Ippigusugiursavik

Brief presented to the

Gouvernement du Québec

Consultation on Mental Health, Homelessness, and Addiction

Toward a Renewed, Integrated, and Coherent Vision

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Presentation

Ippigusugiursavik is a regional non-profit community organization incorporated in 2005 in Kuujjuaq, Nunavik. Its mission is the social reintegration of Inuit living with severe and persistent mental illness, and the destigmatization of mental health disorders within the community.

The organization offers supervised housing for eight residents living with severe and persistent mental illness, providing them with a stable, therapeutic, and culturally grounded environment. It also operates a Day Centre open to the broader community, which welcomes individuals living with mental health disorders, intellectual or physical disabilities, people affected by addiction or domestic violence and youth and their parents. Visitors are whether self-referred or referred by a social worker, nurse, or partner organization.

Ippigusugiursavik's approach is rooted in the therapeutic community model, which also permeates its organizational culture and management practices. The organization provides residents, employees, and Day Centre visitors with the tools they need to advance in their own recovery journey — fostering self-determination, mutual support, and meaningful participation in community life.

This brief was prepared and signed by Mariel Capolla, M.Sc. OT,. Director General of Ippigusugiursavik from 2022 to the present and Jacques Bertrand, M.A. (Political Science), M.Sc. (Mental Health), Ph.D (Public Administration), Director Generalfrom 2009 to 2022.

Key Observations

1.1 The Housing Crisis: The Basis of Instability

Homelessness in Nunavik is not comparable to that of urban centres in southern Québec. It is largely hidden, but its effects are just as devastating.

Problematic Housing Situations

- Extreme overcrowding: Approximately 53% of Inuit households live in overcrowded conditions, compared to less than 9% of Canada's non-Indigenous population (Inuit Tapiriit Kanatami, 2019).
- Structural deficit: It is estimated that more than 1,000 housing units are needed to stabilize the current situation in Nunavik (Aatami, cited in CBC News, 2010; Radio-Canada, 2023).
- Housing quality: According to the 2016 Census, 31.5% of Inuit homes in Inuit Nunangat require major repairs — a figure confirmed by Statistics Canada's 2021 data showing approximately one third of units in similar need (Inuit Tapiriit Kanatami, 2019; Office of the Auditor General of Canada, 2025).
- Residential insecurity and violence: The lack of shelter and affordable housing makes women and members of the 2SLGBTQI+ community particularly vulnerable, sometimes forcing them to remain in situations of domestic violence for lack of alternatives.
- The exodus to the South: The impossibility of adequate housing in the North pushes many Inuit to urban centres such as Montréal. Once there, they often find themselves visibly homeless, facing a foreign environment, systemic racism, and barriers to accessing social services (Makivik Corporation, 2014).

Impact on Homelessness

The lack of emergency shelter (fewer than 100 permanent beds for the entire region) forces vulnerable people into perpetual "couch surfing." This residential insecurity is the main driver of the exodus to Montréal, where Inuit represent 10% of the Indigenous population but account for 43 to 45% of the Indigenous homeless population — a striking overrepresentation relative to their demographic weight (Kishigami, 2008; Centraide du Grand Montréal, 2024; Community Media Portal, 2022).

1.2 Mental Health: From Distress to Cultural Healing

Mental health in Nunavik is characterized by rates of psychological distress and suicide that are significantly higher than the Québec average, particularly among young people aged 15 to 24. In 2019, the suicide rate in Nunavik was 177.1 per 100,000 population, compared to 13.1 per 100,000 for Québec as a whole — more than 12 times the provincial average (Nunatsiaq News, 2024; CBC News, 2025).

Barriers to Care

- Shortage of services: While some services are available in health centres, high turnover of non-Inuit staff and language barriers impede access.
- Therapeutic housing: There is a critical gap between emergency hospital care (often provided in the South) and return to the community. Mental health transition beds are critically needed to prevent relapse. Currently, two non-governmental Inuit resources house approximately 20 people in total and offer reintegration services in their communities.

1.3 Addictions: A Disproportionate Burden

Substances (alcohol, cannabis, cocaine) and behavioural addictions (gambling) often serve as coping mechanisms in the face of trauma.

Consumption Data and Access

- Excessive alcohol consumption: Among drinkers in Nunavik, episodes of heavy drinking occur at a rate three times higher than that observed among Quebecers in regions south of Nunavik (Institut national de santé publique du Québec [INSPQ], 2004).
- Access to treatment: Wait times for specialized addiction services in Québec represent a significant barrier. In Nunavik, logistical and transportation challenges further compound these delays.
- Concurrent disorders: Approximately 74% of people experiencing homelessness or extreme precariousness in Nunavik have both a mental health disorder and an addiction.

