On the move: Exploring health service providers’ perspectives about family participation in care in Nunavik, a qualitative study.

Sarah Louise Fraser (✉ sarah.fraser.1@umontreal.ca)
Université de Montréal
https://orcid.org/0000-0001-7754-2412

Louise Moulin
Université de Montréal

Dominique Gaulin
Université de Montréal

Jennifer Thompson
Université de Montréal

Research article

Keywords: Inuit, participation, Nunavik, youth, families

Posted Date: June 1st, 2020

DOI: https://doi.org/10.21203/rs.3.rs-29188/v1

License: This work is licensed under a Creative Commons Attribution 4.0 International License.
Read Full License

Version of Record: A version of this preprint was published on January 28th, 2021. See the published version at https://doi.org/10.1186/s12913-021-06058-3.
Abstract

Background

Literature on participation in health and social services suggests that youth are difficult to engage within health and social services. Indigenous youth are less likely to access services or to actively participate in decision-making regarding their personal care. This article analyzes health and social service providers’ perspectives, experiences and expectations regarding the roles of a particular group of Indigenous youth, families and community in care settings in Nunavik, Quebec.

Methods

A snowball sampling method was used to recruit participants. A total of 58 participants were interviewed including psychiatrists, general practitioners, nurses, social workers, school principals, teachers, student counsellors, representatives of local committees (education committee, health committee), and police officers. Of the 58 participants, 39 were non-Inuit and 19 were Inuit. The interviews focused on three broad themes: 1) participants’ current and past positions/roles; 2) participants’ perceptions of the clientele (youth and their families) they work with; and 3) participants’ understanding of collaborations taking place within and between services (who works with whom) and community. Applied thematic analyses were conducted. The model that we present allows us to describe health service provider expectations and experiences regarding patient and community participation. Results

We organize findings around three themes: I) The most commonly described interventions, II) different types of challenges to and within participation; and III) what successful participation can look like according to service providers. Participants speak of the challenges for families to go towards services as well as the challenges for services providers to go towards youth and families, including personal, organisational and historical factors. Conclusion

We adopt a critical lens to reflect on the key findings in order to tease out points of tension and paradoxes that might hinder the participation of youth and families. We then use a constructive lens to amalgamate and build on service providers’ descriptions of challenges and successes to identify promising approaches that seem to encourage participation of youth and families.

Background

The World Health Organisation's Declaration of Alma-Ata [1] and many researchers [2–4] call governments and institutions to support participation of citizens in both their personal clinical care as well as in the design and delivery of health and social services. Participation is understood here as a dynamic process and active involvement of youth, their families, and service providers in individual level of care as well as policy and program level of services [2, 5–7]. A growing body of literature in the field of youth mental health suggests that young people from cultural minorities, including Indigenous youth, are less likely to seek help from health and social services and less likely to actively participate in decision-
making regarding their treatment [8] When they do, it is for more chronic and severe situations, and for shorter periods of time [8, 9]. This is not surprising considering the multiple injustices that Indigenous people have experienced with health and social systems throughout history, and still today [10, 11]. These historical and ongoing power imbalances between, on the one hand the structures of care and the workers that work within these structures, and on the other, the Indigenous families and communities that the structures are meant to serve has led to feelings of mistrust [12].

This is unfortunate considering that active patient participation can improve mental health promotion and prevention, decrease health disparities, and improve access to information [6, 13, 14]. Youth who are engaged in the design of their personal or collective care show increased self-esteem and are less likely to be involved in risky behaviours [15, 16]. They also tend to show greater commitment to friends, family and community and civic competence and leadership [15–18]. Youth and family participation within health and social services is particularly critical in contexts of social under-representation and in intercultural contexts where the youths’ culture is not the dominant culture within the service setting [19, 20]. When they participate in services, care becomes more culturally appropriate and acceptable to youth and families, who then show improved access and adherence to existing services [20–24]. In an era where institutions are developing policies meant to improve the care that is offered to Indigenous peoples, it is important to better understand the barriers and facilitators to their active participation in existing services. A slim literature in this field suggests that it is possible to set conditions that support and encourage the participation of Indigenous youth in their mental health care [8].

This article explores the conditions in which Nunavimmiut youth and their families are perceived by service providers and how they are expected to participate in services. Nunavimmiut, which means people of the land, refers to the Indigenous peoples whose ancestors lived in the Northern most regions of what is now called the province of Quebec, Canada. We consider the different and sometimes contradictory ways that participation is conceptualized in the context of Inuit communities in Northern Quebec. We attempt to go beyond the expectations of participation to reflect on paradoxes, tensions and promising practices so that services and service providers can transform their approaches and enhance the possibilities and desires for youth, families and communities to actively participate in more adapted services.

**Context**

The region of Nunavik is home to approximately 13 000 Nunaviammiut. Ninety percent of Nunavik residents are Inuit. Nunavik is composed of 14 communities on two coasts, Hudson Bay and Ungava Bay, with community populations ranging from 200 to 2000 people [25]. Each community hosts a local Health and Social Service center, often referred to as ‘nursing station’, offering front-line medical and social services as well as youth protection services [11]. Although some individuals may approach social services or child welfare services directly for support, many residents enter the health and social system via the nursing services. While larger communities have permanent general physicians, smaller communities receive visits from general practitioners one week a month, sometimes less. Medical
specialists including paediatricians, psychiatrists and dentists fly into specific communities periodically for assessments and follow-ups. Each coast has a hospital, one in Puvirnituq and one in Kuujjuuaq, where people from other communities are flown for certain specialised services. For emergencies and specialised follow-ups, patients may be sent south to Montreal, approximately 1,500 km away.

A recent study conducted by the Nunavik Board of Health and Social Services suggests that Inuit generally feel satisfied with the services offered by their nursing stations and hospitals [26]. However, challenges remain, especially regarding mental health and social services for children, youth and families. Lack of preventative and front-line services leads to an over-reporting of families to youth protection services [27, 28]. Psychosocial difficulties experienced by children and youth can quickly turn into crisis situations, yet there are currently limited specialized services for such cases. Other realities include high staff turnover, and language barriers between staff and families (staff often having French as a first language, families have Inuktitut as a first language and communication generally takes place in English) [29–31].

In previous qualitative research conducted in Nunavik [31], Inuit parents described their perceptions and experiences with services. They spoke of the practices that they appreciate, as well as the barriers they face in accessing and using available services. Among these barriers, parents fear the consequences of using services because of concerns of being reported to youth protection services or the police. In this context with limited prevention and front-line social services, professionals and community members might signal families to youth protection as a way to ensure follow-up, regardless of the severity of a situation. In general, the study found that families’ past experiences with available resources within communities influences their decisions regarding whether or not they should seek support. Families’ perceptions of service providers’ ability to be caring and non-judgemental influences families’ perceptions of the adequacy of care, which in turn influences their desire to seek support. This research suggests that increased use and active participation in personal care and in the creation of programs and services might partly depend on how service providers perceive and interact with families and communities. This invites us to question how service providers conceptualise the role of youth, family members and communities in services, and how this might impact upon the nature of the services that are offered.

