Evaluation of the Project Supporting the Development of Collaboration Agreements in Mental Health and Addictions Between First Nations Communities and Health and Social Services Centers (CSSSs)

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First Nations of Quebec and Labrador Health and Social Services Commission

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The use of the masculine gender in this document is intended to simplify the text, and is without prejudice against women.

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NOTE TO THE READER

This evaluation report documents the implementation and short-term effects of the project to develop collaboration agreements in mental health and addictions between non-treaty First Nations communities and health and social services centers (CSSSs)[1] for the period of March 2013 to March 2015. A final report taking into account the entire project will be submitted to Health Canada on March 31, 2016.

Since the project will be ongoing in 2015-2016, a sustainability plan has not yet been drafted. However, it is expected that discussions on the long-term viability of signed collaboration agreements and the support that could be offered by the FNQLHSSC in the future will be held during the coming year.

[1] For brevity, the term "collaboration agreements" will be used throughout this document to identify collaboration agreements in mental health and addictions between First Nations communities and CSSSs.

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LIST OF ACRONYMS

AHTF: Aboriginal Health Transition Fund

ANPSS: Algonquin Nation Programs and Services Secretariat

ASSS: Agence de la santé et des services sociaux *(health and social services agencies)*

CLSC: Centre local de services communautaires *(local community service centre)*

CRD: Centre de réadaptation en dépendances *(addiction rehabilitation centre)*

CSSS: Centre de santé et de services sociaux *(health and social services centre)*

FNIHB: First Nations and Inuit Health Branch (Health Canada)

FNQLHSSC: First Nations of Quebec and Labrador Health and Social Services Commission

HRO: Human Resources Officer

HSIF: Health Services Integration Fund

MSSS: Ministère de la Santé et des Services sociaux du Québec

NNADAP: National Native Alcohol and Drug Abuse Program

OCAP™: Ownership, Control, Access and Possession (of data)

PMP: Performance Measurement Plan

RHS: First Nations Regional Health Survey

RLS: Réseau local de services *(local health and social services network)*

UQAT: Université du Québec en Abitibi-Témiscamingue

WHO: World Health Organization

THE RESULTS IN BRIEF…

- Early in the project, there were a number of **community expectations**. On the one hand, community interveners expressed the need to better understand the services offered by the Quebec health and social services network and to have better access to training offered in the Quebec network. On the other hand, communities want improved communications with actors in the Quebec network. To achieve this, they expressed the need to establish more formal communication mechanisms, establish bonds of trust and improve the ways information is shared. Finally, the communities want better coordination between community services and those offered by the Quebec network. Improved collaboration and more effective teamwork with external partners would provide the population with better monitoring and continuity of care.
- From the outset, it appeared that the **complexity of the project** had been underestimated. Indeed, although negotiating collaboration agreements is a common approach in the Quebec health and social services network among facilities in the same RLS[2] or between facilities in different regions, this process is innovative between non-treaty First Nations communities and the CSSSs. This new way of proceeding for communities, challenged by the reciprocal lack of knowledge on the part of the Quebec network and the communities about each other, and the occasional non-compliance of the Quebec network in terms of its responsibility to provide services to First Nations people who come to their facilities, led to an underestimation of the time and labor required. In addition, the negotiation of collaboration agreements including both mental health and addiction services also raised a challenge since it required joining these two sectors that are currently still working in silos in a number of communities.
- The evaluation enabled the **elements that facilitated** the establishment of collaboration agreements to be clearly identified. The facilitating factor that seems most critical for a successful collaborative approach is related to the project manager at both local and regional levels. Indeed, the personal characteristics of the project manager in addition to his or her availability are key elements. It is clear that a proactive project manager who believes in the usefulness of the approach is a determining factor. The project manager must also have the necessary time available to devote to this project. In addition, the development of a collaboration agreement should be a priority for all actors concerned. A common understanding of the objectives and the process is also essential. Finally, previous positive experiences of collaboration with the Quebec health and social services network were a factor that facilitated the establishment of partnerships.
- The **challenges** facing communities are primarily related to technical and logistical problems such as the geographical remoteness of partners. It was difficult to have to conduct meetings by videoconference and to deal with the use of multiple languages. The high turnover of project managers, both from the communities and the CSSSs, significantly slowed the process. The context in

[2] The CSSS and its partners constitute a local network of health services and social services (RLS). Included are: family physicians, pharmacies, community organizations, private resources, institutions offering specialized and highly specialized services (hospitals, youth centres and rehabilitation centres) and partners from other sectors of activity (MSSS, 2014).

which the project took place was a decisive influence for some of the local discussion committees. The context of the communities and of the province was sometimes discouraging or slowed the process down. For example, the adoption of Bill 10 negatively influenced the work already underway. Another challenge was that many communities found it difficult to bring all the actors together at the same time. Finally, the fact that previous collaborations were inconclusive was an obstacle to implementing the approach.

- The **accompaniment** provided by the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) to communities was structured around three main roles, including facilitating a number of meetings, serving as a liaison between organizations and providing motivation to maintain people's involvement in the project. The accompaniment provided varied considerably from one community to another and was adjusted throughout the process to respond to community needs and the availability of the FNQLHSSC mental health advisor. An important moment in the accompaniment provided was the first visits to the communities and assisting their preparation for the regional meetings.
- **Cultural awareness** activities were offered to actors from the Quebec network. In order to do this, a partnership with the Université du Québec en Abitibi-Témiscamingue (UQAT) and the Algonquin Nation Programs and Services Secretariat (ANPSS) was established. The Piwaseha training initially set up as part of a project funded by the Aboriginal Health Transition Fund (AHTF) and, in its second iteration, the Wedokodadowiin training designed as a result of a grant from the Health Services Integration Fund (HSIF), were offered to interveners in the Quebec network from two Phase 1 regions. In all, nearly 200 interveners were contacted.
- As of March 31, 2015, two communities have completed the **signing of collaboration agreements** on mental health and addictions with the health and social services centre (CSSS) serving them.
- In addition to the negotiation of collaboration agreements, **other initiatives** arising from the discussion process have had short-term benefits and are directly linked to the project objectives. We note the establishment of new committees and round tables, the provision of clinical support by network interveners, the use of liaison forms and community visits for network interveners. The project was also an opportunity for a number of people to establish contacts with other organizations of the Quebec network operating in their area.
- In light of these results, the signing of a collaboration agreement appears as a **means and not as a final aim** of the project. Indeed, other initiatives led to the desired results of better collaboration and formal communication mechanisms.

INTRODUCTION

The disparities between the state of health of the First Nations and that of all Quebecers are of grave concern. The extent of mental health problems and related issues—suicide, substance abuse, violence, etc.—is equally so. The *Quebec First Nations Regional Health Survey 2008* (RHS) in particular revealed that 26.4% of First Nations adults have considered suicide during their lifetime and more than one quarter of adults have an elevated level of psychological distress according to the Kessler scale (K10). It should also be noted that 84.3% of adults identify alcoholism and substance abuse as the main difficulty that their community faces (FNQLHSSC, 2012).

In response to this situation, an immediate, collaborative and structured action was initiated, but still needs to be consolidated to achieve sustainable outcomes in First Nations communities. In 2011, the report on *Development of a Mental Health Service Organization Model Among the First Nations of Quebec,* a project funded by the AHTF, found that the comorbidity between mental health problems and addictions is rising and is a major concern of interveners working in the communities (FNQLHSSC, 2011a).

Along these lines, an initiative to improve the continuum of mental health and addiction services was initiated by the *Working Committee on Mental Health and Addictions for the Implementation of Protocols Related to Service Trajectories between the CSSSs and non-Treaty Aboriginal Communities of Quebec,*[3] consisting of representatives of the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC), the Ministère de la Santé et des Services sociaux du Québec (MSSS) and Health Canada. This committee has worked to develop a model collaboration agreement to support improved partnerships between health and social services centres (CSSSs) of the Quebec network and health centres in First Nations communities.

This project aims to address service insufficiencies in local communities to improve access and continuity of services in mental health and addictions. To achieve this goal, the project will support the implementation of local protocols between interested First Nations communities and the CSSSs of their territories and raise awareness among actors of the provincial network to First Nations realities. The project will contribute to the facilitation of referrals, knowledge transfer and improvement of access to professional resources for members of First Nations communities.

This report presents the results of the evaluation of the implementation and short-term benefits of the project for the period between March 2013 and March 2015. The first chapter provides a brief literature review focusing on a description of the organization of health services and social services in the provincial network and in First Nations communities, and the process related to the negotiation of collaboration agreements. The second chapter provides some context that includes an overview of the project to develop collaboration agreements and how it was originally designed to unfold. The third

[3] For brevity, the term "working committee" will be used throughout the document to refer to the *Working Committee on Mental Health and Addictions for the Implementation of Protocols Related to Service Trajectories between the CSSSs and non-Treaty Aboriginal Communities of Québec*.

chapter discusses the methodology used to evaluate the project's implementation and short-term effects. The fourth chapter presents the main results. A summary with recommendations supported by the results follows, and a conclusion closes the report.

LITERATURE REVIEW

This chapter reviews the literature covering various elements related to the project supporting the development of collaboration agreements in mental health and addictions between First Nations communities and their respective CSSSs. This literature review is designed to provide support for the project and to identify various aspects that can guide the evaluation.

1. Mental health and addictions among the First Nations

a. What the statistics tell us

As discussed in the introduction, the available data on the state of mental health and use of substances that can lead to addiction among the First Nations demonstrate the urgency of taking action. The data obtained through the last phase of the *Quebec First Nations Regional Health Survey 2008 (RHS)* reveal that a large percentage of First Nations adolescents and adults are living through situations that place their mental health in jeopardy.

According to the psychological distress index, 25.3% of adults presented a high index. Nearly one in ten adolescents reported feeling quite a bit or a lot of stress. The results of the survey show that 19.2% of adolescents reported having had suicidal thoughts, a percentage that rises to 26.4% in adults. In addition, 7.7% of adolescents and 14.6% of adults reported having already attempted suicide during their lifetime (FNQLHSSC, 2013a). Province-wide, 4.4% of Quebec adults reported having attempted suicide during their lifetime (MSSS, 2012).

Regarding the use of alcohol and drugs, the RHS shows that 68.2% of respondents aged 12 and up consumed alcohol in the year preceding the survey. The 15 to 34 age bracket includes the largest percentage of drinkers. In terms of heavy drinking (five or more drinks on the same occasion), 55.2% of respondents reported having consumed this amount at least once in the last twelve months and 40.4% at least once a month. In terms of the entire population, 82.9% of Quebeckers aged 12 and up drank and 18.5% consumed excessive alcohol at least once in the last year (Institut de la statistique du Québec, 2011).

As for drug use, 37.2% of those 12 and older reported consuming at least one type of drug in the last twelve months. Among consumers, daily consumption of cannabis and cocaine—the two most consumed drugs among survey respondents—reached 35.5% and 8.9% respectively (FNQLHSSC, 2013b).

A comparison of RHS data from 2002 and 2008 in the 12 and over age bracket shows that there was an increase of daily cocaine use (0.4% of respondents in 2002 vs. 8.9% in 2008) and daily consumption of cannabis (29.3% in 2002 and 35.5% in 2008).

Different elements found in the RHS 2008 also give clues about gambling problems among the First Nations of Quebec. The results show that 16.8% of respondents 18 years and older have borrowed money to gamble and 8.4% of respondents have experienced personal or family financial problems due to gambling (FNQLHSSC, 2013b).

