Consultation to Remote and Indigenous Communities

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Introduction

Most models of mental health services have been developed in urban settings, with large populations and many specialized resources. Rural and remote communities pose challenges to these models for reasons of geography, social structure and culture. In Canada and other countries, rural and remote communities include a high proportion of Indigenous peoples, with important cultural differences from the urban population. In this chapter, we discuss the role of cultural consultation in providing mental health services for remote and rural communities, with an emphasis on the mental health of Indigenous peoples in Canada. The authors have worked as psychiatric consultants to First Nations and Inuit communities in Northern Quebec and draw from this experience and the work of the CCS to outline key issues for cultural consultation in this setting.

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The Context of Rural and Remote Communities

Rural and remote communities can be defined in various ways reflecting relative size and density of population, level of infrastructure and distance from urban centers (Hart, Larson, & Lishner, 2005). A rural community is located outside an urban area has smaller size, lower population density and less infrastructure. A remote community is situated at a great distance from a metropolitan region and is difficult to reach by regular transportation. Such communities typically have a small population and low population density and usually have very limited infrastructure. The costs of providing mental health services in such settings are high.

In Canada, the population of most remote communities is predominately Aboriginal peoples (First Nations, Inuit or Métis).[1] Although more than 50% of the Indigenous population live

[1] Although "Aboriginal" is the official term used by government to designate the Indigenous peoples of Canada (including First Nations, Inuit and Métis), in this chapter we will use the term "Indigenous" which is increasingly preferred by groups internationally.

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in cities, and many live in reserves located near cities, according to Statistics Canada (2008), approximately 20% of Indigenous people in Canada live in rural or remote non-reserve communities. In this context, rural and remote includes wilderness areas and agricultural lands, as well as small towns, villages and other populated places with a population of less than 1,000 and a density of less than 400 persons per square kilometer. Many of these communities are located in Canada's northern regions. The social, cultural and political issues of Indigenous peoples combined with logistical issues of geographical location and scale pose distinct challenges for mental health services.

Fully 90% of Indigenous communities across Canada consist of less than 1,000 people. These communities are often located in regions with very low population density. Some of these communities, especially arctic and northern communities, are more than 2,000 km from a major city. Access to many of these centers from rural and remote areas is often difficult. Few roads connect some of the smaller communities, which may be hundreds of kilometers from neighboring communities.

Small communities have some advantages with regard to mental health. There can be greater social cohesion, easy access to social and family support systems, a strong informal network of helpers and widely shared knowledge of the community and available resources. In small communities, personal networks and professional relationships are likely to overlap. This can be an advantage when an immediate response is needed to avert a crisis but can be a disadvantage to both clinicians and clients when privacy and professional distance is desired. Community workers may be closely connected to the people they are supposed to help, implicated in their conflicts, and may never have any respite from their role as caregivers.

A variety of forms of mental health service have been provided to rural and remote Indigenous communities, including primary care, crisis intervention, prevention and health promotion programs. However, many people living in rural or remote areas do not have ready access to professional mental health care. Larger communities may have a primary health clinic staffed by a physician and other health or social service professionals. Smaller communities may have a nursing station, with nurse practitioners, assisted by visits from other health professionals on a rotating basis. Specialist, secondary and tertiary services are generally not readily available in smaller rural and remote communities. Patients with serious health problems may therefore need to travel long distances at considerable expense to receive the appropriate medical care.

This situation is compounded by common difficulties faced in the provision of mental health services in rural and remote settings. These include (1) shortage of trained professionals or other helpers, (2) the pressure on the mental health workers living in a small community who work alone with limited access to ongoing clinical supervision and continuing education, (3) the difficulty of ensuring confidentiality when people live in close proximity, (4) stigma associated with mental illness that is difficult to conceal in small communities and (5) the costs and logistical challenges associated with transportation of providers or patients (McDonel et al., 1997; Nagarajan, 2004).

In addition to the challenges associated with geographical remoteness, rural and remote communities face similar challenges to those faced by Indigenous people across Canada. Many remote Indigenous communities have social problems including housing shortages, overcrowding, poverty, unemployment as well as issues of substance abuse and domestic violence that may reduce well-being and increase the prevalence of mental health problems (King, Smith, & Gracey, 2009; Kirmayer, Tait, & Simpson, 2008). Social and mental health services may be underfunded, while rates of substance abuse, violence and suicide often are high (Kirmayer, Whitley, & Fauras, 2010).

Beyond the geographical and environmental challenges associated with remoteness, there are dilemmas for health service delivery in remote and rural communities reflecting jurisdictional issues in the ways that services have developed (Macdonald, 2008; McCormick & Quantz, 2009):

- Services tend to be provided in reaction to crises, with fewer resources invested in primary and secondary prevention or mental health promotion activities.

- Services are often fragmented with lack of continuity of care over time and across sectors. The lack of temporal continuity results from staff shortages, high levels of staff turnover, and shortages of resources. Remote and rural communities often rely on locum or itinerant physicians and nurses on rotation (Armstrong, 1978; Group for the Advancement of Psychiatry, 1995). Discontinuity across sectors occurs because services are segmented in silos, i.e. substance use disorder services, mental health services, social services and education are not integrated and may provide contradictory advice or interventions.
- Often services are provided through specific time-limited projects or initiatives. Funding tends to be available for pilot projects on a short-term basis, with promising and innovative projects terminated just as communities are becoming more comfortable with the intervention.
- Program evaluation is less common in rural mental health than in urban settings, due to the shortage of resources, costs of hiring outside researchers to evaluate projects and the lack of trained personnel on the ground to conduct evaluation. There may also be a heightened sensitivity on the part of providers about the potential perception of urban-based outsiders that their services are of an inferior quality. The result of all this is that there is a lack of rigorously evaluated, evidence-based interventions relevant to promoting mental health and well-being in rural and remote regions.

In the absence of a comprehensive service, it has been suggested that a community mental health liaison service or related models of collaborative care can provide support for primary care practitioners, while also assisting family carers, though again this model has not been rigorously tested (Hazelton, Habibis, Schneider, Davidson, & Bowling, 2004).

In additional to these pragmatic and logistical considerations, there is increasing recognition that conventional services may create situations that are unsafe for Indigenous peoples and other groups that have experienced oppression. Building on work by Maori nurses in New Zealand (Papps & Ramsden, 1996), Indigenous scholars and organizations have endorsed the notion of cultural safety as a way to highlight and address issues of power, institutionalized racism, and discrimination in the health care system (Brascoupé & Waters, 2009; Koptie, 2009; Smye, Josewski, & Kendall, 2010). The Indigenous Physicians Association of Canada (2009) has produced a curriculum for training health professionals to give them some of the basic historical and contemporary background knowledge needed to understand the experience of Indigenous patients and to begin to address their own attitudes and stereotypes. Any approach to services for Indigenous peoples must engage these principles of cultural safety to insure that the context of health care delivery and the modes of interaction acknowledge and redress the legacy of colonialism and ongoing power disparities that continue to affect the health and well-being of Indigenous individuals and communities.