In this context, we co-developed an action-oriented research program with local and regional partners in the region to support community mobilisation and decision-making for youth and families. A community-led organisation was developed to support youth and family oriented prevention activities. As part of this program, our local and regional partners wanted to better understand the existing institutional services and the experiences and needs of youth, families and service providers in order to better reflect on ways to support the health and psychosocial needs of families. Our partners felt that this information would help develop new strategies to improve community decision-making within community-led initiatives as well as within government-led health and social services. Specifically, this research would not only help understand but also transform services to improve youth participation in services.

**Methods**
The project was submitted to the Nunavik Regional Board of Health and Social Services (NRBHSS), the Kativik School Board (KSB), now called Kativik Ilisarniliriniq (KI), and the first author’s university ethics review board for approval. Two research assistants worked with agents from the health board and from the school board to prepare a list of service providers who represented all “levels” (front-line workers, specialists/consultants, administrators, directors) of multiple health and social service organizations. The agents distributed letters to all service directors and school principals, explaining the project and inviting their staff to participate. A snowball sampling method was used [32] to recruit participants in three communities as well as in Montreal to include service providers residing in Montreal but who fly in and out of communities for consultations. A total of 54 interviews were conducted with 58 participants. Four interviews were conducted with two participants simultaneously, as decided by the participants. Participants included psychiatrists, general practitioners, nurses, social workers, school principals, teachers, student counsellors, representatives of local committees (education committee, health committee), and police officers. Of the 58 participants, 39 were non-Inuit and 19 were Inuit. Interviews were conducted in English or in French and lasted approximately 90 minutes. The interviews focused on three broad themes: 1) participants’ current and past positions/roles; 2) participants’ perceptions of the clientele (youth and their families) they work with; and 3) participants’ understanding of collaborations taking place within and between services (who works with whom) and community. All interviews were audio-recorded, transcribed, and subsequently analyzed using QDA Miner, a qualitative data software. 

Applied thematic analyses were conducted in order to explore emerging issues and experiences in the data rather than pre-determined hypotheses [33]. This initial analysis was therefore iterative and inductive. The three interviewers jotted their thoughts and impressions immediately after each interview. The first author held brainstorming sessions with the interviewers as well as with the last author. The health board agent and two community members also participated in discussions about the emerging themes. Once these themes were identified, we returned to the coded interviews to extract all content related to each specific theme. In this article, we focus on the theme patient, family and community participation. The two first authors read through the entirety of the material and extracted initial themes and their related impressions. A first impression was the high presence of negativity. In order to determine whether this impression was a coder-bias or a phenomenon that was specific to certain groups of participants, extracts were organised into positive, neutral and negative statements depending on the portrayed feelings. We then organized the extracts within a large matrix based on service providers’ descriptions of their relationships with other service providers, youth, families, extended families, and community members. We considered each of these relationships as a type of dyad. We conducted an across dyads thematic analysis to explore emerging themes, which included perceived roles, movement (actions) of collaboration and place of collaboration. We then conducted a with in category thematic analysis, which allowed us to explore the challenges and positive collaborations specific to each dyad. We selected citations to represent each of the various themes and dynamics. To ensure participant anonymity, we made slight modifications to the citations as well as to participant job titles.
We do not presume that this analysis captures the entirety of experiences and perceptions, however it offers a model for discussion and reflection. The model that we present below allows us to describe health service provider expectations and experiences regarding patient and community participation as a complex, dynamic and sometimes contradictory process.

## Results

We organize findings around three themes: I) The most commonly described interventions, II) different types of challenges to and within participation; and III) what successful participation can look like according to service providers.

### I) Commonly described interventions

In this section, we find the most commonly described social interventions with youth and families. As mentioned above, participants spoke predominantly of the difficulties engaging youth and families in services. We describe 1) the various actors discussed by participants and their perceived roles and 2) their location and movements between locations.

#### 1) Actors and their perceived roles

Five core groups of actors emerged as essential partners with different roles and responsibilities for effectively providing services to youth and their families: a) service providers; b) youth; c) parents; d) extended families; e) the community.

**Service providers.** Service providers are described as having to share information with other professionals. They are seen as having to communicate with parents in order to obtain consent to offer services to youth who are under the age of 14. Service providers feel that they often take the first steps in initiating contact and follow-up.

**Youth.** Service providers do not describe youth as having a particular role or responsibility. Youth are often described for their willingness to receive services, their behaviours, symptoms and family contexts. They are rarely mentioned by service providers, despite the fact that interviews are specifically on child and youth mental health and wellbeing.

**Parents.** Service providers describe parental involvement as essential in the service delivery process. A mental health nurse explains:

“We ideally with children and teens you want to work with their families, with the school, and obviously the youth. It’s really difficult when you don’t have the support of the family. If we do not have the support of the family, we will not be able to solve the mental health problem.”

Parents are sometimes described as potential coordinators of services. A doctor explains that parents can have a beneficial impact on the continuity and coherence of services as they can relay information
from one service to another:

“What goes best in paediatrics is when the parents are able to take on the role of kind of coordinating the care, it’s really when it goes well. Yeah, for coordinating and also for speaking for the child. Like, “You sent me for that specialist but that wasn’t the one I needed. What I needed was this”. So when there’s that kind of empowerment and ability, then those really go best”.

Service providers also described how parents can support professionals in finding solutions for youth:

“The parents came in for a meeting and we discussed the plan with the parents and [they] gave us their feedback about how it (the plan) would affect their children and some ideas were put forward”.

**Extended family:** Service providers described the role of extended family members as support systems for parents when they are not physically or emotionally available. In fact, extended family is considered the first placement option when children must be removed from the immediate family environment. A Crown attorney emphasized how extended family can also be a source of information for service providers:

“Family members will get involved most of the time, to help to find a solution for the child to be protected. Maybe they’ll take the child home and then this way the parents will maybe get a break for a while because sometimes it’s difficult for them. So yes, family members will help, and will also help me understand the situation a little bit better by giving me input, information.”

**Community** Finally, service providers often described “community” as a necessary and needed collaborator for effective care and more specifically for prevention. Service providers spoke of their desire to have community members guide their work and “mobilize” around health and social issues. This broad system is seen as a possible locus for change however it is unclear who is seen as a participant. One teacher spoke about the supporting role that community must play for a young girl with behavioural issues:

“She needs hope. How do we give hope? It’s a community thing so we just need the people now to be better role models. We need to do our best and hope that she does her best, and that the community speaks to her and we need to hope that everyone will do their best (to help).”

These five groups of actors are reported as having distinct yet highly connected roles and responsibilities: In order for the service provider to work with the youth they must interact with parents; for parents to be supportive towards their children and youth service providers feel that they need support from extended friends and family, who is turn require the support of community. However, services providers rarely describe interactions with extended family or with community representatives or organisations.