In terms of comorbidity between mental health problems and those of addictions, the results of the RHS 2008 show a higher prevalence of drug and alcohol use among adults whose psychological distress index is high. There are twice the number of drug users among adults who have attempted suicide (FNQLHSSC, 2013b).

b. The definition of mental health from two points of view

The definition of mental health differs according to the perspective in which we place ourselves. For the World Health Organization (WHO):

> "Mental health is not just the absence of mental disorder. It is defined as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." (WHO, 2007)

For the First Nations, the following definition of mental health reflects a unique worldview:

> "Mental health (wellness) is a state of harmony and balance based on personal self-esteem and dignity, which implies positive physical, emotional, mental and spiritual interactions between the individual and his or her environment that is based on a cultural identity well defined by values and beliefs." (FNQLHSSC, 2001, p. 6—unofficial translation)

Notions of culture, identity and territory are central to the First Nations concept of good mental health. It should be noted that the services available in First Nations communities take these notions into account. For example, traditional healing methods such as forest retreats, sweat lodges and sharing circles are frequently used by interveners working in the communities.

c. Mental health, addictions and the intergenerational transmission of trauma

An explanation for the high proportion of First Nations people struggling with substance abuse problems can be partly found in the intergenerational transmission of trauma caused by the residential schools. The First Nations vision of a cyclical world explains the interrelationship between these elements:

> "A central belief in an Indigenous world view is that all things are interconnected: the past, present, and future; people and all of creation; individuals and their families, communities, and nations; and within each person the body, mind, heart, and spirit." (Aboriginal Healing Foundation, 2007, p. 13)

Thus, according to this worldview:

> "The roots of addictive behaviours are found in the impacts of this mass psychological trauma and these human rights violations. Unexpressed and unhealed, these impacts have manifested in social disorders. Cultures that had never before seen youth suicide, addictive behaviours, substance-abuse, or physical and sexual abuse began a spiral into tragedy." (Aboriginal Healing Foundation, 2007, p. 17)

Other factors have been singled out as being related to the high prevalence of drug and alcohol use among the First Nations, such as poverty, lack of housing and racism (National Collaborating Centre for Aboriginal Health, 2009).

2. The organization of services in First Nations communities

The organization of health services and social services in non-treaty First Nations communities is primarily the responsibility of First Nations organizations and the federal government. In most communities, the band council assumes responsibility for providing certain services, while funding of these services is a federal responsibility.

The community health centres, considered the gateway to the health system in the communities, mainly offer community health programs focusing on health promotion and disease prevention, services considered first-line.[4] Nurses in health centres are expected to provide the full-range of care required, given the limited presence of a doctor in many of these organizations. In communities located in isolated areas or those remote from a hospital or a local CLSC, 24/7 emergency care is also available to the population.

In treaty communities, namely those of the Cree, Inuit and Naskapi, health services are provided by the provincial government. Aboriginal people living in urban areas and those outside the community also receive services from the provincial government (Secrétariat aux affaires autochtones, 2011).

Second- and third-line health and social services, for all First Nations and Inuit living in Quebec, are provided by the Quebec health and social services network (MSSS, 2007). Aboriginals living in the community must travel to access these services. Some communities have developed agreements to provide certain services in relation to the protection of minors.

a. Mental health and addiction services offered in the communities

Like physical health services, mental health services in First Nations communities are first-line services. They are provided in most communities by a range of interveners from different sectors and not only by the interveners from the community health centre. Many communities have preventive first-line social services, NNADAP (National Native Alcohol and Drug Abuse Program) agents, human resources officers (HRO), other interveners directly or indirectly involved in mental health or substance abuse and some family homes.

In addition to these services provided in the community, six treatment centres for First Nations, specialized in the treatment of alcoholism and substance abuse, are funded by Health Canada. Five of these centres are aimed at an adult clientele and one meets the needs of clients from 12 to 17 years of age. In addition, agreements exist between communities and youth centres in the Quebec network to obtain services for young people, as stipulated by the *Youth Protection Act.*

In terms of more specialized (second- and third-line) mental health and addiction services, members of the First Nations living in the communities must turn to the services managed by the provincial network.

[4] The first line of services corresponds to general medical and social services. The second line is defined as the provision of specialized services. The third line includes specialized medical and social services (MSSS, 2004).

This referral process between facilities is one of the issues that needs to be discussed in the context of the implementation of collaboration agreements between First Nations organizations and those of the Quebec network.

3. The population health approach of the MSSS and services offered to the First Nations

All First Nations and Inuit in Quebec, regardless of their place of residence, are covered by the *Health Insurance Act* and the *Hospital Insurance Act.* In addition, they have access to health services and social services offered by the Quebec network, as do all residents of Quebec. Since the federal government is responsible for the health of Aboriginals living in the community, the provincial government cannot provide services in these areas other than medical care funded by the Régie de l'assurance maladie du Québec, with the exception of specific agreements with local authorities (MSSS, 2007).

The Quebec government has assumed two major responsibilities to the Aboriginal population (MSSS, 2007):

1) *Responsibility for public health:* accompaniment provided to communities to provide immunization, monitoring of diseases subject to obligatory reporting, communication about risk situations (e.g., epidemics), providing expertise through knowledge transmission about health promotion and prevention;
2) *Responsibility in order to improve the continuity and complementarity of services*: creation of mechanisms to ensure better continuity of service between those offered in the community and those offered by network facilities (establishment of protocols), transfer of expertise and knowledge (e.g., training of community personnel).

Quebec has the responsibility to provide Aboriginals equal access to its first-, second- and third-line services, as it does for all Quebecers.

4. Existing agreements between First Nation health centres and CSSSs

In relation to the provincial government's responsibility to improve the continuity and complementarity of services, two First Nations communities have undertaken in recent years a negotiation process leading to the signing of a collaboration agreement with their respective CSSSs. These protocols were designed to ensure a better continuum of mental health services for their people. The two communities, Manawan and Opitciwan, signed protocols in 2010 providing better sharing of information and expertise between organizations. A liaison committee ensures compliance of the agreement and the establishment of other committees to support the development of services is also envisaged.

Besides these two protocols, other agreements have been signed between First Nations communities and the Quebec network to ensure continuity in the delivery of services to the members of their communities. Most are service agreements and not collaboration agreements. For example, the communities of Listuguj and Gesgapegiag have an agreement with their CSSSs to improve communication and ensure continuity of services between the hospital emergency department and the health centres of the two communities for patients with psychosocial or mental health problems. Similarly, the CSSS in Mingan, in partnership with the two First Nations communities it serves,

Ekuanitshit and Nutashkuan, has worked to establish an agreement for the provision of psychosocial services.

5. Favourable conditions for the establishment of a collaboration agreement between the two organizations

The development and maintenance of a partnership are demanding modes of action that require the sharing of knowledge and resources. This is an ongoing process that may involve modification of activities, services or operations of the organization (Direction de santé publique – Régie régionale de la santé et des services sociaux de Montréal-Centre, 2003).

As part of this project, in addition to the establishment or enhancement of partnerships between communities and their CSSSs, the project involves a negotiation process to reach a collaboration agreement that is satisfactory and realistic for both parties. Various elements influence this type of process.

Author Michael Coyle (2011) established the various determinants that influence any process of negotiation between two parties. A major element that can influence this process is the existence of a power relationship between the two parties. This power relationship, often at the expense of the First Nations, creates an imbalance of power and weakens their ability to influence the other party.

On the other hand, the creation of a dynamic of sufficient participation that allows for exchange, the adoption of a principle of equality of powers and the combining of the knowledge of all the actors involved, are favourable conditions for quality collaborative actions (Direction de santé publique – Régie régionale de la santé et des services sociaux de Montréal-Centre, 2003).

A successful partnership is brought to fruition in seven stages according to the experience of the establishment of a partnership between a CSSS and an addiction rehabilitation centre (CRD): 1) come together and assume a strategic position; 2) conduct an assessment of the situation; 3) build on other organizations' success at making change; 4) provide a forum for exchange, discussion and making specific decisions related to the partnership project; 5) develop a common vision on key concepts; 6) choose a number of actions to be undertaken at the start; and 7) create a favourable context for involving actors in the change process (Centre de réadaptation en dépendance *Le Virage* and CSSS Pierre-Boucher, 2012). So the focus must be placed on dialogue and exchange to promote change.

The regional evaluation of the *Aboriginal Health Transition Fund* revealed common challenges experienced by several projects attempting to develop partnerships. These barriers relate to the difficulty of getting the actors to meet, language, geography, the time required to create links, staff turnover, lack of shared vision and different operating rules from one organization to other (FNQLHSSC, 2011b).

THE PROJECT SUPPORTING THE DEVELOPMENT OF COLLABORATION AGREEMENTS

1. The history of the project

A project coordinated by the FNQLHSSC, which began in 2009 under the *Aboriginal Health Transition Fund* (AHTF), led to the development of an organizational model of mental health services to improve the continuum of services[5] available for First Nations people living in the communities (FNQLHSSC, 2011). The project also resulted in the finding that comorbidity between mental health and addiction issues is widespread in the communities and represents an intervention priority for actors working in the communities.

In keeping with this project, a working committee consisting of representatives of the FNQLHSSC, MSSS and the FNIHB was created. The committee was mandated to work on the issue of continuity and accessibility of mental health and addiction services. But in any event, no funds were then available to implement the recommendations from the FNQLHSSC's report.

The announcement of possible funding through the *Health Services Integration Fund* (HSIF), a new initiative of Health Canada, presented an opportunity. It became possible to put forward a *project supporting the development of collaboration agreements in mental health and addictions between First Nations communities and their respective CSSSs*. A project application was submitted to Health Canada and the funds were made available. The project got underway in March 2012 and continued until March 2015. The FNQLHSSC was tasked to oversee the implementation with the collaboration of partners involved in the working committee.

2. The Health Services Integration Fund (HSIF)

This project is funded by the *Health Services Integration Fund (HSIF)* and administered by the General Directorate of the First Nations and Inuit Health Branch (FNIHB) of Health Canada. This federal initiative follows the *Aboriginal Health Transition Fund* (AHTF). This five-year fund, announced in 2010, was implemented at the regional level but also supported at the national level. Across Canada, 70 projects were approved and will receive funding until March 2015 and, in some cases, projects have until March 2016 to complete their activities.

The objectives of the HSIF include facilitating the integration of health services funded by the federal, provincial and territorial governments, establishing multipartite partnerships to improve access to health services and strengthening the participation of First Nations and Inuit in the design, delivery and evaluation of health programs and services.

It should be noted that in addition to funding received by the HSIF, the MSSS has also contributed financially to the project, for example by supporting regional organizations of the Quebec health network that are participating.

[5] A full continuum of care includes the following services: primary prevention, secondary prevention, assessment and referral, diagnosis, precare, tertiary intervention, aftercare and booster programs (Aboriginal Healing Foundation, 2007).

3. The project's objectives

The long term objective of this project is to improve access and continuity of mental health and addiction services for the First Nations of Quebec. To achieve this ultimate goal, the project aims to support in the short- and medium-term, the implementation of collaboration agreements between interested First Nations communities and CSSSs and raise the awareness of the provincial health and social services network of the reality of the First Nations. The project aims to facilitate referral processes and the transfer of knowledge between organizations.

The project to improve collaboration between organizations is in line with the *Quebec First Nations Health and Social Services Blueprint 2007-2017, Closing the gaps... Accelerating change* (FNQLHSSC, 2007). The Blueprint points out that poor access to social services in many First Nations communities in Quebec means that a significant number of individuals do not receive the services to which they are entitled. It also emphasizes the need to create a continuum of social services that ensure that the First Nations can benefit from services adapted to their needs (FNQLHSSC, 2007).

4. The partnerships created

In 2011, a working committee was formed to implement the project, to develop a model collaboration agreement and to monitor the progress of the work.

Each of the partners involved in the working committee exercised a different role. The mandates assigned to each of them, as set out early in the project, are described in Table 1.