Social Determinants of Mental Health in Rural and Remote Settings

As a result of the social, economic and technological changes in developed countries in the last 200 years, there has been an enormous migration from rural to urban regions. One result of this migration is the preferential move of young people to urban centers, with a corresponding aging of rural populations (Judd et al., 2002). A more recent phenomenon is counter-urbanization, with the movement of low-income families from urban zones towards rural areas, often searching for housing at lower costs (Fitchen, 1995). Increased mobility has also resulted in greater circulation of people back and forth between urban rural and remote communities.

Generally speaking, health indicators in urban and rural regions are similar, and both present a profile that is less favorable than the profile found in suburban regions that are comprised of a large proportion of high-income families. In the United States, many rural regions have higher rates of premature mortality (before 75 years of age),

child mortality, suicide, accidents, tobacco consumption and chronic obstructive pulmonary disease (Eberhardt & Pamuk, 2004).

Few studies have considered area of residence (rural, urban or suburban) as a risk factor for psychiatric illness. The prevalence of illness seems to be influenced more by socioeconomic factors (such as unemployment, poverty, social support networks) that vary within rural and urban zones as well as between them (Judd et al., 2002). The socioeconomic profile of rural areas in North America has evolved in the last decades, but the populations remain disadvantaged in many ways in comparison to urban centers, with lower employment rates and average salaries, higher poverty rates and a larger proportion of individuals depending on social security, as well as a globally lower level of education (Gamm, 2004; Judd et al., 2002; Nelson, Pomerantz, & Schwartz, 2007).

Further, the lifestyle in rural communities differs in many ways from the lifestyle in cities. Many authors use the concept of subculture to describe the particularities of values, traditions, religious practices and attitudes towards illnesses that are common in rural populations. As an example, some authors cite the prevalence in rural areas of the values of independence, self-management and a strong work ethic (Fuller, Edwards, Procter, & Moss, 2000; Hoyt, Conger, Valde, & Weihs, 1997; Nelson et al., 2007; Strasser, 1995). The church holds a place of prominence in many communities (Judd & Humphreys, 2001), and there is evidence that, when dealing with issues of mental illness, rural residents have a tendency not to use health services and are more inclined to rely on informal support including neighbours, the church, police, teachers and community groups (Bushy, 1994; Fuller et al., 2004; Judd et al., 2002).

The standard models of mental health services and interventions, which have been developed mainly for urban contexts, must be adapted to fit rural situations (Gamm, 2004). This may involve considering issues of lifestyle, values, community dynamics and the overall organization of place and time. The values and perspectives of rural communities may be unfamiliar to health professionals who have been born, raised and trained exclusively in urban centers. For example, in some rural regions where hunting is an important activity, patterns of health utilization reflect the impact of the migration of animals. Adapting the hours of service availability to respect this community activity is a simple expression of respect for local values and priorities. Providing mental health services in remote regions also poses many logistical challenges. Rural populations may be dispersed across large areas, with a low population density, long distances for patients to travel to see clinicians and difficult climatic conditions that cause transportation problems and make it more difficult to organize services efficiently (Gamm, 2004; Nelson et al., 2007).

One of the most common problems in providing mental health services in remote regions is the lack of professionals and other appropriately trained staff. This problem affects mental health providers, general practitioners and psychiatrists. In industrialized countries such as Australia, Canada and the United States, approximately 20% of the total population lives in rural areas, whereas only 10% of physicians practise in these areas (Gamm, 2004; Judd & Humphreys, 2001). These regions typically have limited access to specialized services. Various strategies have been used to improve access to services in remote areas, including the use of itinerant specialists, training community workers to address basic needs and transferring patients to urban regions where they can receive specialized care. Increasingly, telemedicine and telepsychiatry have been used as ways to provide assessment and treatment for patients as well as consultation and support for providers (Calloway, Fried, Johnsen, & Morrissey, 1999; Judd et al., 2002).

Although technology has influenced the organization of mental health services in rural areas, there are continuing problems of engagement and retention of professionals to support local workers. Furthermore, local resources including community organizations may also be limited in rural areas. Small communities may have a few community workers who may be integrated within the health and social services system but rarely have an organization of their own. The Internet has allowed a growing number of support networks for

people with mental health problems and concerns. Yet access to the Internet may be less available and reliable in remote areas where such networking is most needed. Overall, therefore, access to mental health services remains limited in rural regions, and as a result, patients, their families and relatives all face greater challenges than their urban counterparts (Judd & Humphreys, 2001).

Mental health services in rural areas face specific challenges in relation to stigmatization and the protection of patient confidentiality. In small communities where everyone knows each other and a clinic visit will not go unnoticed, the fear of being identified and stigmatized as mentally ill can be a major barrier to help-seeking. This reality of the proximity of caregivers to patients can lead to delays or avoidance in seeking professional help.

Rural populations have been described as holding negative attitudes towards mental illness and as being prone to stigmatizing individuals struggling with mental illness. Stigmatization, shame, social exclusion and isolation can occur because individuals are identified as "carriers" of mental illness or because they have displayed inappropriate behavior in public situations (Crawford & Brown, 2002; Fuller et al., 2004; Judd et al., 2002; Lambert & Hartley, 1998; Nelson et al., 2007). However, some studies also demonstrate greater acceptance and better social integration in rural areas of individuals with mental health problems. Thus, rural communities, particularly those in remote regions, may display a greater tolerance of individual idiosyncrasies or social deviance because the community may view each person in terms of their network of social relations.

Case Vignette 11-1

Markoosie was a 32-year-old Inuit man living in a remote village in northern Quebec. He had auditory and somatic hallucinations and a persistent delusion that three men from the south, who he had never met, were planning to come north to kill him. One day he mistook three co-workers driving the water truck for his southern assassins and shot at them with his rifle. He fled home in fear and was brought to the nursing station by police who asked that he be taken south to be hospitalized. On assessment at a hospital in Montreal, he received a diagnosis of paranoid schizophrenia and was put on neuroleptic medication. When he returned to his community, he was soon put back to work as the village dog catcher, shooting stray dogs with his rifle. Although he continued to have auditory hallucinations and delusions, even on neuroleptic medication, he kept these experiences to himself and was viewed by many community members as recovered.