2) Locations and movements
The physical locations of services and of those seeking services played an important role in service provider narratives about the role of participation in care. Children and youth often met with service providers inside organisations such as youth protection offices, nursing stations, and schools. Parents were at times described as partners within the services, although mostly described as being difficult to reach and outside of services. They were described as being in their homes, in their community, and the Coop or Northern (grocery store chain).

Participants used a variety of action verbs including *go to, come to, send*, and *call* that imply the need for movement when speaking of their attempts to collaborate with families and communities. These movements seem to take place each time an actor goes towards another actor, or every time an actor poses a gesture meant to invite (hospitably or forcefully) another actor towards them. These movements occur within the different health and social services (between professionals), from the community to services (youth and parents seeking services), from services to the community (service providers attempting to meet with families and community members) and within communities (between families and community members).

Service providers generally described their movements and actions towards families and youth as attempts to invite youth and parents to come see them, or asking parents for consent to work with the youth. They describe using email, letters, and phone calls, or at times going directly to their homes. However, they also spoke of feeling uneasy going to peoples’ home, especially if they know that the family has difficult psychosocial dynamics. At times they will ask a colleague from another service to accompany them. They describe the movements and actions from services towards community to sometimes include individual consultations with particular members of the community, such as the mayor or an elder.

Regarding youth and families, very rarely do service providers speak of active steps taken by youth towards services. Instead, youth were described as being “picked up” by service providers

“*But of their own will? Would youth come consult themselves? Teens? Because they aren't doing well? No! What happens most of the time is that a youth will attempt suicide in the middle of the night and be admitted to the nursing station. We have youth attempting suicide every week, mostly teens. Sometimes serious, sometimes less… well less intention of dying. But we bring them to the hospital. We keep them over for the night. The next day we talk to them. We meet a social worker and all that. And often we start a follow-up, either medical or with DYP. But it wasn't intentional, or it wasn't youth who were brought in by their family. We just picked them up at the hospital in a crisis situation. The fact is that at least three quarters will not continue the follow-up. Its just a quarter that will continue*.”

**II) Challenges to and within encounters**

Service providers’ narratives about patient involvement in care emphasized two broad types of challenges in relation to making connections with youth and families: 1) Challenges that inhibit the use of services
by youth and families (as understood by service providers); and 2) Challenges that impact service providers’ ability and desire to go towards youth, families and communities;

1) Inhibitors in the use of services, according to service providers

In this section we identified four broad categories that influence families’ use and perception of services: a) history; b) Service provider’s attitudes; c) fear and stigma; d) limited service mandates.

**History.** Only a few participants spoke of how colonial histories influence how families might interact with services. These participants described how history could influence community and family wellbeing, families’ feelings towards non-Inuit service providers, and their feelings towards the system. A nurse explained the irony of the situation:

“They lived in igloos and they had their traditional way of life, and then we came in and said we're gonna give you those villages and we're gonna kill your dogs. We're gonna force a different kind of food on you and we're gonna basically manage you the way we want to. Then we're gonna put you in schools, where a lot of you are gonna get it and abused and whatnot. Then suddenly we're in 2014 and we're asking: How come you guys are not taking care of you own life?”

This nurse described a feeling of frustration and disempowerment in the larger social context where Inuit families are asked to trust services and mobilize healthcare plans made within a colonial system. Similarly, a psychiatrist explained:

“Of course, sometimes there are people who are reluctant, and with good reason because colonial history has not been rosy. There are still people with a mentality of domination so it (colonisation) isn't just a thing of the past, unfortunately. So we can understand (families) mistrust.”

**Service provider attitudes.** Participants feel that service providers’ attitudes influence whether or not services are deemed acceptable by youth and families. Some participants described negative, and at times hostile, attitudes amongst their colleagues who act in ways that enact or reinforce colonial relations. These discriminatory attitudes can directly influence families’ abilities to trust the services. A family doctor at the hospital described some of the judgemental attitudes that she has observed among her colleagues, which she believes may impact families’ comfort in using services:

“I find there are lots of people who judge quickly (...) Like, my child is half Inuk and she says that when she goes to the hospital, if she is with me, she sees a difference in how she is treated. When she isn’t with me, she says that they don’t always treat her nicely. I feel there can be discrimination.”

Some participants also felt that certain service providers interpret and label behaviours as *cturalsay*, rather than truly attempting to understand the uniqueness of a person, and the complexities and contexts within which behaviours take place. This tendency creates another obstacle to deeper respect and understanding. As an example of this type of attitude, an Inuk youth protection worker described the
negativity that she hears from some of her colleagues who might believe that Inuit do not talk very much or share particular aspects of their life for cultural reasons:

“Some workers make conclusions like, “ahhh it’s because of their culture, she can’t tell me this or she can’t talk.”

**Families’ Fear of services and of the stigma attached to using services.** Some service providers feel that families might see services as a form of punishment rather than as a source of support. They also feel that for some parents, seeking help through services can be stigmatizing within their community. Other parents may fear service providers taking away their children or the police getting involved in their family life. A child psychiatrist gave an example of a family dealing with this fear:

“The mother was very traumatized by the DYP (Departement of Youth Protection), so she will stay away from the medical (services) as much as possible; basically all that is White. It’s a shame because the children... they (families) need help, they have a lot of learning difficulties and then they go to look for help. Sometimes a mother accepts, then she withdraws because she is so afraid (...) she remains scared that her children will all be removed again.”

A social worker described how parents might feel guilty when a service provider or teacher approaches them with a situation concerning their child, which can lead to distancing themselves from the service providers:

“Well, if there is any [problem], there is tension with the family. If your child is not doing well at school, the parent feels guilty about everything, and then they close-down”.

A crisis center coordinator felt that families might fear being judged by other community members by accessing particular services, for example, related to mental health:

“I think a lot of the families have a hard time when it’s mental illness and with the medication. A lot of family members won’t want them taking the medication ‘cause they don’t want to say they have a mental health problem. There is sometimes stigma associated with our clients, which is too bad, with people in the community as well.”

**Service mandates.** Several service providers also described how different understandings of the role and mandate of the services could impact how patients access and use services. A mental health nurse shared how he responded to a situation when a youth misunderstood the role of his youth protection worker:

“Often they don’t understand. Like for example, I was following a youth under DYP. The youth verbalised that he hated his DYP worker but he didn’t understand her role at all, what she was doing for him. Sometimes I spent time with him, telling him: Listen she wants what is best for you, she is there to ensure this, that and that. She wants to help you go back to school.”
2) Factors that influence service providers’ ability and desire to go towards youth, families and communities

The following is organized around five themes: a) Parental consent; b) lack of resources within the community; c) language; d) culture; e) mismatched timing.