Table 1. Mandates of the partners of the working committee as part of the collaboration agreements project

Organization	Specific mandates
First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC)	○ Serve on the working committee; ○ Inform and liaise with communities and with other partners as appropriate; ○ Provide accompaniment to communities in their negotiations with their CSSSs; ○ Collaborate with communities in awareness raising activities for the actors of the provincial network; ○ Perform the evaluation.
Ministère de la Santé et des Services sociaux du Québec (MSSS)	○ Serve on the working committee; ○ Provide the necessary knowledge concerning the organization of mental health and addiction services in Quebec; ○ Inform and liaise with the Quebec health and social services network as well as other partners as appropriate; ○ Collaborate in awareness raising activities for the actors of the provincial network; ○ Participate in the evaluation of the project.
First Nations and Inuit Health Branch (Health Canada), Quebec Region (FNIHB)	○ Attend meetings of the working committee when required; ○ Keep members of the working committee informed of developments in its programs or services relevant to the project; ○ Keep its employees with relevant responsibilities for the project informed; ○ Consult as needed and obtain approvals that may be required on the part of Health Canada.

Overall, members of the working committee have the responsibility to meet regularly to ensure project monitoring. These meetings serve to update the project's progress, prepare various visits to communities, validate information transmitted to communities and to CSSSs and settle any difficulties which may arise during the implementation of the project.

As described in its mandate, the committee consists of the following members: four representatives of the MSSS (Direction des affaires autochtones, ethnoculturelles et régions nordiques; Direction de la santé mentale; Direction des dépendances et de l'itinérance; Direction générale de santé publique), four representatives of the social services sector of the FNQLHSSC (violence and suicide prevention advisor, mental health advisor, addictions advisor and first-line child and family social services advisor) as well as three people from Health Canada (manager of community programs, regional coordinator of the mental wellness sector and regional coordinator of the addictions sector).

Throughout the committee's mandate, its composition can vary and other resource persons from the FNQLHSSC or MSSS may occasionally be required to participate in one or more meetings to provide their expertise to the committee.

The roles of the committee are well described in the terms of reference adopted by its members: 1) collect the necessary information so that each member of the committee can inform its respective networks of the benefits associated with the establishment of collaboration agreements; 2) support the First Nations communities and organizations in the establishment and application of these protocols; 3) provide advice and counsel to First Nations communities and organizations that decide to evaluate the implementation of the protocols, as necessary.

Besides the partnership created through the work of the committee, the project also had as its objective the development and consolidation of partnerships between First Nations communities and CSSSs taking part in the negotiation process. From the outset, it was recognized that the existing collaborations between communities and their CSSSs differed and the workload required to gather everybody around the same negotiating table would differ from one case to another. So while some communities have good links with their respective CSSSs, other communities have little contact with the CSSS of their territory. The creation and maintenance of these partnerships are therefore major challenges for the project and an indicator of the likely success in concluding an agreement favourable to both parties.

5. The operationalization of the project

The next section describes how the operation of the project was conceived during the planning stage, before communities and CSSSs were approached to participate. In the chapter on the results obtained (chapter four), the project as it really functioned will be presented. The reader will note the changes to the project during implementation as well as the reasons for them.

a. The implementation phases and the number of participating communities

When the project was submitted, it was planned that the FNQLHSSC would provide accompaniment to three communities a year in a negotiating process with their CSSS (for a total of nine communities over the three years of the project). In 2012, the development of collaboration agreements became a ministerial orientation. It was therefore agreed to offer the project to all Quebec First Nations communities wishing to participate.

Two administrative regions were targeted to begin the implementation of the project, Abitibi-Témiscamingue and the Côte-Nord (Phase 1). These two administrative regions were selected because they had certain favourable conditions for the development of these collaborations: they both comprise a significant number of First Nations communities and both have had positive experiences of communities and CSSSs collaborating. In addition, the health and social services agencies (ASSS) of these two regions agreed to take part in the process when contacted by the MSSS.

It was anticipated that the activities related to the negotiation of agreements in these two regions would begin before March 31, 2013. In February 2013, all First Nations communities in both regions were invited to undertake a process of negotiation with their respective CSSSs. As a result of this first

invitation, 11 communities out of a possible 17 showed an interest in taking part in the project's first phase (Tables 2 and 3).

Table 2. List of First Nations communities of Abitibi-Témiscamingue Interested in February 2013 in participating in a negotiating process and their respective CSSSs

Community	CSSS
Pikogan	CSSS des Eskers
Lac-Simon	CSSS de la Vallée-de-l'Or
Kitcisakik	
Eagle Village	CSSS du Témiscamingue
Timiskaming	

Table 3. List of First Nations communities of the Côte-Nord interested in February 2013 in participating in a negotiating process and their respective CSSSs

Community	CSSS
Pessamit	CSSS de Manicouagan
Ekuanitshit	CSSS de la Minganie
Nutashkuan	
Unamen Shipu	CSSS de la Basse-Côte-Nord
Pakua Shipi	
Uashat mak Mani-Utenam	CSSS de Sept-Îles

First Nations communities in other administrative regions of Quebec were informed in September 2013 about the opportunity to participate in the project during the fiscal year 2014-2015 (Phase 2). In February 2014, the FNQLHSSC mental health advisor contacted each of these communities to confirm their interest in participating in the project. Six communities subsequently expressed interest (Table 4).

Table 4. List of First Nations communities in other administrative regions of Quebec interested in February 2014 in participating in a negotiating process with their respective CSSSs during the fiscal year 2014-2015

Community	Administrative region
Wendake	Capitale-Nationale
Kanesatake	Laurentides
Gesgapegiag	Gaspésie–Îles-de-la-Madeleine
Listuguj	
Mashteuiatsh	Saguenay–Lac-Saint-Jean
Kitigan Zibi	Outaouais

b. The accompaniment provided to the communities

The FNQLHSSC is responsible for providing accompaniment to communities that request it throughout the negotiation process with their CSSS. This accompaniment is intended to be flexible from one community to another and is not in any case imposed. A schedule of meetings was drafted by the FNQLHSSC mental health advisor and was presented to all project partners, to give an indication of the type of process proposed for the establishment of a collaboration agreement. An overview of this schedule is described in the following table (Table 5).

Table 5. Tentative schedule of meetings planned for the establishment of collaboration agreements

	Participants	Objectives of the meeting
Meeting 1 *Presentation of the project*	Representatives of the community	○ Present the project and the FNQLHSSC's proposed provision of accompaniment to the communities; ○ Clarify roles and expectations (FNQLHSSC and communities); ○ Listen to the needs and challenges presented by the communities.
Meeting 2 *Community preparedness*	Directors of health/social services and other representatives of the community	○ Support the communities in defining their needs and priorities and designate persons who will participate in the process of establishing the collaboration agreement; ○ Prepare for meeting 3.
Meeting 3 *Meeting with the partners*	Representatives of the community, the CSSS, the ASSS, the MSSS and the FNQLHSSC	○ Review the project context and objectives; ○ Clarify the roles of the different partners; ○ Present the organization of services in mental health and addictions, the realities and needs; ○ Clarify the implementation steps (regional and local).
Meeting 4 *Learning about each other (ongoing)*	Representatives of the community and the CSSS	○ Visit the organizations and teams, meet and exchange (communities and the CSSS); ○ Validate the needs for information and for raising awareness (communities and the CSSS); ○ Present the CSSS's services and trajectories in mental health and addictions.
Meetings 5-6-7 *Process of establishing a collaboration agreement*	Representatives of the community and the CSSS	○ Develop a common vision for the creation of a collaboration agreement and identify ways to make it happen (e.g., implementation committee, work plan, cultural awareness, training, etc.).
Meeting 8 *Implementation of the collaboration agreement and monitoring*	Representatives of the community and the CSSS	○ Identify ways to monitor the implementation of the collaboration agreement and make adjustments as needed.

Please note: The number of meetings presented in this schedule is indicative only, as are the objectives of each of the meetings.

Also according to their desires, participating First Nations communities can receive accompaniment by the FNQLHSSC mental health advisor at any of the meetings or throughout the negotiation process. This accompaniment can be provided remotely, by phone, email or videoconference, or the mental health advisor can travel to attend meetings. Other partners involved in the working committee may also be called upon to provide support to communities.

c. The model collaboration agreement developed by the working committee

One of the mandates of the working committee was to develop a model collaboration agreement to guide the communities and CSSSs in their negotiations. This model agreement can be found in the appendices of this report (Appendix 1).

> As part of the project, the working committee proposes that local organizations (CSSSs and First Nations health centres) establish collaboration agreements and not service agreements. By collaboration agreement, we understand a commitment with the objective of improving communication channels between organizations to improve access to and continuity of services. A service agreement is more focused on an exchange of services or the provision of a service in exchange for remuneration.

The model collaboration agreement represents a base designed to be a starting point for negotiations. It is not imposed on the organizations, who are free to chose whether or not to use it and can adapt it according to their needs and realities. The model collaboration agreement was written in the perspective of facilitating the discussion process and ensuring that the partners have a clear idea of the type of items that can be included in their agreement. To produce the model, the working committee drew from agreements signed in 2010 by the communities of Manawan and Opicitiwan with their respective CSSSs.

The model agreement, in addition to having been validated by various resource persons of the MSSS and the FNQLHSSC, was presented and approved by the ASSSs of the two regions initially involved in the project (Abitibi-Témiscamingue and Côte-Nord) and the health and social services directors of the Phase 1 communities.

THE METHODOLOGY OF THE EVALUATION

1. The mandate of the evaluation

The mandate to conduct the evaluation of the project was given to the research sector of the FNQLHSSC by the social services sector of the FNQLHSSC. It is a requirement that all HSIF funded projects must undergo an evaluative process. An evaluation framework has thus been provided by Health Canada for all HSIF-funded projects. The evaluation design was developed in collaboration with the mental health advisor responsible for the project to meet the needs expressed by the social services sector. The working committee was also asked to validate the evaluation specifications and ensure that the evaluation would respond, at least in part, to its own concerns.

It should be noted that the MSSS has also set up an evaluative approach to this project. The evaluation design, the tools that were developed and the results of the evaluation were thus also shared with the Direction de l'évaluation of the MSSS.

2. Evaluation objectives and questions

The evaluation's objective is to understand the process of establishing new collaboration agreements between health centres in First Nations communities and the CSSSs, and to document the short-term effects of the implementation of these agreements.

Considering that the project to support the development of a continuum of mental health and addiction services has accepted the mandate to provide accompaniment for the creation of new collaboration agreements between First Nations communities and the CSSSs by formalizing service trajectories, the evaluation of the project has six specific objectives:

- Document the implementation of new collaboration agreements;
- Identify the factors that facilitated or hindered the implementation of collaboration agreements, and the solutions put in place to overcome these barriers;
- Measure the effectiveness and sustainability of the partnerships created for the project;
- Document the satisfaction of interveners in the communities in relation to the process of creating new collaboration agreements;
- Document the support provided by the FNQLHSSC to the First Nations involved in the project;
- Identify the initial impacts of the project on the continuum of services offered to people in First Nations communities.

For each of these objectives, more specific evaluation questions were developed (Table 6).

Table 6. Evaluation objectives and questions

Objectives of the evaluation	Questions of the evaluation
Document the implementation of new collaboration agreements	○ What were the steps carried out to implement the new collaboration agreements? ○ Were the steps that were originally planned carried out? ○ What resources were allocated for the implementation of these agreements (financial, human and material) and who provided them?
Identify the factors that facilitated or hindered the implementation of collaboration agreements, and the solutions implemented to overcome these barriers	○ What elements facilitated the implementation of collaboration agreements? ○ What elements hindered the implementation of these agreements? ○ What solutions were put in place to overcome the difficulties encountered during the implementation process of these agreements?
Measure the effectiveness and sustainability of the partnerships created for the project	○ Were the partnerships created during the project sustainable? ○ What were the difficulties in creating and maintaining partnerships?
Document the satisfaction of interveners in the communities in relation to the process of creating new collaboration agreements	○ Were the community interveners satisfied with their participation in the creation of new collaboration agreements? ○ According to the interveners, how did the project benefit the people of the communities?
Document the support provided by the FNQLHSSC to the First Nations involved in the project	○ What form did the support offered by the FNQLHSSC to the communities take? ○ What were the impacts of this support on the negotiation process between the communities and the CSSSs?
Identify the initial benefits of the project on the continuum of services offered to people in First Nations communities	○ What are the short- and medium-term impacts of these agreements on the services provided to First Nations?

