support for service providers will vary across organizations. This is an important consideration as these variables play an important role in the development of vicarious trauma (Cohen & Collens, 2013; Finklestein et al., 2015; Michalopoulos & Aparicio, 2012; Trippany et al., 2004).

Conclusion

This research adds a nuanced perspective to the vicarious trauma literature to include the perspective of FIFO mental health service providers who deliver services to communities in Inuit Nunangat. The findings from this study confirm and extend prior research to suggest that FIFO models of care may reduce the impact of vicarious trauma by allowing providers to reduce their caseload and limit their exposure to traumatic work. Furthermore, this research provides valuable theoretical contributions to the CSDT framework by highlighting the risks of developing vicarious trauma for FIFO mental health providers. By applying the CSDT model to their own experiences, professionals can prevent negative consequences of vicarious trauma and encourage self-care (Trippany et al., 2004). Although there is a significant amount of literature that has

investigated ways to predict the development of vicarious trauma, this study acknowledges the potential benefits of the FIFO model for mental health service providers.

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Chapter Three: Plan A, Plan B, and Plan C-OVID-19: Adaptations for Fly-in and Fly-out Mental Health Providers During COVID-19

Abstract

Mental health providers have rapidly pivoted their in-person practices to teletherapy and telehealth interventions to address the increased demand for mental health services during the COVID-19 crisis. The change to service delivery has emphasized challenges for mental health service providers, particularly in regions that rely on fly-in and fly-out (FIFO) mental health service providers who are no longer able to travel to their places of work. In this qualitative study we examined the impact of COVID-19 on the delivery of mental health services in Inuit Nunangat. Using a participatory action research methodology, we conducted semi-structured interviews with eight FIFO mental health service providers to understand their experiences and implement strategies to effectively deliver mental health services in a pandemic. We identified three themes through thematic analysis: 1) Service providers identify the challenges in adapting their practices to meet individual and community needs; 2) Service providers recognize the opportunities for enhancements to service delivery; 3) Service providers identify telemental health services as a potentially effective adjunct to in-person sessions. The findings support reconceptualizing post-pandemic mental health service delivery to include both face-to-face and telemental health services.

Keywords: COVID-19, fly-in/fly-out, telemental health, mental health, mental health service provider

The COVID-19 pandemic has drastically changed the ways in which we live and work. It has not only affected the physical health of many but also the mental health and wellbeing of individuals worldwide (Fiorillo & Gorwood, 2020). Strict social distancing guidelines in many countries have forced mental health providers to shift their current practices to support individuals experiencing mental health problems (Fiorillo & Gorwood, 2020). Mental health service providers have rapidly pivoted their practices to teletherapy and telehealth interventions to support individuals throughout the pandemic (Reay et al., 2020; Taylor et al., 2020; Torous et al., 2020). The pandemic has resulted in significant challenges for the traditional delivery of mental health services and has highlighted the necessary role of telehealth, and the importance of online tools such as digital platforms (Torous et al., 2020). Researchers have recognized the COVID-19 emergency as a catalyst for change for digital mental health practices (Madigan et al., 2020; Taylor et al., 2020).

Rapid responses and adaptations to mental health service provision have resulted in challenges for providers, especially in regions that rely on fly-in and fly-out (FIFO) health service providers. Health care delivery in circumpolar regions poses unique challenges that result in health care systems relying on short-term locum providers who come from outside the region (Huot et al., 2019). Similar to Canada, Australia has a vast expanse of land making it difficult to recruit health professionals in remote areas (Hussain et al., 2015). Researchers in Australia have found that individuals living in remote areas, including Indigenous communities, are made vulnerable to COVID-19 due to geographical and historical factors; as a result, they face higher rates of chronic disease and other socio-economic factors such as overcrowding, making compliance with social distancing guidelines difficult (Fitts et al., 2020). Residents of Indigenous communities in northern Canada experience similar vulnerabilities (ITK, 2014) as Indigenous

peoples in Australia. While researchers have examined FIFO services globally (Hussain et al., 2015; Sutherland et al., 2017; Wakerman et al., 2012), to my knowledge, there is little peer-reviewed research on FIFO mental health service provision in northern Canada. Furthermore, we were unable to find any academic literature on the impact of COVID-19 on FIFO mental health service providers in the northern Canadian context. To understand the implications of COVID-19 on the delivery of FIFO mental health provisions in Inuit communities in northern Canada, we conducted interviews with eight FIFO mental health providers. My goal was to understand the experience of FIFO providers and to learn from the current situation to make recommendations as providers move forward with considerations of pandemic risks.

Literature Review

Inuit Context

Inuit Nunangat consists of four areas including the Inuvialuit Settlement Region in the Northwest Territories, Nunavut, Nunavik in northern Quebec, and Nunatsiavut in northern Labrador. Residents of these regions experience many indicators of poor health (ITK, 2014). Access to mental health services is particularly important for Indigenous peoples who, due to colonialism, the legacy of residential school trauma, and racism – amongst other challenges (Kirmayer et al., 2011), experience high rates of substance abuse, risk-taking behavior, and suicide (Nelson & Wilson, 2017). Indigenous peoples living in northern Canada face many barriers when accessing mental health services such as geographical isolation (O'Neill, et al., 2013) and lack of health and telecommunications infrastructure (Nunavut Tunngavik, 2020).

In a position paper titled *Development and Implementation of the Arctic Policy Framework*, Inuit Tapiriit Kanatami (ITK) (2018a) acknowledged the gap in infrastructure that affects Inuit Nunangat. In its report, ITK recognized this gap as a barrier to the economic, social,

and cultural development of Inuit and non-Inuit alike. Recently, Nunavut Tunngavik (2020), the Nunavut Land Claims organization, published a report titled *Nunavut's Infrastructure Gap*, which echoed ITK's statements regarding the effects of lack of infrastructure. Highlighted in this document were infrastructure gaps specific to the Nunavut context that contribute to poverty and lower quality of life for Inuit such as gaps in housing, education, health, telecommunications among many others (Nunavut Tunngavik, 2020). This report addressed serious gaps in mental health-related infrastructure, citing a lack of facilities and low percentage of residents with a regular health care provider (Nunavut Tunngavik, 2020). Limited access to mental services further perpetuates mental health problems in Inuit communities. Health care such as physician services delivered outside of main hubs are often delivered remotely but can be hindered by poor internet connections (Nunavut Tunngavik, 2020). Due to the remoteness of communities in Inuit Nunangat, internet connectively plays an important role in enabling access to healthcare and education among other factors. When this document was published in 2018, it was reported that all but one community in Inuit Nunangat are served by satellite, with a lack of fibre optic connectivity across the region (ITK, 2018a), resulting in slow and unreliable internet. Difficulties in telecommunications have been emphasized during the COVID-19 pandemic, during which many services shifted to be online.

Telemental Health Services

Telemental health is described as the delivery of mental health services through telecommunications or computerized services (Chakrabarti, 2015). This term is used broadly to include a wide range of services and professionals that provide mental health care from a distance both in real time, such as in videoconferencing or over the telephone, and asynchronously through email (Chakrabarti, 2015). Traditional mental health systems (i.e., in

person) often do not meet the needs of communities in remote areas due to their geographical location (Chakrabarti, 2015), and so telemental health offers an alternative to rural and remote populations by enhancing access to mental health services for underserved and hard to reach populations with restricted mobility such as geographical limitations (Whaibeh et al., 2020). Two notable studies have looked at the use of telemental health services for Indigenous peoples across Canada from the providers' perspective. Gibson et al. (2011) and Shang et al. (2021) concluded that providers found telemental health to be a beneficial extension of conventional in-person mental health services to rural and remote communities (Gibson, O'Donnell, Coulson, & Kakepetum-Schultz, 2011; Shang et al., 2021). Gibson et al. (2011) noted the benefits of telemental health in rural First Nations communities by acknowledging that this model provides continuity of care and allows clients to remain in community while receiving therapeutic services. However, the authors noted that this type of service delivery is not without its challenges, such as concerns regarding infrastructure and cultural appropriateness (Gibson et al., 2011). Shang et al. (2021), who looked at service provision in various Inuit and Cree communities in northern Quebec as part of their study, recognized the technological limitations by expressing concerns of reduction in efficiency of telemental services as a result of outdated computers. In another study, Gibson et al. (2011) researched community experiences of telemental health services and found that clients associated the use of these services with an increase in access and continuity of mental health services. Participants in their study recognized the benefits of not having to travel, and commented on how videoconferencing may facilitate disclosure through increased comfort of communicating online (Gibson et al., 2011).

Alternatively, some clients in the study questioned the usefulness and appropriateness of these services, and expressed concerns about privacy and safety. COVID-19 has served as a

catalyst for the implementation of telemental health as the demand for services and resources are rising and the ability to provide in-person care is limited due to travel restrictions (Madigan et al., 2020).

COVID-19 and Mental Health

Public health emergencies have the ability to affect the health and wellbeing of individuals and communities (Pfefferbaum & North, 2020). In January 2020, the World Health Organization declared COVID-19 a public health emergency, which was later characterized as a pandemic when infection rates increased globally (World Health Organization, n.d.). Of significant concern is how COVID-19 not only compromises physical health, but also how it affects mental health and wellbeing (Fiorillo & Gorwood, 2020). Work and school closures, a lack of medical resources, and physical and emotional isolation have resulted in negative health outcomes such as emotional distress and unhealthy behaviors such as substance abuse (Pfefferbaum & North, 2020). Recent research suggests that COVID-19 is having a negative impact on Canadians' mental health, with stress levels doubling since the onset of the pandemic (CAMH, 2020). Particular populations are at an increased risk of experiencing psychosocial effects related to COVID-19 including racialized individuals, Indigenous peoples, individuals with disability, and low-wage workers who live in communal housing due to the pre-existing inequities in access to health care (CAMH, 2020). Health care professionals are particularly vulnerable to increased stress as a result of increased work hours, safety concerns, and participation in resource-allocation decisions (McMahon et al., 2020; Pfefferbaum & North, 2020). Mental health providers play an essential role in mitigating emotional outcomes from the pandemic (Pfefferbaum & North, 2020), though they themselves are not immune from the adverse effects of COVID-19.

COVID-19 and Health Service Delivery

The current pandemic has shifted the priorities of mental health professionals who have adapted their services to comply with the changing restrictions in order to provide support to those experiencing mental health problems, and to those who are recently suffering from the psychosocial effects of COVID-19 (Fiorillo & Gorwood, 2020). Mental health service providers who deliver services to Inuit communities are affected by COVID-19 due to travel restrictions and quarantine recommendations by community leaders, governments, and organizations in Inuit Nunangat (Penny & Johnson-Castle, 2020). In response to these new guidelines, many mental health providers have shifted their practice to incorporate telehealth services. As expected, this pivot has come with its own challenges for implementation. Commonly reported barriers to offering services via telehealth or online include concerns regarding privacy and safety, impact on rapport building between provider and clients, reduced non-verbal communication (gestures), and insufficient technological support (Feijt et al., 2020; Madigan et al., 2020). In an Australian study in which researchers examined the impacts of COVID-19 on Aboriginal peoples and Torres Strait Islanders, these populations were found to experience a higher prevalence of chronic diseases and tobacco use but were also affected by socio-economic factors such as overcrowding, rendering Indigenous populations particularly vulnerable to COVID-19. In addition to the existing challenges that residents of remote communities face in accessing and receiving care in Australia, additional workforce challenges have also been noted during the pandemic such as changes in national demand for short-term work force and increased risk of losing permanent staff due to burnout (Fitts et al., 2020). Although it is a different country and cultural context, there are some overlapping concerns that relate to Inuit communities in Canada (ITK, 2014).

