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Plan A, Plan B, and Plan C-OVID-19: adaptations for fly-in and fly-out mental health providers during COVID-19

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ABSTRACT

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

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Introduction

The COVID-19 pandemic has drastically changed the ways in which we live and work. It has not only affected the physical health of many but also the mental health and wellbeing of individuals worldwide [1]. Strict social distancing guidelines in many countries have forced mental health providers to shift their current practices to support individuals experiencing mental health problems [1]. Mental health service providers have rapidly pivoted their practices to teletherapy and telehealth interventions to support individuals throughout the pandemic [2–4]. The pandemic has resulted in significant challenges for the traditional delivery of mental health services and has highlighted the necessary role of telehealth, and the importance of online tools such as digital platforms [4]. Researchers have recognised the COVID-19 emergency as a catalyst for change for digital mental health practices [3,5].

Rapid responses and adaptations to mental health service provision have resulted in challenges for providers, especially in regions that rely on fly-in and fly-out (FIFO) health service providers. Health care delivery in circumpolar regions poses unique challenges that result in health care systems relying on short-term locum providers who come from outside the region [6]. Similar to Canada, Australia has a vast expanse of land making it difficult to recruit health professionals in remote areas [7]. Researchers in Australia have found that individuals living in remote areas, including Indigenous communities, are made vulnerable to COVID-19 due to geographical and historical factors; as a result, they face higher rates of chronic disease and other socio-economic factors such as overcrowding, making compliance with social distancing guidelines difficult [8]. Residents of Indigenous communities in northern Canada experience similar vulnerabilities [9] as Indigenous peoples in Australia. While researchers have examined FIFO services globally [7,10,11], to our knowledge, there is little peer-reviewed research on FIFO mental health service provision in northern Canada. Furthermore, we were unable to find any academic literature on the impact of COVID-19 on FIFO mental health service providers in the northern Canadian context. To understand the implications of COVID-19 on the delivery of FIFO mental health provisions in Inuit communities in northern Canada, we

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conducted interviews with eight FIFO mental health providers. Our goal was to understand the experience of FIFO providers and to learn from the current situation to make recommendations as providers move forward with considerations of pandemic risks.

Background

Inuit context

Inuit Nunangat consists of four areas including the Inuvialuit Settlement Region in the Northwest Territories, Nunavut, Nunavik in northern Quebec, and Nunatsiavut in northern Labrador. Residents of these regions experience many indicators of poor health [9]. Access to mental health services is particularly important for Indigenous peoples who, due to colonialism, the legacy of residential school trauma, and racism – amongst other challenges [12], experience high rates of substance abuse, risk-taking behaviour, and suicide [13]. Indigenous peoples living in northern Canada face many barriers when accessing mental health services such as geographical isolation [14] and lack of health and telecommunications infrastructure [15].

In a position paper titled *Development and Implementation of the Arctic Policy Framework*, Inuit Tapiriit Kanatami (ITK) [16] acknowledged the gap in infrastructure that affects Inuit Nunangat. In its report, ITK recognised this gap as a barrier to the economic, social, and cultural development of Inuit and non-Inuit alike. Recently, 15, the Nunavut Land Claims organisation, published a report titled *Nunavut's Infrastructure Gap*, which echoed ITK's statements regarding the effects of lack of infrastructure. Highlighted in this document were infrastructure gaps specific to the Nunavut context that contribute to poverty and lower quality of life for Inuit such as gaps in housing, education, health, telecommunications among many others [15]. This report addressed serious gaps in mental health-related infrastructure, citing a lack of facilities and low percentage of residents with a regular health care provider [15]. Limited access to mental services further perpetuates mental health problems in Inuit communities. Health care such as physician services delivered outside of main hubs are often delivered remotely but can be hindered by poor internet connections [15]. Due to the remoteness of communities in Inuit Nunangat, internet connectively plays an important role in enabling access to healthcare and education among other factors. When this document was published in 2018, it was reported that all but one community in Inuit Nunangat are served by satellite, with a lack of fibre optic connectivity across the region [16], resulting in slow and unreliable internet. Difficulties in telecommunications have been emphasised during the COVID-19 pandemic, during which many services shifted to be online.