The community's acceptance of Markoosie as recovered, partially reflected Inuit notions of the nature of mental illness as a potentially transient or reversible state of mind (Kirmayer, Fletcher, & Boothroyd, 1997b). However, it also seemed to result from the familiarity people had with him as an individual, with a long history in the community and many connections to cousins and other members of his extended family. The sense of interconnectedness and familiarity with individuals can contribute to a sense of community cohesion, responsibility and solidarity that encourages support and integration of individuals suffering from severe mental illnesses (Fuller et al., 2000; Hoyt et al., 1997; Judd et al., 2002; Lambert & Hartley, 1998; Sommers, 1989). Of course, not all communities function this way for all afflicted members, and this portrait of the cohesive rural community caring for its mentally ill members has been criticized as a romantic ideal by some authors (Murray & Kelleher, 1991). Supporting patients in the face of potential stigmatization is a major challenge for community mental health.

From the point of view of clinicians working in small rural communities, the challenge of maintaining confidentiality in health clinic depends on the discretion with which the services can be delivered. Unfortunately, maintaining the most

rigorous confidentiality may require holding oneself apart from the community in ways that are neither practical nor positively viewed in the community. While communication that occurs in the clinical consultation must remain private, the consultant's everyday presence in the community and interactions with others afford a more ecologically meaningful, contextualized understanding of patients' problems that can point to creative solutions. Modifications of conventional mental health professional strategies around boundaries should be made when needed, after weighing the potential risks and benefits (Savin & Martinez, 2006).

Indigenous Communities

In certain industrialized countries such as Australia, Canada, New Zealand and the United States, Indigenous peoples constitute a larger proportion of rural and remote populations. Indigenous populations suffer from the legacy of colonization and subsequent policies of forced assimilation that have resulted in loss of cultural traditions and rapid changes in way of life. These communities continue to face serious political, economic and social challenges that are reflected in poor health (King et al., 2009; Reading, 2009; Reading & Wien, 2009).

Many Indigenous communities have high rates of mental health and social problems including suicide, depression, substance abuse, violence, sexual abuse, conjugal violence, incarceration, accidents, child mortality, type II diabetes, tuberculosis, hepatitis, and chlamydia (Adelson, 2005; Canadian Medical Association, 2003; Gamm, 2004). Life expectancy in Australia, Canada, New Zealand and in the United States for Indigenous peoples is less than in the general population (Cass, 2004; Durie, Milroy, & Hunter, 2008). In Canada, this difference is of 7.4 years in men and 5.2 years in women. The discrepancy in health indicators for Indigenous populations is largely determined by socioeconomic factors including income, employment, education, housing, infrastructure and environment (Adelson, 2005; Cass, 2004; King et al., 2009). In Canada, a high proportion of Indigenous peoples live in overcrowded housing and lack basic services. Although academic enrolment is improving, the level of education attained by students is still significantly below the national average. The employment rate is one-third that of the rest of the population (Tang & Browne, 2008). The average income is also greatly inferior to the national average (Adelson, 2005). Given these disparities, improvement in the health of Indigenous communities depends not only on providing services but on the correction of social and economic inequalities, which requires political will (Canadian Medical Association, 2003).

Health services in Indigenous communities face several challenges. Despite the high prevalence of psychosocial distress and substance abuse in these communities, there is a lack of specific services to address these problems (Gamm, 2004). The provision of health care services faces challenges in language and communication, the cross-cultural validity of diagnosis and the fit with indigenous concepts of health and illness (Judd et al., 2002). Indigenous concepts of well-being include notions of physical, emotional, mental and spiritual wellness of the person at hand. The individual is understood as an element in a larger ecosocial system, involving the family, community and environment (Adelson, 2005; Kirmayer, Fletcher, & Watt, 2008). Various forms of indigenous healing and helping may be preferred ways to address common mental health problems (Gamm, 2004).

Biomedical health care was established in Indigenous communities as part of the process of internal colonization. Today, there is increasing awareness of the need to provide culturally responsive services and to insure that non-Indigenous health workers have knowledge of cultural values and perspectives and the ability to work across cultures (Canadian Medical Association, 2003). Contemporary health services in Indigenous communities often repeat and perpetuate the hierarchical, paternalistic and even racist attitudes of the colonial process. Clinicians have a tendency to assume they understand the nature of the problem and the best intervention, to the exclusion of indigenous ways of knowing and healing. These issues lead to a fail-

ure to engage and support the capacity of local resources (McCallum, 2005).

Indigenous people making use of mainstream health services may face institutional racism and discrimination (Currie, Wild, Schopflocher, Laing, & Veugelers, 2012). One of the more prevalent discriminatory beliefs in the non-Indigenous health community involves assumptions that the disparity of health issues in Indigenous communities results from their own poor choices. This reflects general ignorance of the historical impact of colonization, sedentarization and the systematic destruction of Indigenous culture and identity through the Indian Residential Schools and other methods of forced assimilation (Tang & Browne, 2008). Other expressions of bias and discrimination may take subtler forms. The remote regions inhabited by Indigenous peoples may be described as harsh and unyielding and the Indigenous peoples perceived in romanticized and exoticized ways, while the non-Indigenous health professionals may describe themselves in paternalistic language reminiscent of the era of colonization as heroic workers "saving" the community (McCallum, 2005).

In recent years, Indigenous peoples in Canada have gained an increasing measure of control over health services in their own communities. This has been driven in part by top-down policies of "devolution" that seek to transfer responsibility for health care from centralized government institutions to regional and local authorities. It also reflects ongoing efforts to reassert community autonomy and local control. While the devolution process has tended to lead to the replication of bureaucratic models of health care regulation at different levels, the assertion of local autonomy suggests that services and intervention models must be revised to fit local aspirations as part of a process of decolonization and reconstruction (Kirmayer, Brass, & Valaskakis, 2008; MacKinnon, 2005).

There is evidence that local control of health services along with other key services and institutions is associated with better community health, including lower suicide rates (Chandler & Lalonde, 1998, 2008). The maintenance, strengthening or reintroduction of traditional healing practices is also an important part of cultural revitalization, spirituality and identity for many Indigenous people (McCormick, 2008). Many questions remain about how best to integrate or achieve the effective coexistence of mainstream mental health services and traditional or indigenous healing systems. For example, some Aboriginal clinicians argue for integration of indigenous healing with professional mental health services (Wieman, 2008), while others suggest they should remain separate to insure that the conventional health care system does not simply appropriate community-based indigenous approaches and apply them in ways that undermine or betray their fundamental values and principles (McCormick, 2008; Mussell, 2005).

Increasing representation of professionals with Indigenous background in the milieu of health professionals is an important dimension of this self-determination. At present, health services in most Indigenous communities are still provided by a majority of non-Indigenous practitioners, including nurse practitioners or family physicians living in communities and other itinerant, periodic visitors. Although the number of Indigenous professionals in health services is growing, and measures have been taken to promote their training, they remain under represented in the health professions, particularly medicine and nursing (Lecompte & Baril, 2008). There has been greater progress in Indigenous representation in alternative professions such as midwives and natural medicine practitioners.