Fly-in and Fly-out Health Service Provision

The shortage of healthcare professionals in rural communities is a global problem, and Canada is not immune to such challenges (Wilson et al., 2009). Despite residents of rural communities experiencing greater health inequities than those in urban areas, developed countries report skewed distributions of health care professionals, with higher numbers in urban and wealthy areas (Wilson et al., 2009). Though 90 percent of Canada's land mass is considered to be rural and remote, 20 percent of Canada's population live in remote, rural, Indigenous, coastal or northern communities (Government of Canada, 2019; O'Neill, 2010). In 2018, it was noted that there are approximately 65,030 Inuit living in Canada, most of whom live in Inuit Nunangat (73%), while 27% live outside of the region (ITK, 2018b). Individuals in remote and rural communities experience inequitable access to healthcare services compared to their urban counterparts (Wilson et al., 2020), highlighting the necessity for FIFO services to these areas. FIFO services provided by non-resident workforces have been categorized in five different ways:

1. Specialist outreach services.
2. Hub-and-spoke or outreach arrangements for various allied health and specialist programs, such as women's health educator or mobile dental service.
3. 'Orbiting staff' who spend significant periods of time (12 months or more) in one or two specific communities, self-regulate stress levels and work elsewhere for periods, then return to the same communities where orientation is not required.
4. Long-term shared positions, such as month-on/month-off, where the same practitioners service the same communities.
5. Short-term locum or agency staff who move from place to place or as a one off. (Wakerman et al., 2012, p. 1)

These services have the potential to improve health care access for rural residents and cost-efficiency (Wakerman et al., 2012). FIFO services present many benefits for community members who would otherwise have to travel long distances to receive care (Hussain et al., 2015). Furthermore, travelling health care providers can enhance quality of existing care in rural regions (Hussain et al., 2015). Although there are benefits to these services, FIFO models of care are not without challenges. Hanley (2012) recognized the high cost associated with travel to remote communities, and the pressures to accommodate travelling staff at local sites as drawbacks to this model of care. Hussain et al (2015) also noted that while this model can be convenient for community members, providers have to sometimes "waste their time travelling" to communities, which can be seen as unproductive. Much of the demand for FIFO providers is due to limited community capacity to offer services locally, and a lack of interest from medical staff to permanently reside in rural and remote communities (Hussain et al., 2015; O'Neill, 2010). Other well-documented barriers to attracting permanent health care professionals in rural and remote communities include long hours, poor access to professional development and training, high cost of services such as food and travel, and feelings of isolation (Hussain et al., 2015; O'Neill, 2010). Nevertheless, when implemented effectively, FIFO services can ensure that residents of rural and remote communities have access to health care practitioners.

There is little known about the experience of FIFO mental health service providers in Inuit communities in Canada. The vast majority of studies that have been conducted to understand the provision of health care services in a FIFO capacity have examined the Australian context (Gardner et al., 2018; Hussain et al., 2015; Sutherland et al., 2017; Wakerman et al., 2012). Sutherland et al. (2017) found FIFO services particularly challenging for professionals who provide psychological and similar services that require building longer-term, trusting,

therapeutic relationships. An Australian study that has looked at the impact of COVID-19 in remote communities found that many of the existing challenges for mental health care provision in remote populations have been exacerbated with the onset of the current pandemic, such as instability of the workforce due to the reliance on FIFO providers and include issues such as expensive quarantine, demand for short-term staff and permanent staff burnout (Fitts et al., 2020).

To my knowledge, the impact of COVID-19 on service delivery for FIFO mental health service providers has not been examined in the Canadian context. The purpose of this participatory action research was to understand the impact of COVID-19 on FIFO providers who deliver services to Inuit Nunangat, the changes to provision of services, and to propose strategies and solutions, as identified by providers, moving forward in post-pandemic times.

Methodology

This research was guided by a participatory action research (PAR) approach, through which researchers and participants co-created action and change (Baum et al., 2006). Action is achieved through collecting and analyzing data to determine the most appropriate action to bring about change (Baum et al., 2006). In accordance with a PAR approach, an advisory board comprised of two FIFO mental health service providers, two researchers, and one representative from my partner organization, Northern Counselling and Therapeutic Services, directed all aspects of this research. Research findings will be used to improve service provision through policies and regulation recommendations within the partner organization. Ethics approval was obtained from the Carleton University Research Ethics Board (CUREB-B 112643).

The focus of the current article and analyses was to describe the challenges to mental health service provision that practitioners are currently facing; thus, I conducted semi-structured

interviews with eight FIFO mental health service providers who work with Northern Counselling and Therapeutic Services (See Table 3: Service Providers) and deliver services to communities in Inuit Nunangat. For the purposes of this paper, participant names have been replaced with pseudonyms to protect their identities. Inclusion criteria including speaking English and having experience with the delivery of mental health services to residents of communities in Inuit Nunangat. All participants were recruited through emails shared by my partner organization and through snowball sampling. The study sample included mental health service providers who have completed training/education in social work or counselling. All eight participants identify as Caucasian, including six women and two men who reside outside of Inuit Nunangat. Participants reported working in a FIFO capacity for between one year to ten years. Prior to being hired with NCTS, all participants had a minimum of ten years' counselling experience, most of whom worked with Indigenous populations and communities. The participants described spending differing amounts of time in communities based on the types of contracts they had. Time spent in the community ranged from a few weeks for crisis response, short-term staff fill in, and ongoing organization support to months for school settings and longer-term staff fill in. Prior to the onset of COVID-19, providers reported delivering mostly in-person care with minimal telemental health service provision.

Participants provided written informed consent prior to being interviewed and received a $25 gift card as a token of my thanks. The questions guiding the semi-structured interviews, which were created by the advisory board members, included but were not limited to the following: *How has the development of COVID-19 changed the way you practice? Do you foresee remote counselling as a sustainable solution/option for fly in-/fly-out service providers moving forward? Do you foresee any lasting impacts that COVID-19 may have on the fly-in/fly-*

out community of mental health practitioners? Each interview lasted between 45-90 minutes. All interviews were audio-recorded, transcribed verbatim, accuracy checked by me, and sent back the participants for verification. Two participants made slight changes to their transcripts, while one participant included additional information. Considering the rapidly changing COVID-19 situation, at the time of the interviews, the communities serviced by the participants had minimal to no cases of the virus; this changed just prior to our analysis; thus, a follow-up email was sent to participants to determine if/how their situations had changed. Questions in the follow-up email included: *How has the recent increase of COVID-19 cases changed the demand for your services? As a result of the uptake in COVID-19 cases, have you experienced any different/new challenges with remote counselling?*

Table 3: Service Providers

Pseudonym	Years of Service Provision to Inuit Nunangat
Susan	10 years
James	10 years
Diane	1 year
Tanya	2 years
Carol	7 years
Rebecca	5 years
David	2 years
Rachel	3 years

Analysis

The first author and Darroch followed Braun and Clarke's (2006) six-step approach to thematic analysis while also engaging in reflexivity as a part of Braun and Clarke's (2019) update to this approach. To begin, we uploaded all data to NVivo[10], a qualitative data analysis

software package. Once the transcripts had been read by the first author and Darroch, we generated initial codes, and assigned descriptive labels to data segments. We examined the codes and organized the data to develop themes. Darroch and I assessed the preliminary themes to determine if they captured the experience of FIFO providers. To ensure we accurately reflected the perspectives of the service providers, we shared the findings with the advisory committee; they agreed with the results. We identified three themes through a process that Braun and Clarke (2006) referred to as "developing the essence" (p. 22) of what the theme is about: 1) Service providers identify the challenges in adapting their services to meet individual and community needs; 2) Service providers recognize the opportunities for enhancements to service delivery; 3) Service providers identify telemental health services as a potentially effective adjunct to in-person sessions. To ensure reflexivity, the authors reflected on their positionality and their own biases about the delivery of mental health services and COVID-19. All authors have had to switch their work from face-to-face to online over the pandemic, and may have assumptions of the effectiveness of online services.

Results

THEME 1: Service providers identify the challenges in adapting their practices to meet individual and community needs

The first theme, "there's all these logistical challenges as well that are probably quite unique to the North," reflects the challenges that mental health service providers face while adapting their services to meet individual and community needs. Many providers acknowledged the complexity of travelling to the North to deliver services in light of the restrictions and guidelines[1] in place in northern Canada. David explained:

[1] COVID-19 restrictions and guidelines varied across Canada in different regions/provinces/territories

> We’re not going north with two-week isolation after you're finished. I think it’s very difficult to get people to go, and frankly the north[ern] communities… they're pretty restrictive right now. They don’t really want outsiders coming in. And so it’s a real mixed bag - on the one hand they want services and sometimes they want you there, but the restrictions and the limitations on what you can do and how you can deliver the services has certainly created road blocks.

As David asserted, the logistics of travel are complex with many aspects to consider by both the provider and the community. Rebecca argued that quarantining “comes at a considerable expense, you know in terms of monetary resources, time resources.” These factors present many challenges, first and foremost being the difficulty of providing in-person services. Rebecca emphasized how the “human presence is important” and “being, you know, a couple thousand kilometers away” can make connecting with clients difficult. Susan echoed these sentiments by suggesting that community outreach to clients while unable to be in the community would be particularly challenging:

> [E]specially in the North, people might not all have access to the technology that's needed. People might not be able to afford doing phone counseling and there might not always be an option for them to do it in a safe space, whether they're coming from an overcrowded home - so there's all these logistical challenges as well that are probably quite unique to the North or to Indigenous communities that we also have to consider.

Carol suggested that remote counselling is challenging but that it can be effective if the provider has had some pre-established face-to-face contact with community members:

> My remote counselling is most effective in the communities where I’ve worked the longest. So, it’s easy to have a phone conversation with so and so, because I’ve also met

> them for the last five years, so that makes it easy. When you don't have a relationship - so I have a community where I've only visited [for] two weeks…that's way more difficult.

Rachel added to this discussion by noting the difficulty of connecting to community members when there is no existing connection: "I think it's hard for people to feel safe enough or to kind of know that the service is there and to activate the services." She highlighted the importance of FIFO services and establishing connection within the community.

Rachel offered examples of the ways in which she has had to adapt her services to overcome these challenges and meet individual needs during COVID-19. She stated:

> Sometimes I offer texting sessions because many of my clients are living at home with their families, and they're all around all the time. So, they can't, they just don't have the privacy to even have a phone conversation with me. I've had walking sessions with my clients, who've walked outside and with their phone. I've had car sessions where they've either used their phone or their video, in a car, to have privacy…I'm just doing everything I can to keep connected.

In this example, the barriers to service delivery were highlighted by identifying the difficulties with privacy that clients may face. To overcome this, Rachel envisioned adapting medical spaces to include safe and private areas for sessions: "maybe communities could offer a room that's confidential." Moreover, Rachel emphasized the important roles that service providers play in addressing these challenges:

> We focus on those receiving care but delivering sessions you need to be courageous - working online and working remotely, that's hard … it's important to address the complete turn that people [who provide mental health care] have had to take to do their job.

In this statement, Rachel emphasized the challenges in shifting all services online, and the difficulties that service providers have encountered in adjusting to COVID protocols, safety measures, and restrictions.

THEME 2: Service providers recognize the opportunities for enhancements to service delivery

While service providers identified barriers to accessing the communities they serve, they also acknowledged the opportunities for enhancement to service delivery as a result of the changes implemented in response to COVID-19 restrictions. As Tanya remarked, "I think it's forced us to be very innovative in the way that we do our work now." The quick onset of COVID-19 forced providers to rapidly adapt their services, and most of the providers who we interviewed expressed hope that this could bring positive changes to FIFO services in the North. David stated:

> I think this COVID situation could be very positive for the development of services in the North. I think it could be of real benefit. So again, the impetus is there, and the opportunity has come of this - we just have to make sure that it takes place.

David emphasized the potential to create new services and implement them as an important outcome of the changes in services due to COVID-19. He continued by further explaining what these new services could look like:

> Well, I'm hoping that what comes of it is…that there ends up being a continuum of service that's offered. And rather than focusing on going in and doing crisis management, which we all are aware is not the ideal model, that we have a model where we may fly-in, and if we don't fly-in, then we have some way of establishing that initial… familiarisation process. And then that the follow up is that we are able to do ongoing

> service for some period of time - I would suggest nothing less than a year. Preferably two or three years, being available to do that ongoing counselling on a remote basis. So, I do think that COVID has probably accelerated the development of that kind of a model.

Similar to David, Susan also emphasized the importance of establishing an initial connection within a community and then maintaining services with the community through ongoing remote counselling that supports a continuum of care model. She stated:

> [T]o me, it makes perfect sense for counselors to do a couple of fly-in sessions maybe per year and do these face-to-face clinics but then follow up virtual and remote. And if they establish these trust relationships with the community by being there in person and introducing themselves and becoming part of that community fabric, then I think it will be much easier for us to keep connecting with clients afterwards.

In contrast, Carol has observed the benefits of remote counselling with new clients, and the benefits that meeting remotely can have over meeting them in person. Carol asserted:

> I've been working with this couple throughout COVID, and I've never met them [in person], and I can't believe how effective a phone call can be. I'm kind of shocked, yeah… I feel like they feel safe…there's a lot of comfort and a lot of openness and you can interpret a lot through someone's voice and the intonations and the breathing.

In addition to the benefits Carol observed in communicating by telephone, David recognized an opportunity to advance the development of platforms to enhance the virtual counselling experience:

> Certainly, we still run into situations where internet connections and phone service are not the quality that we would like them to be, but I think all that's going to be resolved within the next few years, and I actually think that COVID has probably accelerated that.

> I think some of the platforms . . . they've all accelerated the development of their platforms, and I think they're better than they used to be. I think the foundation of all of this service delivery, whether it's remote or in person, is building relationships and clarifying the mandate so that we are welcomed into the community, we're a part of the fabric of the service delivery. And if that ground is well prepared, then I think we should be fine.

David acknowledged the benefits of developing more efficient platforms while recognizing that regardless of in-person or remote services, building relationships within the community is of utmost importance and essential for these services to be effective. While the benefits for digital platforms and enhancements to service provision were highlighted, Rebecca added a caveat:

> I guess making sure that we're connected with on the ground emergency response, that I have numbers and things like that, because I'm – I'm not right there in the room with someone. So, if they're in danger…I would have my numbers for RCMP, head nurse, you know wellness worker, emergency folk, right beside me.