**Parental consent** Participants spoke of legal challenges to truly engaging youth and families in service provision. Parental consent is legally required for youth under 14 years old. Consent is also required to share information with other service providers. Service providers described a dynamic between themselves and families where they feel dependent on parents until they either receive consent or instead chose to use the institutional power of youth protection services to oblige service provision. A social worker from the nursing station who also worked at a local school described the challenges to obtaining parental consent:

“I always try to get consent from parents, especially when the youth is under 14 and well, sometimes they refuse. You cut the grass under my feet, I can’t do anything. Sometimes I work in collaboration with DYP and then they might be able to get a consent from parents after trying very hard. I have to send a paper, they have to sign it, and then I never see the parents. They sign, I have the paper, we invite parents to come meet, again with pressure from the youth protection and often the parents won’t show up.”

The required consents are necessary in order to ensure parents are decision-makers in a process of care for their children however they seem to construct and formalize particular types of relationships between the service providers and the families.

**Lack of resources.** Service providers perceived a lack of resources as a challenge to setting up alternative services that would better respond to people’s needs, for example related to emergency housing, in-community alcohol and drug rehabilitation services, psychotherapy, and financial assistance. One youth protection worker, a specialist in clinical activities, explained how the lack of resources for children who are signalled under youth protection directly impacts the chain and quality of services that health workers can provide for youth:

“There is a lot of placement and there are very specific protocols and frameworks on when to put a child in and what to try, how to do it, and how to prioritize and what to do with it… The law can be rigid. But here, unfortunately, we do not have foster families. So we end up placing [youth] in places that are not necessarily better, or place with Whites who will eventually go one day. And I do not judge, but that’s it anyway. So we take children, we take them away [from their families] and they lose all contact because the Whites who speak Inuktitut are not many.”

Service providers like this youth protection worker described feeling frustrated and discouraged that they do not have more adequate resources to develop/implement comprehensive solutions/plans that better meet the needs of the youth and family they work with.
Participants identified language as a major impediment to developing positive interactions with families. Communication challenges seem to create frustrations for both service providers and family members who feel that their exchanges are limited when they would like to go further. One psychoeducator explained:

“One of the problems I have, it’s Inuktitut. I do not speak Inuktitut, because the problem I have is when you have young people, when you get into the emotions, it’s all in Inuktitut. They spit it to you and you would have liked to understand what is said. There are young people who know I do not speak Inuktitut, but sometimes I get a sentence in Inuktitut and they are discouraged that they do not know how to say it in French or in English.”

Service providers rarely speak Inuktitut. At times they will have learned a few basic words. Moreover, for many service providers English is a second language. In these cases both the family and the worker are exchanging in a second language. This is challenging in any situation, but particularly tedious when speaking about emotions and relationships.

Some participants spoke of the ambivalence and complexities related to learning about and from Inuit culture. On one hand, some participants remarked that making such efforts may be perceived as a form of respect. On the other hands, participants suggested that these efforts can also be perceived as “wanting to be Inuit.” Participants described how community members can limit non-Inuit access to cultural activities, and general interactions with these individuals if they are perceived as not being authentic in their attempts to learn, or if they are view as attempting to appropriate traditional activities. A nurse explained:

“There are some (non-Inuit) who will be able to speak Inuktitut (...) They always come up with Inuktitut sentences in the meetings. Then Inuit will tell me: damn they annoy us (...). But it was only after a few years that I started hearing that. In the beginning you think I have → becomeliket; I have → . But now, collaboration for me ... It’s about being yourself.”

Cultural challenges also emerge when people have different and often incompatible expectations. One social worker offered examples like school teachers expecting youth to attend classes every day and all day and social workers hoping youth attend prevention sessions on a regular basis, whereas families might feel that activities such as hunting, camping or staying at home are most helpful for the youth.

Mismatched timing. From the perspective of service providers, families use services at times and in ways that are inconsistent with the way services are delivered. Indeed, service providers report that families often ask for help when they are in a precarious situation. However, because of the lack of resources, families often only receive help when the situation becomes critical. A planning officer at the Youth Family Service described the situation of a family who had been asking youth protection services for help because they felt that their teenager was displaying problematic behaviors including drug use and sexualized behaviors. In a moment of crisis, one family member hit the teenager. Youth protection services then got involved and placed the children in foster care. In another example provided by an
intervention worker, a parent called the police to ask for help to deal with their teenager who was heavily intoxicated. Yet the police did not see themselves as having a mandate or a role in this situation. In these two examples, families reached out for help but could not access these services at the moments they were needed the most.

Furthermore, many service providers described their impression that in times of crisis, families expected services to take charge of a situation and of their children, relegating their parental responsibilities entirely. A psychiatrist described how youth can end up hospitalised alone in Montreal:

“Sometimes, youth that are hospitalised, their parents don’t come to see them. We have to run after the parents. The social services try to reach the parents. The youth is a minor and doesn’t have family around. We have extended family who might be there a bit and that is really helpful. Or else, they end up alone.”

In a contrasting example, one social worker explained how families might show up in times of crisis:

“People call when they are having a big issue, big distress, cries, they are really upset. They aren’t able to keep their child, not able to keep their elderly parent, or not able to deal with alcohol problems of a family member. It’s pretty much what we deal with. Yes, we offer support, but it stops there. Because if people don’t take things into their own hands, well the problem just starts all over again. Me, I try to show the cycle of dependence. I try to show ways out, ways of affirming oneself, how to face our own problems.”

Family members may seek services on different occasions or may stay at home feeling that the resources are not helpful. If the situation spirals into a crisis, families may either feel the need to go back for support or end up forcefully receiving court-ordered services. This spiral has multiple repercussions. In the moment when services are offered or available, the family may have already fallen into feelings of hopelessness and disengagement towards the situation.

Service providers spoke of feeling frustrated when situations ended in crisis when they thought that the crisis could have been prevented. This frustration was at times articulated by a general belief that families and communities, or even Inuit in general, are not prevention or iented as can be observed in the following quotation.

“In general, health services are very well received by the population. Typically, the Inuit population is a population that lives from day to day. So when we talk about curative health care, yes they are engaged, they come to seek this care. Less when we talk about prevention, it is not necessarily a population that will be compliant with prevention programs or come for their medical appointments. If it is beautiful that day, they will go fishing and then hunt. They will not come to their appointments. Then I say that we are not adapted to this reality.”

These generalisations and frustrations may be felt and heard by other service providers as well as by the families, who may feel judged or misunderstood. One elder explained the challenges of having a genuine community voice within services:
“Even if we meet and talk and say what we need as a people, there are too many other things that influence decision-making, things we cannot see. So in the end we don’t feel heard, we don’t feel understood. What is the point?”

With these mismatched timings between the services that are offered (at the breaking point) and the services that are needed (before breaking point) seems to impact both service providers’ and families’ perceptions of one another, limiting their ability to truly collaborate towards a common goal.

III) Building on strengths

Despite the multiple challenges above, few service providers also described successful encounters with youth and families as well as specific ingredients or approaches that they felt would lead to more positive and meaningful participation of youth, families and communities. We organized the results around 5 categories: a) developing trusting relationships; b) informal encounters; c) reaching out to extended family and community; d) responding to the right needs; e) attitude and care from service providers. These findings allow us to reflect on ways of learning from positive experiences and building on existing strengths.