Service Models

Service models in rural and remote regions must adapt to a multitude of factors that vary considerably from one region to another. These factors include the size of a community, the demography and population density, the distance of the region from urban centers, the health profiles of the communities, the acceptance of health services within the community subcultures, socioeconomic conditions as well as the infrastructure and the available professional staff on location (Judd et al., 2002; Kirmayer et al., 2010).

The organization of health services in a specific geographical area must take into account the economic factors that define the service threshold, i.e., the minimum population required to justify the development and sustain the provision of a particular service over time. Some services with a very high threshold, such as a unit specialized in nutrition problems, can be justified only as regional programs for an entire province or region. Small rural populations with a low population density, however, cannot sustain even low threshold services, despite the fact that these communities might need certain specialized services, particularly in mental health (Judd et al., 2002). Clearly, the service threshold is not only an economic issue but depends on political choices that reflect cultural, social and moral values.

In urban centers in Canada, mental health service models have been built around hospital services with medical specialists as key providers. This organization persists despite the fact that there is evidence that many patients with mental health problems are treated exclusively in primary care. Recent efforts in Quebec to redefine the role of psychiatrists as consultants to primary care providers have been slow to take hold not only because the primary care system is overburdened but also because patients with mental health problems pose particular challenges in terms of time, resources and skills that may be difficult to provide in overburdened family medicine settings. Successful collaborative care demands adequate support for primary care practitioners and a reorientation towards community-based care among tertiary care mental health practitioners (see Chapter 10).

The rural model is structured differently, as it is built around frontline professionals. The family physician or general practitioner is the key medical resource. Interdisciplinary teams specialized in mental health are developed within the community making use of other professionals or local social workers, educators and others. In remote or dispersed communities, the key resource person is more often a nurse practitioner who must work with community workers or others with less professional training and support. Ironically, then, those with less training and resources must provide the broadest range of services (Judd et al., 2002; Tobin, 1996).

Local teams of frontline workers in mental health must be supported and complemented by specialized services made available in rural areas through outreach strategies. There are three common strategies to provide this support: (1) mobile and itinerant services involving specialized workers in mental health, such as psychiatrists that make periodic visits to isolated communities; (2) telepsychiatry, which refers to the use of audio–visual communication technologies to provide psychiatric services and support for frontline professionals on either a regular schedule or an urgent basis; and (3) the use of satellite services established through agreements between rural mental health teams and large psychiatric centers in urban settings that provide isolated communities with resources that they lack, including psychiatric hospitalization, medico-legal evaluation and residential substance abuse treatment (Henderson, Vanier, & Noel, 1991; Judd et al., 2002; Owen, Tennant, Jessie, Jones, & Rutherford, 1999; Samuels & Owen, 1998; Yellowlees, 1992). In primary care models for rural services, the main role of the psychiatrist or mental health practitioner is no longer the direct provision of care. Instead, the specialist's tasks are those of consulting, training, education and support of general practitioners and other health professionals in frontline positions.

Onsite Service Delivery

The challenges of providing mental health services in remote or isolated communities include developing a practical and efficient organization, training and sustaining an adequate team of providers and addressing the unique personal and professional dilemmas of working in a small community.

Small rural and remote communities generally have access only to general health services. Specialized services usually are available to the population only via outreach strategies. Furthermore, because there is a shortage of health

professionals in rural regions, frontline professionals face additional challenges. Professionals with limited training in psychiatry must address a wide range of clinical problems, broadening the scope of their professional functions and playing a more polyvalent role compared to practice in urban settings (Humphreys, Hegney, Lipscombe, Gregory, & Chater, 2002).

This type of work requires flexible organization among professionals who must collaborate to meet the needs of a rural community. To work well in this setting, professionals must be flexible, eclectic and creative (Fuller et al., 2004). For example, in isolated regions, social workers are often called upon to play multiple roles simultaneously, including the psychosocial follow-up of children, adults and the elderly, social interventions for medical or psychiatric conditions, ensuring the application of child protection laws, evaluating potential danger for self-injury or violence, crisis intervention and psychotherapeutic interventions. This work cannot all be carried out in the confines of a clinic office and may require extensive travel for home visits in rural populations that are widely dispersed.

Developing human resources for mental health services constitutes a significant problem in isolated regions. Recruiting well-trained professionals is difficult and there is often a high rate of turnover of professionals who stay for only brief periods in communities. The difficulty of recruiting and of retaining professionals can be attributed to several factors, including professional isolation, poor collegial support (due to limited resources), the scarcity of professional development opportunities, heavy workload and responsibilities and the demand for an unusually wide range of skills. As well, there is often some stigma associated with being a mental health worker who is known and identified as such by the entire community (Judd et al., 2002; Nelson et al., 2007). Academic issues are also part of the problem in recruiting as mental health professionals are often poorly prepared to practise in isolated regions during their training. Most professionals are trained exclusively in urban centers, and their training does not include the needs and realities of practice in rural contexts (Gamm, 2004; Merwin, Goldsmith, & Manderscheid, 1995).

Given the lack of local professionals, isolated regions frequently rely on outside aid workers who rotate through communities every few weeks or months. Although these teams insure basic services, they have many limitations. They cannot provide continuity of care at the level of clinical follow-up of patients, communication and transfer of information or provision of supervision of medication and treatment. The lack of continuity can increase the risk of deterioration in patients with unstable chronic conditions. The responsibility for maintaining follow-up then falls more often on patients and their families, despite the fact that they may lack the necessary skills and resources to deal with the problems or may be acting in ways that contribute to stressors. Because of limited human resources, these regional organizations tend to privilege short-term services, such as emergency care, to the detriment of long-term services focussed on prevention and health promotion, screening, counselling and adequate supportive care for the chronically ill (Fuller et al., 2004; Minore et al., 2005).

Additional problems arise from the rotation system of itinerant professionals. These workers have little opportunity for immersion in the community in which they work and therefore have limited knowledge of the social and cultural context. Consequently, they are ill-prepared to culturally adapt their services and interventions. In such a system, it is the patients who must continually adapt to new professionals with whom they must communicate intimate problems as they tell the same story over and over again. Patients also face the repeated threat of losing the aid worker, which places them in the precarious and uncertain position of anticipated loss. As a result, they may eventually become reticent or resistant to invest in a therapeutic relationship and may maintain a dubious or disengaged attitude towards health services. For professionals working in remote communities, it is a common observation that the local population takes a certain period of time to accept and "adopt" professionals; this period of reticence gives locals a chance to assess the durability of the helper's

presence in the community. Local community and health care workers also experience the discontinuities in this model of care, since they must train new visiting professionals regularly and adapt to their differing styles of working (Fuller et al., 2004; Gamm, 2004; Minore et al., 2005).