For telemental health services to be effective, legal and safety concerns must also be addressed so that providers can use this model of care. Despite these caveats, providers welcomed the opportunity for a change in service delivery by highlighting the many benefits and advancements that have been presented as a result of COVID-19.

THEME 3: Service providers identify telemental health services as a potentially effective adjunct to in-person sessions

The counsellors reported that the adaptations to COVID restrictions changed their practices in many ways and have influenced what they view as best practices for FIFO providers in a post-pandemic Inuit Nunangat. Seven of the providers noted that some combination of in

person and telemental health services would be the best strategy to optimize FIFO mental health service provisions in the North. Rachel noted, “I don't think it's [remote counselling] unsustainable. I think we can do it for as long as we need to… [but] [i]t cannot replace face to face.” Diane agreed that remote counselling could be used as an addition to their services but that she would not want to see it replace FIFO services. She stated:

> Yeah, I do think it [remote counselling] can be an adjunct, I would not want to personally see it go just to remote counseling. I think the time in the community is really important and essential. It’s just so different than only knowing a person by phone or video counseling. And so, I think it can work really well and can be a good adjunct…I could see flying in and then also having a period of remote [counselling] and then both together.

Tanya affirmed these opinions by emphasizing the importance of seeing clients in person, especially if there is a need for emergency response.

> I think they [community members in crisis] need to see people, they need to talk to somebody, we need to see their body language. But then, when it’s more like therapy, then they could have follow-up by – virtually. Yeah, I would think though for crisis, it’s good to have people there. And often, they like – some of them, they like to introduce their family [in person], and then sometimes they are more inclined to come and see us, as well, right? [If it’s] by Zoom or things like that, they won’t, right?

Tanya suggested that clients would be less inclined to access services virtually, and that having services available in-person would promote accessibility.

Until FIFO services return, David proposed creative solutions to engaging with individuals and communities:

> I like the idea of the webinars or the online workshops, or things like that where we can establish a bit of a relationship. I mean ideally, again, we go back to the idea of being able to go in person to the community and sort of shake hands and make contacts and so on. But if that can't happen, then we've got to figure out other ways of building that familiarity.

Susan concurred with David's remarks regarding additional services and added that "psychoeducation [services] offer support to a broader population base." David continued to reiterate the importance of being in the communities in person by proposing a model that utilizes both FIFO and remote counselling services, "a wonderful model [for clients and providers] is to have us flying into these communities, establish a caseload, get to know people, build relationships, build credibility and then continue to offer some sort of ongoing counselling on a remote basis."

In alignment with other service providers, James viewed remote counselling as a "complementary service that should never go away." However, he also pointed out the drawbacks of FIFO and noted positive adaptations due to COVID-19:

> Fly-in fly-out services are…very expensive, delays associated with it, you know something like this [COVID-19] happens then it gets shuts down. However, as we move away from the reactionary, immediate nature of having to adapt our model towards a more sustainable, responsive model for Northern Service delivery - to me this inevitably means a blended model of services, where possible.

Since the shift to remote counselling has started, James has seen the benefit, stating, "I hope it never goes away. I hope that it proves its usefulness … it already has, lives have been saved." Thus, the potential of enhanced service delivery to rural and remote regions by using telemental

health services while building on existing models of care is clearly being identified by service providers through experiences informed by COVID-19.

Discussion

The current study provides insight into the experiences of FIFO mental health service providers as they adapt to shifting service delivery as a result of the COVID-19 pandemic. This study advances the previous research on successful telemental health strategies with Indigenous populations in Canada from the provider perspective (Gibson, et al., 2011; Shang et al., 2021) to include Inuit Nunangat context and the impact of the COVID-19 pandemic. To my knowledge, this is the first study focused on the impacts of COVID-19 for FIFO providers in Canada. The rapid and drastic changes that required changing in-person mental health service delivery in Inuit Nunangat to telemental health services presented numerous challenges for providers. Prior to the onset of the COVID-19 pandemic, providers reported delivering mental health services face-to-face with limited usage of telemental health services. Mental health providers recognized the difficulties of travelling given the restrictions and guidelines put in place by community leaders, governments, and organizations in Inuit Nunangat (Penny & Johnson-Castle, 2020), while acknowledging that community members may not feel comfortable with individuals entering the community from areas in the South with higher rates of COVID-19. Fulfilling the required isolation period for travelling to different provinces and territories (for instance, self-isolation for two weeks before and two weeks after) was deemed to be too expensive and would demand considerable time resources from the provider. Although these challenges among others were identified, providers acknowledged the opportunities to enhance mental health service delivery to Inuit communities through increased use of digital technology and online tools. Although advantages to telemental health service provision was noted, providers maintained the

importance of providing in-person care. Providers in this study expressed the importance of providing optimal services during a pandemic while recognizing the need for a more enhanced continuum of care in a post-COVID context.

Perceived Challenges

Participants in this study identified barriers to optimal mental health service delivery as including logistical challenges such as lack of technology, privacy and safety concerns, and difficulties with establishing relationships with clients and the community. Lack of technology (and/or lack of access) was most frequently reported as a challenge to providing virtual mental health care. Additionally, they presented concerns over privacy as a challenge for clients, which is unsurprising given the high rate of overcrowding in homes in Inuit communities (ITK, 2014). These logistical challenges are consistent with researchers findings from the Netherlands, which explored the sudden change in service provision as a result of COVID-19 (Feijt et al., 2020). We interviewed mental health practitioners to understand the implications of swift and drastic transfer of practices from in-person to online. The practitioners reported similar technological and usability problems that impacted their ability to establish rapport with clients. Outside of the COVID-19 context, in a systemic review of healthcare providers' attitudes toward telemental health in eight countries including Canada (Connolly et al., 2020), the researchers similarly found that healthcare providers were concerned their services would be affected by insufficient technological infrastructure. In this study, the providers felt the therapeutic interaction was also affected by not having the opportunity to build rapport with clients and within the community. Providers highlighted the difficulties of service provision in communities with which they had no pre-established relationship prior to COVID-19 by emphasizing the effectiveness of virtual counselling in communities where they have previously worked and built relationships. This, as

suggested by David, could perhaps be improved by establishing a continuum of services that allows practitioners to continue to build relationships after leaving the community, thereby eliminating some of the challenges being described. Although this would demand initial contact to be in-person, it does provide continuity of care when providers fly-out of the community. This, however, brings its own challenges as providers have concerns with not being physically present in the community. Similar to perspectives presented in this research, in their systematic review, Connolly et al. (2020) found that healthcare providers had safety and legal concerns regarding the inability to be physically present within a community, especially in cases of crisis or in circumstances that would require further action, such as transferring patients to a hospital (Connolly et al., 2020). For providers to feel supported in successfully adapting to telemental health services, connections to on-the-ground services and the community were deemed essential, highlighting the need to be familiar with the community and its resources. Although establishing a continuum of care was strongly encouraged by service providers we interviewed, there are broader potential implications that must be considered. The lack of infrastructure reported by ITK (2018) may not support virtual counselling while the provider is away from the community, and issues of privacy remain a concern. Furthermore, there is an additional cost to having providers and clients engage with a long-term continuum of services such as travel and accommodations. These barriers are ongoing concerns that must be met before effective implementation of a continuum of care. In an Australian study, Fitts et al. (2020) noted that the pandemic has highlighted the vulnerability of communities who rely on FIFO staff, and suggest a "well-funded, appropriately trained, stable and accessible health workforce in all remote communities" (pg. 4). While efforts are made to work towards stable and accessible workforces

in remote communities, FIFO service provision will remain a crucial aspect of care for the foreseeable future for Inuit communities in northern Canada."

Perceived Opportunities

In contrast to perceived challenges, the providers in this study also reflected on opportunities as a result of COVID-19. The drastic change to service delivery created space for adaptations including enhancements to the continuum of care by incorporating telemental health services, advancing platforms to facilitate the delivery of these services, and re-envisioning medical spaces to accommodate these additional services. These results are largely in line with Australian scholars' findings on perceived opportunities for telemental health as a result of COVID-19. They found that the virus has created increased potential for digital technology through improving accessibility and quality of mental health service provision (Balcombe & de Leo, 2020; Taylor et al., 2020). Connolly et al. (2020) noted that clinician satisfaction with telehealth via videoconferencing in mental healthcare is positive, citing advantages such increasing access to care for patients in remote communities and saving time and money while increasing efficiency of services. These findings are in accordance with the results from this study who agreed that telemental health could provide many opportunities regardless of the difficulties that may arise.

Synergistic Models of Care

Although the advantages of telemental health services were highlighted by providers, Connolly et al. (2020) found that providers still preferred to conduct appointments in-person rather than through videoconferencing but noted that satisfaction level varied based on the type of services provided. Short-term consultations delivered via videoconferencing were deemed equivalent to face-to-face sessions, while establishing relationships for longer-term care was

found to be more difficult online. Our findings are in alignment with Connelly et al's (2020). Indeed, the mental health service providers in this study found that telemental services can be effective given the current COVID-19 pandemic; however, it is critical to note that the providers in this study unanimously agreed that remote counselling should be used as a complementary service to their in-person services.

The need for synergistic models of care has been emphasized in the Canadian context with Indigenous populations in previous studies (Gibson et al., 2011; Shang et al., 2021). Other research that has been conducted in Canada with providers who deliver mental health services to Indigenous communities found that providing telemental health care to Indigenous communities is suitable for those living in rural and remote communities when provided in combination with in-person care (Shang et al., 2021). Connolly et al. (2020) suggested the use of videoconferencing, especially in particular circumstances such as when access to services is limited. In these conditions, despite the challenges that may arise, the advantages outweigh the disadvantages according to providers included in the systematic review (Connolly et al., 2020). Providers in this study reported using a range of technology to support their clients in the North, including telephone counselling, videoconferencing, as well as direct or text messaging. Despite the challenges it has presented, the COVID-19 pandemic has created opportunity for adaptations and growth for providers and the way in which services are delivered.

Study Limitations

This study has several limitations. Given that the focus of this paper was on FIFO service providers' perspectives, we identify that the most important perspective should be the clients seeking care. It is imperative that mental health providers and policy makers for Inuit should, first and foremost, consult the communities and local government before applying results.

Research on the perspectives of Inuit towards changing models of care is of the utmost importance and is essential to understand the applicability of FIFO services combined with telemental health strategies. While not the focus of the paper, certainly another limitation is the lack of consideration of local health workforce in Inuit communities. Fitts et al. (2020) described challenges faced by Aboriginal and Torres Strait Islander communities in Australia that, much like Inuit in remote Canada, rely heavily on FIFO staff. The authors called for a well-funded workforce based in all remote communities which may alleviate some challenges noted in this paper. For suggestions such as long-term counselling interventions to be effective, understanding clients' perspectives and health outcomes is crucial, and needs to be a future area of research. Further understanding of Inuit perspectives and needs must be addressed.

Moreover, the scope of this study was limited, as we only spoke with providers who are employed within one organization. It is nevertheless likely that other FIFO mental health providers who work with the same population may share similar perspectives. It is also worth noting that the providers who participated in this study all live in southern Canada, outside of the communities in which they deliver services and do not identify as Inuit. We did not discuss the personal benefits to providers who are able to continue to work without having to travel to these remote communities since the onset of the pandemic such as the ability to work from home and remain close to family. Thus, while there was obvious concern for the clients being served, there may have been additional benefits and/or motivation to encourage a combination of in-person and telemental health services.

Conclusion

There is a dearth of research focused on the experience of FIFO mental health service providers in Canada. This research adds a nuanced perspective to the growing literature on

telemental health strategies with Indigenous communities in Canada by considering the COVID-19 context and providers who serve Inuit Nunangat communities. The information presented in this study highlight the complexity of offering mental health services in a pandemic and suggests opportunities to build upon the FIFO model of care. COVID-19 has served as an impetus for change to the continuum of FIFO services to Inuit communities to include a combination of face-to-face care and telemental services. Our findings provide insight into the complexities of mental health providers delivering traditionally in-person services online. Central are the challenges that providers face in adapting rapidly developing their services to meet the needs of individuals and the community. Importantly, there are opportunities to enhance FIFO model of care for communities in Inuit Nunangat, and an opportunity for providers who share unique relationships with the communities they service to voice their perspectives on the rapid change of service delivery due to COVID-19. Pivotal to such changes is the need for research that evaluates the applicability of FIFO synergistic models of care in Inuit communities. Argued here is the need for a more comprehensive continuum of care that can withstand rapid changes to service delivery if need be.