Telemental health services

Telemental health is described as the delivery of mental health services through telecommunications or computerised services [18]. This term is used broadly to include a wide range of services and professionals that provide mental health care from a distance both in real time, such as in videoconferencing or over the telephone, and asynchronously through email [18]. Traditional mental health systems (i.e. in person) often do not meet the needs of communities in remote areas due to their geographical location [18], and so telemental health offers an alternative to rural and remote populations by enhancing access to mental health services for underserved and hard to reach populations with restricted mobility such as geographical limitations [19]. Two notable studies have looked at the use of telemental health services for Indigenous peoples across Canada from the providers' perspective. 20 and 21,concluded that providers found telemental health to be a beneficial extension of conventional in-person mental health services to rural and remote communities. 20 noted the benefits of telemental health in rural First Nations communities by acknowledging that this model provides continuity of care and allows clients to remain in community while receiving therapeutic services. However, the authors noted that this type of service delivery is not without its challenges, such as concerns regarding infrastructure and cultural appropriateness [20]. 21, who looked at service provision in various Inuit and Cree communities in northern Quebec as part of their study, recognised the technological limitations by expressing concerns of reduction in efficiency of telemental services as a result of outdated computers. In another study, 22 researched community experiences of telemental health services and found that clients associated the use of these services with an increase in access and continuity of mental health services. Participants in their study recognised the benefits of not having to travel, and commented on how videoconferencing may facilitate disclosure through increased comfort of communicating online [22]. Alternatively, some clients in the study questioned the usefulness and appropriateness of these services, and expressed concerns about privacy and safety 22. COVID-19 has served as a catalyst for the implementation of telemental health as the demand for services

and resources are rising and the ability to provide in-person care is limited due to travel restrictions [5].

COVID-19 and mental health

Public health emergencies have the ability to affect the health and wellbeing of individuals and communities [23]. In January 2020, the World Health Organization declared COVID-19 a public health emergency, which was later characterised as a pandemic when infection rates increased globally [24]. Of significant concern is how COVID-19 not only compromises physical health, but also how it affects mental health and wellbeing [1]. Work and school closures, a lack of medical resources, and physical and emotional isolation have resulted in negative health outcomes such as emotional distress and unhealthy behaviours such as substance abuse [23]. Recent research suggests that COVID-19 is having a negative impact on Canadians' mental health, with stress levels doubling since the onset of the pandemic [25]. Particular populations are at an increased risk of experiencing psychosocial effects related to COVID-19 including racialised individuals, Indigenous peoples, individuals with disability, and low-wage workers who live in communal housing due to the pre-existing inequities in access to health care [25]. Health-care professionals are particularly vulnerable to increased stress as a result of increased work hours, safety concerns, and participation in resource-allocation decisions [23,26]. Mental health providers play an essential role in mitigating emotional outcomes from the pandemic [23], though they themselves are not immune from the adverse effects of COVID-19.

COVID-19 and health service delivery

The current pandemic has shifted the priorities of mental health professionals who have adapted their services to comply with the changing restrictions in order to provide support to those experiencing mental health problems, and to those who are recently suffering from the psychosocial effects of COVID-19 [1]. Mental health service providers who deliver services to Inuit communities are affected by COVID-19 due to travel restrictions and quarantine recommendations by community leaders, governments, and organisations in Inuit Nunangat [27]. In response to these new guidelines, many mental health providers have shifted their practice to incorporate telehealth services. As expected, this pivot has come with its own challenges for implementation. Commonly reported barriers to offering services via telehealth or online include concerns regarding privacy and safety, impact on rapport building between provider and clients, reduced non-verbal communication (gestures), and insufficient technological support [5,28]. In an Australian study in which researchers examined the impacts of COVID-19 on Aboriginal peoples and Torres Strait Islanders, these populations were found to experience a higher prevalence of chronic diseases and tobacco use but were also affected by socio-economic factors such as overcrowding, rendering Indigenous populations particularly vulnerable to COVID-19 [8]. In addition to the existing challenges that residents of remote communities face in accessing and receiving care in Australia, additional workforce challenges have also been noted during the pandemic such as changes in national demand for short-term work force and increased risk of losing permanent staff due to burnout [8]. Although it is a different country and cultural context, there are some overlapping concerns that relate to Inuit communities in Canada [9].