Issues, Challenges, and Problems

The following challenges apply across all age groups — youth, adults, and older adults — with particular impacts on Inuit and First Nation populations, women, and 2SLGBTQI+ individuals. They concern both the implementation of existing directions and fundamental structural gaps that no policy has yet adequately addressed.

2.1 Multifactorial and Intergenerational Causes of Addiction

Addiction among Nunavik Inuit cannot be understood in isolation: it is the product of a deeply interlocked set of historical, structural, and social factors that span generations and that no single intervention can resolve.

Historical and Intergenerational Trauma

The colonial history of Nunavik is directly tied to the current addiction crisis. The Indian Residential School system forcibly separated Inuit children from their families, erasing language, culture, and identity. The systematic slaughter of sled dogs (*qimmiit*) by the RCMP and federal authorities throughout the 1950s and 1960s was formally acknowledged in November 2024 by the Government of Canada, which apologized and committed $45 million in reconciliatory programming. This slaughter stripped Inuit communities of their mobility, autonomy, and connection to the land — foundational elements of Inuit identity (Crown-Indigenous Relations and Northern Affairs Canada, 2024; CBC News, 2024). The federal government's forced relocation of Inuit communities into permanent settlements further dissolved traditional social and family structures, simultaneously introducing alcohol into communities (Poliakova et al., 2022).

These accumulated harms produce intergenerational trauma: parents who survived residential schools experienced diminished parenting capacity, elevated rates of substance use, and trauma-related difficulties in relationships — all of which are risk factors for substance use disorders in subsequent generations (Marsh et al., 2015; Bombay et al., 2014). Research consistently links attendance at residential schools with increased risk of alcohol addiction, particularly among women who also experienced sexual abuse (Ross et al., 2015). Addiction thus persists across generations not because of individual weakness, but because of structural violence transmitted through family systems.

Intersecting Risk Factors

A youth growing up in Nunavik today faces a constellation of simultaneous vulnerabilities that, taken together, dramatically elevate the risk of substance use:

- Youth Protection (DYP): According to a 2010 follow-up report from Québec's *Commission des droits de la personne et des droits de la jeunesse,* approximately 30% of children in Nunavik were the subject of a report to the DYP — half of them under the age of five. Children placed in care far from their families experience additional ruptures of attachment and cultural connection (CBC News, 2016). Parental substance use is a documented risk factor for child welfare involvement,

and substance use itself carries an intergenerational effect on the children of affected parents (Conroy et al., 2019).

- Family violence: The 2004 Nunavik Inuit Health Survey documented high rates of physical and sexual violence within communities (Anctil, 2004, cited in Gravel et al., 2012). Women are particularly vulnerable: violence at home drives migration to the South, where many find themselves isolated and homeless, without access to culturally appropriate services. For women, childhood sexual abuse and residential school exposure are among the strongest predictors of alcohol addiction (Ross et al., 2015).
- Education and school dropout: Overcrowded housing makes studying at home nearly impossible, contributing to school disengagement (Radio-Canada, 2023). In comparable northern Inuit territories, school attendance rates fall as low as 60–68%, with fewer than one in three youth graduating from high school (Nunatsiaq News, 2019). Low educational attainment narrows employment options and limits access to meaningful activities.
- Lack of meaningful employment and leisure opportunities: Despite a relatively higher employment rate than other Inuit regions (largely driven by the public sector), many young Nunavimmiut — especially those without a diploma — face limited access to meaningful, well-paying work. The absence of recreational infrastructure (sports facilities, cultural programming, youth centres) in small, remote communities leaves youth without structured alternatives to substance use.
- Community-wide substance use: In 2017, 63% of Nunavimmiut over age 16 consumed alcohol at least monthly, and 29% engaged in weekly heavy drinking; cannabis was used by 63% of the adult population, with 32% consuming it daily (Courtemanche et al., 2022). In this context, substance use is not merely an individual behaviour but a community norm, making recovery especially difficult without broader community-level change.
- Addiction services not anchored in communities: As noted by Poliakova et al. (2022), access to addiction recovery in Nunavik often requires transfer to the South, which disrupts family ties, cultural continuity, and social support networks — the very factors most protective against relapse.

The cumulative weight of these factors — trauma, family disruption, poverty, isolation, lack of opportunity, and community-wide substance use — creates conditions in which addiction is not a choice but an adaptive response to chronic adversity. Effective intervention must address these structural determinants simultaneously, rather than treating addiction as an individual problem requiring individual solutions.

2.2 Difficulty Recruiting and Retaining Inuit Workers in the Community Sector

One of the most persistent structural challenges is the difficulty in recruiting and retaining Inuit workers within community mutual aid organizations (such as Family Houses) and health institutions (CLSCs, hospitals, legal resources, police services). High turnover of mental health interveners at CLSCs creates discontinuity of care and erodes trust. When frontline workers

are not from the community, they lack the cultural knowledge and linguistic capacity to offer appropriate, effective services.