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Chapter Four: Conclusions

During my Master's of Science research, I had the opportunity to learn about the experiences of FIFO mental health providers who deliver mental health services to community members in Inuit Nunangat. Although FIFO mental health providers have indeed been recognized as an integral part of service provision for northern Inuit communities (ITK, 2021), there is limited literature surrounding their perspectives on service delivery. Through speaking with the FIFO mental health providers, along with guidance from the advisory board, I was able to better understand the challenges and the opportunities they encounter as practitioners in the North.

In this final chapter of my thesis, I discuss the key implications of my research, through which I address the gaps in knowledge pertaining to the experiences of FIFO mental health service providers. Below, I also examine the limitations of my research and present my closing thoughts concerning the contributions of my research to the area of remote service provision and FIFO models of care for communities in Inuit Nunangat.

Addressing Gaps in Knowledge

People living in rural and remote communities in Canada face unique challenges when accessing mental health care, making the delivery of these services complex (Caxaj, 2016). Many of these barriers have been attributed to the limited local workforce and clinicians, resulting in high travel costs and inaccessibility of services (Dyck & Hardy, 2013). These challenges are exacerbated in Inuit communities, where individuals experience a multitude of barriers relating to geography, culture and language, and human resources, which have collectively contributed poor health outcomes (ITK, 2014). The health disparities that Inuit continue to face are well documented (ITK, 2014) and have roots in colonialism, racism, and marginalization (Kirmayer et al., 2011; Nelson & Wilson, 2017). Obtaining adequate health

services is a significant problem for Inuit in Inuit Nunangat who must either be flown to southern centers for treatment (ITK, 2014; Tait, 2008) or rely on transient healthcare professionals (ITK, 2021). This shortage of healthcare staff affects the continuity of care for Inuit individuals, resulting in reduced effectiveness of the Canadian health care system (National Collaborating Centre for Aboriginal Health, 2011).

To optimize mental health service delivery to Inuit communities, understanding the experiences of FIFO mental health service providers is necessary. Providers may also experience barriers that could impede their ability to effectively deliver mental health services, including interruptions to services or experiences that impact their own wellbeing. Previous research has been conducted to explore the perspectives of mental health providers who deliver mental health support to isolated Indigenous communities (Gibson et al., 2011b; O'Neill et al., 2016); however, there is a lack of information available surrounding the experiences of FIFO mental health service providers. Therefore, as presented in the two studies within this thesis, I investigated two important aspects that impact mental health service provision for FIFO providers in Inuit of Nunangat. In the first of these two studies, I examined the providers' experiences of vicarious trauma. In the second study, I explored the changes to FIFO service delivery as a result of the novel COVID-19 virus and resulting global pandemic.

Through my research I believe I have made three important contributions to the field of mental health service provision: 1) I have made a novel addition to the literature surrounding FIFO health providers in a Canadian context and in the context of a global pandemic; 2) I have illustrated the potential risk and protective factors of developing vicarious trauma for FIFO mental health providers; and 3) I have identified opportunities to enhance FIFO models for communities in Inuit Nunangat.

Experiences of Vicarious Trauma

In the second chapter, I used a constructivist self-development theory (CSDT) lens to understand the factors that influence the experience of vicarious trauma for FIFO mental health providers, and how the high exposure to traumatic material can affect their wellbeing. Being aware of how the self (frame of reference; self-capacities; ego resources, psychological needs; and cognitive schemas, memory and perception) is disrupted by vicarious trauma may help providers prevent or manage traumatization (Trippany et al., 2004). For example, if the providers ego resources are affected, symptoms such as perfectionism and overextension may occur at work resulting in the inability to be empathic with clients (Trippany et al., 2004). Although this was not directly addressed with providers, they did note the difficulty managing negative emotions, which is related to the second component of CSDT which is self-capacities (Trippany et al., 2004). The providers in this study emphasized the inherent risk of working with traumatized clients and communities. They also recognized the factors that may increase the risk of developing vicarious trauma that are specific to the FIFO model of care: duration of time spent in community and heavy caseloads. Providers reported engaging with a variety of self-care strategies to manage the development of vicarious trauma such as physical activity, social support, and engaging with colleagues; however, many providers posited that one of the most significant strategies to reduce the risk of traumatization is the FIFO model itself. In this first paper, I elaborated upon previous research on vicarious trauma to suggest that FIFO practices may reduce the risk of developing vicarious trauma through less time spent in the community and thus time restricted exposure to traumatic material.

Impact of COVID-19 on Service Provision

In the third chapter, I examined the rapid changes to mental health service delivery in Inuit Nunangat as a result of the COVID-19 pandemic. With the collaboration of my advisory board, we identified the challenges of adapting mental health practices to meet community needs, as well as opportunities to enhance service delivery to better understand how to improve the continuum of care for Inuit communities. The most notable challenge faced by providers was the lack of (and/or lack of access to) technology, which is an ongoing challenge for communities in Inuit Nunangat region (ITK, 2018a). These changes did, however, create space for enhancements to the continuum of services by incorporating more frequent use of telemental health services, and by advancing platforms to facilitate the delivery of these additional services. The findings enabled us to envision synergistic models of FIFO services, which include a combination of face-to-face and telemental health services. Using a CSDT framework, I was able to explore the changes to service delivery as an opportunity to manage the risk of vicarious trauma through a combination of in-person and remote counselling as a result of COVID-19. The onset of COVID-19 gave us a novel opportunity to explore what happens when organizations are forced to change the ways in which they deliver mental health services. As observed in this study, organizations can be quick and responsive when required, which was witnessed with the rapid uptake of telemental health services.

Within these two studies, I highlighted two key considerations that may strengthen the effectiveness of FIFO mental health services from the perspective of service providers. First, organizations should consider a combination of in-person and telemental health counselling services whereby providers establish connections with people in the community and maintain that relationship through online service. Secondly, considerations of the optimal time spent in community to manage the risk of developing vicarious trauma for providers need to be explored.

Implications

These research findings offer important opportunities to inform future practice and policy for the delivery of mental health services to Inuit Nunangat. By highlighting the challenges and opportunities providers face when delivering mental health services, my partner organization is in the process of revising policies and guidelines based on the results from this research to optimize their service provision in the North. Recommendations to reduce the risk of vicarious traumatization include reducing long-term contracts, balancing caseloads to reduce the exposure to traumatic material, and ensuring adequate access to self-care strategies while in community. To facilitate telemental health services, improving access to technology in communities where face-to-face services are not available and working with local community members to address privacy concerns are essential. Although changes such as the use of telemental health strategies were implemented as a result of COVID-19, organizations should consider offering both face-to-face and online services on an ongoing basis. Not only would this provide continued support to communities, but–as providers noted–it would also help manage the risk of vicarious trauma.

This work also makes important theoretical contributions, as it builds upon the CSDT theoretical framework to include potential risk and protective factors. Being aware of these factors that are unique to FIFO service provision may prevent vicarious traumatization for FIFO providers, thereby avoiding potential negative professional and personal consequences (Trippany et al., 2004).

Limitations

In my research, there were three significant limitations: 1) the perspectives of Inuit community members were not included; 2) the scope was limited to mental health providers employed by one company; and 3) I do not identify as an Inuk.

Although the focus of this research was to understand the perspectives of FIFO mental health service providers, the most important perspectives to consider are those of Inuit community members. While understanding the perspectives of the community members who are serviced by the FIFO providers was beyond the scope of this study, it is imperative to explore the usefulness and appropriateness of strategies such as telemental health services for service users before implementation. Additionally, the local health workforce in Inuit communities were also not considered. As noted by the providers in this research, local staff play an important role in the delivery of mental health services. Research has been conducted to understand community members' perspectives on the usefulness of telemental health in rural and remote First Nation communities (Gibson et al., 2011a); however, to my knowledge, there has been no research conducted to understand the perspectives of Inuit community members who receive FIFO services. Based on the COVID-19 restrictions in place at the time this research was conducted, it was not possible to enter Inuit communities. Beyond these restrictions imposed because of the pandemic, it would have not been ethical to enter communities give the short timelines of a Master's thesis.

The scope of this research was limited to FIFO providers who are employed within my community partner organization, NCTS. Though it is likely that the experiences of the providers in this research are shared among other FIFO mental health providers, it is important to note that professional and organizational variables (such as training and support for practitioners) may differ depending on their organization. Professional and organizational factors are important to consider because, as suggested in the literature, these factors can impact the manifestations of vicarious trauma (Cohen & Collens, 2013; Finklestein et al., 2015; Michalopoulos & Aparicio, 2012). Although providers outside of my partner organization were not interviewed, it is

important to highlight the significance of the perspectives that were captured, as these contribute to filling the gap in the literature surrounding FIFO mental health service provision. This participatory action research gives voice to FIFO mental health providers who have largely been ignored within the literature, and who are often left out of policy and practice decision making. Addressing unequal power relations within research and society is a central tenet of PAR (Benjamin-Thomas et al., 2018). Although the participants in this study identify as white counsellors who may not experience imbalances in power in the way the communities in which they serve do, they are disadvantaged within the systems they work in. By being included in the research process, their capacity as powerful agents increased which encourages trust and involvement in any ongoing work.

As a white, cis-gendered woman, who lives in southern Canada, I must also acknowledge my positionality and the role it has played in this research. As I am not an Inuk, I acknowledge that I could not contribute to the research as someone holding Inuit worldviews. I also recognize that Inuit have an extensive history of being exploited by Western researchers who share a comparable positionality to mine. Similarly, all the providers who participated in this study identify as white and permanently reside in southern Canada, outside of the communities in which they deliver services. Despite providers receiving training and, in some cases, providing support through counselling in the development on the Truth and Reconciliation (Truth and Reconciliation Commission of Canada, n.d.) and Missing and Murdered Indigenous Women and Girls (National Inquiry into Missing and Murdered Indigenous Women and Girls, n.d.) reports, they each ultimately have a different epistemological lens than Inuit and see the world differently than Inuit because they are white. I attempted to address these limitations by prioritizing engaging with members of the FIFO community who have experience working with Inuit

communities and who have spent time living in Inuit Nunangat, though I/we will not claim to hold an Inuit perspective.

Future Research

This research is a starting point to explore the delivery of FIFO mental health services in Inuit communities. There are many factors that need further research to have a nuanced understanding of the complexities of offering mental health services on a FIFO basis, not only in a pandemic, but also beyond the immediate situation. Most importantly, it is clear the perspectives of Inuit community members should be central in guiding future policies and practices. Research that includes Inuit perspectives could provide insight into 1) the needs of individuals as well as the community as a whole; and 2) the usefulness and appropriateness of an enhanced continuum of care. This research must be supported and led by Inuit community members and work in collaboration with FIFO mental health providers and local health workforce, to ensure the needs of the community are met.

Data collection for this research took place from July 2020-October 2020 amid the COVID-19 pandemic. Moving forward into a post-pandemic environment, there are a few important results to consider. Given the established link between exposure to trauma and provider well-being (Pearlman & Mac Ian, 1995; Quitangon, 2019; Trippany et al., 2004), and the increased time working at home due to travel restrictions as a result of COVID-19, future qualitative research could explore how COVID-19 has impacted mental health and wellbeing of service providers. The personal benefits to providers who work from home instead of traveling into community was not investigated in this study but may provide further insight into some of the conclusions found in this research. COVID-19 has arguably expedited the need to determine a balance between in-person and online services, and it has served as a catalyst for the

implementation of synergistic models of care that include both in-person and online care. From this research, it was clear that providers felt it was beneficial to spend time in the community in order to build trust and relationships with members before offering telemental health services remotely; however, there remains a gap in terms of understanding the optimal balance of mental health service provision from the community members' perspectives. Determining an optimal balance of time spent in and away from the community, from both the providers' and community members' perspectives, would thus be an important contribution to the literature.

Concluding Thoughts

This research serves as only the beginning of understanding the complexity of delivering FIFO mental health services to residents of Inuit Nunangat. Throughout my thesis, I have highlighted the challenges and opportunities that FIFO providers faced during the COVID-19 pandemic, and the importance of maintaining the health and wellbeing of FIFO mental health providers. Based on the results of this research, I suggest improvements to ensure the wellbeing of providers; however, community members' needs must also be considered. To gain further insights into best practices and policies for FIFO service provision, it is crucial to explore Inuit perspectives on mental health service provision to determine how to optimize care moving forward.

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Appendices

Appendix A

Semi-Structured Interview Guide

INTRODUCTORY SCRIPT

I want to start off by saying that I am so grateful that you are willing to do this interview with me today - thank you for taking the time to connect with me!

I am a graduate student at Carleton university, who as you may know, is conducting this research to better understand the experiences of fly-in/fly-out mental health practitioners who deliver services to Inuit Nunangat (NEW-NAN-GAT). I am here today because we are interested in learning more about your experience in order to make recommendations on how to enhance support for fly-in/fly-out providers. To situate myself and my interests in this study, I'd like to share that the reason why I am passionate about this research is because I am originally from a remote fishing village in northern Quebec, and have received care from fly-in/fly-out providers for most of my life.