3. The type of evaluation conducted and the approaches used

To meet the fixed objectives, an implementation evaluation was conducted. This type of evaluation is used to determine the differences between what was originally planned and what was actually implemented. It also documents the elements that had either positive or negative influences on the implementation.

In terms of the approaches advocated, the evaluation was conducted at first in a formative manner. In effect, it was carried out on the basis of feedback on the preliminary results from the regional actors

coordinating the project. This approach enables all participants to make adjustments to meet the needs and for the research agent to better contextualize the results in light of the information provided by the project managers that are in contact with the communities as well as information provided by the actors from the provincial network. In this same vein, the evaluation undertaken is collaborative because the regional actors (the working committee and mental health advisor) were asked to give their views on the evaluative process. It is recognized that this appreciation of the participation of actors leads them to use more of the evaluation's findings and recommendations.

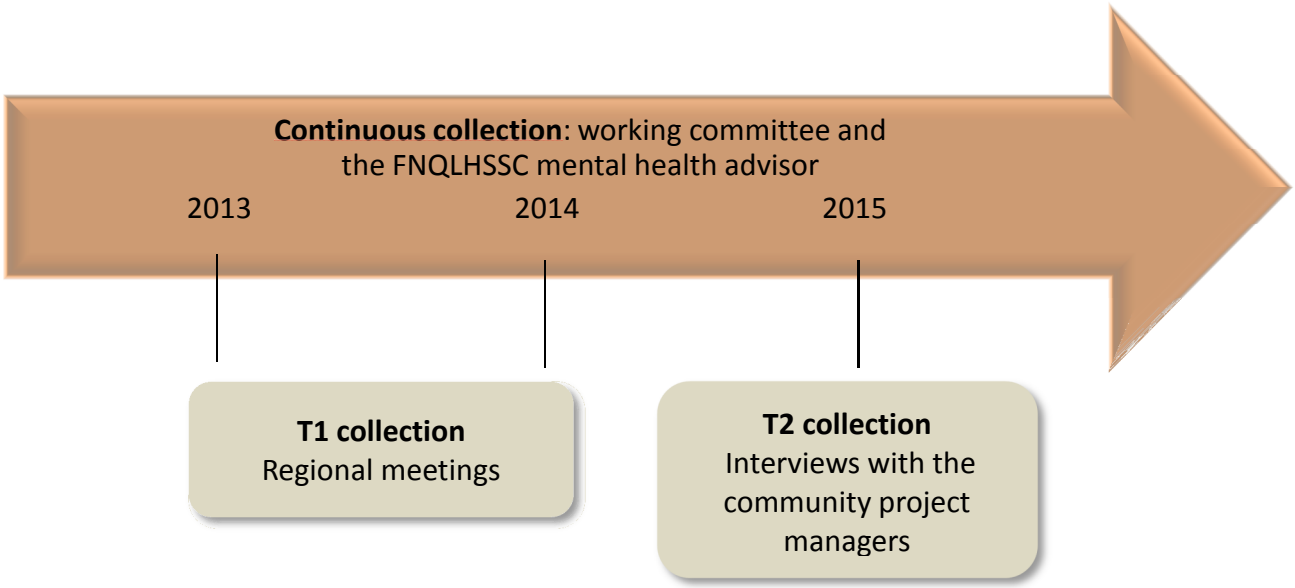
It should be noted that in the framework of this project, other concerned actors, including community interveners and local actors from the Quebec network, were not asked to participate in the evaluation as were the regional actors. Indeed, the number of these actors, the difficulty of reaching the actors of the Quebec network and the evaluation's limited resources prevented the evaluation from being fully participatory. However, the research agent was able to assume that the regional actors were familiar enough with the concrete situation to ensure that the evaluation would be able to meet the needs and demands of the communities.

4. The evaluation plan

Continuous data collection was conducted with the FNQLHSSC mental health advisor and with the working committee composed of the three regional project partners. This enabled information to be gathered on the accompaniment provided to communities and helped the research agent to monitor the progress of the implementation of the project and to observe the changes that were made and the reasons for them. In addition, the research agent attended several meetings held between the FNQLHSSC mental health advisor and community project managers.

To collect all the necessary data and best meet the objectives, ad hoc data collections were also carried out (*time 1* and *time 2*). The *time 1* (T1) collection corresponds to regional meetings held with the communities and the Quebec network in order to present the project and start the negotiation processes. These meetings took place in autumn 2013 for the regions of the Côte-Nord and Abitibi-Témiscamingue and fall 2014 for other administrative regions. The *time 2* (T2) collection was held in winter 2014-2015 and corresponds to a collection of data from key community actors who participated in the negotiation process leading to the signing of a collaboration agreement with their CSSS. This collection aimed to document the satisfaction of community interveners about the project's progress as well as the short-term impact of the implementation of these new agreements. The figure below displays the different data collection periods planned over the course of the evaluation (Figure 1).

Figure 1. Data collections in the context of the project supporting the development of collaboration agreements between First Nations communities and their respective CSSSs



A performance measurement plan (PMP) was drafted and reflects the expected course of the evaluation, and what was achieved. It is available in the appendices (Appendix 2).

5. The data collection methods used

To achieve the above-mentioned objectives, interviews, participant observations and document analyses were conducted.

a. Interviews conducted

Throughout the project, regular monitoring in the form of individual interviews was carried out by the FNQLHSSC mental health advisor. These interviews allowed the research agent to monitor the progress of the project, to stay informed about the local approaches being pursued and to understand the changes made to the project.

An interview was conducted with the two project managers of a community taking part in the negotiation process in January 2015. It was designed to provide an understanding of the experience of these and to document the other initiatives put in place during the process. Other project managers were approached, but no other interviews were conducted to this point. A collection of data from this group of key actors is planned for the coming year.

b. Participant observations at various meetings

The research agent attended all meetings of the working committee. Participation in these meetings enabled the agent to have access to complete project updates, and to understand the regional mechanisms set up to facilitate the implementation at the local level. The agent also attended two regional meetings held in the fall of 2013 and one that occurred in the fall of 2014, which aimed to present the project to all concerned actors and to offer everyone a chance to introduce themselves and

express their needs and expectations of the process. In addition, participant observations were conducted by videoconference at several meetings of a local committee.

c. The analysis of the documentation produced by the project

Various project documents were consulted, including minutes of meetings and follow-up tables compiled by the FNQLHSSC mental health advisor.

6. The analysis of the data collected

The data collected as part of this evaluation are essentially qualitative. Content analysis was used to analyze them based on the initial objectives and the performance measurement plan that was conducted. This information processing strategy is based on deduction and inference. The aim is to analyze the data corpus by identifying the different concepts while keeping in mind the contextual elements.

Validations with the FNQLHSSC mental health advisor enabled the research agent to refine the analysis with the addition of organizational and contextual elements.

7. The relevance of evaluating this project

The evaluation of the project supporting the development of collaboration agreements between First Nations communities and their respective CSSSs will enable different groups of actors to gain relevant knowledge.

a. The relevance of the evaluation for the member organizations of the working committee

For the three organizations represented on the working committee (FNQLHSSC, MSSS and Health Canada), the evaluation process itself as well as the results are relevant. The participation of these actors in the entire evaluation process enables them to be fully informed of the steps taken and to be able to use the results emerging from different data collections. In this context, an update of the evaluation is carried out at each meeting of the working committee. In addition, a regular follow-up is conducted with the FNQLHSSC mental health advisor.

The results of the evaluation will enable regional actors to obtain knowledge about postures of accompaniment facilitating the process of negotiating agreements, lessons learned that can be used in similar processes leading to signed agreements between First Nations member organizations and non-member organizations, as well as elements that can influence this process. The evaluation also enabled these regional organizations to adjust their interventions as the project proceeded in order to provide optimal accompaniment to the communities and to the facilities of the provincial network involved in the negotiations.

b. The relevance of the evaluation for First Nations communities

From the point of view of the communities, the results of the evaluation will provide an opportunity for them to share their experiences of the project. The evaluation report will thus be able to be used by all First Nations communities in the Quebec region, whether or not they are participating in the project

developing collaboration agreements. The lessons learned from this project will guide the First Nations communities in the establishment and consolidation of partnerships with the Quebec network.

For the communities involved in the evaluation, it is an additional opportunity to be in contact with an evaluative process and eventually to integrate this kind of approach into their internal procedures.

8. The limits of the evaluation

Given the limited financial resources and the firm deadlines for completing the evaluation of this project, the research agent had to produce the evaluation with certain limitations and some challenges.

Thus, the evaluation could not take into account the experience of all the communities and actors involved in the project. However, as a result of regular monitoring in the form of individual interviews with the FNQLHSSC mental health advisor and participant observations conducted in the working committee, the research agent was able to stay informed of the work done in the communities taking part in a negotiation process.

Again because of the limited resources, but also due to changes made over the course of the project, the evaluation questions that the research agent had determined were restricted. Indeed, certain project activities had to be evaluated less exhaustively.

Despite these limitations, the results of this evaluation will enable the reader to grasp the dynamics surrounding the planning and implementation of the project, and to understand the impact that the establishment of new collaboration agreements has had. It should be noted that the results presented are not generalizable to all communities, but still offer a good overview of the achievements and challenges that could be experienced over the course of similar projects.

9. The ethical considerations

A number of methods were developed as part of this evaluation to ensure it was conducted ethically and in compliance with the various principles governing research among the First Nations of Quebec.

Each community participating in a collaboration agreement negotiation process was approached in order to ascertain their interest in participating in the project evaluation. An information note was thus sent to the health directors and directors of social services in the communities. Free and informed consent of all persons asked to participate in this evaluation was also obtained. Individual consent forms were developed and all participants were informed about the fact that their participation was voluntary and that they could withdraw from the evaluation process at any time, and without any prejudice.

All information collected will remain confidential and no raw data will be made public. Finally, all the collected data will be kept under lock and key at the FNQLHSSC for five years and destroyed thereafter in an appropriate way.

a. The First Nations Research Protocol and the OCAP™ principles

The evaluation of this project was conducted in accordance with the *First Nations of Quebec and Labrador Research Protocol* of the AFNQL (2014) and OCAP™ (the collective **O**wnership of information by

members of the First Nations, the **C**ontrol of research processes and the information gathered, the **A**ccess to the information and the data and physical **P**ossession of the data).

b. The validation of results

The information in this report has been validated by key actors who participated in the project, and to ensure that the information presented is consistent with the reality of the different partners.

THE RESULTS OF THE EVALUATION

This chapter presents the results of the evaluation. It addresses the issues dealt with by the working committee, the project development, the accompaniment provided and the short-term benefits of the project.

As stated above, the six objectives of the evaluation were:

- Document the implementation of new collaboration agreements;
- Identify the factors that facilitated or hindered the implementation of collaboration agreements, and the solutions implemented to overcome these barriers;
- Measure the effectiveness and sustainability of the partnerships created for the project;
- Document the satisfaction of interveners in the communities in relation to the process of creating new collaboration agreements;
- Document the support provided by the FNQLHSSC to the First Nations involved in the project;
- Identify the initial benefits of the project on the continuum of services offered to people in First Nations communities.

1. The composition and mandates of the working committee

The composition of the working committee, made up of three regional partners, has varied considerably over time. When the committee began taking concrete steps, at the time of making initial contacts with the communities and the CSSSs, the active members of the committee were: the FNQLHSSC mental health advisor responsible for the project, the manager of the FNQLHSSC social services sector, the FNQLHSSC research agent responsible for the evaluation, two advisors from the Direction des Affaires autochtones, ethnoculturelles et régions nordiques of the MSSS and an evaluation advisor from the MSSS's Direction de l'évaluation. It should be noted that Health Canada's participation was sporadic at this point in the project. According to the stages and progress of the project, not all the partners were needed to attend each meeting of the working committee. More regular meetings were held between the FNQLHSSC mental health advisor and one of the MSSS advisors. The entire committee met in April 2014 and February 2015. Although Health Canada representatives were not present at all the meetings, they nevertheless were kept aware of the project's progress.