This gap is acutely felt across the mental health, addiction, and homelessness continuum, and disproportionately affects populations — including women fleeing violence and youth in distress — who most need sustained, trusted relationships with service providers. Research consistently shows that culturally safe care requires Indigenous service providers, and that the absence of such providers is itself a major barrier to help-seeking (Goetz et al., 2022; Auger et al., 2021).

2.3 Pervasive Stigma and Exclusion at Multiple Levels

Stigma surrounding mental health, addiction, and homelessness operates at every level of Nunavik's service landscape: in institutional and community resources alike (CLSCs, hospitals, women's shelters, homelessness services, Family Houses, police services), among employers, and within the general population.

Diagnostic Exclusion from Shelters

A documented and particularly severe manifestation of this stigma is the refusal of certain emergency resources — including homeless shelters and women's shelters — to admit individuals on the basis of a mental health diagnosis. A person who is simultaneously homeless and living with a serious mental illness, or a woman who is both a victim of domestic violence and has a psychiatric diagnosis, may be turned away from the very services designed to protect them. This creates a profound and dangerous gap: the most complex clients — those with co-occurring disorders and behavioural challenges — are systematically excluded from emergency resources.

Stigma in Small, Isolated Communities

A second and often underestimated dimension of stigma is specific to the geography and social fabric of Nunavik. In communities of 500 to 3,000 residents, virtually everyone knows one another — and knows one another's history. Interveners, care attendants, and even health professionals may hold pre-formed judgments about clients based on family reputation, past events, or social relationships. This absence of anonymity makes it extremely difficult for individuals to seek help without fear of judgment, gossip, or social consequences. It also creates risks of unconscious bias in service delivery, with certain clients receiving lower-quality or less empathetic care based on who they or their families are known to be. This dynamic affects all age groups, but is particularly constraining for youth and women, for whom social reputation carries particular weight.

Stigma also operates at the community level: communities have, in documented instances, refused the development of new housing resources (such as supportive housing or transitional facilities) near residential areas, citing concerns about the population that would be served — effectively excluding the most vulnerable from access to appropriate support.

2.4 Siloed Services and Weak Intersectoral Collaboration

There is little collaboration between institutional and community resources, and between community organizations themselves. Services operate in silos, with minimal coordination across the mental health, addiction, and homelessness sectors. This fragmentation is particularly damaging for people with complex, overlapping needs — such as Inuit individuals experiencing homelessness alongside addiction and trauma.

Structural Reasons for Siloed Operations

Several factors help explain why organizations struggle to collaborate, even when all parties recognize the need:

- Crisis-driven operations with no time for prevention: CLSCs and community organizations are overwhelmed by acute needs, leaving no capacity for preventive outreach, case coordination, or joint planning. Without breathing room, even motivated organizations default to managing crises individually rather than building shared systems.
- Absence of shared frameworks: Institutional actors (CLSCs, hospitals, police) operate within biomedical and legal frameworks, while community organizations are guided by cultural, relational, and holistic approaches. These differing paradigms — what counts as a "problem," a "solution," or a "successful outcome" — can make genuine collaboration difficult, even with goodwill on all sides.
- Mutual distrust between institutions and community organizations: Community organizations, many Inuit-led, have historically experienced their expertise as undervalued or co-opted by institutional actors. Institutions, in turn, may view community organizations as lacking the professional structure required for formal partnership. This legacy of asymmetric power shapes current relationships and inhibits trust (Auger et al., 2021; Lavoie et al., 2023).
- Short-term and siloed funding: Funding mechanisms typically allocate resources by sector (mental health, addiction, housing) and within short time frames. This discourages the sustained, cross-sectoral collaboration that complex needs require, and creates incentives for organizations to protect their own mandates and client populations rather than coordinate with others.

The result is a service landscape where a person in crisis must navigate multiple disconnected systems, often re-telling their story, facing gaps between services, and falling between the mandates of organizations that do not share information or coordinate care. This affects adults and youth equally — and is particularly acute for women with children and for individuals with co-occurring disorders.

2.5 Insufficient Resources Across the Continuum, and the High Cost of Inaction

Nunavik faces a critical shortage of services in mental health, homelessness, and addiction — both for prevention and crisis management. CLSCs lack the capacity to offer preventive services; they are overwhelmed by acute needs. The continuum of services — including group

homes, mental health resources, Isuarsivik (the regional addictions treatment centre), and post-hospitalization support both in the South and in the North — is nearly non-existent.