Before we get started, I just want to share a little bit about the logistics of the research process. I will record the interviews today with your permission, they will then be transcribed and at that point we will send you a copy of the transcriptions so that you may remove any information that you feel uncomfortable sharing. Just to note, we will de-identify the data so your name will not be connected with any of the stories that you share today. That being said, you may be identifiable by some of the information you share.

I hoping to not take up too much your time today, I suspect the interview to take between 30-90 minutes. Please feel free to take a break if you need to or skip any questions you are not comfortable with.

**It is possible that during the interview that Zoom may freeze, if this does happen, would you be open to completing the remainder of this interview over the phone? PAUSE We could use the chat function to exchange phone numbers if that is the case.*

Before we begin, do you have any questions for me?

QUESTIONS

Just confirming I started recording, are you ok with that?

Background
Preamble: In the first few questions, I am looking to understand your role as a fly-in/fly-out service provider.

So, let's start by having you tell me about your role?

- What are the typical qualifications someone might have to provide fly-in/fly-out services?
    - Could you touch on your background/experience?

How many years have you been providing mental health services in a fly-in/fly-out capacity?

Within that time, can you tell me about the services you provide?

- What specific types of services do you provide? I.e. counselling sessions, family counselling, training
- What are the most prominent themes that you see you in the services you provide? I.e. trauma, grief, suicidality, abuse, addiction

In what ways do the services you provide differ from non-fly-in and fly-out settings?

Challenges

Preamble: In the next few questions, I am looking to understand the challenges of fly-in and fly-out service providers.

Are you willing to share some of the challenges you face?

Would you be willing to discuss some of the common issues or situations that communities are experiencing that you would provide support for?

Supports

Preamble: Next, I would like to understand how you are supported in your work.

When working in the north, which types of supports are available from the company you work for, community supports, the government, and similar organizations?

- Can you discuss some of the resources, tools, or relationships that would enhance the work you do or the longevity of careers in the north?

Community Supports

Preamble: Now we will shift to community support.

Outside of your work, are you engaged with the community in other ways? If yes, in what ways?

We've learned that some communities have "Inuit peer supports" or Inuit counsellors and informal support groups, have you ever used these resources in the community? Yes/no

- Can you explain further?
- Can you see any barriers to this approach?

How do you navigate and assess the community's response and feelings regarding the work of fly in/fly out providers?

- Does the duration of time spent in the community affect the quality of service you provide?

What steps are taken to ensure the consistency or access to care for clients after flying out of the community?

Do you have any recommendations on how you or your agency could enhance long term supports for your clients and their communities?

- What type of feedback, if any, do you receive from clients, community or the company you work for?

Vicarious Trauma

Preamble: One of the concepts that I am particularly interested in is vicarious trauma because research suggests that working in an isolated community can increase risk of exposure to vicarious trauma.

We know that there is a lot of compassion fatigue or vicarious trauma among mental health practitioners, would you agree with this?

- What would you or your colleagues do to mitigate the risk of vicarious trauma?

What supports are available for practitioners who experience vicarious trauma?

What motivates you to return to northern communities to provide mental health services?

Training

Preamble: The next few questions will address your perceptions on the importance of cultural grounding in your services.

Do you see the need for culturally grounded services? If so, what would that look for you?

- Do you think it would benefit your practice to have more training in cultural awareness, sensitivity and safety?

Are you familiar with the Truth and Reconciliation Commission of Canada and Missing and Murdered Indigenous Women recommendations?

- Have the recommendations from the TRC and/or MMIW inquiry changed the way in which mental health services are delivered?

COVID 19:

Preamble: I promise these are the last few questions. What I would like to do is address the changes in service delivery as a result of COVID-19.

Our current COVID-19 environment has drastically changed the way we live and work. How has the development of COVID-19 changed the way you practice?

- If yes, in what ways?

- Is there an increase in demand for your services?

Do you foresee remote counselling as a sustainable solution/option for fly in-/fly-out service providers moving forward?

- What challenges do you anticipate with remote counselling for the counsellor and the client?
- What support would be required for you or your clients for this approach to work?
- Could you recommend other unique/creative solutions to remote counselling?

Do you foresee any lasting impacts that COVID-19 may have on the fly-in/fly-out community?

ENDING:

It's officially over! I want to thank you again for your participation in my research study. To thank you for your time, we are providing a $25 honoraria to Tim Hortons or Starbucks. Please let me know your preference and I can email you the gift card. Keep an eye out and you can expect this very shortly!

Appendix B

Most Recent Ethics Approval

Office of Research Ethics
4500 ARISE Building | 1125 Colonel By Drive
Ottawa, Ontario K1S 5B6
613-520-2600 Ext: 4085
ethics@carleton.ca

CERTIFICATION OF INSTITUTIONAL ETHICS CLEARANCE

The Carleton University Research Ethics Board-B (CUREB-B) at Carleton University has renewed ethics clearance for the research project detailed below. CUREB-B is constituted and operates in compliance with the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (TCPS2).

Title: Enhancing Mental Health Services for Inuit Communities: A Service Providers Perspective

Protocol #: 112643

Principal Investigator: Candace Roberts

Department and Institution: Faculty of Science\Health Sciences (Department of), Carleton University

Project Team (and Roles): Candace Roberts (Primary Investigator)
Francine Darroch (Research Supervisor)

Funding Source (If applicable):

Effective: **May 11, 2021** Expires: **May 30, 2022**.

Please ensure the study clearance number is prominently placed in all recruitment and consent materials: CUREB-B Clearance # 112643.

Restrictions:

This certification is subject to the following conditions:

1. Clearance is granted only for the research and purposes described in the application.
2. Any modification to the approved research must be submitted to CUREB-B via a Change to Protocol Form. All changes must be cleared prior to the continuance of the research.
3. An Annual Status Report for the renewal or closure of ethics clearance must be submitted and cleared by the renewal date listed above. Failure to submit the Annual

Status Report will result in the closure of the file. If funding is associated, funds will be frozen.

4. During the course of the study, if you encounter an adverse event, material incidental finding, protocol deviation or other unanticipated problem, you must complete and submit a Report of Adverse Events and Unanticipated Problems Form.
5. It is the responsibility of the student to notify their supervisor of any adverse events, changes to their application, or requests to renew/close the protocol.
6. Failure to conduct the research in accordance with the principles of the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans 2nd edition* and the *Carleton University Policies and Procedures for the Ethical Conduct of Research* may result in the suspension or termination of the research project.

Special requirements for COVID-19:

If this study involves in-person research interactions with human participants, whether on- or off-campus, the following rules apply:

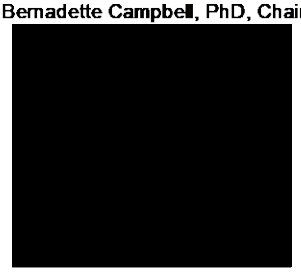
1. Upon receiving clearance from CUREB, please seek the approval of the relevant Dean for your research. Provide a copy of your CUREB clearance to the Dean for their records. See Principles and Procedures for On-campus Research at Carleton University and note that this document applies both to on- and off-campus research that involves human participants. Please contact your Dean's Office for more information about obtaining their approval.
2. Provide a copy of the Dean's approval to the Office of Research Ethics prior to starting any in-person research activities.
3. If the Dean's approval requires any significant change(s) to any element of the study, you must notify the Office of Research Ethics of such change(s).

Upon reasonable request, it is the policy of CUREB, for cleared protocols, to release the name of the PI, the title of the project, and the date of clearance and any renewal(s).

Please email the Research Compliance Coordinators at ethics@carleton.ca if you have any questions.

CLEARED BY: **Date: May 11, 2021**

Bernadette Campbell, PhD, Chair, CUREB-B



Natasha Artemeva, PhD, Co-Chair, CUREB-B

Appendix C

Consent Form

Carleton UNIVERSITY
Canada's Capital University

Informed Consent Form

Name and Contact Information of Researchers:

Candace Roberts, Carleton University, Faculty of Health Sciences

Tel.: [redacted]
Email: candaceroberts@cmail.carleton.ca

Supervisor and Contact Information:

Dr. Francine Darroch, Carleton University, Faculty of Health Sciences

Email: Francine.darroch@carleton.ca

Project Title

Enhancing Mental Health Services for Inuit Communities: A Service Providers Perspective

Carleton University Project Clearance

Clearance #: 112643 Date of Clearance: May 11, 2020

Invitation

You are invited to participate in this study by taking part in a semi-structured interview. You will be asked to provide your perspective on the delivery of emergency mental health services to Inuit communities in Inuit Nunangat. Hearing what you have to say will be helpful in guiding and potentially creating resources that will support mental health providers travelling to these remote areas. The information in this form is intended to help you understand what we are asking of you so that you can decide whether you agree to participate in this study. Your participation in this study is voluntary, and a decision not to participate will not be used against you in any way. As you read this form, and decide whether to participate, please ask all the questions you might have, take whatever time you need, and consult with others as you wish.

What is the purpose of the study?

The purpose of this study is to understand the experiences of mental health practitioners who fly-in and fly-out of Inuit Nunangat to provide emergency mental health services. This project will aim to better understand the perspective on the complex barriers you face as a mental health practitioner. Results from this work may inform future policies and practice through the development of recommendations aimed at

enhancing mental health services. This study will help to conceptualize the challenges of northern work and work towards creating best practices for fly-in/fly-out service providers.

What will I be asked to do?

If you agree to take part in the study, we will ask you to:

Complete an interview with the researcher. The total time commitment will be around 30-90 minutes. The interview will take place at a time that is convenient for you. You will have the option to participate by telephone or by zoom. Only an audio-recording will be taken that will then be later typed up for our analysis (audio-recordings are optional).

The interview will ask questions about your experience providing emergency mental health services to Inuit communities Inuit Nunangat such as how this experience has impacted the way in which you deliver your services?; If you think there is a need for further training specifically in Indigenous mental health?; How do you think you or your organization could enhance mental health services in rural and remote communities?

All participants will be asked if they are interested in being contacted to receive a final report of the findings of this work. If you are interested in receiving findings, a copy of the findings will be sent to you.

Risks and Inconveniences

The risks of taking part in this study are minimal. Some individuals may find talking about mental health services in Indigenous communities upsetting. If you require any additional supports, please know that these services are available: *Crisis Services Canada (CSC) – 1-833-456-4566 or text 45645 OR Canadian Crisis Hotline – 1-888-353-2273.*

Possible Benefits

You may not receive any direct benefit from participating in this study. The interview may give you a chance to share your thoughts and experiences about mental health services in Inuit communities. Your participation may allow researchers to create resources and programs that will benefit you and other individuals in the community. The knowledge you share may also help policy makers develop informed policies to improve the delivery of services in these areas.

Compensation/Incentives

To thank you for your time, participants will be paid an honorarium for attending the interview. You will be given a $25 gift card that you will be offered even if you decide to withdraw from the study.

No waiver of your rights

By signing this form, you are not waiving any rights or releasing the researchers from any liability.

Withdrawing from the study

If you withdraw your consent during the course of the study, all information collected from you before your withdrawal will still be used unless you request that it be removed from the study data. You will

have the opportunity to review their transcripts upon completion of transcription. You can ask to remove any data that would be potentially identifiable. If you would like your data to be removed, or would like to review your transcript, please contact the primary researcher, Candace Roberts.

After the study, you may request that your data be removed from the study and deleted by notice given to the primary researcher within *1 month* after your completion.

Confidentiality

We will treat your personal information as confidential, although absolute privacy cannot be guaranteed. No information that discloses your identity will be released or published without your specific consent. Research records may be accessed by the Carleton University Research Ethics Board in order to ensure continuing ethics compliance. We encourage all participants to refrain from sharing information shared during the discussion outside of the interview, however, we cannot control what other participants do with the information. There are a number of other ways we will protect your confidentiality:

1. Your name will not be attached to the interview transcripts. Instead, a number code and pseudonym will be created for each person in the study.
2. The only people that will see the responses will be the research team members listed above.
3. The results of this study may be published or presented at an academic conference or meeting, but your name or any other identifiable information will never be used in any of the reports of this research. Please let the researchers know if you would like a report of what we learn.
4. You will be assigned a code and pseudonym so that your identity will not be directly associated with the data you have provided. All data, including coded information, will be kept in a password-protected and encrypted file on a secure computer, but may be disclosed via a court order or data breach. If Zoom is used to conduct the interview, your data will be stored and protected by Zoom in a location outside of Canada but may be disclosed via a court order or data breach.
5. At any point in the study, if the researcher becomes aware that there has been abuse and/or neglect of a child or an elderly person (or that there is a risk of such occurring in the future) please be advised that the researcher must, by law, report this information to the appropriate authorities.

Data Retention

With permission, your data will be stored and protected in a server located at Carleton University. Paper files (eg. consent forms and research notes) and stored contact information will be stored in locked cabinets in the primary researcher's supervisor's office at Carleton University. After the study is completed, your de-identified data and contact information will be retained and then destroyed after 5 years. Audio recordings will also be used, though the participant will not be identified in the recording as they will be assigned a code.