Several measures have been proposed to minimize the negative impact of rotating professionals. Encouraging and supporting the recruitment of aid workers from within the communities where services are dispensed will provide a stronger base for the outside worker. Itinerant professionals need training in the organizational and interpersonal dynamics of episodic work and more specifically in the sociocultural realities of the communities in which they are to work, as well as in how local services function. This formal training should be a prerequisite for working in rural and remote communities. In situations where the use of rotating teams and outside professionals is necessary, it is important to assign the same professionals to the same communities during their rotations in order to minimize the discontinuity of care (Minore et al., 2005).

The work of local aid workers in mental health in small rural communities raises distinctive issues of professional limits. In contrast to the usual anonymity of practice in urban settings, the social and geographical isolation and scale of small communities put professionals in direct interaction with patients in public areas and social events. Professionals living and working in small communities then must provide services to individuals with whom they have frequent informal contacts and ongoing personal relationships. For example, a psychiatrist may meet patients while grocery shopping, be obliged to intervene medically with a neighbor or a colleague or find that his child's teacher is a patient (Crawford & Brown, 2002; Judd et al., 2002; Nelson et al., 2007). This phenomenon of multiple or overlapping relationships requires rethinking professional roles, boundaries and rules designed to maintain ethical standards.

Mental health workers in small rural communities are known by the entire population. They must build trust and earn the respect of community members, as well as accepting that their private life will be the object of scrutiny. This demands high standards of comportment to maintain one's good standing and leaves the worker with little privacy (Minore et al., 2005). Of course, this proximity also has benefits and other authors have emphasized the advantages for assessment and intervention where the practitioner is able to observe patients in their alternative environments (Jennings, 1992).

For example, when working in small remote communities with a population, the consultant will regularly meet patients at the grocery store, airport or on the street. These meetings provide important information about patients' social functioning, support networks, resources as well as the ways in which their community view them. Seen in community context, many patients appear more functional than when assessed only within the narrow confines of the clinical setting.

Certain rules of conduct in mental health are not applicable in isolated regions. For example, psychiatrists are usually dissuaded from providing care for several members of the same family, in order to better preserve boundaries, confidentiality or a position of neutrality. In small communities, where there is a single consultant, this rule cannot be observed, as the inhabitants would then be deprived of medical services. The same clinician may have to deal with simultaneously treating a spouse, a parent and a child, siblings and others within an extended social network. This state of affairs can lead to challenging clinical issues, as illustrated by the following case.

Case Vignette 11-2

In the context of ongoing consultation work in an isolated First Nations community of 600 inhabitants, a psychiatric consultant provided care for Mary, a 40-year-old woman suffering from schizoaffective disorder, and her 23-year-old son, with schizophrenia. When the son presented with a psychotic decompensation with aggressive behavior, the psychiatrist had to arrange for

(continued)

his hospitalization against his will. This event strongly impacted on the clinician's therapeutic relationship with the mother, who was staunchly opposed to the hospitalization of her son. The mother's position was influenced by several factors. She had maintained denial of her own condition in parallel with the denial of her son's symptoms. In this way, she demonstrated solidarity with him against the threat of psychiatric services, which she viewed as persecutory. The procedure of hospitalizing her son awakened memories of her own compulsory hospitalizations earlier in her life during acute relapses, which were traumatic and difficult for her to integrate. To help her come to terms with her son's need for hospitalization, the psychiatrist had to address and work through some of these past traumatic experiences with psychiatric services.

Although we have touched upon some of the difficulties that occur when dealing with local mental health services in isolated regions, there are advantages as well. In particular, the smaller community may provide a strong support network for patients, information about patients may be easier to obtain, and there may be fewer communication problems than in urban settings (Calloway et al., 1999; Judd et al., 2002).

Itinerant Consultants

Some mental health professionals work as itinerant consultants, making periodic short visits to isolated regions. In mental health, psychiatrists are the practitioners who use this approach most frequently, providing consultation to general practitioners and frontline workers, as well as training and continuing education to support mental health teams in the communities. Itinerant psychiatrists may also offer certain specialized services directly to patients. Because the services provided by itinerant workers are intermittent, they cannot provide reliable emergency care. For local teams, effective use of itinerant consultants depends on close coordination of services and logistical arrangements for transportation and housing. Compared with the services provided by local teams, the work of itinerant professionals has its own particularities, advantages and limitations.

First, an itinerant consultant is less subject to the multiple or overlapping relationships which constitute a major issue for local professionals and the population. Thus, the itinerant consultant, who is usually a stranger to the intricate social structure of small communities, can avoid some of the difficulties that can arise from encountering patients in social settings. From the patient's perspective, the caregiver may be the only person they have never had personal interactions with, and therefore they can offer a fresh account and reflection on their problems to someone with a "neutral" or outsider perspective. As an outsider and temporary visitor, the itinerant clinician can offer greater confidentiality and less potential for stigmatization compared to relationships with local caregivers (Fuller et al., 2004). This outsider position may provide a comfortable distance between patient-therapist that allows some patients a safe space to discuss sensitive topics. This distance may be particularly useful in dealing with the impact of traumatic events within the community or within their families of origin.

Case Vignette 11-3

Paulusie, a 45-year-old Inuit man, asked the community nurse for a meeting with the visiting psychiatrist to discuss some private matters. Alone with the consultant, he divulged his concerns about his wife's mental health. She had become intensively involved in a local Pentecostal church and was urging him to join as well. He felt uncomfortable about this and found her overzealous. The discussion centered on

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strategies for him to improve his communication with his wife. Several weeks after the consultant has returned to the south, he received a long letter from Paulusie describing his own traumatic experiences that, he said, had made him especially insecure and apprehensive about his wife's religious involvement. He had never disclosed these events, and apologized for using the letter this way, but said it made him feel better to write this down to someone he trusted.

The visiting consultant is outside local systems, better able to provide confidentiality, and potentially can provide a safe place to confide painful or shameful secrets. The consultant can symbolically hold or contain the traumatic secret. The departure of the consultant from the community may then provide symbolic distance from the painful memories and can diminish the threat posed by ongoing therapeutic work.

For local aid workers, the itinerant consultant can be a precious source of professional support, in addition to performing their standard tasks. The position of outsider to the local social and professional systems has certain advantages. The outsider can provide alternative viewpoints and fresh thinking about clinical issues and organizational challenges in work relationships.

Of course, the position of itinerant consultant also has limitations. As a stranger to the community, the itinerant consultant has but brief exposure to local issues and may have very limited knowledge of the sociocultural milieu. The periodic nature of visits does not promote continuity of care, with stable and reliable access to the consultant's services, nor does it allow for the timely management of emergency and crisis situations that emerge between visits. The itinerant consultant may lose therapeutic momentum due to the episodic nature of interactions with the community and have to rebuild trust and renew working relationships to some degree on each visit (Fuller et al., 2004). The problems associated with lack of continuity can be reduced when the consultant is able to provide telephone or video services between visits. Using telecommunication to maintain a link can be extremely useful for local professionals working in isolated situations.