Absence of Intensive Community Support

There is no Intensive Community Support (*Soutien intensif dans le milieu*) in Nunavik for homelessness prevention (including support for maintaining housing), substance use follow-up, or mental health stabilization. This absence has severe cascading consequences: without community-based follow-up, people who might have maintained stable housing deteriorate into homelessness; people managing addiction without support relapse; people with untreated mental health conditions escalate into crises requiring hospitalization.

The Human and Financial Cost of Insufficient Community Services

The absence of community-based mental health and addiction services is not only a human rights failure — it is also economically costly. A growing body of evidence demonstrates that prevention and supportive housing generate substantial savings compared to the costs of repeated emergency response:

- Research shows that every $1 spent on homelessness prevention saves $4 to $5 in downstream costs related to emergency shelters, hospitals, and justice (Urban Institute, 2023).
- A major study in New York found that supportive housing reduced total service costs by $16,282 per person annually, covering 95% of housing program costs through savings on emergency services and psychiatric hospitalization (Culhane et al., 2002).
- Housing-based approaches have been shown to reduce emergency department visits by up to 61% for people experiencing homelessness (National Perspectives on Supportive Housing Coalition, 2022).
- A study examining mental health services found a 57% reduction in mental health service costs over six months following housing placement, driven largely by a 79% drop in psychiatric hospitalization costs (National Perspectives on Supportive Housing Coalition, 2022).

The Human Cost: Uprooting, Isolation, and Dependency

Beyond financial costs, the absence of community-based services generates profound human consequences, affecting all ages but particularly adults and youth:

- Geographic uprooting: When there are no local resources, individuals must travel — often to Montréal or other southern cities — for specialized care. This severs connections with family, elders, community, and land — the very relationships most protective against relapse and most central to Inuit identity and healing.
- Reduced family contact: Extended periods away from family for treatment or hospitalization weaken relational bonds and parenting capacity, particularly for women with children. Children whose parents are uprooted for care are at elevated risk of experiencing further family instability and entering the child welfare system (Conroy et al., 2019).

- Disempowerment of individuals and families: When care occurs in distant, unfamiliar settings — often delivered in French or English by providers without cultural knowledge — individuals cannot participate meaningfully in their own recovery. This undermines self-efficacy and community resilience. The inverse is also documented: land-based activities and cultural connection in Nunavik are protective factors against substance use, and elders' involvement is associated with stronger community resilience (Courtemanche et al., 2022).
- More hospitalizations, more specialized beds required: The absence of early and continuous community support increases the frequency and severity of mental health and addiction crises, requiring more costly and intensive interventions: psychiatric hospitalizations, emergency transports, and placements in specialized resources, many of which are located outside the region.

2.6 Disparity in Services Between Nunavik and the Rest of Québec

There is a profound and unacceptable disparity between the range and quality of services available in the rest of Québec and those accessible in Nunavik. This disparity also exists within the region itself: larger communities such as Kuujjuaq have access to more resources than smaller, more remote villages. Geographic isolation — all 14 Nunavik communities are fly-in only — compounds every structural deficit, from staffing to transportation to service continuity (CBC News, 2025). Indigenous people living in remote areas are three times less likely than those in urban areas to receive mental health services (Goetz et al., 2022). The Gouvernement du Québec's future directions must explicitly and measurably address this disparity if they are to have any impact on First Nations and Inuit populations.

2.7 Lack of Gender-Specific and Complexity-Appropriate Housing Resources

There is a critical shortage of non-mixed housing resources for Inuit women, and of appropriate accommodation for Inuit individuals with mental health issues, co-occurring disorders (mental health and addiction), or behavioural challenges including violence or aggression. Women fleeing domestic violence face an impossible choice: remain in a dangerous situation or face the street, because there is no adequate alternative.

The absence of safe, appropriate housing is not merely a housing issue — it is a mental health issue, a safety issue, and a women's rights issue. Women with a psychiatric diagnosis are further marginalized by the refusal of some shelters to admit them (see section 2.3). This leaves the most vulnerable Inuit women — those facing the intersection of violence, mental illness, poverty, and cultural displacement — without any adequate option, and at elevated risk of homelessness, continued violence, and death.

Recommendations on Possible Solutions

The model of care must shift from a reactive, colonial approach to a holistic, Inuit-led approach. What is needed is not a series of additional services grafted onto an unchanged system, but a structural transformation of governance: who makes decisions, who delivers care, where care happens, and on whose terms. The recommendations below are organized in three parts: a description of the proposed new model, an analysis of how it responds to the specific failures of the current system, and concrete implementation recommendations.

3.1 A New Governance Model: Community Organizations as the Primary Point of Contact

We propose that community-based non-profit organizations become the primary point of contact between the Inuit population and health and social services. This is not a supplementary role: it is a fundamental reorientation of the care system, in which institutional actors — CLSCs, hospitals, specialized services — become partners and supporters of community-led action, rather than the default first and only door. The community organization is the hub; the institution is a resource it can call upon.