New information during the study

In the event that any changes could affect your decision to continue participating in this study, you will be promptly informed.

Version 2019-03-28

Ethics review

This project was reviewed and cleared by the Carleton University Research Ethics Board B. If you have any ethical concerns with the study, please contact Carleton University Research Ethics Board (by phone at 613-520-2600 [ext. 4085 for CUREB B] or by email at ethics@carleton.ca).

Statement of consent – print and sign name

I voluntarily agree to participate in this study.	___Yes	___No
I agree to be audio recorded	___Yes	___No
I would like to receive study findings	___Yes	___No
If yes, please provide email	_____	

_____ _____

Signature of participant Date

Research team member who interacted with the participant

I have explained the study to the participant and answered any and all of their questions. The participant appeared to understand and agree. I provided a copy of the consent form to the participant for their reference.

_____ _____

Signature of researcher Date

Appendix D

Knowledge Mobilization Report

JULY 2021

A participatory action approach to enhance the experiences of **fly-in fly-out mental health service providers**

Photo by Michelle Marie Doucette

AUTHORS: ROBERTS, C., DARROCH, F., SHEPPARD-PERKINS, M.

northern

Health & Wellness EQUITY RESEARCH GROUP

TABLE OF CONTENTS

Health & Wellness EQUITY RESEARCH GROUP

BACKGROUND

JUNE 2021

Inuit History

Inuit are Indigenous peoples who primarily live in Inuit Nunangat, which is composed of four regions in northern Canada (ITK, 2018b). These regions include Nunavut, Nunavik (Northern Québec), Nunatsiavut (Northern Labrador), and the Inuvialuit Settlement Region (Northwest Territories) (ITK, 2018). Archaeologists have suggested that the Inuit and their ancestors have been living in the artic dating back to approximately 12,000 years ago (Bonesteel, 2006). Inuit were able to maintain their traditional subsistence practices into the twentieth century which included primarily whaling and hunting. These procured items were bartered in exchange for European goods such as metal knives, tobacco, cloth, and food; however, with the growth in the fur trade and increased European contact, the focus shifted from subsistence hunting to commercial trapping by the late nineteenth century (Bonesteel, 2006). Eventually the overhunting by European whalers and traders led to the collapse of the fur trade and subsequent lack of employment for Inuit (Bonesteel, 2006).

In response to the loss of employment opportunities, the Government of Canada encouraged settlements, thereby eliminating the Inuit's nomadic way of life. This act began the acculturation and assimilation of Inuit to southern Canadian culture through forced programming (Bonesteel, 2006). Between the years of 1953 to 1955, the Government of Canada relocated Inuit families from Northern Quebec to the High Artic, which is known today as the Resolute Bay area (Crawford, 2014). Inuit peoples found themselves in a harsh environment that had little in common with the region in which they had grown up in, and had fewer opportunities to hunt (Crawford, 2014). Further, promises made by the government to allow them to return home if they were unsatisfied with the High Artic were not kept, resulting in the separation of families over generations (Crawford, 2014). Other examples of colonialism that impacted Inuit peoples include relocations, tuberculosis treatment in the south, killing of sled dogs, residential schools, loss of traditional belief system, loss of traditional relationship with the land, and language (Crawford, 2014). These economic, political, and religious influences have led to the displacement and oppression of many Indigenous communities, which has subsequently resulted in adverse health problems and high-risk behaviours (Kirmayer at al., 2000). To address the disparities in health and health outcomes for Indigenous populations, it is crucial to understand the impacts of colonization.

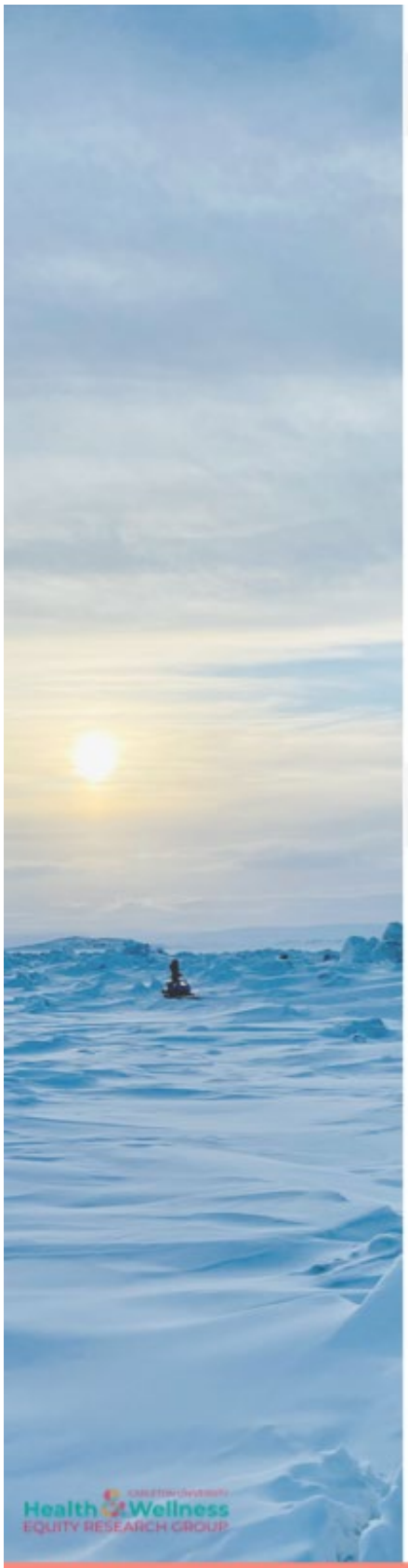
Impacts of Colonization on Health

There is ample evidence to show Indigenous health outcomes are linked to the legacy of colonization (Kirmayer et al., 2000; Nelson & Wilson, 2017). Indigenous peoples in Canada have experienced historical trauma and a loss of cultural cohesion through social and cultural assimilation policies such as residential school programs (Brascoupé & Waters, 2009). These efforts of forced assimilation have resulted in a disproportionate burden of disease and inequalities in healthcare services for this population (Kirmayer et al., 2011; Nelson & Wilson, 2017). The chronic exposure to trauma has manifested in health-risk behaviors and negative symptoms like anxiety and depression, which have reverberated throughout generations (Bellany & Hardy, 2015; Bombay et al., 2009). In a scoping review looking at the mental health of Indigenous peoples, Nelson and Wilson (2017) found that the higher rate of mental health problems in Indigenous populations was universally linked to historical trauma.

Inuit Health and Wellbeing

In a report describing the health status of the Inuit population, Inuit Tapiriit Kanatami (ITK) (2018b) outlined health indicators currently impacting the health of Inuit in Canada. Low life expectancy as well as other poor health indicators such as suicide, chronic illnesses, and infectious diseases highlight the many challenges that Inuit in Canada face (ITK, 2014). In a 2006 survey on Inuit health and social conditions, Inuit adults were also found to be less likely to report excellent or very good health (Tait, 2008). These poor health outcomes are a symptom of colonialism, racism, and marginalization amongst other challenges that result in persistent inequality (ITK, 2014; Kirmayer et al., 2011).

Disparities in the provision of care negatively impact those living in the Canadian North (Mendez et al., 2013). Although many of the barriers are associated with geographic location (Friesen, 2019), other factors affecting accessibility include social, economic, and cultural access barriers, emphasizing that healthcare services in rural communities is a complex, multifactorial issue (Caxaj, 2016; Friesen, 2019). These complexities are exacerbated in Indigenous populations who have been impacted by colonialism and continue to face inequitable access to health care in rural communities (Nelson & Wilson, 2017). Even when Indigenous peoples do access services, Nelson and Wilson (2018) found that they experience racism and discrimination. Perhaps the most significant barrier for Inuit is the limited access to health services, which is reflected in the health disparities that exist (ITK, 2014). Challenges related to geography, culture, language, and human resourcing have resulted in poor availability of health services, and led to poor health outcomes for this population (ITK, 2014). Due to the reduced number of local health professionals, many Inuit are required to leave their communities to access care (ITK, 2014; Tait, 2008) or rely on health professionals who fly into communities (Oosterveer & Young, 2015). The absence of health care in these regions not only affects treatment, but it also impacts the overall health and wellbeing for this population (Huot et al., 2019).



Impacts of Colonization on Health

There is ample evidence to show Indigenous health outcomes are linked to the legacy of colonization (Kirmayer et al., 2000; Nelson & Wilson, 2017). Indigenous peoples in Canada have experienced historical trauma and a loss of cultural cohesion through social and cultural assimilation policies such as residential school programs (Brascoupé & Waters, 2009). These efforts of forced assimilation have resulted in a disproportionate burden of disease and inequalities in healthcare services for this population (Kirmayer et al., 2011; Nelson & Wilson, 2017). The chronic exposure to trauma has manifested in health-risk behaviors and negative symptoms like anxiety and depression, which have reverberated throughout generations (Bellany & Hardy, 2015; Bombay et al., 2009). In a scoping review looking at the mental health of Indigenous peoples, Nelson and Wilson (2017) found that the higher rate of mental health problems in Indigenous populations was universally linked to historical trauma.

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Service Provision in Inuit Nunangat

The substantial need for mental health providers in rural areas is often paired with a shortage of mental health services (Barbopoulos & Clark, 2003). This is especially true for communities in Inuit Nunangat, as none of the communities in this region have year-round road access, and only a few have hospitals (Tait, 2008). In 2008, it was reported that adult Inuit living in Inuit Nunangat were 49% less likely to come in contact with a doctor in the past year compared to 79% of the total Canadian population (Tait, 2008). Physical geography is frequently reported as a barrier to access of healthcare services in rural, northern communities (Huot et al., 2019; ITK, 2014; National Collaborating Centre for Aboriginal Health, 2011; Oosterveer & Young, 2015). In fact, in a study looking at primary health care service delivery in remote Indigenous communities in the Northwest Territories, both service providers and service users recognized that equal and equitable access to primary health services was unrealistic to the geographical characteristics of the communities analyzed (Oosterveer & Young, 2015).

The remoteness of communities combined with the small Inuit populations creates difficulty for the recruitment and retainment of permanent health professionals, which can hinder care (ITK, 2014; Oosterveer & Young, 2015). When services are not available locally, Inuit often must leave their homes for extended periods of time to access specialized care in regional "hubs", or travel outside of Inuit Nunangat to urban and southern-based hospitals in Happy Valley-Goose Bay, Ottawa, Montreal, Winnipeg, or Edmonton (ITK, 2014; NCCAH, 2011; Tait, 2008). Being away from community and support has significant collateral impacts (ITK, 2014), highlighting the importance of local service provision. For services available within their communities, many Inuit regions rely on transient healthcare professionals to provide services (ITK, 2021). The healthcare professionals who deliver these services often do not reside in Inuit communities, and rotate in and out of Inuit regions from southern Canada (ITK, 2021). This engenders its own set of problems as healthcare professionals travelling to these communities may not be familiar with Inuit culture or language (ITK, 2014). Although this approach is complex, FIFO services to these regions are necessary for Inuit to obtain health services.

Fly-in Fly-out Providers

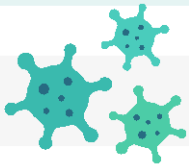
As a result of the low retention and recruitment of permanent rural health workforce, many rural communities in Inuit Nunangat rely on transient staff (ITK, 2021) who fly-in and fly-out of northern communities. Hanley (2012) argued that these outreach models make significant contributions in the health sector as they represent a necessary compromise between equitable access of care and the "tyranny of distance" (p. 1). Wakerman et al. (2012) categorized FIFO or drive-in and drive-out (DIDO) provided by a non-resident workforce in five different ways:

Service Provision in Inuit Nunangat

FIFO CATEGORY	DESCRIPTION	NCTS
SPECIALIST OUTREACH SERVICES	Models that mobilize specialists to provide services away from the location where they usually work	Psycho-educational assessments
HUB-AND-SPOKE MODELS OR OUTREACH ARRANGEMENTS	Models that consist of an establishment (hub) providing services to multiple secondary establishments (spokes)	-
'ORBITING STAFF'	Staff who spend 12 months or more in specific communities, who may work elsewhere but return to the same communities.	School-based contracts (annual basis)
LONG-TERM SHARED POSITIONS	Positions where the same practitioners visit the same communities, for example using a month-on/month-off schedule.	Monthly designated clinical days to support local counsellors or mental health staff; monthly designated clinical days and ongoing psychoeducation for large organizations
SHORT-TERM OR AGENCY STAFF	Staff who visit communities as a one-off, and move from place to place.	Crisis response

Researchers in Australia have highlighted some of the advantages and disadvantages of FIFO models of care (Gardner et al., 2018; Hanley, 2012; Hussain et al., 2015; Sutherland et al., 2017; Wakerman et al., 2012). Hanley (2012) recognized the potential benefits for the individual practitioner to develop broader professional experience without having to move entirely from their home, commitments, and social and professional networks. Hussain et al. (2015) posited that FIFO services offer a great alternative for community members who would otherwise need to travel long distances. There are, however, inherent challenges to these practices. Some disadvantages of these models cited in the literature include the high cost of travel to rural communities, increased demands on local infrastructure, and wasted time travelling to communities for providers (Hanley, 2012; Hussain et al., 2015). These are consistent with the barriers of recruiting and retaining permanent local staff, which include poor access to personal and professional supports, lack of anonymity and privacy, and poor work-life balance (Hussain et al., 2015; O'Neill, 2010). In a study by Sutherland et al. (2017), the authors found that FIFO mental health service delivery is particularly challenging in a FIFO context given the nature of therapeutic work. Psychologists, in the aforementioned study, described the difficulties associated with having to work within short time frames to efficiently conduct psychological assessments, while also having to reinforce therapy skills and maintain rapport with their clients (Sutherland et al., 2017).