**Developing trusting relationships.** Participants spoke of service providers who have lived in a community for many years and who have established a trusting relationship with families. They felt that when this was the case, families would mobilize in their care and proactively seek help. A child psychiatrist described how her ongoing relationship with and commitment to the community helps build trust and collaboration:

“I've been there for a few years. [Families are] starting to recognize me, they greet me. Then they'll come to the airport and then they’ll tell me “you know my daughter, such, such thing”. It is in the long term that the relationship is established and then the collaboration is done”.

After having received training from an Indigenous organisation, a nurse reflected on what she learned through the training:

“Often when Inuit go towards services, it's because they are in crisis and they just don't have any other choice. But, would they really just go when they are in crisis if they felt that they had strong trusting relationships and if services were adapted? I don't think so because I know people who have good relationships with workers and they don’t just go when they are in crisis.”

When a relationship has been difficult to establish with a patient or family, some service providers spoke of building on another service provider's trusting relationship by asking the colleague to speak with the family for them or to accompany them in their meeting with the family. This approach was particularly relevant with Inuit colleagues. In the next citation, an Inuk youth protection worker describes how she has collaborated with her non-Inuit colleagues:
“Literally for every intervention. I heard so many [of my colleagues], like “it’s impossible to get to this mother, it’s impossible to go to this house” ‘cause they are alone, you know? Like, we discussed before, you should have an Inuk with you every time you go to someone’s house. So I follow to people’s houses just to go translate and it usually works.”

Another Inuit psychosocial worker described playing a similar role:

“When I was in charge of this service, we had caseloads and we had waiting lists and everything. But we could work much faster and quicker with Inuit families because we’re Inuit. I had an assistant who was also Inuit, and elderly experienced people working with us as community workers and going to visit families and knocking on doors and working with the police. So it was much more community-oriented.”

**Informal encounters** Informal approaches such as “having an open door to just come and meet” were also helpful for facilitating encounters and the participation of families in their care. A social worker described what this open door could potentially look like:

‘there’s got to be an open door. You know, I was even discussing with a couple of the local staff in the school - how cool would it be if once a month, we just had like an open-door night for a few hours? Like, not parent-teacher night, not talking about report cards... we are not discussing the academics. Just come and meet the teacher. Come have a coffee, relax, you know? It doesn’t have to be fancy, it doesn’t have to be organised. The idea that the teacher is not this scary entity that sits in a classroom, right? That we are human beings and we’re just here to help your kids.”

One teacher explained that he tends to spend a lot of time within the community, at events and just walking around chatting with people:

“I guess it’s also about being in the community a fair amount, so I am very close with a lot of parents. Like, I know them on a social basis. And I’ll talk to them about their kids at those points, too. I think it helps sometimes.”

Having the community offer support, education, and spaces to go in the community are seen as very important. An Inuk complaints commissioner gave the example of a community kitchen:

“There is a community kitchen that happens every Monday, Wednesday, Friday. Three times a week, going on here at school for the whole family. Sometimes I bring my children and then you can bring your children; they have animators for the children. I think little things like that can help relationships between parents and young people.”

**Reaching out to extended family and community** Working with extended family members such as grandparents, aunts and uncles, and cousins as well as key members of the community can also help service providers connect with the family and youth. One general practitioner explained:
“[The] times I've seen beautiful interventions were often [with] the grandparents who know the children well, and the grandparents really have a respect here from young offenders. I think it's often them who have a lever to try to reason youth and talk to them about more emotional things.”

A psychiatrist explained the particular involvement of extended family in Nunavik:

“I find that compared to the south, the extended families really get very involved with patients (...) Aunts, cousins, there is really this sense of family that goes beyond the nuclear family. And generally it goes pretty well with them when they see that we are interested in them, that their opinions count, that we are soliciting them for that, when we thank them for their support for example. They are often really pleased. They have a collaborative mindset”.

A few participants spoke of these types of consultations, yet admitted only seeking this wider community engagement once or twice during their time in the north. More frequently, service providers encouraged patients to consult extended family as well as members of the clery.

“When I started working in my two regular villages, I went to see the Mayor of each community to ask what he saw, as a leader, what were the main problems. And what he thought could be done to adapt service more to their culture. I did it at the very beginning of my practice. I was well received each time. The Mayors were very grateful. But after that, I never did it again”.

On a more individual basis, a program manager, a planning officer and a school director described trying to “go towards community” as a way of learning from community and integrating the environment they live and work in. They spoke of attempting to learn Inuktitut or trying traditional activities, going on the land, participating in community activities, and integrating themselves into the community.

Responding to (the right) needs. Many participants articulated the importance of responding to families’ needs as they were understood and communicated by families, and not only as they were understood by service providers. This can mean diverging from service mandates. One teacher provided examples of ways in which he has adapted his work approach and how he thought others could do the same:

“I have been trying to volunteer like a workshop, like to train parents by doing home visits, just teach them the basic needs and what they need at home. It’s a lot of fun because it’s a lot of interactions and some parents they don’t know what to do so it would be fun to have home visits. Talk about what kind of support they need; the resource team is there to help them. They could help them to get jobs, not there to force them but to help them. Maybe tell them what kind of job is open in the community and the father, for sure he needs support to, non judgmental cause he is affecting the whole family.”

Attitude and care. Finally, participants spoke of how attitudes of respect and care for families can allow for positive interventions built on trust. A doctor explained the importance of recognizing the role that families play in patient care:
“To feel that [service providers are] interested in what [families] have to say, that their opinion counts, that they have been asked for that, that they are thanked for the support they give for the patient, for example. They are often very happy with that”.

In the quotation below, a psychosocial worker recounted the story of a foster family and youth protection agent who respected the importance of the mother in the child’s life, despite her challenges:

“The baby is placed in foster care in the South, but this foster family is so available and open. They text [the mother] and they talk to each other every day [on] Facebook, so that the mother can keep a link with [her] baby, [her] daughter who is 2 years old. But this foster family there, so available. Then the social worker who works with her, she is very aware about the reality of First Nations, the importance of maintaining links, culture. That, for me anyway, I think it’s a beautiful success story”.

We have organized our description of results around the more commonly described interactions (section 1), the challenges that explain these interactions, and the more positive interactions that we can build on (section 3).

The first figure illustrates the interventions that are more common. Service providers might speak to each actor but rarely together and services providers and family members occupy distinct spaces within the community making it difficult to meet. The second figure illustrates successful and desired intervention that are collaborative and place the youth and the family at the center. **Collaborative** is understood as many people sharing the work and decision-making related to a patient or a family in a way that recognizes and respects the strengths and the knowledge of all those involved. The patient, the youth the family are all seen as equal partners in the decision-making for their health and wellbeing. As the interviews show, there are many challenges to putting this vision into practice. As we have seen, the challenges are numerous: capacity to acquire parental consent, human and material resources, mandate of the service providers (ex: prevention vs crisis intervention vs postvention), history of coloniality, fear and stigmas, having a trustful relationship with the community, etc.