This model is grounded in a pilot project that aims to develop and strengthen the interaction between two networks: the external social network — the community and its organizations — and the internal network: the formal care pathway and therapeutic relationships found in primary health care (Perry, 2015). These two networks are currently disconnected. The model proposed here is designed to weave them together, with community organizations providing continuity, trust, and cultural grounding, and institutional actors providing clinical expertise and specialized resources (Kirmayer et al., 1993; Kirmayer et al., 1997).

At the heart of this model is a shift in governance: Inuit communities — through their organizations — reclaim the right to define what constitutes a problem, what constitutes a solution, and what a good outcome looks like for their population. The health system does not deliver care to Inuit communities. It supports Inuit communities in delivering care to themselves.

What community organizations bring that institutions cannot

- More Inuit workers, less institutional distance. Indigenous community-controlled organizations consistently employ a higher proportion of Indigenous staff than mainstream health institutions — a pattern documented across Canada, Australia, and New Zealand, where the cultural safety and community embeddedness of these organizations make them more attractive and sustainable workplaces for Indigenous workers (Shahid et al., 2020; Grimson et al., 2019). In Nunavik, where CLSCs and hospitals rely predominantly on non-Inuit rotational staff, this difference is acutely felt. Approaching a community organization is less confrontational, less formal, and less freighted with the associations of judgment or authority that institutional settings carry

— particularly for people who have experienced trauma, stigma, or negative encounters with the state.

- Increased access to services. Evidence consistently shows that Indigenous community-controlled and community-led health organizations improve access to care, prevention uptake, and adherence to care plans compared to mainstream institutional services (Shahid et al., 2020; Davy et al., 2016). This is explained by geographic proximity, cultural safety, use of Indigenous languages, and the trust generated by community ownership of services. For Nunavik, where the disparity between available mental health services and those accessible in the rest of Québec is profound and well-documented (see Section 2.6), and where cultural and linguistic barriers further reduce engagement with institutional services, the shift to community-based delivery is the most direct lever available to increase access.
- Services in Inuktitut, embedded in community life. Language is not a minor accommodation: it is the condition of genuine communication. Community organizations offer services in Inuktitut, within the daily social fabric of communities, often through activities that people already participate in — meals distribution, land outings, the community thrift store, the youth centre — rather than requiring a formal appointment at a clinic.
- A “no wrong door” approach. In the proposed model, a person can arrive at a community organization for any reason — food, a social activity, a conversation — and find, in the same place, access to housing assistance, food security, employment reintegration support, emotional support, cultural activities, and referral to health services if and when needed. There is no wrong door, no wrong reason to show up, and no form to fill out before being seen as a person.
- Services when the person shows up. Community organizations respond to people in the moment they are ready — not after a three-week wait, not at a scheduled appointment that a person in crisis cannot keep. This responsiveness is not inefficiency; it is the design of effective outreach for populations that have learned, through experience, that institutions are not reliably there when needed.
- A more horizontal hierarchy. Community organizations operate with flatter governance structures than institutions. Crucially, this model acknowledges that clients hold knowledge that workers do not — about their own lives, their communities, their needs, and what has and has not worked. That knowledge is not background context; it is clinical information. Workers in community organizations are positioned to learn from the people they serve, and to bring that knowledge back into the wider service system.
- Shared values with Inuit culture. The way community organizations work — sharing resources, respecting each person’s strengths, attending to relationships, connecting to the land, prioritizing collective well-being — reflects Inuit values in ways that institutional care does not. This alignment is not cosmetic. It is the reason engagement is possible: people participate in systems that reflect who they are. Evidence from Indigenous community health research consistently shows that interventions grounded in community values, traditional knowledge, and cultural identity produce better outcomes than those that are culturally neutral or externally designed (Huria et al., 2021; Reading, 2018).

- Safe spaces: physically, emotionally, and culturally. Community organizations are places where people feel they belong. They are spaces of discovery, of sharing, of connection to self and community. They are not places of diagnosis or judgment. This safety — physical, emotional, and cultural — is the precondition for everything else: disclosure, help-seeking, healing.
- Task-sharing, cultural brokerage, early detection, and navigation. Inuit community workers serve simultaneously as task-sharing partners for clinical professionals, cultural brokers who translate between Inuit worldviews and institutional frameworks, trusted navigators who help people understand and access services, and early-detection supports who can identify signs of crisis before they escalate — and act on them, or call in clinical support, from within a relationship of trust (Morin et al., 2025; Le et al., 2022).
- Autonomy and rights. Community organizations promote the decision-making autonomy of the people they serve and advocate for their rights within a complex service system that is frequently difficult to navigate alone.