The Impact of COVID-19



Recently, the challenges of delivering FIFO services have been exacerbated by the onset of the COVID-19 pandemic. In March 2021, the World Health Organization (WHO) declared the outbreak of the novel coronavirus a pandemic (WHO, n.d.). The virus impacted the ability for service providers to deliver care to Inuit Nunangat due to travel restrictions and quarantine recommendations by community leaders, governments, and organizations in Inuit Nunangat (Penny & Johnson-Castle, 2020). Many FIFO service providers shifted their practices to include telemental health services in response to the preventative guidelines. Although telemental health services is not a new strategy, there are still many challenges associated with the delivery of online services to rural and remote Indigenous communities. In a study looking at the experiences of delivering telemental health services to Inuit and Cree communities in Northern Quebec, outside of the COVID-19 context, mental health service providers acknowledged the benefits of telemental health strategies for individuals living in rural communities (Shang et al., 2021). It was, however, emphasized that these online services should be provided in conjunction with in-person visits, thereby highlighting the importance of FIFO models of care (Shang et al., 2021). Furthermore, providers in the study noted the technological limitations of offering online services, which is unsurprising considering the significant infrastructure gaps in Inuit Nunangat (ITK, 2018a).

Inuit Nunangat Infrastructure Gaps

In a position paper titled Development and Implementation of the Arctic Policy Framework, the ITK (2018a) acknowledged the gap in infrastructure as a contributor to the social, economic, and health disparities between Inuit and non-Inuit. Noted in this report was the extreme digital divide that separates this region from the rest of Canada, which impedes healthcare access. Due to the remoteness of Inuit communities, internet connectivity is necessary for the delivery of telemental health services, especially when entering the community is not possible.

A Nunavut Land Claims organization, Nunavut Tunngavik, also indicated the gaps in health care infrastructure in their report, highlighting the shortage of basic mental health care and addictions infrastructure as problematic (Nunavut Tunngavik, 2020). Difficulties in telecommunications and health care infrastructure have been highlighted during the COVID-19 pandemic according to ITK (2021) as FIFO services have shifted to online services.

Risks of Northern Practice

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Mental health service providers face inherent risks when working with traumatized patients. Quitangon (2019) proposed that mental health providers are vulnerable to developing vicarious trauma; a concept that has been defined as the inner transition of a trauma provider as a result of empathetic engagement with the traumatic experiences described by clients (Pearlman & Mac Ian, 1995). Despite not being exposed directly to trauma, overly engaging empathetically with traumatized clients can result in vicarious traumatization (Finklestein et al., 2015). Changes that occur through the process of vicarious traumatization include changes of worldview, psychological beliefs and needs, as well as changes in self-capacities and abilities (Pearlman & Mac Ian, 1995). Certain factors contribute to the increased risk of developing vicarious trauma, such as a greater caseload and more time spent with patients (Finklestein et al., 2015). O'Neill (2010) noted the increased risk of northern practice for providers, and how aspects of working in an isolated community can increase risk of exposure to various constructs of secondary trauma. Working in isolation away from personal and professional supports, with limited training opportunities and clinical supervision, may leave providers vulnerable to vicarious trauma (O'Neill, 2010). The researchers highlighted the complexities of providing isolated mental health services to northern communities because of the interactions between mental health support, secondary trauma, and histories of historical and intergenerational trauma.

ABOUT THE RESEARCH

Context and Purpose

This Master's research was a two-year partnership between the Health and Wellness Equity Research Group at Carleton University and Northern counselling and Therapeutic Services. The purpose of this research was to gain insight into the experiences of FIFO mental health providers who deliver mental health services to communities in Inuit Nunangat.

Research question

This research aimed to answer the following questions:

1. What factors influence FIFO mental health service providers' experiences of **vicarious trauma**?
2. What are the impacts of the **COVID-19** pandemic on FIFO mental health service delivery?

Activities

Between **September 2019** and **August of 2021,** key research activities included developing an advisory board, data collection using surveys and semi-structured interviews, data analysis and interpretation, and presentation of findings.

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Forming an Advisory Board

An advisory board comprised of two FIFO mental health service providers, two community-based researchers, and one representative from our partner organization, NCTS.

Data Collection

Graduate student, Candace Roberts, conducted interviews with participants through scheduled interview times on the phone or via zoom.

Interviews. The graduate student conducted, and audio recorded, qualitative semi-structured interviews with the study participants lasting between 40 - 90 minutes. A series of open-ended questions, pre-approved by the community advisory board, were used to gain a deeper understanding of participant experiences and insight into participant's experience delivering mental health services to Inuit Nunangat.

Follow-up

Follow-up questions were asked of study participants 3 months after the initial data collection period to determine if/how their situations had changed considering the rapidly changing COVID-19 environment.

Analysis

Qualitative data analysis. NVivo qualitative software was used for organizing data and supporting thematic analysis.

Participants

This research included a sample of eight participants. Interview data was collected over 3 months from July 2020-October 2020. Inclusion criteria required that individuals: (a) English speaking; and (b) have FIFO experience with the delivering mental health services to residents of communities in Inuit Nunangat.

Research Findings

Drawing on the data from semi-structured interviews, a detailed analysis illustrates the complexities of delivering FIFO mental health services to communities in Inuit Nunangat. Through thematic analysis, the interviews provided valuable insights into the many factors which impact the work of FIFO providers. Below we present the findings of this research.

SUPPORT

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Key Messages

- Participants found that having on-the-ground connections prior to entering a community was useful and resulted in more effective service provision
- Although counsellors felt supported by NCTS while in community, providers reported having to seek our and navigate various supports while in community e.g., elders, police force, etc. Collaboration with the community was identified as important to service provision.
- Counsellors found that "Inuit peer supports" or Inuit counsellors and informal support groups were particularly helpful and enabled the counsellor to establish connections faster

GENERAL SUPPORT

"The only thing I did with one community, we – every day, we would meet at the end of the day, we would meet with the - one representative of the firefighter or the police or the nurse or things like that, of the band. And we would talk about how it went, where do we see – without saying any name, we would talk about the need. What are the needs now? What are the steps we have to take now and still do things like that? So, that was very helpful."

"So when you talk about support, I think it's often mixed reviews. There will be the people who hired you, brought you in, who I think are coming from a place of wanting to obviously provide services. Sees that these challenges that they brought you into deal with are being addressed, but then you've got everybody else, all the other players. And there's just a huge disconnect, in terms of whether people really value you or want you there and I think that's a huge problem with these client type of services here. It's preparing the ground and making sure that you have a healthy environment to come into is not easy. And certainly goes beyond the whole fly-in fly-out thing, doesn't it. I mean it's characteristic of what's happening in the North right now, they struggle to build services and resources."

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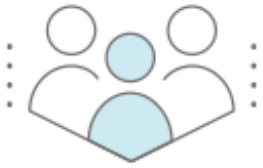
SUPPORT

"It's supportive for me to have my housing set up, to have some other folks in the field I can debrief with discreetly, to get support and ideas, to collaborate with local community members who are involved."

COMMUNTIY SUPPORT

"So the community piece is big in terms of that cultural aspect and also in terms of ...our services are not effective unless we really work not just within but with the community so with the local service providers that are there, with the informal support groups like an elders group that we know do a lot of counseling in the schools and sometimes when southern service providers come in they either don't know about it or they don't know how to reach out and it's kind of that discomfort maybe and that lack of understanding so there's kind of that divergence between the southern and the local service provision and there really shouldn't. So there really isn't any effective service delivery until we are really and truly collaborating with the community from both a cultural perspective and from an existing services perspective."

"In terms of the community, there's next to nothing for the most part. You'll sometimes have a community rep and I'm pretty impressive about finding people who can support me. I sort of create my contacts when I go into those communities. But it's not volunteered and it's not easily available and again, you're dealing with resentment. So those are huge barriers to support, to offering services."



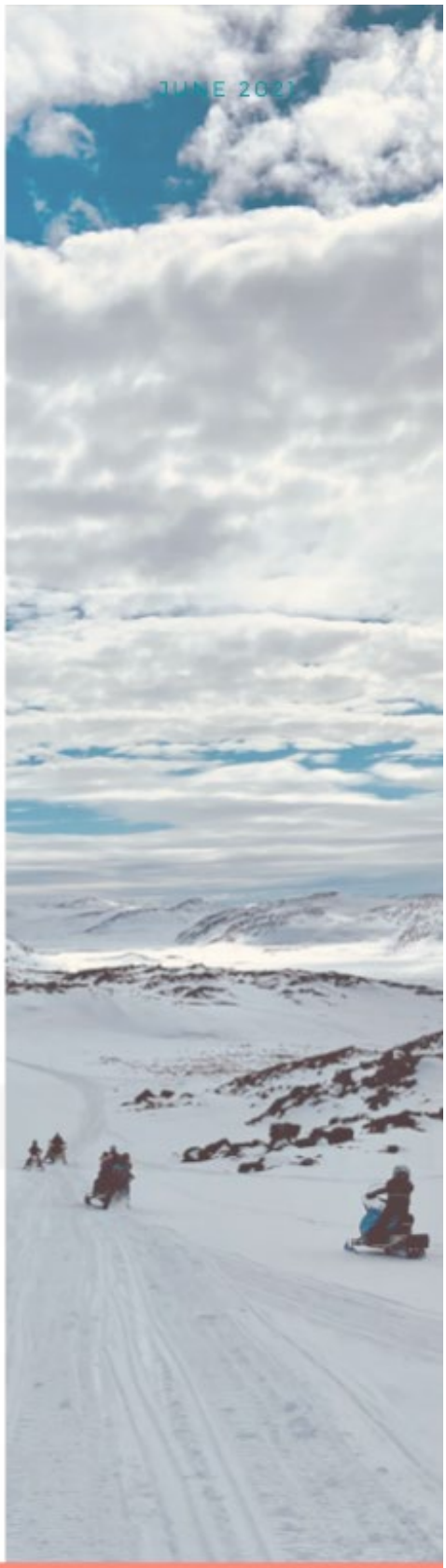
SUPPORT

ORGANIZATIONAL SUPPORT

> Certainly NCTS are very good and helpful at making sure you're connected with key people that are on the ground so in Iqaluit there's other people who have been working there for a long time and so I was connected to other counselors who had originally been fly and fly out but remained there and had been there for a long time so I was connected to them to help me sort figure out the community and give me support and also I was connected to an Inuit organization, and there was somebody there that was really helpful to kind of have a sense of the community and to get to know the community. So that was really helpful.

INUIT COUNSELLORS

> Yes, we have people that we ask if they could be there when we meet people or, for example, if I meet with the, like, translator, but also [supportive]. So, you try to have both, they could translate so the people are more comfortable to talk in their own language.



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SUPPORT

"A lot of times, their training is in generalist counselling and not really intensive trauma training is what I find. So I come in for sure with a different lens, a different set of skills, whereas they are very culturally aware. And sometimes I know [name] has consulted with those teams in working with different areas. So I know they're a part of our team, an extension for sure."

"Yeah, definitely and Ilisaqsivik as well, has wonderful peer supports and we team up with Ilisaqsivik counsellors all time to go into communities and it really is a wonderful combination and also it kind of cuts down on that time that it takes to get out there, in the community, and to activate counselling services because we already have a leg in there and they already know the communities and they already know the people in the communities. So, it really makes a big difference because, so we can get in there and get active faster."

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TRAINING

Key Messages

- Counsellors suggested that training in cultural awareness, cultural sensitivity, and cultural safety would be beneficial and improve their practice
- Many participants expressed interest in engaging with more Inuit-specific training through courses and increased access to training materials
- Counsellors noticed little to no changes in service provision as a result of the TRC and MMIWG inquiry which may be an opportunity to integrate educational opportunities within this area

"I've been trained in different cultures, but specific to Inuit to First Nation would be great. I find there's more with First Nations than with Inuit. And I would love to see more of that. Yeah. It could be online, could be here, it could be – because when you go there, they know we have some experience and training. So, it would be good to have more available."