Telepsychiatry

Telepsychiatry refers to the use of telephone, interactive video, electronic medical records and the Internet to allow communication between doctors, patients and other health care personnel for the assessment, treatment or prevention of mental health problems. Many different types of service can be dispensed through telepsychiatry, including clinical evaluations, medico-legal evaluations, legal audiences, neuropsychological assessment, consulting with frontline teams and clinical supervision, individual, family or group psychotherapy and continuing professional education both in didactic presentations and clinical case conferences.

Telepsychiatry is a particularly important strategy for providing specific mental health services and reducing health disparities for people in remote areas where specialist providers are not available (Hilty, Yellowlees, Sonik, Derlet, & Hendren, 2009). Telepsychiatry can reduce the need for lengthy, expensive and arduous trips for patients or health care personnel to and from urban centers. It can increase access to psychiatric services and reduce professional and frontline worker isolation in under-serviced regions (Hilty, Marks, Urness, Yellowlees, & Nesbitt, 2004; Hilty, Servis, Nesbitt, & Hales, 1999). Telepsychiatry is also consistent with efforts to provide community-based care and promote community involvement in and control of service delivery.

There is increasing evidence that telepsychiatry can be an effective method to deliver mental health services for both children and adults. It can be used for training, supervision, team building, assessment and intervention. It may allow teams to feel supported and sustain their work in challenging clinical situations. Telepsychiatry can be a reliable method of assessing psychiatric

disorders (Shore, Savin, Orton, Beals, & Manson, 2007) and a cost-effective method of assessing suicidal patients (Jong, 2004). Studies have demonstrated the reliability of diagnostic evaluations using telepsychiatry compared to live evaluations (Baigent et al., 1997; Bear, Jacobson, Aaronson, & Hanson, 1997; Elford et al., 2000; Hilty, Luo, Morache, Marcelo, & Nesbitt, 2002; Hilty et al., 2004; Ruskin et al., 1998; Singh, Arya, & Peters, 2007). Several studies have found that videoconferencing and face-to-face meetings have comparable effectiveness for diagnostic and therapeutic intervention (Elford et al., 2000; O'Reilly et al., 2007). Telepsychiatry also can work well for providing specialized services in child and adolescent mental health, including cognitive behavioral interventions (Lingley-Pottie & McGrath, 2008; McGrath et al., 2011; Myers, Valentine, & Meltzer, 2007; Nelson, Barnard, & Cain, 2003; Paing et al., 2009).

Patients and clinicians, both in the general population and in Indigenous communities, generally report high levels of satisfaction with telepsychiatry services (Alexander & Latanzio, 2009; Greenberg, Boydell, & Volpe, 2006; Hilty et al., 2009). Both mental health providers and patients tend to be comfortable with this method, in part because it allows them to avoid lengthy and costly travel and stay in their work setting or community while giving (or receiving) consultation (Hilty, Yellowlees, & Nesbitt, 2006; Kennedy & Yellowlees, 2000).

Although some patients and clinicians express scepticism or apprehension when first presented with the idea of telepsychiatry, most quickly adapt to the situation. In a study with rural American Indian youth, patients expressed some concern at the beginning of videoconferencing about "talking to a box" (Savin, Garry, Zuccaro, & Novins, 2006). However, knowing that the session was conducted by an expert, and having their own local clinician present in the room, helped them become comfortable with the process. Clinicians sitting-in with the patient at the teleconference reported that the sessions acted as training experiences, increasing their knowledge and skills as clinicians. They also reported feeling less professionally isolated and appreciated the regular contact that the teleconferences allowed as a better format for learning than irregular and infrequent visits to the city. Consultants did express apprehension about the potential for decreased rapport with the patients seen only by teleconference and the challenge of collecting all the needed information for clinical assessment through teleconference. However, these concerns subsided with increased familiarity with telepsychiatry.

There are several different models of telepsychiatry based on the available resources at each end of the link (Janca, 2000). The community primary care clinic may have general practitioners, nurse practitioners, social workers or Indigenous community mental health workers with varying level of training. The outside consultant may be a psychiatrist, psychologist, psychiatric nurse or social worker or a multidisciplinary team consisting of some or all of these types of practitioners.

Telepsychiatry can facilitate communication between a centrally located mental health care team (generally consultant psychiatrists in urban centers) and scattered primary care providers practicing in geographically remote locations (Hilty et al., 2006). A collaborative care model can be implemented for remote rural areas through telepsychiatry (Fortney et al., 2007). Telepsychiatry can be used to build a mental health team (Cornish et al., 2003) and can be used to network clinicians located in remote communities. Community mental health workers or teams operating in rural and remote areas can use telepsychiatry for training, supervision and support, to the specific needs of clients with persistent difficulties, or simply for routine follow-up appointments.

To work effectively, mental health professionals and mental health workers on both ends of the line must be trained in the use of telepsychiatry (Szeftel et al., 2008). Outside professional consultants should have expertise in working with multidisciplinary teams and knowledge of the Indigenous communities where the patients involved live. In some circumstances, the outside consultant may be chosen for their specific expertise in Indigenous mental health. This might

include Indigenous mental health workers from one community or organization consulting with another community where such expertise is not available.

Telepsychiatry may be safest and most effective when used in conjunction with local community mental health workers. Community workers can provide support on the ground for people with mental health problems under the supervision of psychiatrists based elsewhere. Telepsychiatry can be used to deliver training programs, case supervision and case conferences as part of the development and continuing education of a cadre of community-based mental health works. Telepsychiatry also can provide essential backup for the assessment and management of challenging cases. Without adequate training and supervision, however, telepsychiatry may be ineffective (Bartik, Dixon, & Dart, 2007; Crowe, Deane, Oades, Caputi, & Morland, 2006; McBride & Gregory, 2005).

Given the increasing use of Internet communications, familiarity with and acceptance of the use of telepsychiatry is likely to grow over time. Nevertheless, many patients do prefer face-to-face mental health assessment. In addition to patient preferences, being present in a community allows a consultant to gain a much greater appreciation of social context and environment and may allow various forms of networking, mobilizing and negotiating with others that can lead to new clinical strategies.

The Internet and electronic media can be used in other ways to deliver educational health promotion and training materials. There is evidence that Internet-based programs are well received and may be especially appealing to youth who make use of such technologies for social networking (Di Noia, Schwinn, Dastur, & Schinke, 2003). Such communications technology can provide a way to disseminate and share resources to be used by individuals on their own in self-management of mental health problems or as an adjunct to other forms of mental health promotion (Griffiths & Christensen, 2007).