As anticipated in the mandates of the committee, certain FNQLHSSC and MSSS resource persons were asked to participate in one or more meetings to provide their expertise to the committee from time to time. Note also that the liaison agents of the Abitibi-Témiscamingue and Côte-Nord ASSSs were invited to attend the working committee meetings to inform the committee of the project development in their respective regions.

The meetings of the working committee, held farther apart early in the project, were held more frequently as the project progressed. Several in-person and telephone meetings, bringing together all the members or some of them, took place between March and September 2013 to conclude the work surrounding the drafting of the model collaboration agreement and the preparation of regional meetings scheduled to take place in the fall of 2013. Subsequently, the meetings of the working committee started

to once again become more spaced out, but the FNQLHSSC mental health advisor conducted regular telephone follow-up with the MSSS advisor responsible for the project.

The working committee was mandated to play a project coordination role enabling both organizations (MSSS and FNQLHSSC) to act more in concert with their respective networks and to discuss the challenges raised in the local discussion groups. The committee worked on preparing regional meetings in the fall 2013 and fall 2014.

a. Relations between the FNQLHSSC and the MSSS

The FNQLHSSC and the MSSS have collaborating for a number of years on various issues affecting the health of the First Nations. The project to develop collaboration agreements was another opportunity to grow this partnership. The relationship between the two organizations can be fairly said to have been very good throughout the project. However, the complexity of the organizational structure of the MSSS and its network impacted on the pace of the project. The FNQLHSSC perceived the necessity of slowing down at times. The FNQLHSSC also worked with the existence of a predefined communication channel between the MSSS, the ASSSs and CSSSs. Despite these pre-established communication mechanisms, the FNQLHSSC mental health advisor conducted regular follow-up with ASSS planning, programming and research agents (Aboriginal respondents) to better coordinate actions in the field with the communities and the CSSSs concerned.

2. The conduct of the project

This section presents the results obtained in respect to the conduct of the project and reveals the differences between what was planned and what was actually done.

a. The project phases

The project was scheduled to begin in March 2012 and terminate on March 31, 2015. With the passage of time required to receive funding, the project began in earnest in March 2013 when a person assigned full time to this project was hired by the FNQLHSSC. Prior to this, the FNQLHSSC served on the working committee, but no action directly involving the communities had been taken. Note that the person devoted to the project had already been employed by the FNQLHSSC for some years and had previously worked as an advisor during the implementation of a mental health pilot project in two First Nations communities.

A postponement of the funding announced in January 2015 pushed the end date of the project to March 31, 2016.

The **planning phase** of the project therefore took place between March and September 2013. During this phase, the following activities took place:

- Meetings of the working committee to finalize the model collaboration agreement;
- Letters of invitation sent to First Nations communities in the regions of the Côte-Nord and Abitibi-Témiscamingue;

- Creation of tools to support communities in their preparation for regional meetings, such as an indicative schedule of meetings and a preparation tool (portrait of the community and the needs at the project start);
- Contacts made between the MSSS and the ASSSs of the Côte-Nord and Abitibi-Témiscamingue;
- First meetings between First Nations communities and the FNQLHSSC mental health advisor.

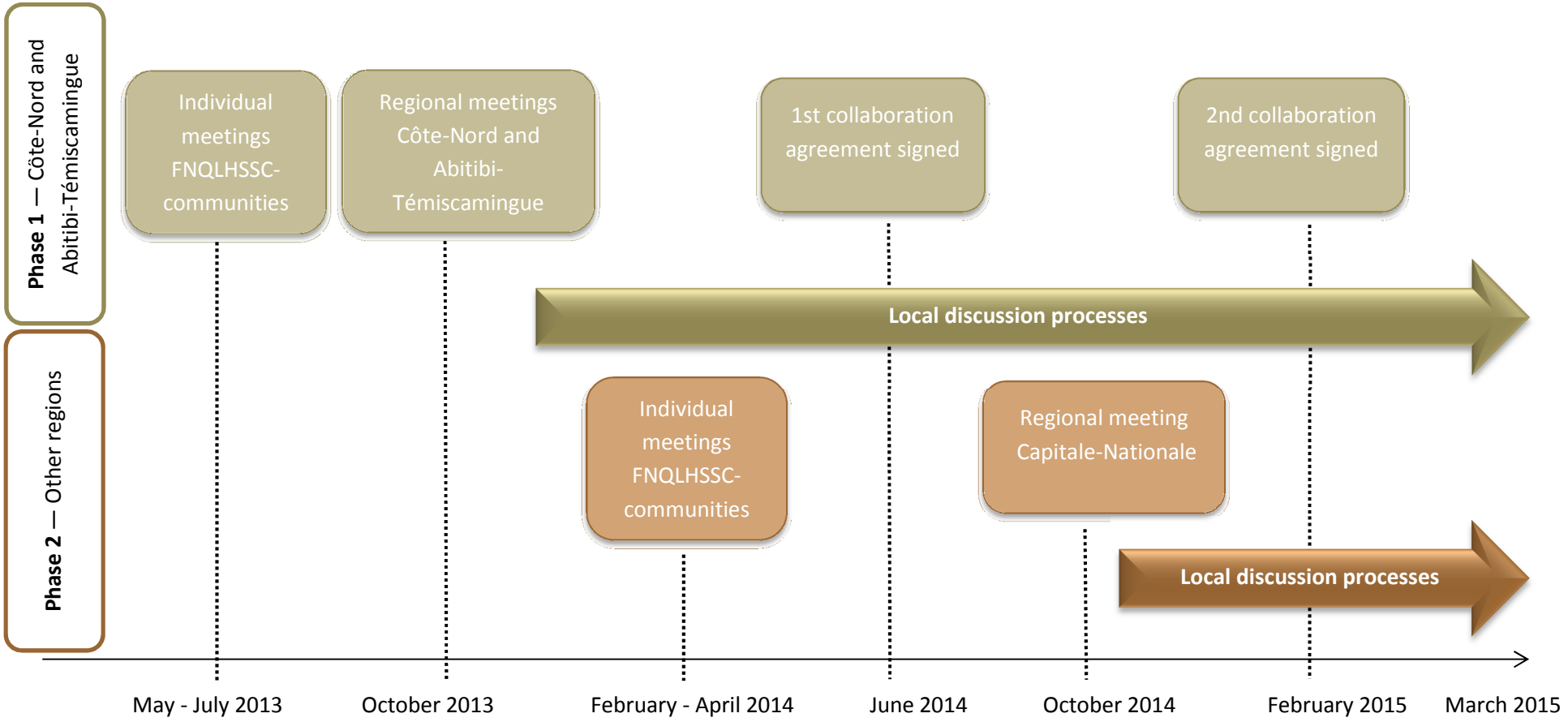
Subsequently, the **implementation phase** took place beginning in October 2013 and is still ongoing. Several activities took place simultaneously:

- Regional meetings of First Nations communities, the CSSSs, the ASSSs and members of the working committee;
- Discussion processes within the various local committees with representatives of the communities and the CSSSs;
- Working committee meetings to monitor project progress and coordinate the actions to be taken;
- Support for the communities provided by the FNQLHSSC mental health advisor;
- Support for the CSSSs provided by the ASSSs.

The last month devoted to the project should enable **the synthesis, the conclusion of activities and preparation for the withdrawal of accompaniment**. The role of the mental health advisor and other members of the working committee will be to ensure that the communities and the CSSSs will have available all the information and tools needed to pursue discussions with their local partners and to establish mechanisms for their collaboration agreement to continue in an ongoing way or to be concluded.

The figure below shows the project's progress over time (Figure 2).

Figure 2. The progression of the project supporting the development of collaboration agreements starting with the first official meetings between the communities and the FNQLHSSC



b. The provincial context influenced the progress of the project

The change of provincial government in the spring of 2014 affected the pursuit of the project. In the autumn of 2014, the new government submitted Bill 10: *An Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies*.

The tabling of Bill 10 created new uncertainties in the Quebec health and social services network. As the second phase of the project began with the planning of fall 2014 regional meetings, three ASSSs decided to postpone the implementation of new projects within their territories after March 2015. Of the five First Nations communities still interested in the project, only one was able to participate after the fall of 2014.

This development disappointed some communities that had wanted to improve their partnership and communication mechanisms with their CSSS. The FNQLHSSC mental health advisor followed-up with these communities to encourage them to develop local initiatives with similar goals to those of the project. The model collaboration agreement produced by the working committee, the preparation tools as well as the sample collaboration agreement signed by a community and its CSSS were sent to these communities.

As for the communities that had already opened discussions with their CSSS, the impact of the bill was less pronounced. However, a slowdown was still felt and communities felt apprehensive at the possibility of losing their counterparts with whom they had developed links.

The impacts of this reorganization of the Quebec network, intended to go into force on April 1, 2015, will be evaluated over the next year and described in the evaluation report to be tabled in March 2016.

c. Discussion meetings in the communities

In the initial planning of the accompaniment process, it was thought that the schedule of meetings would kick off with a regional meeting bringing together the various actors that would be involved in the process and then proceed to meetings with each community to support them in starting the process of collaboration with their CSSS. Because of the time that was needed for the MSSS to contact its network to introduce the project and plan the next steps, the FNQLHSSC decided to go ahead and start with individual meetings for discussion and information with each community. This change in how the project unfolded was very positive. Communities had more time to work on the portrait of their service organizations and their needs and priorities and came to regional meetings well prepared.

Preparatory meetings with communities

Between May and July 2013, the communities of Abitibi-Témiscamingue and the Côte-Nord wishing to negotiate a collaboration agreement with their CSSS were visited by the FNQLHSSC mental health advisor. These first meetings helped to further explain the project and answer everybody's questions.

Community representatives who attended this first meeting varied considerably from one community to another and the choice of these representatives was left to the directors of health or social services in the community. While some communities were represented by only one or two individuals, other communities delegated a significant number of interveners to attend the first official meeting. These meetings, lasting from half a day to a day, helped to explain the project, its objectives, the accompaniment provided by the FNQLHSSC and the proposed timeline for the process. In addition, the

meetings helped prepare the communities for regional meetings planned for fall 2013 that were designed to bring together all the partners involved in the project.

Communities who became involved during the second phase were also met by the mental health advisor at the beginning of their participation, between February and April 2014. The experience gained by the advisor led to slight modifications in the meetings between Phase 1 and Phase 2. The accompaniment process was refined and the presentation of the project was synthesized and simplified. Moreover, the communities' Phase 1 experience enabled the discussion points to be illustrated very concretely and provided the new communities with available tools and helpful references.

Regional meetings

During the fall of 2013, two regional meetings were held, one in Rouyn-Noranda in Abitibi-Témiscamingue and another in Sept-Îles, on the Côte-Nord. These meetings gathered at the same table all the actors involved in the project, including the members of the working committee and representatives of the communities, the CSSSs, the ASSSs and other facilities working in the Quebec mental health and addictions network. The interveners from these communities present were mainly health directors, NNADAP agents, first-line services interveners and clinical supervisors. As for the CSSS, program directors and liaison agents represented their organizations and for the ASSS, Aboriginal respondents, mental health and addictions respondents and the agency's Director General or his representative also attended the regional meeting.

These events of a day and a half were first of all an opportunity to take stock of the project, to present the tools available to support organizations in their discussions and present the project evaluation. The focus during these meetings was on the importance of achieving better collaboration to provide better services:

> "If the protocol only gets people talking with each other about the clients, it will be a success."
> (Regional actor, October 2013)[6]

Thereafter, each CSSS and each community had sufficient time to present their respective offer of services and express their needs and expectations in relation to a new collaboration agreement. A question period following each presentation was an opportunity for partners to clarify certain elements and discuss the issues they faced.

[6] All the words quoted in this report have been translated, as they are originally in French.