Fly-in and fly-out health service provision

The shortage of healthcare professionals in rural communities is a global problem, and Canada is not immune to such challenges [29]. Despite residents of rural communities experiencing greater health inequities than those in urban areas, developed countries report skewed distributions of health care professionals, with higher numbers in urban and wealthy areas [29]. Though 90% of Canada's land mass is considered to be rural and remote, 20% of Canada's population live in remote, rural, Indigenous, coastal or northern communities [30,31]. In 2018, it was noted that there are approximately 65,030 Inuit living in Canada, most of whom live in Inuit Nunangat (73%), while 27% live outside of the region [17]. Individuals in remote and rural communities experience inequitable access to healthcare services compared to their urban counterparts [32], highlighting the necessity for FIFO services to these areas.

FIFO services provided by non-resident workforces have been categorised in five different ways:

(1) Specialist outreach services.
(2) Hub-and-spoke or outreach arrangements for various allied health and specialist programs, such as women's health educator or mobile dental service.
(3) "Orbiting staff" who spend significant periods of time (12 months or more) in one or two specific communities, self-regulate stress levels and work elsewhere for periods, then return to the same communities where orientation is not required.

(4) Long-term shared positions, such as month-on /month-off, where the same practitioners service the same communities.
(5) Short-term locum or agency staff who move from place to place or as a one off.

[11, p. 1]

These services have the potential to improve health care access for rural residents and cost-efficiency [11]. FIFO services present many benefits for community members who would otherwise have to travel long distances to receive care [7]. Furthermore, travelling health care providers can enhance quality of existing care in rural regions [7]. Although there are benefits to these services, FIFO models of care are not without challenges. 33,recognised the high cost associated with travel to remote communities, and the pressures to accommodate travelling staff at local sites as drawbacks to this model of care. 7,also noted that while this model can be convenient for community members, providers have to sometimes "waste their time travelling" to communities, which can be seen as unproductive. Much of the demand for FIFO providers is due to limited community capacity to offer services locally, and a lack of interest from medical staff to permanently reside in rural and remote communities [7,31]. Other well-documented barriers to attracting permanent health care professionals in rural and remote communities include long hours, poor access to professional development and training, high cost of services such as food and travel, and feelings of isolation [7,31]. Nevertheless, when implemented effectively, FIFO services can ensure that residents of rural and remote communities have access to health care practitioners.

There is little known about the experience of FIFO mental health service providers in Inuit communities in Canada. The vast majority of studies that have been conducted to understand the provision of health care services in a FIFO capacity have examined the Australian context [7,10,11,]. 10,found FIFO services particularly challenging for professionals who provide psychological and similar services that require building longer-term, trusting, therapeutic relationships. An Australian study that has looked at the impact of COVID-19 in remote communities found that many of the existing challenges for mental health care provision in remote populations have been exacerbated with the onset of the current pandemic, such as instability of the workforce due to the reliance on FIFO providers and include issues such as expensive quarantine, demand for short-term staff and permanent staff burnout [8].

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

Methodology

This research was guided by a participatory action research (PAR) approach, through which researchers and participants co-created action and change [34]. Action is achieved through collecting and analysing data to determine the most appropriate action to bring about change [34]. In accordance with a PAR approach, an advisory board comprised of two FIFO mental health service providers, two researchers, and one representative from our partner organisation, Northern Counselling and Therapeutic Services, directed all aspects of this research. Research findings will be used to improve service provision through policies and regulation recommendations within the partner organisation. Ethics approval was obtained from the Carleton University Research Ethics Board (CUREB-B 112643).

The focus of the current article and analyses was to describe the challenges to mental health service provision that practitioners are currently facing; thus, the first author conducted semi-structured interviews with eight FIFO mental health service providers who work with Northern Counselling and Therapeutic Services (See Table 1: Service Providers) and deliver services to communities in Inuit Nunangat. For the purposes of this paper, participant names have been replaced with pseudonyms to protect their identities. Inclusion criteria including speaking English and having experience with the delivery of mental health services to residents of communities in Inuit Nunangat. All participants were recruited through emails shared by our partner organisation and through snowball sampling. The study sample included mental health service providers who have completed training/education in social work or counselling. All eight participants identify as Caucasian,

Table 1. Service providers.