There is evidence that with proper attention to local protocols, telepsychiatry and tele-mental health can be used effectively in Indigenous communities (Muttitt, Vigneault, & Loewen, 2004; Shore, Savin, Novins, & Manson, 2006). A recent study that examined the acceptability of telepsychiatry in American Indian communities found that, in comparison to interviews in person, the use of this technology did not present patients with any significant difference in level of comfort, satisfaction and cultural acceptance (Shore et al., 2008). To be most effective, however, teleconferencing should be a complement to, not a replacement for face-to-face services.

Studies that have examined the effects of telepsychiatry on the therapeutic relationship show that a good therapeutic alliance is possible despite some difficulties in reading nonverbal or body language cues (Hilty et al., 2004; McLaren, Ball, Summerfield, Watson, & Lipsedge, 1995; Nelson & Palsbo, 2006; O'Reilly et al., 2007). Research on the nature of online communication offers support for the position that with sufficient bandwidth, electronic communication can provide a satisfying level of emotional rapport. A sense of contact can certainly be created through language alone (Havens, 1986). Nevertheless, the lack of physical presence experienced by clinician and patient when sitting together in the same room must have some effect on the nature of clinical communication and the therapeutic process, changing its rhythm and increasing the possibility of miscommunication or ruptures when the quality of transmission is poor or timing lags (Kappas & Krämer, 2011).

Another important challenge for telepsychiatry is the limited access that the long-distance consultant has to the everyday social contexts of the patient's life. A distinctive feature of work in small communities is the likelihood of seeing patients outside non-clinical settings—at the grocery store, at recreational facilities or other community activities or just walking about. This allows the clinician a view of patients in everyday contexts in ways that can inform diagnostic assessment, treatment and outcome. With telepsychiatry, there are few opportunities for this type of encounter. As well, the patient has little sense of how to locate the consultant in an

institutional setting. The use of telecommunication technology may exacerbate the tendency in psychiatric assessment to focus only on symptoms and signs instead of the patient's experience and social context.

The consultant who will work repeatedly with patients from a particular region or community can gain some sense of the social and cultural context of a community through periodic visits. During these visits, in addition to doing consultations on site, the clinician spend time with community workers and others to learn something of local realities, including the physical environment, socioeconomic issues and the dynamics between community members and outside workers.

Satellite Services

Satellite services involve transferring patients from isolated regions to urban centers to provide care that is not available either from visiting services or through telecommunication technology. These services rely on agreements between rural service teams and urban medical centers. The most common satellite services are psychiatric hospitalization, inpatient on a specialized unit (medico-legal maternal-infant, eating disorder, etc.) and residential substance abuse programs. Satellite service provision demands careful attention to organization, communication and coordination between services for continuity of care. The logistical details extend to transport and housing supports for patients and their carers who are far from their homes (Judd et al., 2002). Clinicians working in satellite services must have a clear sense of the context that patients come from and to which they will return for effective assessment, treatment and discharge planning.

From the patient's perspective, a key issue is the separation from the familiar home and community environment at a time of crisis and sickness. This separation may be helpful because it reduces stressors that contribute to distress but it may also exacerbate illness or impede recovery because it constitutes a rupture in bonds of attachment and social support, as well as disrupting the cognitive, emotional and environmental landmarks that serve to anchor or orientate the self. Being ill in an alien environment and unable to access personal networks of family, friends and community may pose significant risks for patients. This disconnection from family and community supports and environment can be partially mitigated by maintaining telephone or Internet connections as well as by creating some forms of familiarity within the hospital environment such as visits by interpreters and providing traditional food.

Satellite services for children usually include the presence of at least one legal guardian; however, the options are often limited due to financial constraints and housing problems. Separations caused by hospital admissions are difficult for families in the best of circumstances. When such separations involve great distances and lack of contact for long periods, they provoke significant anxiety for patients and their families. If a parent accompanies a child to hospital, the stress of separation may still be high if this requires leaving younger children in the community. While for some adolescent or adult patients, being away from the family can foster new levels of autonomy and independence, this developmental benefit may occur only if the process of leave-taking and returning is predictable and controlled by the patient. The sense of disorientation, loss and disconnection found in foreign hospital settings may far outweigh any sense of discovery or stimulation provided by exploring a new place. These separations for hospitalization may also be experienced as resonant with stories of past forced separations experienced by others in the family or community. Many Indigenous people in Canada experienced long periods of forced separation and institutionalization in association with the residential school system or prolonged confinement in sanatoria for tuberculosis (Adelson, 2005; McCallum, 2005). For some Indigenous people, hospitalization outside their community may elicit memories or images of these oppressive experiences. When Indigenous patients from remote communities are sent to urban centers,

they may also experience new forms of racism, discrimination and social exclusion.

From the point of view of the caregiving team, satellite services are equally challenging. Since the team cannot meet and consult with family members, it becomes imperative to find alternate ways to collect information, communicate intervention plans and provide a holding environment and ongoing support for the community-based care providers after the patient is discharged. In addition to the usual issues of cultural countertransference, health professionals may have their own biases or reactions to a patient who has been flown in from a remote community.

A Consulting Service to Inuit Children and Youth Communities in Nunavik, Quebec

The arctic region of northern Quebec, called Nunavik, is populated mainly by Inuit, who live in 14 communities scattered along the coast of Hudson's Bay and Ungava Bay, ranging from few hundred people to about 1,500. Demographically, the population is very young, with 40% of the population under the age of 15 (Auclair & Sappa, 2012). Like other Indigenous peoples in Canada, Inuit have struggled with many challenges that have followed from the history of colonization, sedentarization and bureaucratic control, including forced displacements, relocation and prolonged childhood separation and traumas suffered in residential schools or during hospitalization for tuberculosis (Kirmayer et al., 2008). The high levels of exposure to traumatic events, losses and abuse have influenced the mental health of the communities. In recent decades, there have been very high rates of youth suicide (Boothroyd et al., 2001; Kirmayer, Boothroyd, & Hodgins, 1998; Kirmayer, Fletcher, & Boothroyd, 1997a). Inuit are under represented in health and social service professions. Community members may be reluctant to invest in relationships with non-Inuit professionals coming from "the South." In this context, a culturally informed collaborative care consultation program has provided a useful supplement to local primary care services (see Chapter 9 for a general discussion of cultural consultation in collaborative care).