3.2 How This Model Responds to the Failures of the Current System

Each of the structural failures identified in Section 2 has a direct response in the community-based model proposed here. The following analysis shows how the model addresses the specific gaps that have defined Nunavik's care system to date — and names concrete examples of how Nunavik's existing Inuit-led organizations already demonstrate this response in practice.

Responding to workforce shortages and high turnover

The chronic shortage of Inuit workers in health and social services — and the high turnover of non-Inuit staff — means that many people in Nunavik have no stable, trusted relationship with a service provider. Community organizations that are culturally grounded and locally governed create conditions that support the recruitment and retention of Indigenous workers in ways that institutional environments frequently cannot: they offer cultural safety, shared values, community belonging, and meaningful roles that reflect workers' own identities and knowledge systems (Grimson et al., 2019; Shahid et al., 2020). In the proposed model, community organizations become the anchor of continuity: the person who knows a client's history, their network, what approaches work for them, and how to reach them when crisis looms. This knowledge is then made available to clinical professionals — who visit clients in community settings rather than expecting them to come to a clinic.

Responding to stigma and diagnostic exclusion

People with a psychiatric diagnosis are currently refused entry to emergency shelters in Kuujjuaq, Nunavik's principal urban centre. In small communities where everyone knows everyone, seeking help at a CLSC or hospital carries reputational risk. The community organization model reduces both forms of stigma: it creates low-barrier, informal spaces where people can appear without announcing a problem, and it builds relationships across difference

— as Ippigusugiursavik's "I Care, We Care" thrift store and its other programs do, by bringing together community members with and without mental health diagnoses in shared, meaningful activities. Contact-based destigmatization is the most consistently effective anti-stigma strategy in the evidence base (Gyamfi, 2024).

Responding to siloed services and lack of collaboration

The community organization becomes the physical and relational space where collaboration happens — not through formal inter-institutional agreements, but through shared presence. When a social worker visits their client at Ippigusugiursavik, they meet the community workers, the other residents, the people volunteering at the thrift store. When a psychiatrist comes to the Family House, they observe the social context of their patient's life. The hierarchy is not eliminated, but it is disrupted: the professional comes to the community, rather than expecting the community to come to them. This proximity produces better clinical information, earlier identification of warning signs, and more collaborative care planning — while reducing the professional isolation that drives burnout.

Responding to insufficient resources and the cost of inaction

The community organization model is itself a form of Intensive Community Support (*Soutien intensif dans le milieu*). When a person receives food, social connection, cultural activities, peer support, and navigation assistance at a community organization — and when clinical professionals are present on-site as needed — the conditions for crisis are reduced. Hospitalizations become less frequent. Emergency transfers to the South become less necessary. The cost savings are real and well-documented internationally (Culhane et al., 2002; Urban Institute, 2023). More importantly, people remain in their community, connected to their family, their land, and their culture — the conditions most protective against relapse and most conducive to lasting recovery.

What this looks like in practice: Ippigusugiursavik as a working example

Ippigusugiursavik Supervised House in Kuujjuaq offers a concrete illustration of what the proposed model can look like in practice. Its eight residents — individuals living with severe mental illness — participate in on-the-land outings, contribute to the food security of their community through the organization's meal distribution program, and engage with the broader community through activities such as the "I Care, We Care" thrift store, where staff distribute second-hand furniture and goods to people in need. This model — combining supervised housing, meaningful employment, and community service — could be replicated in other communities through existing structures such as Family Houses, which are present across the region and already serve as trusted community hubs. Under the proposed governance model, health professionals would be invited to visit community organizations regularly: they would participate in activities alongside clients and staff, build relationships in context, and make themselves available for voluntary consultation. Each client would have access to a community worker acting as a navigator — a person who helps them understand available services, access what they need, and progressively develop the autonomy to manage that process independently. This is not a hypothetical model; it is the formalization and expansion

of what Ippigusugiursavik already does, with the clinical and financial support it currently requires.