As expressed by a community project manager, this official regional meeting was very rewarding:

> "This meeting allowed me to have a better understanding, for example, that there were liaison agents, what the issues were for the CSSS we work with, especially the second-line with whom I had absolutely no relationship. Also to understand what are the issues and the reality of being a CSSS. [...] Also, I discovered many addiction services, I had no knowledge about the addiction services that were offered on our territory. [...] The meeting also made it possible to hear what people are going through in our community, what is experienced by all communities in relation to all CSSSs and that the CSSSs are all in the same situation in relation to the issues related to covering Aboriginal peoples."
>
> (Local actor, January 2015)

The following table (Table 7) summarizes the main expectations and needs expressed by the representatives of the First Nations communities of Abitibi-Témiscamingue and the Côte-Nord in relation to developing collaboration agreements with their respective CSSSs.

Table 7. Expectations and needs of First Nations communities at regional meetings held in the fall of 2013 in Abitibi-Témiscamingue and the Côte-Nord

Expectations and needs of the Abitibi-Témiscamingue communities	Expectations and needs of the Côte-Nord communities
Relative to the establishment of partnerships and communication mechanisms	
○ Exchange about values and ways of doing things; ○ Recognize the expertise of community interveners; ○ Work in collaboration and by networking; ○ Make known to the Quebec network the services offered by the communities; ○ Address the lack of communication with the CSSS by establishing a formal mode of communication; ○ Eliminate prejudice both among certain network interveners and the population in general.	○ Consolidate the links and relationships of trust; ○ Take the time to get to know each other, including network interveners' visits to communities; ○ Clarify the respective roles and mandates; ○ Improve ineffective or non-existent communication mechanisms; ○ Work together, build partnership and implement the collaboration with the network; ○ Work in better complementarity with community organizations; ○ Work in multidisciplinary teams; ○ Create a regional consultation table in mental health and addictions; ○ Eliminate prejudice both among certain network interveners and the population in general; ○ Ensure the sustainability of the agreements.
Relative to the services offered by the CSSS and the communities	
○ Adapt services to the reality of the communities (approach, language, etc.); ○ Formalize the procedures already in place; ○ Facilitate the replacement of staff; ○ Establish liaison agents; ○ Be engaged in the production of intervention plans; ○ Improve monitoring of hospitalized patients; ○ Clarify the corridors of 2nd and 3rd line services; ○ Access specialized services in the community; ○ Receive support to develop and deliver services in the communities; ○ Improve services for people with multiple problems; ○ Improve access to detoxification services, including in English; ○ Improve access to post-therapy services for addiction problems; ○ Be familiar with methadone substitution treatment programs; ○ Improve access to psychologists and other professionals; ○ Improve links with the youth centre; ○ Know about programs promoting healthy lifestyles in the Quebec network; ○ Improve access to network training.	○ Clarify service trajectories; ○ Improve the knowledge of community interveners about the mental health and addiction services and resources of the network; ○ Understand more about the structure of the Quebec network; ○ Establish links between NNADAP agents and interveners in the Quebec network; ○ Improve access to detoxification services; ○ Improve the support provided by psychiatrists (telehealth, clinical discussion committees, etc.); ○ Recognize the healing methods of the First Nations (forest retreats, sweat lodges, sharing circles); ○ Know about the mental health and addictions prevention programs offered by the network; ○ Provide adequate mechanisms for monitoring patients referred to the CSSS; ○ Apply Jordan's Principle (primacy of children's interests when resolving jurisdictional conflicts in health and social services); ○ Have access to continuous training.

It is clear from the table above that there are many similarities between the two regions in terms of the need to improve communication mechanisms, to establish trusting relationships, share information and communicate better. This first step in planning a partnership is of strategic importance because it enables partners to take stock of the situation and for each person to feel engaged in the process.

> "The will to come together must be accompanied by the skills for creating and maintaining links where the managers concerned can quickly develop the confidence needed to assume the expected strategic positioning, to plan a partnership."
>
> (Centre de réadaptation en dépendance *Le Virage* and CSSS Pierre-Boucher, 2012, p. 21)

We can thus see a desire on the part of communities to formalize communication channels between them and their respective CSSSs.

> "[...] What we wanted with this project is really to formalize our efforts, because we know it often depends on the people that are in place and if these people leave, we don't want to have to go back to step one."
>
> (Local actor, October 2013)

Another observation that can be drawn from the table is the obvious need to work in teams, to work collaboratively with the network and ultimately to facilitate the linkage between services in the communities and those offered by the CSSS.

> "I'm dreaming of when the First Nations will be in a strong enough position not just to ask for a hand, but to offer one as well."
>
> (Local actor, October 2013)

Among the needs expressed by the community in relation to services, having better knowledge of the services provided by the network and improved access for community members should be especially noted. Follow-up and continuity of care for patients also emerged as crucial elements to address when agreements are being negotiated. Finally, the communities of the two regions expressed a desire to improve, for their interveners, access to training provided by the Quebec network.

These expectations and needs expressed by participants from the communities resonate with the recommendations of the report on the *Development of a Mental Health Service Organization Model Among the First Nations of Quebec* (FNQLHSSC, 2011a). Interveners consulted during this project funded by the AHTF also emphasized the need to improve communication mechanisms, to provide better monitoring of the clientele and to establish formal collaboration agreements.

For the CSSSs, this meeting enabled each organization to present its addiction and mental health services. Both the CSSSs and the ASSSs demonstrated an openness and willingness to improve partnerships with First Nations communities. They expressed a willingness to listen to the needs and to

work together over the coming months to improve collaboration and possibly sign a collaboration agreement.

For the second phase of the project implementation, regional meetings were planned. However, because of the changes to the provincial context discussed above, only one regional meeting bringing together around the same table representatives of one community, the CSSS, the ASSS, a CRD, the FNQLHSSC and the MSSS was held in October 2014.

The meeting, lasting half a day, provided an opportunity to update the project by addressing among other objectives, the support provided by the FNQLHSSC, the proposed approach and schedule and a presentation of the evaluation of project. Afterwards, a discussion between people from the community, the ASSS and the CSSS was an opportunity to identify the needs of the community and to establish a follow-up list. Unlike most of the situations described at the regional meetings in Abitibi-Témiscamingue and the Côte-Nord, it emerged that relationships already existed between the community, the CSSS and the ASSS. However, the community desired to make more formal the existing agreements between community interveners and the CSSS. The difficulty associated with personnel turnover was discussed:

> "Before, we had a relationship with the coordinator."
>
> (Local actor, October 2014)

Various needs were expressed by the community during this meeting. For example, the community expressed the desire to have access to the computerized adult mental health records database which is used by several organizations in the Quebec City region, and thus benefit from the exchange of information and have access to training offered by the CRD. Finally, the community expressed a desire to be quickly made aware of changes to the services offered by the CSSS, particularly by being integrated into its "Directors Table" and other official communication channels.

A regional follow-up meeting

A second regional meeting for the Côte-Nord region was planned for the month of February 2015. The meeting, to be held in one of the communities involved in the project, had to be cancelled. The meeting was designed to enable the communities and the CSSSs to review their work and share with other organizations present the challenges and successes they had experienced. This second meeting on the Côte-Nord was in response to a request from several communities and organizations in this region.

The main reason for the cancellation was a lack of participation. The difficulty in getting the participants to come to a meeting can be linked to the provincial context and to the imminent coming into force of Bill 10, but also to the fact that two other regional events involving the First Nations were being held during the same period.

In Abitibi-Témiscamingue, no need was expressed at that time to participate a meeting of this type.

d. The establishment of the local committees and the discussion process

The complexity of the process

From the outset, it appeared that the complexity of the project had been underestimated. Although negotiating collaboration agreements is a common approach among facilities in the Quebec health and social services network, this process is innovative between First Nations communities and the CSSSs. Although some communities have a formal agreement with their CSSS or hospital, for other communities, this approach is new. Indeed, we find that informal collaboration mechanisms cover a variety of situations. They often take the form of an agreement between a community intervener and an intervener from the network that facilitates the referral and follow-up processes for patients from the communities. It is not difficult to imagine that this type of arrangement is precarious due to high personnel turnover, both in the communities and in the provincial health system. In addition, the fact that collaboration agreements are designed to cover both mental health and addiction services is also an issue. It should be noted that there are still many organizations, both among the First Nations and in the CSSSs, where these sectors are still working in silos to a great extent.

This new way of proceeding for communities, added to the reciprocal lack of knowledge on the part of the Quebec network and the communities about each other, and the occasional non-compliance of the Quebec network in terms of its responsibility to provide services to First Nations people who come to their facilities, led to an underestimation of the time and labour required. It soon became clear that the signing of three agreements per year for a period of three years, as had been hoped during the deposition of the project, was unrealistic and did not take into account the real issues related to the process.

Another major factor to consider is that many communities began the process by working to consolidate their own service offering. This effort, shorter or longer depending on the community, was a beneficial step from all points of view. It enabled communities to identify gaps in services so they could be filled, redistribute mandates for work teams and be better prepared for the collaborative approach with their CSSS. In addition, some communities had other priority issues to work out with their CSSS even before starting a process leading to the signing of a collaboration agreement. There is one case of an isolated community that first wanted to formalize its agreement covering doctor visits and move things forward on collective prescriptions.

The composition of the local committees

The composition of the local committees was completely at the discretion of the communities and the CSSSs. However, it was suggested to the communities that they include people with a variety of expertise from the milieu and that the approach be intersectoral. The community representatives on these committees were mainly directors of health or social services, first-line interveners, NNADAP agents and other interveners working in mental health. Representatives for the CSSSs were department managers or directors. Representatives of other organizations of the RLS of the Quebec network, such as the youth centres or addiction rehabilitation centres, also attended some of the meetings given their CSSS mandate to provide service continuity. Aboriginal respondents from the ASSS and the FNQLHSSC mental health advisor were invited to participate in these local committee meetings.

One finding that emerged during the project is the fact that the negotiation process is facilitated when interveners around the table are at the same level of authority. In several local committees, the community representatives were interveners working directly with the clientele, while the CSSS had designated managers or directors to serve on the committee. Members of the committee must also have decision-making authority recognized by their organization to accelerate decision making and the progress of the project.

Facilitating factors and challenges identified by the local committees

Various challenges were raised when the local committees were set up and during the discussions about establishing collaboration agreements. However, despite these challenges, there were facilitators that helped the local committees to advance the project. Tables 8 and 9 list the facilitating factors and challenges observed locally.

Table 8. Facilitating factors and challenges identified for the establishment of local committees

Facilitators	Challenges
○ Previous positive experience of collaboration; ○ Round table already existing before the project; ○ Common vision that the agreements could improve access to services, follow-up and communication between the communities and the CSSSs; ○ Holding of regional information and sharing meetings to officially launch the project; ○ Organizing certain communities at the beginning of the process to work together; ○ Openness on the part of both sides to work together.	○ Distance between partners (few in-person meetings, thus more difficult to bond); ○ Postponement within some local committees in starting discussions; ○ Reciprocal knowledge or links nonexistent prior to the project; ○ Unfolding of the project at the regional level; (e.g., number of partners, delay in the schedule); ○ Failures in previous experiences, protocols that have already fallen through; ○ Frustration with a lack of recognition of community interveners' skills by the network (especially regarding client assessments); ○ Project does not have the same priority for all; ○ Little or no contact with the ASSS before the project; ○ Language of communication (English communities vs. French-speaking CSSSs); ○ No one available to be project manager; ○ No funding provided to communities to support the logistics of their meetings with their CSSS.