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

including six women and two men who reside outside of Inuit Nunangat. Participants reported working in a FIFO capacity for between one year to ten years. Prior to being hired with NCTS, all participants had a minimum of ten years' counselling experience, most of whom worked with Indigenous populations and communities. The participants described spending differing amounts of time in communities based on the types of contracts they had. Time spent in the community ranged from a few weeks for crisis response, short-term staff fill in, and ongoing organisation support to months for school settings and longer-term staff fill in. Prior to the onset of COVID-19, providers reported delivering mostly in-person care with minimal telemental health service provision.

Participants provided written informed consent prior to being interviewed and received a 25 CAD gift card as a token of our thanks. The questions guiding the semi-structured interviews, which were created by the advisory board members, included but were not limited to the following: *How has the development of COVID-19 changed the way you practice? Do you foresee remote counselling as a sustainable solution/option for fly in-/fly-out service providers moving forward? Do you foresee any lasting impacts that COVID-19 may have on the fly-in/fly-out community of mental health practitioners?* Each interview lasted between 45 and 90 minutes. All interviews were audio-recorded, transcribed verbatim, accuracy checked by the first author, and sent back the participants for verification. Two participants made slight changes to their transcripts, while one participant included additional information. Considering the rapidly changing COVID-19 situation, at the time of the interviews, the communities serviced by the participants had minimal to no cases of the virus; this changed just prior to our analysis; thus, a follow-up email was sent to participants to determine if/how their situations had changed. Questions in the follow-up email included: *How has the recent increase of COVID-19 cases changed the demand for your services? As a result of the uptake in COVID-19 cases, have you experienced any different/new challenges with remote counselling?*

Analysis

The first and second authors followed 35 six-step approach to thematic analysis. To begin, they uploaded all data to NVivo[10], a qualitative data analysis software package. Once the transcripts had been read by the first and second authors, we generated initial codes and assigned descriptive labels to data segments. The first and second authors examined the codes and organised the data to develop themes. All authors then assessed preliminary themes to determine if they captured the experience of FIFO providers. To ensure we accurately reflected the perspectives of the service providers, we shared the findings with the advisory committee; they agreed with the results. We identified three themes through a process that 35,referred to as "developing the essence" (p. 22) of what the theme is about: 1) Service providers identify the challenges in adapting their services to meet individual and community needs; 2) Service providers recognise the opportunities for enhancements to service delivery; 3) Service providers identify telemental health services as a potentially effective adjunct to in-person sessions.

Results

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

The first theme, "service providers identify the challenges in adapting their practices to meet individual and community needs," reflects the challenges that mental health service providers face while adapting their services to meet individual and community needs. Many providers acknowledged the complexity of travelling to the North to deliver services in light of the restrictions and guidelines[1] in place in northern Canada. David explained:

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

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

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

community outreach to clients while unable to be in the community would be particularly challenging:

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

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

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

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

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

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

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

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

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

THEME 2: service providers recognise the opportunities for enhancements to service delivery

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

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

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

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

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

> [T]o me, it makes perfect sense for counselors to do a couple of fly-in sessions maybe per year and do these face-to-face clinics but then follow up virtual and remote. And if they establish these trust relationships

> with the community by being there in person and introducing themselves and becoming part of that community fabric, then I think it will be much easier for us to keep connecting with clients afterwards.

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

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

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

> Certainly, we still run into situations where internet connections and phone service are not the quality that we would like them to be, but I think all that's going to be resolved within the next few years, and I actually think that COVID has probably accelerated that. I think some of the platforms … they've all accelerated the development of their platforms, and I think they're better than they used to be. I think the foundation of all of this service delivery, whether it's remote or in person, is building relationships and clarifying the mandate so that we are welcomed into the community, we're a part of the fabric of the service delivery. And if that ground is well prepared, then I think we should be fine.