3.3 Culturally Grounded Addiction and Prevention Services

- Expand Saqijuq's Mobile Intervention Teams and On-the-Land program to all 14 communities. In 2025, MITs resolved over 90% of 747 crisis calls without judicial action (The Regional, 2026). The Nitsiq Wellness Court offers rehabilitation as an alternative to sentencing (Government of Québec, 2019). Funding for rotational workers is the primary barrier.
- Fund land-based and cultural programming as mental health intervention. Active organizations include Saqijuq's On-the-Land program (seven communities), the Qajaq Network, Men's Associations, Inukrock, Family Houses, and Nunami (the NRBHSS's land-based wellness program). Cultural connection is a documented protective factor against substance use (Courtemanche et al., 2022).
- Support Nunalituqait Ikajuqatigiitut (NI) and similar Inuit-led organizations in delivering community and school-based addiction prevention in Inuktitut.
- Complement Isuarsivik — trauma-informed, land-based, and a genuine regional success — with community-based SIM that addresses societal determinants alongside addiction and does not require relocation.
- Invest in Wraparound Services for youth, and support Suilaaqivik (NYHA) in completing Youth House infrastructure across all 14 communities and sustaining their recurring programming as safe spaces for prevention, cultural connection, and parenting skill-building. Funding must support both capital infrastructure and ongoing operations.
- Support Nunavimmi Ilagiit Papatauvinga (NIP) as it implements Inuit-governed family services and progressively assumes responsibility for youth protection by 2030 (Makivvik, 2025).
- Develop Inuit-led community education — via radio, social media, and community gatherings — to normalize help-seeking and reduce stigma. Peer discussion groups and shared experience circles are low-cost, high-impact tools.

3.4 Building an Inuit Workforce: Task-Sharing and Training

- Expand the *Parcours Inulijiri Nunavik* / Cégep Marie-Victorin training pathway with shorter, modular formats accessible to Inuit at all education levels, including those with lived experience, via the community organization they work for.
- Strengthen Community Liaison Wellness Workers (CLWWs) and community wellness committees — present in all 14 communities — as an existing foundation for task-sharing, outreach, and peer support.
- Develop a formal peer support program that trains and compensates Inuit with lived experience as community health workers.
- Embed clinical professionals within community organizations; pair social workers, nurses, and psychiatrists with Inuit community workers; require mandatory Nunavik orientation for professionals from southern partners such as the Douglas Institute.

- Recognize Ikajurtigiit — Inuit construction training and employment with integrated psychosocial, emotional, and legal support — as a replicable model of the workplace as a site of healing and prevention.
- Support and replicate Ippigusugiursavik's model (supervised housing combined with social and employment insertion programs such as the "I Care, We Care" thrift store and meal distribution), which integrates housing support, meaningful employment, community service, and contact-based destigmatization (Gyamfi, 2024). This model could be adapted and replicated in other communities through existing structures such as Family Houses.
- Develop and sustain Communities of Practice (CoP) in mental health, addiction, and homelessness to reduce professional isolation, transfer tacit knowledge, improve collaboration, and reduce practitioner stigma (Wenger et al., 2002; Barnett et al., 2023; Zamo et al., 2024).

3.5 Eliminating Stigma and Diagnostic Exclusion

- Eliminate diagnostic exclusion criteria from emergency shelters. No person should be refused access to emergency resources on the basis of a psychiatric diagnosis. Resources must be equipped to receive complex profiles.
- Develop an Inuit-run advocacy organization for people living with mental illness, addiction, and homelessness to defend rights and document service refusals.
- Equip all services in crisis intervention and de-escalation; invest in destigmatization within institutions (CLSCs, hospitals, police).

3.6 Intersectoral Collaboration and Stable Funding

- Establish a shared coordination structure anchored in community organizations, bringing together CLSCs, hospitals, police, schools, DYP, and CBOs around individual cases and population-level planning.
- Create multi-year, cross-sectoral funding envelopes. Organizations like Aaqitauvik Healing Centre in Quaqtaq — delivering free trauma-healing programs across Nunavik, including in Montréal correctional facilities, since 2008 — need stable, multi-year funding to sustain their work (Nunatsiaq News, 2025).
- Provide sustained financial, administrative, training, and organizational management support to community organizations. Many — the Qajaq Network, Family Houses, NI, wellness committees, and others — operate with minimal infrastructure and without stable governance capacity or succession planning.
- Formalize co-governance and shared decision-making in service planning (Lavoie et al., 2023; Auger et al., 2021). Develop community-based reintegration programs following hospitalization, detention release, or Youth Protection transitions.

3.7 A Full Continuum of Adapted Housing

- Implement Housing First adapted to Nunavik realities, with SIM for people at risk of homelessness, in addiction recovery, or managing mental health in the community.

Every $1 in prevention saves $4 to $5 downstream (Urban Institute, 2023); supportive housing reduces psychiatric hospitalization costs by up to 79% (Culhane et al., 2002).

- Expand social housing across all 14 communities. Develop the full continuum: emergency shelter, transitional housing focused on rehabilitation, supportive long-term housing with SIM, and supervised apartments (building on Uvattinut in Puvirnituq).
- Develop adapted housing for Inuit with co-occurring disorders and complex behavioural profiles, alongside social reintegration programming. Count hidden homelessness in all policy planning.