**Discussion: Shifting How Service Providers See Participation**

In this study, we were interested in how service providers invite and imagine participation in their work, how they perceive the roles with youth and families, and how they experience their relationships with youth and families. Interviews were conducted with service providers working for different organizations including schools, hospitals, nursing stations, youth protection services, police and more. Interviewees also included administrators and directors of services for a complete view of possible participation including not only individual care but also program design and delivery. Interestingly, youth were rarely discussed as potential partners, and design and delivery of collective services was not brought forward by interviewees. Participants spoke mostly of the challenges of meeting and engaging youth and families. Various aspects of our findings offer new insight to the literature on youth and family participation in services. Participants mentioned many of the challenges to involving youth and families in care but also provided insight into promising approaches. In this discussion we explore four findings:
connecting various actors; spaces of encounters and how this relates to trust building; historical experiences and how it relates to care; offering meaningful decision-making opportunities.

First, service providers identified a multitude of interdependent actors. These findings contrast with the literature on collaborative care, patient-centered care, health coalitions, and youth engagement, which each tending to focus on more narrow relations, often between two actors. Collaborative care, patient-centered care, health coalitions and youth engagement scholarship each focus on the relationships between a very restricted group of actors: ie service providers connecting with patients, different types of health professionals connecting amongst themselves [34, 35], community organisations connecting with institutional (formal) organisations [36]. Our findings highlight that youth are clearly connected to a variety of actors who play distinct roles (parents, extended family, community), and who are co-dependent in the care of youth. However, our findings show that they do not all interact with one-another and this lack of integration may be one of the barriers to successful collaboration of youth and families around their care. To encourage participation of these various actors, service providers may find it helpful to collaborate with Inuit workers, cultural consultants, or at least, non-Indigenous professionals that have an established trusting relationship with the community. Vicary [37] found that 92% of Aboriginal people in his study would not see a non-Indigenous service provider unless a cultural consultant recommended the service provider to them. Westerman [8] adds to this literature by suggesting that engaging a cultural consultant in service provision has to be done in manner that is coherent with culture and beliefs. Connecting with key players within the family of community helps to recognize and respect the different supportive relationships in the lives of youth. Inuit workers who are connected to community can play an essential role in increasing family participation in clinical decision-making if organisational cultures support this.

Second, the position of various actors within specific geographical locations shapes the possibilities of participation of youth. Youth, family and community are largely expected to enter into health and social centers to receive services, and service providers are expected to enter into community. Our findings suggest that these different groups of actors try to meet but that these attempts often remain invisible. The service-provider-family interactions that are described positively are those that take place outside of the boundaries of institutional services. This question of location has been highlighted as a crucial element to engaging patients in care or youth in services [40, 41]. When “ties to place” (people relationship with spaces and places) are respected and strengthened, community participation in services can be improved [40, 41, 42]. Our findings align with research exploring ways of engaging Indigenous youth in health and social services which highlights the importance of reaching out to youth, and meeting youth in their environments and on their own time with informal interactions and trust building [8; 20; 43; 44]. This is important to reflect upon. If service providers expect families to go towards services and participate within the institutional boundaries then the absence of family members within the walls of the nursing station can be frustrating for the service providers. Indeed, many participants mentioned that if families “collaborated” with services, decision-making might be easier and closer to community needs. Critically, many service providers expressed the desire that communities takechar ≥ ; communitiesempowerthemselves; and
Whiteserviceproviders have be ∈ theN or thanym or e. This discourse related to community participation and autonomy has also been observed in research with service providers working with Indigenous communities in Australia [45]. We question whether the way in which participation is conceptualized might limit the possibilities of participation [46]. Going towards families might be understood as a parteralistic approach, one that goes against the notion of supporting engagement of families. However, moving towards families allows members to build trust, observe the care of the workers. They can then engage in a relationship with the workers and participate in service plans. Ermine [47] develops on the notion of Ethical Space. Ethical space is the understanding that two individuals from different experiential backgrounds may not truly understand each other in their intentions and needs. This gap creates an ethical space that requires reflection and actions. Ermine extends this in his piece Ethical Spaces of Engagement reminding readers that intentions and experiences between non-indigenous and Indigenous peoples have been blurred and complexified over centuries. Ethical practice therefore requires an understanding of these experiences and a move towards a better understanding of the experiences and needs of Indigenous peoples in order to rebuild trust and eventually an ethical space of engagement. Various Indigenous authors remind us that community is the space where people can gain deep insight into the hearts and realities of Indigenous peoples and therefore the service providers who wish to bridge this gap must integrate community to connect with people [8, 44, 48]. Our findings suggest that positive encounters are often described as informal, which means being flexible, spontaneous and open to meet and discuss. For example, service providers speak of the important benefits of participating at community events or activities for building trust within and among the community. In their article, Vicary & Westerman [44] showed that participants preferred a non-Indigenous therapist who was interested in developing a holistic relationship with them, not limited to professional settings. Inviting participation is not an event (a phone call, or an email), it is a bond and an open attitude. Campbell and Erbstein [48] highlighted the need for greater time and resources for intervention, for cultural changes within organizations, and for the development of particular values that underpin leadership, such as community rootedness, relationships, knowledge, and legitimacy among the staff. Adapting services to Indigenous needs and culture, particularly of youth, often requires extending beyond service mandates [48]. This suggests a need to revisit the current scope of service mandates and practices.

Third, service providers in this study identified potential explanations for the difficulties they have connecting with and engaging families within institutional services. These challenges include historical factors, ongoing colonial attitudes, fear of the consequences of obtaining services, limited mandates of services providers and the impact of language and culture on communication. These findings complement Fraser and Nadeau’s [31] research with Inuit families about the factors that affect families’ desire to seek services. Bringing these family perspectives together with the service providers perspectives in the current study, we identify the following common themes: 1) the gap between perceived psychosocial needs and available service within communities, 2) experiences of prejudice resulting from racism and the negative attitudes of some service providers, and 3) the presence of strong negative social representations of services within communities. In a context where so many youth are being signaled to youth protection services, in part due to a lack of other services and a lack of
understanding about family and community dynamics, service providers can at times be viewed as a threat to family and youth wellbeing rather than as allies [49]. This perception clearly hinders youth and families’ desire to access and participate in care. Despite the importance of these structural barriers grounded in historical considerations, very few service providers spoke of history and its potential impact on families. Colonization and traumas (loss and grief, separation of families and children, the taking away of land, loss of culture and identity impact of social inequities) still affect the way youth and families perceive services and interact with them [20, 44]. The persistent remnants of colonial history can infiltrate within the health professionals-patient interactions leading to difficulties in building trusting relationships [23], along with the importance for service provider to recognize the importance of culture, language, identity and place. In our view, understanding history offers a critical entry point to possibilities of relationships building and participation.