The Nunavik collaborative mental health care initiative consists of regular visits by a child psychiatric consultant to Inuit communities of the Hudson coast, supplemented by a weekly half-day of indirect consultation by telephone. During visits, the local health care service (nursing station or, in one of the larger communities, a hospital) provides the consultant with an interpreter, as Inuktitut is the main language used, with more than 90% of Inuit speaking Inuktitut at home. Work with interpreters is well organized in Nunavik, and visiting medical specialists are always paired with an interpreter. Interpreters are available throughout the visit and often function as culture brokers as well, providing information about the community dynamics at the time of the visit. Interpreters are often able to give a general sense of how the patient seems to be doing in the community, and this complements information available from family, caregivers or others. The interpreter thus becomes an essential member of the collaborative care team. Telehealth conferences were organized to provide the interpreters with an arena to discuss challenging aspects of mental health interpreting in a small community. These meetings also allowed the interpreters to provide the consultant with practical advice concerning clinical meetings with parents and families.

At the start of the project, while planning the visits to the communities, the consultant invited primary care workers, including social workers, community workers, primary care physicians and school professionals, to take part in the consultation in order to strengthen collaboration and to reinforce their role in the continuity of care. This proved difficult due to the workload of most primary care workers, who are often dealing with emergencies. The consultation process therefore has been approached as a two-step process including a meeting with the family providing the core of the consultation, supplemented by a number of discussions with other treating providers.

Finally, the consultation process relies on the supportive presence of another consulting pediatrician who has been regularly visiting this area and who represents an important asset in terms of continuity of care.

For the non-Inuit consultant, there are many challenges in building bridges with the communities. First, being white brings the shadow of colonization, with wariness about the potential for racism, discrimination and exploitation. Second, as a visiting professional with limited time to spend in the communities, the consultant's commitment may be questioned. As people in these isolated communities are accustomed to frequent brief visits by itinerant professionals, they may expect little from these relationships and remain guarded or hesitant to build new partnerships unless there is evidence that the relationship will be sustained. Third, cultural styles of communication raise complex issues. Inuit, traditionally, strive to avoid overt conflict or anger in interpersonal relations (Briggs, 1970). While avoiding discussion of conflictual issues and valuing non-interference with other's autonomy may contribute to family or community harmony, it may also reflect social pressures that silence individuals and the legacy of a history of individual and collective trauma.

For Inuit professionals participating in this collaborative care model, key challenges exist around the burden of expectations and community members' trust in confidentiality. Inuit mental health workers experience the double burden of professional and community expectations in their roles. Their working conditions are challenging, as few first-line professionals are employed in these communities. The limited availability of trained professionals restricts the multidisciplinary work that can be done in mental health promotion. Access and continuity of care remain major challenges. To be successful, interprofessional collaborative care must be sustained by an adequate structure and a diversity of collaborators (Pauzé, Gagné, & Pautler, 2005). The limited resources in the north present a major challenge to sustained collaboration. Strategies to address these limitations have included providing support to primary care workers, sharing with them know-how to improve continuity of care in the community and creating opportunities to share their ideas around the care needed. Continued advocacy for sufficient community resources remains imperative. Supporting collective efforts may assist the community in voicing their concerns and proposing possible solutions (Kirmayer, Sedhev, Whitley, Dandeneau, & Isaac, 2009; Law & Hutton, 2007). Given the close ties and similarities in experience across families in many Indigenous communities, interventions focussed on one individual may have immediate relevance to others or to broader concerns in the community.

Building partnerships with Indigenous communities is a long process which must take into account the historical background and appreciate the constraints of everyday life in these communities. Partnerships may require constant adjustment and renegotiation in view of ongoing relationships with other individuals and institutions in the south. Each new interaction is measured against previous experiences, as well as on the actual results of the current collaboration and on the potential future of consequences of engaging with a new visiting health professional. This renegotiation demands understanding, respect and collaboration between health workers and community members.

Case Vignette 11-4

Adamie was a 27-year-old Inuit man with schizophrenia and substance abuse problem, living in a remote community in Nunavik. After an episode of psychotic decompensation, he drank heavily and became violent with several members of the community. Everyone in the community knew of these events and community members approached their general practitioner, a non-Indigenous professional from outside of Nunavik, for help. They

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requested intervention and hospitalization for the young man and safety for their community.

The general practitioner organized a medical evacuation and transfer of the patient to an urban general hospital affiliated with the region. At the hospital, Adamie was admitted to psychiatry and stabilized with neuroleptic medication. Hospitalization and medication reduced his psychotic symptoms and violent behavior. His time in the hospital also gave him an opportunity to reflect on his actions and his responsibility in seeking the community's forgiveness. Reclaiming the respect of the community was a critical reparation task for his reintegration.

Adamie recognized that his use of cannabis had contributed to a psychotic decompensation and that his alcohol abuse had caused disinhibition with aggressive outbursts against members of the community. He thus prioritized treatment for his substance abuse problems. Because there were no resources available for substance abuse within his community, he developed a creative plan to reach out to the community to help him with his addiction issue.

Back in his village, after his return, he requested permission from the mayor to speak on the community radio. He asked the community for forgiveness for his violence. He also asked the community, with support from the mayor, to no longer sell or give him drugs or alcohol. He explained that he was incapable of controlling his intake once he started drinking and the drinking led to uncontrolled aggression. His public plea served several functions: It displayed his honesty and integrity; it showed him to be someone who was reaching out to the community seeking their support and help to recover; it allowed him to seek pardon from the community and allowed the community, in turn, to include him rather than exclude him. Importantly, it gave the community a central role in his recovery and reinforced a sense of collective agency to address local problems including substance abuse and violence. The intervention combined medical, social and community approaches in a creative cultural way, ultimately empowering the patient, his community and the care team.

As this case illustrates, community-based interventions for individual cases may have a broader impact. The approach taken in this case, emphasizing public apology, efforts at restitution and taking responsibility for obtaining care, fits well with Inuit values of maintaining connections and reincorporating the person who has transgressed (Drummond, 1997). In the criminal justice system, these values have led to methods of reparative and restorative justice. In the mental health field, they have been expressed through family group conferencing, decision making, network therapy and other methods that emphasize reintegrating the individual into family and community (Speck & Attneave, 1973). The cohesion of small, remote communities may allow interventions based on forms of solidarity and mobilization that are difficult to achieve in urban settings.

Conclusion

In Canada, as in many other countries, mental health services are limited in many remote and rural areas. Even where there are adequate primary health care services, community mental health workers or teams in rural and remote areas may lack access to experts who can assist them in case management. Innovative strategies for service delivery need to be developed to allow appropriate management of patients, support community workers and contribute to mental health promotion. Such methods may include telepsychiatry and mobile consultation teams as well as regional and national networking

strategies. All of these programs require training and support of Indigenous and non-Indigenous community mental health workers who can deliver improved primary mental health care with the collaboration of outside consultants.

Mental health services for Indigenous communities need to be provided in culturally appropriate ways, both through supporting the use of traditional healing approaches and ensuring that mainstream mental health services are culturally safe and competent. Specific issues reflecting each community's social, cultural and historical context must be addressed. Because of the diversity of cultures, communities, populations, settings and individual needs, one model or approach will not suffice.

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