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

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

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

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

The counsellors reported that the adaptations to COVID restrictions changed their practices in many ways and have influenced what they view as best practices for FIFO providers in a post-pandemic Inuit Nunangat. Seven of the providers noted that some combination of in person and telemental health services would be the best strategy to optimise FIFO mental health service provisions in the North. Rachel noted, "I don't think it's [remote counselling] unsustainable. I think we can do it for as long as we need to … [but] [i]t cannot replace face to face." Diane agreed that remote counselling could be used as an addition to their services but that she would not want to see it replace FIFO services. She stated:

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

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

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

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

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

> I like the idea of the webinars or the online workshops, or things like that where we can establish a bit of a relationship. I mean ideally, again, we go back to the idea of being able to go in person to the

> community and sort of shake hands and make contacts and so on. But if that can't happen, then we've got to figure out other ways of building that familiarity.

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

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

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

Discussion

The current study provides insight into the experiences of FIFO mental health service providers as they adapt to shifting service delivery as a result of the COVID-19 pandemic. This study advances the previous research on successful telemental health strategies with Indigenous populations in Canada from the provider perspective [20; 21] to include the Inuit Nunangat context and the impact of the COVID-19 pandemic. To our knowledge, this is the first study focused on the impacts of COVID-19 for FIFO providers in Canada. The rapid and drastic changes that required changing in-person mental health service delivery in Inuit Nunangat to telemental health services presented numerous challenges for providers. Prior to the onset of the COVID-19 pandemic, providers reported delivering mental health services face-to-face with limited usage of telemental health services. Mental health providers recognised the difficulties of travelling given the restrictions and guidelines put in place by community leaders, governments, and organisations in Inuit Nunangat [27], while acknowledging that community members may not feel comfortable with individuals entering the community from areas in the South with higher rates of COVID-19. Fulfiling the required isolation period for travelling to different provinces and territories (for instance, self-isolation for two weeks before and two weeks after) was deemed to be too expensive and would demand considerable time resources from the provider. Although these challenges among others were identified, providers acknowledged the opportunities to enhance mental health service delivery to Inuit communities through increased use of digital technology and online tools. Although advantages to telemental health service provision was noted, providers maintained the importance of providing in-person care. Providers in this study expressed the importance of providing optimal services during a pandemic while recognising the need for a more enhanced continuum of care in a post-COVID context.

Perceived challenges

Participants in our study identified barriers to optimal mental health service delivery as including logistical challenges such as lack of technology, privacy and safety concerns, and difficulties with establishing relationships with clients and the community. Lack of technology (and/or lack of access) was most frequently reported as a challenge to providing virtual mental health care. Additionally, they presented concerns over privacy as a challenge for clients, which is unsurprising given the high rate of overcrowding in homes in Inuit communities [9]. These logistical challenges are consistent with researchers findings from the Netherlands, which explored the sudden change in service provision as a result of COVID-19 [28]. We interviewed mental health practitioners to understand the implications of swift and drastic transfer of practices from in-person to online. The practitioners reported similar technological and usability problems that impacted their ability to establish rapport with clients. Outside of the COVID-19 context, in a systemic review of healthcare providers' attitudes towards telemental health in eight countries including Canada [36], the researchers similarly found that healthcare providers were concerned their services would be affected by insufficient technological infrastructure. In our study, the providers felt the therapeutic interaction was also affected by not having the opportunity to build rapport with clients and within the community. Providers highlighted the difficulties of service provision in communities with which they had no pre-established relationship prior to COVID-19 by emphasising the effectiveness of virtual counselling in communities where they have previously worked and built relationships. This, as suggested by David, could perhaps be