Conclusion

Rather than asking how we can increase youth and family participation in health and social services, we propose a shift in perspectives. We propose the following question: how can we create spaces and processes for service providers to better see and support the existing participation of family members in the design and delivery of care? Youth, families and communities are already participating in daily life and care of youth in ways and places that are not often acknowledged by service providers or within the mainstream participation literature. A highly acclaimed therapist, de Shazer [50] suggests that there is no such thing as non-collaboration. If people seem like they are not-collaborating it is because we haven’t understood their need.

Participation requires first and foremost that families be able to access services that are believed and felt to be useful. This access will happen with the development of trust. Once services are accessed, they must feel that they have the legitimacy to continue their involvement with the services, not only as passive receivers but as active decision-makers. Indeed, encouraging the participation of Inuit youth in health and social services requires offering real roles and relevant issues, valuing young people’s contribution, as well as that of their family and community, involving them from beginning to end and creating a youth-friendly environment. Many of the enabling conditions that support the participation of Indigenous families and communities in the services they receive reflect the enabling conditions identified in the youth participation literature. In French, Reardon, & Smith’ article, at risk youth identified three primary themes crucial to the engagement process (1) attractiveness which should fit with the youth’s beliefs that the service will meet his or her needs; (2) accessibility which refers to the practical parameters of service and (3) assertive follow-up which refers to action taken by the service provider to maintain the relationship with the youth [51]. For Zeldin, Christens and Powers [52], youth engagement requires authentic decision-making, mentors, reciprocal activity and community connectedness.

Increasing the current levels of participation of Indigenous youth, families and communities in health and social services requires change at multiple levels, including challenging normalized practices at the practitioner level and addressing systemic power structures [8, 48, 52]. Our findings suggest a need for
practitioners to transform their practice, in ways that involve going outside and beyond their service mandates and institutional settings to build meaningful connections with communities.

**Abbreviations**

Not applicable.

**Declarations**

**Ethics approval and consent to participate**: Ethics was obtained from the Comité d’Éthique de la Recherche en Éducation et en Psychologie from University of Montreal. Written consent was obtained from all participants.

**Consent for publication**: Not Applicable

**Availability of data and materials**: The dataset generated and analysed during the current study are not publicly available due to the confidential information that is shared in interviews conducted in a small region where people could be recognizable. However, the data could be made available from the corresponding author on reasonable request and with the approval of the Nunavik Regional Board of Health and Social Services.

**Competing interests**: The authors declare that they have no competing interests

**Funding**: Funding for this research was made available by the Sick Kids Foundation New Investigator Research Grant, in partnership with the Canadian Institute of Health Research. Funding was obtained through a competitive yearly call for proposals. As funders they evaluated the grant proposal and provided the funding for the project.

**Authors contributions**: S.L.F is the principal investigator of the project. She was responsible for the conception and design of the project. She participated in data analysis and writing of the article. L.M participate in data analysis and writing. JF and DG participated in interpretation of the data and revising the work. All authors have approved the submitted version of this article.

**Acknowledgements**: We are very grateful to the community members who have helped to reflect on the project, its design and the impacts of the research results for their community and region. This includes: Raymond Mickpegak, Jennifer Hunter, Caroline Weetaltuk, Mina Beaulne, the Sukait Committee, and all friends and community partners who share their experiences and knowledge with us helping us better understand the needs and realities of families of Nunavik. We are also grateful to the representatives of the Nunavik Regional Board of Health and Social Services who have helped reflect on the data and on ways of ensuring knowledge mobilisation among professionals and community members. This includes Chloe Nahas, Jean-Etienne Begin, Vanessa Legault, and Stephanie Mathieu. Thank you to all participants
of this project for your generosity and your care. As always, a huge thank you to Minnie Grey, Executive Director of NRBHSS and leader of Nunavik for your trust, support and knowledge.

References

1. WHO. Declaration of Alma Ata. International conference on primary health care, Alma-Ata, USSR, 6–12 September 1978. Geneva: WHO, 1978.

2. Bate P, Robert G. Experience-Based Design: from Redesigning the System around the Patient to Co-Designing Services with the Patient. BMJ Quality Safety. 2006;15(5):307–10.

3. Conway J, Johnson B, Edgman-Levitan S, et al. Partnering with Patients and Families to Design a Patient and Family-Centered Health Care System: A Roadmap for the Future: A Work in Progress. Bethesda: Institute for Family-Centered Care; 2006. http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.100.9620&rep=rep1&type=pdf.

4. Lasker RD, Weiss ES. Creating Partnership Synergy: The Critical Role of Community Stakeholders. JHHSA. 2003; 119–139.

5. Boyle D, Coote A, Sherwood C, Slay J. Right here, right now. Taking Co-production into the Mainstream. London: National Endowment for Science, Technology and the Arts; 2010. https://neweconomics.org/uploads/files/8678a9d67320a294b4_38m6ivak1.pdf.

6. Eldh AC, Ekman I, Ehnfors M. Conditions for Patient Participation and Non-Participation in Health Care. Nursing Ethics. 2006;13(5):503–14.

7. Tutton EM. Patient Participation on a Ward for Frail Older People. JAN. 2005;50(2):143–52.

8. Westerman T. Engaging Australian Aboriginal Youth in Mental Health Services. Australian Psychologist. 2010;45(3):212–22.

9. Cauce AM, Domenech-Rodríguez M, Paradise M, Cochran BN, Shea JM, Srebnik D, Baydar N. Cultural and Contextual Influences in Mental Health Help Seeking: A focus on Ethnic Minority Youth. JCCP. 2002;70(1):44.

10. Kral MJ. Suicide and Suicide Prevention among Inuit in Canada. CJP. 2016;61(11):688–95.

11. Lessard L, Bergeron O, Fournier L, Bruneau S. Étude Contextuelle sur les Services de Santé Mentale au Nunavik. 2008. https://www.inspq.qc.ca/pdf/publications/868_SanteMentalNunavik.pdf.

12. Browne AJ, Varcoe C, Lavoie J, Smye V, Wong ST, Krause, et al. Enhancing Health Care Equity with Indigenous Populations: Evidence-based Strategies from an Ethnographic Study. BMC Health Services Research. 2016;16(1):544.

13. Crawford MJ, Rutter D, Manley C, Weaver T, Bhui K, Fulop N, Tyrer P. Systematic Review of Involving Patients in the Planning and Development of Health Care. BMJ. 2002;325(7375):1263.

14. Tobin M, Chen L, Leathley C. Consumer Participation in Mental Health Services: Who wants it and why? Aust Health Rev. 2002;25(3):91–100.