"I think that model of having an online module of some sort of training program would be stellar. I think it's going to be very difficult to get people together in physical spaces to have this kind of learning. And the other nice thing about online materials is you can revisit them and have resources you can check with and I think it's great. It is tricky going into a new community. I'll tell you one thing I ran into is, when I was in Kuujjuaq for example, I tried to get information on what natural healing practices and what sort of traditional medicines and knowledge existed within the Inuit culture. And I talked to people, talk to Inuit, I went online, I looked for materials. There is a scarcity of any kind of information in that regard. And it was, it was disappointing to me. I really wanted to learn more and see how I can integrate that in, because when I worked in the BC Interior for example, that was a really big part of what I did is I worked with natural healers, I worked with medicine people. And again, huge increase in credibility."

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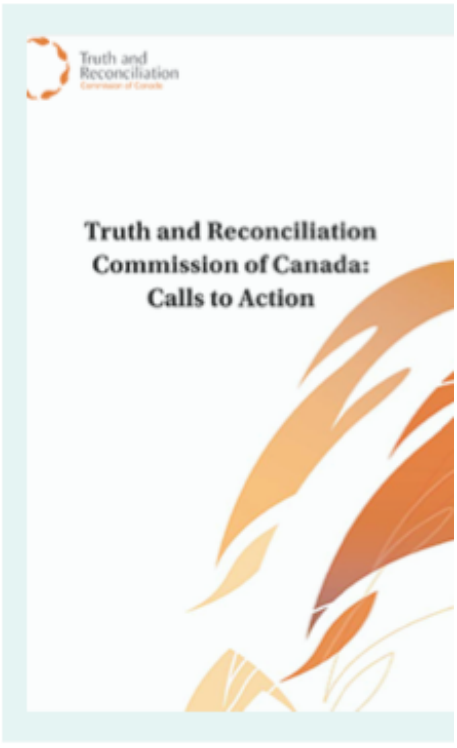
TRAINING

"So, it would be great if there were some standard courses or trainings that everybody needs to take. And I think that when I moved to Inuvik, I know that I was – I was only hired because of my experience with Residential School impact. But then we had a real – like a two or three-day immersion as well. So, we – we went in and we had a couple – two or three days of presentations by Gwich'in and Inuvialuit leaders and representatives about culture, about history, about practices, about expectations of us coming into the community, you know and that was amazing."

TRUTH AND RECONCILIATION (TRC) & MISSING AND MURDERED INDIGENOUS WOMEN AND GIRLS (MMIWC)

"No I don't think they [the TRC and MMIWG recommendations] have [changed service delivery] whatsoever. I think it changed the way education is you know educational content is delivered in Canada mental health service delivery, no, I think it's I think that it created awareness and I don't think that awareness has transferred into on the ground practical commitments nor solutions. I just don't see it. That's kind of understandable, like it takes a long time to steer the container boat in one degrees it's going to take awhile"



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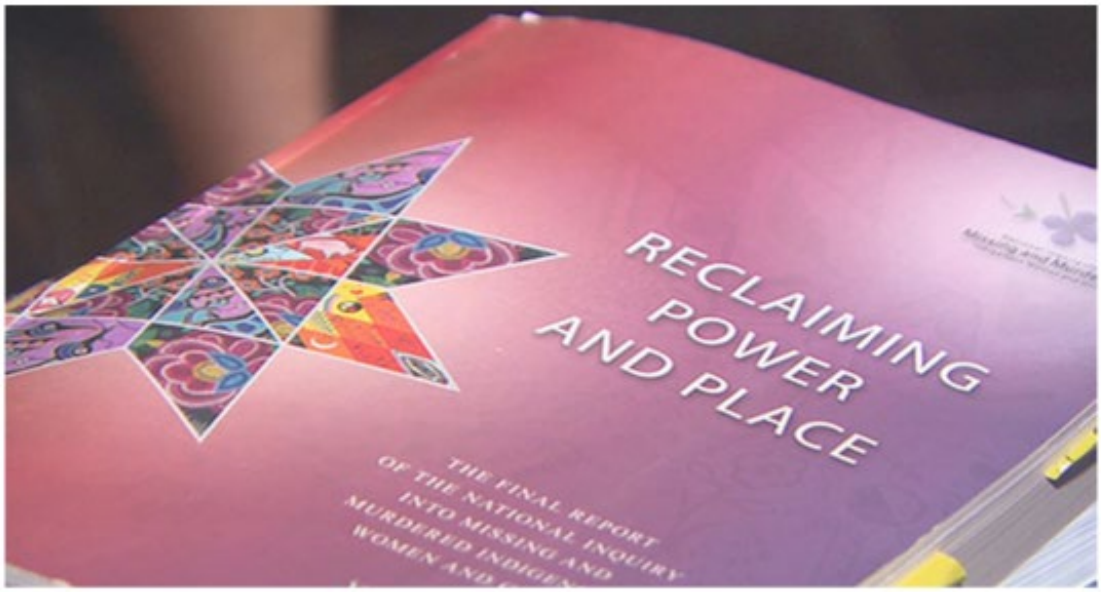
TRAINING

"I'm going to say [the TRC and MMIWG recommendations] have not [influenced service delivery] a great deal. I'm going to say that in my opinion it has probably created some political awareness, it's created sensitivity to the issues. But I do not think that is translated well into service delivery. That would be my opinion."



"I think it [TRC and MMIWG recommendations] has initiated a massive change. I just think this awareness has brought, I think, groups like Quality of Life, to give them power and communities have been, I believe, they have been empowered to see and to face and to ask for what they need in a way that they never could before and that the government is in the very beginning stages of meeting people where they are. It's, I think it has changed the dialogue and it's changed the services that are available."

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VICARIOUS TRAUMA

Key Messages

- Counsellors identified the inherent risk of developing vicarious trauma when working with traumatized clients and communities
- The risk of traumatization was described differently based on the type of contract e.g. short-term, crisis response role or long-term, school-based role
- Counsellors identified prevention strategies to reduce the risk of vicarious traumatization which included: engaging in self-care strategies, debriefing with fellow associates and supervisors, and managing caseload and time spent in the community
- Counsellors reported the benefit of a FIFO model of care to reduce the risk of vicarious trauma

"Just the constant exposure to trauma, right? It's an occupational hazard... it's a small community. You have to manage being discreet and neutral in the community because you're carrying so many people's stories. You're at high risk [of developing vicarious trauma] for sure."

"You have to be really self-aware and [have] excellent self-care. I always find a place that I can work-out in a community. And having the debriefing, open honest debriefing with one of the associates [within NCTS] to work through that, is really important. Because sometimes you can't just say sorry, I can't work with you. That's not always an option."

"Usually, we stay for a week or two. Sometimes, some people stay for three weeks. Myself, I don't want to stay too long, because it's also hard on ourselves, right, and we have lives here [in the South], as well. So – and I find for our home and for health, it's good not to stay too long. So, we can still be objective, and we can be refreshed after a while

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VICARIOUS TRAUMA

"Having that support to process, debrief, release and knowing how to do that for yourself. At NCTS there's strong support to be well within your work as a counselor and so that might mean that I need to talk to my own supervisor and just say I'm really struggling with the situation that I'm in front of right now and I feel like the organization supports that well, but also, I need to take that up as a counselor and be aware that this is a real thing that happens. Overtime you can, if you don't take care and process continuously, fall into vicarious trauma, and compassion fatigue or burn out. I guess it's the awareness that it definitely can happen. I guess as counselors we always need to have a supervisor...who we check in with about our role as the counselor and...when [you're] beginning to feel signs of burnout or anything like that, it kind of keeps you in check."

"Honestly, I think that we are lucky in a sense, if we're doing this kind of work, where we're fly-in and fly-out. We have the opportunity to debrief with Northern Counselling support people and admin people. And then of course once we're back in the South, we have the opportunity to access our own mental health services and our own support networks. And so, I think there's lots of it [support] available once you're out of those communities. When you're in those communities, I don't think there is much available at all. But again, we're not there for a long period of time. So, in a way, it makes a huge difference when you know you're leaving."

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COVID-19

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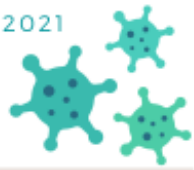

Key Messages

- Counsellors recognized the challenges in adapting their practices to meet individual and community needs as a result of COVID-19. These challenges included: logistical issues with isolation, the lack of human presence, poor access to technology and infrastructure, and privacy concerns.
- Despite the challenges, participants also emphasized the opportunities for enhancements to service delivery through enhancements to the continuum of care by incorporating telemental health services, advancing platforms to facilitate the delivery of these services, and re-envisioning medical spaces to accommodate these additional services.
- Providers identified the potential for a synergistic model of care that incorporates telemental health services as a potentially effective adjunct to in-person sessions.
- ·All providers agreed that that telemental services can be effective given the current COVID-19 pandemic; however, they all agreed that remote counselling should be used as a complementary service to their in-person services.
- An integral part of the discussion surrounding mental health service delivery to Inuit Nunangat was the ability to build a connection or relationship with the community

"Especially in the North, people might not all have access to the technology that's needed. People might not be able to afford doing phone counseling and there might not always be an option for them to do it in a safe space, whether they're coming from an overcrowded home - so there's all these logistical challenges as well that are probably quite unique to the North or to Indigenous communities that we also have to consider."

"My remote counselling is most effective in the communities where I've worked the longest. So, it's easy to have a phone conversation with so and so, because I've also met them for the last five years, so that makes it easy. When you don't have a relationship - so I have a community where I've only visited [for] two weeks...that's way more difficult."

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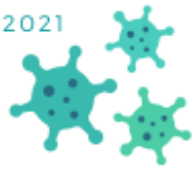
COVID-19

JUNE 2021



"Well, I'm hoping that what comes of it is...that there ends up being a continuum of service that's offered. And rather than focusing on going in and doing crisis management, which we all are aware is not the ideal model, that we have a model where we may fly-in, and if we don't fly-in, then we have some way of establishing that initial... familiarisation process. And then that the follow up is that we are able to do ongoing service for some period of time - I would suggest nothing less than a year. Preferably two or three years, being available to do that ongoing counselling on a remote basis. So, I do think that COVID has probably accelerated the development of that kind of a model."

"I think some of the platforms . . . they've all accelerated the development of their platforms, and I think they're better than they used to be. I think the foundation of all of this service delivery, whether it's remote or in person, is building relationships and clarifying the mandate so that we are welcomed into the community, we're a part of the fabric of the service delivery. And if that ground is well prepared, then I think we should be fine."

"I guess making sure that we're connected with on the ground emergency response, that I have numbers and things like that, because I'm – I'm not right there in the room with someone. So, if they're in danger...I would have my numbers for RCMP, head nurse, you know wellness worker, emergency folk, right beside me."

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> Yeah, I do think it [remote counselling] can be an adjunct, I would not want to personally see it go just to remote counseling. I think the time in the community is really important and essential. It's just so different than only knowing a person by phone or video counseling. And so, I think it can work really well and can be a good adjunct...I could see flying in and then also having a period of remote [counselling] and then both together.

> "I like the idea of the webinars or the online workshops, or things like that where we can establish a bit of a relationship. I mean ideally, again, we go back to the idea of being able to go in person to the community and sort of shake hands and make contacts and so on. But if that can't happen, then we've got to figure out other ways of building that familiarity."

Health & Wellness EQUITY RESEARCH GROUP

RECOMMENDATIONS

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Support

Have a clear and strategic plan for counsellors entering communities for the first time which may include establishing **on-the-ground connections** with public health officials, local organizations, or members of the community that can provide critical supports, information and insights

Encourage connection with "**Inuit peer supports**" or Inuit counsellors and informal support groups, when possible

Training

Seek out **additional training** focused on Indigenous wellbeing, historical context(s) and cultural safety

Provide **standardized training modules** for NCTS counsellors as a key component of the onboarding and ongoing professional development processes

Ensure that resources and training provided to counsellors are **Inuit- and community-specific**

Vicarious Trauma

Formalize policies, procedures, and internal structures to encourage **discreet and accessible pre-, mid- and post-deployment debriefing** with fellow associates or supervisors because of its high effectiveness

Explore the **optimal time spent in community** which would allow the counsellor to develop relationships with the community, and to maintain their mental health

COVID-19

Formalize strategies to **build connection** within community whenever face-to-face visits are not possible

Continue to explore a **mixed-service model** for virtual and face-to-face service provision, considering emergency response, appropriate virtual service delivery contexts, and the effectiveness and feasibility of webinars/workshops to promote ongoing positive mental health

AREAS OF EXPLORATION

While we recognize the counsellors have training and experience in many areas, here are some additional training recommendations for exploration:

Gender-based programming/Gender-based lens for counselling

- https://ca.movember.com/report-cards/view/id/3479/mental-health-practitioner-training-program
- https://ca.movember.com/report-cards/view/id/3274/pathways-to-mental-wellness-for-indigenous-boys-and-men-community-led-and-land-based-programs-in-the-canadian-north

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