improved by establishing a continuum of services that allows practitioners to continue to build relationships after leaving the community, thereby eliminating some of the challenges being described. Although this would demand initial contact to be in-person, it does provide continuity of care when providers fly-out of the community. This, however, brings its own challenges as providers have concerns with not being physically present in the community. Similar to perspectives presented in our research, in their systematic review, 36, found that healthcare providers had safety and legal concerns regarding the inability to be physically present within a community, especially in cases of crisis or in circumstances that would require further action, such as transferring patients to a hospital [36]. For providers to feel supported in successfully adapting to telemental health services, connections to on-the-ground services and the community were deemed essential, highlighting the need to be familiar with the community and its resources. Although establishing a continuum of care was strongly encouraged by service providers we interviewed, there are broader potential implications that must be considered. The lack of infrastructure reported by [16], may not support virtual counselling while the provider is away from the community, and issues of privacy remain a concern. Furthermore, there is an additional cost to having providers and clients engage with a long-term continuum of services such as travel and accommodations. These barriers are ongoing concerns that must be met before effective implementation of a continuum of care. In an Australian study, [8] noted that the pandemic has highlighted the vulnerability of communities who rely on FIFO staff, and suggest a "well-funded, appropriately trained, stable and accessible health workforce in all remote communities" (pg. 4). While efforts are made to work towards stable and accessible workforces in remote communities, FIFO service provision will remain a crucial aspect of care for the foreseeable future for Inuit communities in northern Canada.

Perceived opportunities

In contrast to perceived challenges, the providers in our study also reflected on opportunities as a result of COVID-19. The drastic change to service delivery created space for adaptations including enhancements to the continuum of care by incorporating telemental health services, advancing platforms to facilitate the delivery of these services, and re-envisioning medical spaces to accommodate these additional services. These results are largely in line with Australian scholars' findings on perceived opportunities for telemental health as a result of COVID-19. They found that the virus has created increased potential for digital technology through improving accessibility and quality of mental health service provision [3,37]. [36] noted that clinician satisfaction with telehealth via videoconferencing in mental healthcare is positive, citing advantages such increasing access to care for patients in remote communities and saving time and money while increasing efficiency of services. These findings are in accordance with the results from our study who agreed that telemental health could provide many opportunities regardless of the difficulties that may arise.

Synergistic models of care

Although the advantages of telemental health services were highlighted by providers, 36,found that providers still preferred to conduct appointments in-person rather than through videoconferencing but noted that satisfaction level varied based on the type of services provided. Short-term consultations delivered via videoconferencing were deemed equivalent to face-to-face sessions, while establishing relationships for longer term care was found to be more difficult online. Our findings are in alignment with [36]. Indeed, the mental health service providers in this study found that telemental services can be effective given the current COVID-19 pandemic; however, it is critical to note that the providers in our study unanimously agreed that remote counselling should be used as a complementary service to their in-person services.

The need for synergistic models of care has been emphasised in the Canadian context with Indigenous populations in previous studies [Gibson et al., 20;21]. Other research that has been conducted in Canada with providers who deliver mental health services to Indigenous communities found that providing telemental health care to Indigenous communities is suitable for those living in rural and remote communities when provided in combination with in-person care [21]. [36] suggested the use of videoconferencing, especially in particular circumstances such as when access to services is limited. In these conditions, despite the challenges that may arise, the advantages outweigh the disadvantages according to providers included in the systematic review [36]. Providers in this study reported using a range of technology to support their clients in the North, including telephone counselling, videoconferencing, as well as direct or text messaging. Despite the challenges it has presented, the COVID-19 pandemic has created

opportunity for adaptations and growth for providers and the way in which services are delivered.

Study limitations

This study has several limitations. Given that the focus of this paper was on FIFO service providers' perspectives, we identify that the most important perspective should be the clients seeking care. It is imperative that mental health providers and policymakers for Inuit should, first and foremost, consult the communities and local government before applying results. Research on the perspectives of Inuit towards changing models of care is of the utmost importance and is essential to understand the applicability of FIFO services combined with telemental health strategies. While not the focus of the paper, certainly another limitation is the lack of consideration of local health workforce in Inuit communities. 8,described challenges faced by Aboriginal and Torres Strait Islander communities in Australia that, much like Inuit in remote Canada, rely heavily on FIFO staff. The authors called for a well-funded workforce based in all remote communities which may alleviate some challenges noted in this paper. For suggestions such as long-term counselling interventions to be effective, understanding clients' perspectives and health outcomes is crucial, and needs to be a future area of research. Further understanding of Inuit perspectives and needs must be addressed.

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

Conclusion

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

Disclosure of potential conflicts of interest

No potential conflict of interest was reported by the authors.

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