Table 9. Facilitating factors and challenges identified during the discussion process at the local level

Facilitators	Challenges
○ Personal characteristics of the project manager; ○ Presence of a multisectoral team around the table (not just the health director); ○ Fixed timetable and approach clarified by the MSSS-FNQLHSSC working committee; ○ Monitoring of the negotiations by the mental health advisor and ASSS liaison agents, and then report-backs to the working committee, which improves the coordination of the project; ○ Common understanding, clarified approach and established work approach; ○ Support and accompaniment provided by the FNQLHSSC and ASSS: networking, organization of meetings, development of local capacity; ○ Collaboration between the ASSS and the FNQLHSSC (awareness, networking, sharing of tools and information); ○ Process of preparation and clarification by the community prior to meetings with the CSSS; ○ Visit of CSSS interveners to the community and vice versa.	○ Poor understanding of the project from the start, confusion between a service agreement and a collaboration agreement; ○ Confusion about the mandates/roles/responsibilities of each person related to: 1) local leadership of the communities and the CSSSs; 2) the role played by the ASSS and the FNQLHSSC; 3) the matter of jurisdiction and responsibility for the population; ○ Lack of human resources or new resources in place, which affects project monitoring; ○ Technical difficulties during videoconferences; ○ Difficulty getting all the partners to attend each meeting; ○ Functioning of the community and CSSS project managers; ○ Mental health and addiction teams separate and working in silos, both in the communities and in the CSSSs; ○ Service corridors not clearly defined or services needing to be consolidated or newly developed regionally; ○ Specific needs of each community where the CSSS has worked with several communities; ○ Services in English or interpretation services not offered by the CSSS; ○ Differences in the assessment tools used between the communities and the CSSSs; ○ Large demand for services addressing two mental health and addiction problems (2nd-line) and lack of access to services to meet those needs; ○ Ignorance on the part of the CSSSs as to service delivery and financing arrangements already negotiated between the communities and the federal government; ○ Services requested by the community that are not offered by the CSSS or regionally that can result in the client needing to travel or go on a waiting list (e.g., detoxification services); ○ Complexity of the Quebec network structure; ○ Provincial context (e.g., Bill 10).

The challenges that the communities faced throughout the project were primarily related to technical and logistical problems such as the geographical remoteness of partners and the resulting obligation to conduct meetings by videoconference as well as the fact that participants did not speak the same

language. The issues relating to the remoteness of the partners mainly affected the communities of the Côte-Nord while the language barrier concerned the English-speaking communities of Abitibi-Témiscamingue.

Frequent changes of both community and CSSS project managers significantly slowed the process down in some local committees. We note, for example, the experience of a community where there have been three project managers so far. Whenever a new project manager began working, sometimes weeks after the position was left vacant, the mental health advisor had to resubmit the project and it took some time before the new person took command of the project and its tasks. In this regard, we note that the communities that advanced the most in the project, either because they signed an agreement or because they undertook some positive actions, had the same project manager throughout the project. Also, we note that a poor understanding of the project and the roles and mandates of each participant can be an important limitation to the process. The lack of recognition by the Quebec network of the skills of community interveners as well as the tools they use for assessment also had a negative impact and was seen as a challenge for some communities.

The context in which the project took place had a decisive impact on some of the local discussion committees. We note in particular a community context and way of functioning that at times slowed the project's momentum, added to the impact of the provincial political context with the adoption of Bill 10, which set back the work already accomplished, mainly for the Phase 2 communities. The hierarchical and administrative burden of network facilities also emerged as a factor:

> "A provincial CSSS does not have the same flexibility as a community clinic. [...] I feel that the people are in good faith, but I do not necessarily feel we are going to reinvent the wheel. [...] We can be creative, we have a certain degree of latitude, while their framework is a lot more rigid."
>
> "The boat of the CSSS is harder to turn. We understand that they have limited resources."
>
> (Local actors, January 20)

Other obstacles to the process included the difficulty that many communities had in bringing all the actors together at the same time, failures in previous collaborations and nonexistent or insufficient links with the CSSS and the ASSS before the project .

Finally, we note that some communities had unrealistic expectations of the project, such as access to services and specialists that are not available in their area.

The evaluation on the other hand helped to highlight the elements that facilitated the formation and work of the local committees. The facilitating factor that seems most crucial for a successful approach is related to the project manager at both the local (community and CSSS) and regional (FNQLHSSC and MSSS) levels. Indeed, the personal characteristics of the project manager in addition to his or her availability are elements that appear to be key. A project manager who is unifying, proactive and believes in the usefulness of the approach proves to be a determining factor in the success of the process. He or she must also have the necessary time to devote to this mandate. The support of the project manager by an intersectoral team is also an element leading to success of the process.

The other key facilitating factors were that the development of a collaboration agreement be a priority for all actors involved and that there be a common understanding of objectives and process. We found that the regional meetings held early in the project facilitated the development of this common vision. Finally, a positive previous experience of collaboration with the Quebec health and social services network was a factor facilitating the establishment of partnership, as was the support provided to communities by the FNQLHSSC and that provided to the CSSSs by the ASSSs.

The duration of the discussion process

Despite the delay in receipt of funding, two communities held, as of March 31, 2015, a signed collaboration agreement with their CSSS and another community is at the stage of final approval of its agreement. Note also that nine communities (for the two phases) are still in the process of negotiating an agreement with their CSSS and four communities are awaiting the formal beginning of the process.

For the two communities that signed an agreement and for the one that is waiting for the signing, the duration of the process was spread over a period of time that varied from one local committee to another. Thus, the first signed agreement emerged six months after the regional meeting formalizing the beginning of the process and the second nearly 15 months after the regional meeting.

e. The cultural awareness workshops offered

One of the objectives of the project was to educate interveners from the Quebec network about the reality and culture of the First Nations. Initially, the FNQLHSSC intended to offer training workshops using the materials developed and presented earlier under the name *Adapting our Interventions to Native Reality* (FNQLHSSC, 2005). Since this training program was in the process of renewal, a partnership was set up with the Université du Québec en Abitibi-Témiscamingue (UQAT) and the ANPSS. During the AHTF, a training project was carried out that led to the creation of *Piwaseha,* which aims to bring non-native interveners to collaborate more harmoniously with Aboriginal communities. As part of the HSIF, the same two organizations developed *Wedokodadowiin*, a training program following *Piwaseha*.

The *Piwaseha* and *Wedokodadowiin* training programs (for interveners who have already completed the first training) were offered in the fall of 2014 in Abitibi-Témiscamingue. *Piwaseha* training will be offered in April 2015 to interveners in the Côte-Nord. In all, nearly 200 interveners have been sensitized to the reality and culture of the First Nations with these two training programs during the project.

3. The accompaniment provided to the communities

The accompaniment provided by the FNQLHSSC mental health advisor to communities wishing to be supported at one or another of the steps of the process was implemented, as was planned at the beginning of the project, to meet the distinct needs and expectations of each community. The advisor played different roles: meeting facilitation, motivation of interveners, liaison between organizations, training, assistance in developing tools, coaching and consulting.

Early in the project, the FNQLHSSC mental health advisor visited each community to present the project and to prepare them for regional meetings involving all the actors involved in the process. Depending on the community, the mental health advisor led a workshop to help the interveners present to identify

their offer of services and to determine their needs and expectations for a collaboration agreement to be signed with their CSSS. Tools were provided to the communities to perform this task.

Following regional meetings that marked the official beginning of local efforts, regular follow-up with the communities was conducted by telephone. The mental health advisor also provided support by videoconference and in person when the need was expressed. There were essentially two purposes of community visits: knowledge transfer to new project managers and support during meetings with a CSSS.

Several elements facilitated or constrained the accompaniment provided by the mental health advisor (Table 10).

Table 10. Facilitating and limiting factors observed during the accompaniment of communities

Factors facilitating the accompaniment provided	Factors limiting the accompaniment provided
○ Appointment of a project manager who is the contact point for the community; ○ Community project manager who is available and gives priority to the project; ○ Good knowledge of the reality of the communities and the organization of the Quebec network on the part of the mental health advisor; ○ Good collaboration with ASSS respondents and the members of the working committee.	○ Many communities to accompany; ○ Remoteness of the communities and therefore the need for a number of accompaniment and follow-up sessions conducted by telephone or videoconference; ○ Some project managers have little time to devote to this project and are difficult to reach; ○ Pre-established line of communication to the provincial network; ○ Funding that limits the number of possible visits.

It bears repeating that the project managers, and more precisely their availability and the priority they give to the project are key. The project manager named in each of the communities represented the mental health advisor's access point to the community. An easily accessible project manager enables the advisor to be more aware of the local process and to align his or her actions accordingly. The mental health advisor's personal characteristics also greatly facilitated the help that could be provided to the communities. His availability, openness, knowledge of the organization of services in the communities and in the provincial network, as well as his great ability to establish trust relationships and partnerships enabled him to provide personalized accompaniment to each community.

As for the challenges that emerged, it must be noted that the remoteness of the communities prevented the provision of in-person accompaniment on a regular basis and thus necessitated that follow-up be conducted by telephone and videoconferencing. The large number of communities to accompany (12 communities just for Phase 1) also made it difficult to provide frequent accompaniment sessions in person. As stated above, some project managers were more difficult to reach and therefore the mental health advisor did not receive much information about local progress.

As for the CSSSs, accompaniment was provided to them by the ASSSs. Note that the pre-established line of communication between the MSSS, the ASSSs and CSSSs created certain problems in terms of optimal

organization of concrete actions early in the project. However, the FNQLHSSC mental health advisor was in regular contact with Aboriginal respondents of the ASSSs, which allowed the various participants to align their actions and to better accompany their respective networks.

4. The short-term benefits of the project and the other local initiatives implemented

Although few collaboration agreements had been signed by March 31, 2015, the project's observed impacts were significant.

The short-term benefits of the project:

- The development or enhancement of partnerships between First Nations communities and the Quebec network through the establishment of local committees;
- Raised awareness of the partners of the provincial network of Abitibi-Témiscamingue and the Côte-Nord about First Nations realities and culture;
- A better knowledge of available services in mental health and addictions in the participating communities and the Quebec network of the participating regions;
- A better understanding of mental health and addictions access mechanisms and service trajectories in First Nations communities and the Quebec network;
- One more opportunity for the FNQLHSSC to enhance its partnership with the MSSS and its network, and with First Nations communities.

The establishment of local committees also led to the implementation of local and regional initiatives other than the signing of collaboration agreements. Many of these initiatives move in the same direction as the objectives set at the beginning of the project, that is, the improvement of collaboration and communication mechanisms between organizations.

> “There are relationships that are already more than something on paper.”
>
> (Regional actor, February 2015)

We note the setting up of new committees and round tables bringing together community representatives and organizations of the provincial network. One example is a community of the Côte-Nord that set up a school mental health committee and another that established a committee to coordinate services. The provision of clinical telephone support by an addiction rehabilitation centre has improved the services offered by a community far from any urban centre.

Another important benefit is the increased number of invitations to communities to take part in the training offered by the Quebec network. For example, the communities of the Côte-Nord were invited to training sessions on addictions and motivational interviewing. The communities of Abitibi-Témiscamingue were also informed of the training being offered, but given that they are only available in French, attendance by English-speaking communities in the region was sparse. Among other initiatives launched, we would underline the community visits by network interveners and the development of a liaison form for monitoring clients.

With all the other elements established during the project, it appears that the signing of collaboration agreements is a means rather than an end in itself to improve access and continuity of services for the First Nations. The signing of a collaboration agreement is not always the best option to meet the needs of the community and other mechanisms are sometimes more effective at doing so.

5. Results linked to performance measurement

A series of indicators for measuring performance was identified at the beginning of the project. These indicators enable the evaluation of progress made in achieving the expected results (targets). The achievement of or failure to achieve these targets is one of the factors to be taken into account to measure the achievement of project objectives. As the process of developing collaboration moved forward, the consolidation of partnerships and the development of other initiatives emerged as factors overriding the significance of the agreements themselves and enabling a greater degree of sustainability going forward. The results shown in Table 11 must be viewed keeping in mind that this way of evaluating the approach does not consider the project as a whole and does not properly value all the efforts that were brought to bear.

The table reveals that a number of targets were not able to be reached or measured as of March 31, 2015, the initial date of the termination of HSIF funding. Since an extension of the project funding and evaluation has been granted, a second sampling of measures will be performed on March 31, 2016 and will enable the achievements made during the entirety of the project to be documented.