15. Blanchet-Cohen N, McMillan Z, Greenwood M. Indigenous Youth Engagement in Canada's Health Care. Pimatisiwin. 2011;9(1):87–111.
16. Sanders J, Munford R, Thimasarn-Anwar T, Liebenberg L, Ungar M. The Role of Positive Youth Development Practices in Building Resilience and Enhancing Wellbeing for at-risk Youth. Child Abuse Neglect. 2015;42:40–53.
17. Checkoway B. Youth Participation and Community Change: An Introduction. Youth Participation and Community Change. 2012; 9–18.
18. Suleiman AB, Soleimanpour S, London J. Youth Action for Health through Youth-Led Research. Journal of Community Practice. 2006;14(1–2):125–45.
19. Browne AJ, Fiske JA. First Nations Women’s Encounters with Mainstream Health Care Services. WJNR. 2001;23(2):126–47.
20. Chino M, DeBruyn L. Building True Capacity: Indigenous Models for Indigenous Communities. AJPH. 2006;96(4):596–9.
21. Cook P. Understanding the Effects of Adolescent Participation in Health Programs. Int’l J Child Rts. 2008;16:121.
22. Gulliford M, Figueroa-Munoz J, Morgan M, Hughes D, Gibson B, Beech R, Hudson M. What does 'access to Health Care' Mean? Journal of Health Services Research Policy. 2002;7(3):186–8.
23. Taylor KP, Thompson SC. Closing the (Service) Gap: Exploring Partnerships between Aboriginal and Mainstream Health Services. Aust Health Rev. 2011;35(3):297–308.
24. Zublick S. Silburn S. Western Australian Aboriginal Child Health survey: improving the Educational experiences of Aboriginal children and Young people. Telethon Institute for Child Health Research and Curtin University of Technology, 2006. https://espace.curtin.edu.au/handle/20.500.11937/44850.
25. Nunavik Q. Profil de la population autochtone, Recensement de 2016, produit nº 98-510-X2016001 au catalogue de Statistique Canada. Ottawa: http://www12.statcan.gc.ca/census-recensement/2016/dp-pd/abpopprof/index.cfm, 2018.
26. NRBHSS. Rapport du sondage sur l’expérience usager, 2019. https://nrbhss.ca/sites/default/files/health_services_clinical_plan_report_fr.pdf.
27. Blackstock C, Trocmé N. Community-Based Child Welfare for Aboriginal Children: Supporting Resilience through Structural Change. Social Policy Journal of New Zealand. 2005;24(12):12–33.
28. Rae L. Inuit child welfare and family support: Policies, programs and strategies. Ottawa: National Aboriginal Health Organization; 2011. https://epub.sub.uni-hamburg.de/epub/volltexte/2012/15372/pdf/2011_Inuit_Child_Welfare_Family_Support.pdf.
29. Fournier C. Parcours d’apprentissage et processus de structuration des compétences-clé en milieu extrême: le cas des infirmières dans les dispensaires du Nunavik. HEC Montreal (Canada); 2017.
30. Fraser SL, Hordyk SR, Etok N, Weetaluktuk C. Exploring Community Mobilization in Northern Quebec: Motivators, Challenges, and Resilience in Action. AJCP. 2019;64(1–2):159–71.
31. Fraser SL, Nadeau L. Experience and Representations of Health and Social Services in a Community of Nunavik. Contemporary Nurse. 2015;51(2–3):286–300.
32. Bernard HR. *Social research methods: Qualitative and quantitative approaches*. Sage; 2013.

33. Tuckett AG. Applying Thematic Analysis Theory to Practice: A Researcher’s Experience. Contemporary Nurse. 2005;19(1–2):75–87.

34. Martyn KK, Munro ML, Darling-Fisher CS, Ronis DL, Villarruel AM, Pardee M. Patient-Centered Communication and Health Assessment with Youth. Nurs Res. 2013;62(6):383.

35. Turchi RM, Antonelli R, Norwood KW. Council on Children with Disabilities and Medical Home Implementation Project Advisory Committee. “Patient-and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth across Multiple Systems.” Pediatrics. 2014;133(5).

36. Noiseux S, St-Cyr DT, Corin E, St-Hilaire PL, Morissette R, Leclerc C, et al. The Process of Recovery of People with Mental Illness: The Perspectives of Patients, Family Members and Care Providers: Part 1. BMC Health Services Research. 2010;10(1):161.

37. Vicary D. Counselling as Yarning: Aboriginal Insights into Western Therapy. Australian Journal of Psychology. 2003;55:219.

38. Kesby M. Retheorizing Empowerment-Through-Participation as a Performance in Space: Beyond Tyranny to Transformation. Signs: Journal of Women in Culture and Society. 2005;30(4):2037–2065.

39. Mannion G. Going Spatial, going Relational: Why “Listening to Children” and Children's Participation needs Reframing. Discourse: Studies in the Cultural Politics of Education. 2007;28(3):405–20.

40. Manzo LC, Perkins DD. Finding Common Ground: The Importance of Place Attachment to Community Participation and Planning. Journal of Planning Literature. 2006;20(4):335–50.

41. King M, Smith A, Gracey M. Indigenous Health Part 2: The Underlying causes of the Health Gap. The Lancet. 2009;374(9683):76–85.

42. Schultz K, Walters KL, Beltran R, Stroud S, Johnson-Jennings M. “I'm stronger than I thought”: Native Women Reconnecting to Body, Health, and Place. Health Place. 2016;40:21–8.

43. Cortis N, Katz I, Patulny R. Engaging Hard-to-Reach Families and Children. FaHCSIA occasional paper; 2009; (26). https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1728576.

44. Vicary D, Westerman T. That’s Just the Way he is’: Some Implications of Aboriginal Mental Health Beliefs. Australian e-Journal for the Advancement of Mental Health. 2004;3(3):103–12.

45. Baba JT, Brolan CE, Hill PS. Aboriginal Medical Services Cure more than Illness: A Qualitative study of how Indigenous Services Address the Health Impacts of Discrimination in Brisbane Communities. International Journal for Equity in Health. 2014;13(1):56.

46. Eversole R. Empowering Institutions: Indigenous Lessons and Policy Perils. Development. 2010;53(1):77–82.

47. Ermine W. The Ethical Space of Engagement. Indigenous Law Journal. 2007;6:193.

48. Campbell D, Erbstein N. Engaging Youth in Community Change: Three Key Implementation Principles. Community Development. 2012;43(1):63–79.
49. Lemay V, Prud’Homme B. Former l’Apprenti Juriste à une Approche du Droit Réflexive, Critique et Sereinement Positiviste: L’heureuse Expérience d’une Revisite du Cours «Fondements du droit» à l’Université de Montréal. Les Cahiers de Droit. 2011;52(3–4):581–617.

50. De Shazer S. The Death of Resistance. Fam Process. 1984;23(1):11–7.

51. French R, Reardon M, Smith P. Engaging with a Mental Health Service: Perspectives of At-Risk Youth. CASW. 2003;20(6):529–48.

52. Zeldin S, Christens BD, Powers JL. The Psychology and Practice of Youth-Adult Partnership: Bridging Generations for Youth Development and Community Change. AJCP. 2013;51(3–4):385–97.

Figures

Figure 1

Commonly described interventions
**Figure 2**

Promising strategies