3.8 Gender-Specific and Complexity-Appropriate Resources

- Develop non-mixed housing and support resources for Inuit women (including those with mental health diagnoses or co-occurring disorders) and for 2SLGBTQI+ Inuit. Ippigusugiursavik's application for a women-specific supervised house is a ready-to-support example.
- Ensure all new resources explicitly include women and 2SLGBTQI+ individuals as priority populations, with service design informed by their specific realities.

International Evidence: Community Organizations as the Engine of Change

The challenges facing Nunavik are not unique to the Arctic. Indigenous peoples in Amazonia, Māori communities in Aotearoa (New Zealand), and populations in low- and middle-income countries across Africa, South Asia, and Latin America face comparable conditions. The international evidence converges on a consistent finding: the most effective and durable responses in under-resourced, complex contexts are those driven by community-based organizations, with institutional systems in a supporting role.

Task-sharing — training community members to deliver targeted mental health and social support alongside clinical professionals — has been formally endorsed by the WHO and demonstrated effective in over 100 countries through the mhGAP programme (Keynejad et al., 2022). Randomised trials in Ethiopia show that task-sharing care for severe mental disorders by trained community workers supervised by specialists is non-inferior to specialist-delivered care at a fraction of the cost (Hanlon et al., 2016). In Guyana, PAHO adapted mhGAP for Indigenous health workers in isolated hinterland communities, training over 440 workers in their native dialects through partnerships with local Indigenous organizations — a direct model for the *Nunavik Parcours Inulijiri* (PAHO, 2021). A 2025 meta-analysis further shows that task-shared interventions that simultaneously address social determinants — housing, violence, income — produce significantly better outcomes than clinical-only approaches (Purgato et al., 2025).

In Amazonia — facing geographic isolation, high youth suicide rates, and colonial trauma strikingly similar to Nunavik — community health workers recruited from within Indigenous communities serve as cultural brokers, early-detection supports, and trusted navigators of fragmented care (Morin et al., 2025; Scopel et al., 2022). Brazil's national CHW program embeds community workers within multidisciplinary primary health care teams, contributing to a 75% reduction in child mortality by making community organizations the front door to the system (Exemplars in Global Health, n.d.). This "intermedicality" — mediating between biomedical systems and traditional healing — directly mirrors what Saqijuq, Family Houses, and Ippigusugiursavik already do in Nunavik.

Aotearoa (New Zealand) offers the most documented example of a high-income country that formally recognizes and funds Indigenous community organizations as primary mental health and addiction providers. Kaupapa Māori services — governed and delivered by Māori, grounded in Whānau Ora and Te Whare Tapa Whā — are the primary point of care for Māori populations, not supplements to the system (Ministry of Health NZ, 2020; Durie, 2001; McMeeking et al., 2023).

Across all contexts, the evidence demands four things of Québec's forthcoming directions: invest in community organizations as primary providers, not clinical overflow recipients; recognize cultural grounding as the mechanism of effectiveness, not a decoration; address social determinants alongside clinical care; and treat Indigenous self-determination as a health intervention in itself. Nunavik's Inuit-led organizations are already the engine of that approach. The task of policy is to fuel them.

Conclusion

The challenges described in this brief are severe. But they are not without answers. What the evidence from Nunavik itself — and from Indigenous and low-resource communities around the world — demonstrates is that the solutions are already present, in embryonic form, within the region: Inuit-led organizations that have built trust where institutions have failed, community workers who reach people that no clinic ever will, cultural practices that heal what biomedical care cannot touch alone.

What is missing is not the knowledge of what works. It is the political will and the sustained resources to let it grow.

The Government of Québec has an opportunity, through its forthcoming directions on mental health, homelessness, and addiction, to make a genuine shift: from a system that delivers care to Inuit communities to one that supports Inuit communities in delivering care to themselves. This means formally recognizing Inuit-led organizations as primary providers — not supplements to institutional services — and funding them with the stability, flexibility, and respect for governance that their roles require. It means investing in the full continuum of community-based services, from land-based prevention to transitional housing, before crisis forces the far more costly interventions of hospitalization and southern transfer. And it means accepting that the most effective interventions for Inuit are those designed, delivered, and governed by Inuit.

The international evidence is unambiguous: when communities are the architects of their own healing, people engage, outcomes improve, and systems become more equitable and more efficient. Nunavik's Inuit-led organizations — Saqijuq, Nunavimmi Ilagiit Papatauvinga, Ippigusugiursavik, the Qajaq Network, Suilaaqivik, Ikajurtigiit, Nunalituqait Ikajuqatigiitut, Family Houses, the Community Liaison and Wellness Workers, community wellness committees, and others — are already building that future, often with insufficient and precarious resources. The Government of Québec is invited to stand behind them: with stable funding, formal recognition, genuine governance, and the political resolve to let Inuit communities lead their own healing.

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