The complexity of the process and the challenges raised previously are reasons for the fact that the targets that were identified early in the project were not met. It is hoped that the tools that were developed and the accompaniment that was provided enabled communities and their partners to take ownership of the process and to continue their work in the coming years.

Table 11. Performance measurement results as of March 31, 2015

Elements to evaluate	Indicators	Objectives/Targets	Results as of March 31, 2015
Establishment of partnerships	Number of partnerships established	A partnership established for each of the communities	12 partnerships have been established out of the 17 communities involved
Negotiation process	Number of negotiation meetings conducted	Sufficient number of meetings to provide for negotiations	Not available (n.a.)
	Satisfaction of the communities with the negotiation process	Satisfaction of all partners with the negotiation process	The two project managers interviewed are satisfied with the negotiation process
Support provided by the FNQLHSSC to assist with the establishment of partnerships	Satisfaction with the support provided for the establishment of partnerships	Support appreciated and helpful for the communities	The two project managers interviewed are satisfied with the support provided for the establishment of partnerships
Awareness of the actors of the provincial network to the reality of the First Nations	Number of awareness workshops	An awareness workshop offered to each CSSS concerned	Phase 1: n.a., Phase 2: n.a.
	Number of workshop participants	All interveners involved in services offered to the First Nations	About 200 interveners attended awareness workshops in the two Phase 1 regions
	Satisfaction with the workshops	Workshops appreciated by all the interveners	n.a.
Local agreements developed	Number of agreements signed at the end of the project	An agreement signed for each participating community	Two collaboration agreements were signed
Support provided by the FNQLHSSC for achieving agreements	Satisfaction with the support provided for the achievement of agreements	Support appreciated and helpful for the communities	The two project managers interviewed are satisfied with the support provided
Short-term impacts of the project on the services offered	Decrease in the number of problems encountered by First Nations clients attending the CSSS after the signing of agreements	Fewer clients experiencing problems receiving CSSS mental health and addiction services	n.a.
	Satisfaction of the communities with the level of collaboration with the CSSS after the signing of agreements	Improved collaboration between the communities and the CSSS	n.a.
Sustainability of the partnerships	Number of still active partnerships after the signing of agreements	All partnerships still active after the signing of agreements	n.a.

SUMMARY AND RECOMMENDATIONS

The development of collaboration agreements between the First Nations and the health and social services centres (CSSSs) is an innovative project whose main objective is to improve communication and collaboration between the First Nations and the Quebec network. This major project currently affects 12 First Nations communities, eight CSSSs, two health and social services agencies (ASSSs), the Ministère de la Santé et des Services sociaux du Québec (MSSS), the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) and the First Nations and Inuit Health Branch (FNIHB) of Health Canada. Funding for this project was provided through the *Health Services Integration Fund* (HSIF), a Health Canada initiative to improve partnerships between First Nations and various levels of government in the design, delivery and evaluation of health services and programs. This funding enabled the FNQLHSSC to assign a full-time person to support the process and to provide accompaniment to the communities.

Due to the high number of partners involved, the project unfolded differently than originally planned. An adjustment was made at the very beginning that was related to the amount of time that had elapsed prior to obtaining funding. Thus, the project began in earnest in March 2013 when the FNQLHSSC mental health advisor assumed responsibility for the project. The duration of the project, originally scheduled for 3 years (2012-2015), was revised to 2 years (2013-2015). An announcement received in January 2015 enabled unspent funds to be carried forward and therefore extend the project to March 31, 2016. At the beginning of the project, the order of the meetings was revised. Because of the pace with which the MSSS implemented the project in its network, the FNQLHSSC took the lead and began holding meetings with communities to inform them of the project and to support them in their preparation for the regional meetings. The partnership with the MSSS and its network was also affected by the announcement of Bill 10, which significantly slowed the process of some local committees and even postponed the start of the project for the Phase 2 communities. Collaborative work, while enriching the process, also has its challenges. It is necessary to consider the structure and pace of other organizations and be able to be flexible and to adapt one’s actions.

The project's complexity was underestimated at the beginning of the process. It should be noted that several communities had little or no connection with their CSSS or the ASSS of their region before the project. To have initiated such contact is therefore an immediate major benefit. It is possible to conclude that the project helped to establish or improve communication channels and that collaboration between communities and organizations of the provincial network will intensify in the future.

The project evaluation revealed the challenges facing the communities in their local process to improve collaboration. Besides technical and logistical challenges, the high turnover of project managers, the provincial context of uncertainty with the announcement of Bill 10, the difficulty in bringing together most of the actors at the same time and previous negative experiences of collaboration are difficulties that were experienced during the process. On the other hand, the presence of proactive and available project managers, the priority of the project for all actors, a common understanding of the objectives and the approach and a positive experience working with the Quebec network have emerged as factors favouring the success of the process.

As of March 31, 2015, two collaboration agreements have been signed between a First Nations community and a CSSS. The ten other communities, still in the process of discussion with their CSSS, are at different stages of progress. It should be noted that some local committees have made little progress in the implementation of a collaboration agreement. This can be explained by contextual elements on both the part of the communities and the province. In addition, some communities have undertaken an internal consolidation of their services before beginning the process of collaboration with their CSSS or have chosen to settle other priority issues with their CSSS before moving forward to negotiate a collaboration agreement. Other local committees have identified the elements to be included in the agreement and have arrived at the step of drafting the agreement.

The project has produced a variety of benefits up to this point and has achieved the initial objectives. Indeed, an improvement can be seen in the partnerships between the communities and the Quebec network, a higher level of awareness among the actors of the provincial network to the realities of the communities and better reciprocal knowledge of available services, access mechanisms and service trajectories both within the communities and the network. The implementation of other initiatives with objectives similar to those of the project—improving communication and collaboration mechanisms—appeared to some communities to be more promising than the signing of a collaboration agreement as envisaged at the beginning of the project. Benefits include the establishment of new committees, the use of monitoring tools such as liaison forms, reciprocal visits of people working with the clientele and access to subsidized training programs offered by the Quebec network. The signing of a collaboration agreement is not an end in itself, but a means.

The continued provision of accompaniment to the communities and the evaluation of the approach in the next year will enable the monitoring of the evolution of local discussion processes and the short- and medium-term impacts of the signing of collaboration agreements and other local initiatives being implemented.

The recommendations in light of the evaluation results

In light of the results of the evaluation, a number of recommendations can be offered. Given the fact that evaluation will be ongoing until March 31, 2016, these recommendations are preliminary and will be improved as a result of the inclusion of the experience of the entire project. Although they emanate from the project supporting the development of collaboration agreements, they can be used to better plan and orchestrate any other project with similar objectives and bringing together a large number of partners.

Schedule a regional meeting at the start of the project and encourage the holding of meetings for sharing experiences.

Regional meetings held in fall 2013 and fall 2014 were the official starting point from which all the actors concerned could develop a common understanding of the objectives and the proposed approach. For some communities, these meetings were a first contact with their counterparts in the provincial network. As the project continues, the organization of regional meetings for monitoring local approaches and sharing experiences could be positive. Such events allow participants to share with each other the

challenges they have faced and how they overcame them, the factors that facilitated their approach and other promising initiatives that have been implemented.

> Continue to provide support that is tailored to the needs of each community by having a flexible approach to the accompaniment provided.

During the project, it was found that the support needs varied greatly from one community to another. The FNQLHSSC mental health advisor was able to adapt to these needs despite the large number of communities to support. The FNQLHSSC needs to take up the question of how many communities one person may optimally provide accompaniment to. The pursuit of a flexible approach to providing accompaniment is desirable and will surely enable other communities to sign collaboration agreements with their CSSSs in the coming year.

> Clarify from the outset the roles and mandates of regional and local partners. Clarify lines of communication and establish them as the basis of a solution that is as responsive as possible to the needs and realities of local actors.

The project supporting the development of collaboration agreements is made possible through the collaboration of many partners. It is therefore important that everyone's roles and mandates are clarified from the outset. As the process unfolded, the mental health advisor had to deal with the pre-established line of communication between the MSSS, the ASSSs and CSSSs. However, to try to get all the processes moving in the same direction, regular telephone follow-up was conducted between the FNQLHSSC mental health advisor and the Aboriginal respondents of the ASSS.

> Encourage other initiatives that are established that have the potential to better respond to the needs of the community.

The signing of a collaboration agreement, as it was conceived at the beginning of the project, did not necessarily meet the needs expressed by some communities. The emergence of other initiatives confirms that the signing of a collaboration agreement is a means, not an end, for improving communication and collaboration between First Nations communities and CSSSs.

> Work on developing a strategy for having stable project managers and an efficient transfer of knowledge in case of change.

The high turnover of project managers had negative repercussions on the project, such as significant delays in the discussion processes of several local committees. It would seem necessary to try to conceive a strategy for having stable project managers (for example, to ensure that the project manager is available and views the project as a priority) and for providing an effective transfer of information during a change of personnel. Some thought and discussion at the regional and local levels could lead to reducing the impact of this challenge that disrupted a number of projects.

> Design mechanisms to ensure the sustainability of the signed agreements and other initiatives that have been established.

As with any project, we must think about the sustainability of what is established. In this context, in addition to the two collaboration agreements signed to date, other local initiatives were launched.

Previous negative experiences of collaboration, such as signed agreements with no subsequent follow-up, served as obstacles to this collaborative venture. It is therefore necessary to ensure that the elements introduced in recent months and those to come represent successes that are harbingers of a sustainable collaboration between the various organizations.

Continue raising the awareness of interveners in the Quebec network to the reality and culture of the First Nations.

One of the project's objectives was to raise the awareness of interveners of the network to the reality of the First Nations. It was thus agreed that, to improve collaboration, there had to be a better mutual understanding of the contexts in which people live and work. As part of the project, a large number of interveners in Abitibi-Témiscamingue and the Côte-Nord participated in an awareness workshop. It is recommended that the provision of workshops to these interveners be continued and that the same approach with interveners from other administrative regions of Quebec be implemented.

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The development of collaboration agreements between First Nations communities and the CSSSs is a major project which, hopefully, will be a springboard to a renewed and expanded collaboration between the organizations. The evaluation revealed the potential scope of this project and its merits for the communities in their efforts to build strong partnerships to provide an optimal continuum of services to their people. The year 2015 will mark the arrival of a new MSSS mental health action plan. Hopefully this plan will support the continuation of the project by focusing on community support, transfer of expertise, capacity development and raising the cultural awareness of network interveners.

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Appendix 1. Model collaboration agreement

MODEL COLLABORATION AGREEMENT GOVERNING MENTAL HEALTH AND ADDICTION SERVICE PATHWAYS

BETWEEN

CENTRE DE SANTÉ ET DE SERVICES SOCIAUX OF

_____

Name of center

AND

THE FIRST NATIONS COMMUNITY OF

_____

Name of community

DATE

AGREEMENT ON COLLABORATION

IDENTIFICATION OF THE PARTIES TO THE AGREEMENT ON COLLABORATION

Community of _____ (QUEBEC FIRST NATION)
(Name of community or council)

located at _____

herein acting and represented by_____

duly authorized for the purposes hereof as such representative so declares;

hereafter referred to as **"The community"**

AND

(Name of institution), _____

located at_____

herein acting and represented by_____
duly authorized for the purposes hereof as such representative so declares;

hereafter referred to as **"The Institution"**

PREAMBLE:

Mental health and social services providers operating in the Quebec health system can not assume a populational responsibility with respect to non-treaty Aboriginal communities since Quebec accords these communities the autonomy and responsibility to establish their own services utilizing the methods and setting the objectives that are relevant to them. However, institutions in the Quebec network have a responsibility to provide Aboriginal clientele who request their services— whether under agreement or not—the same primary and second- and third-line specialized services as those provided to all Quebecers.

In addition, Quebec recognizes its responsibility for the continuity and complementary of services provided to non-treaty Aboriginal communities. It demonstrates this recognition by ensuring the existence of appropriate orientation mechanisms when residents of these communities receive services in institutions of the Quebec network and by facilitating the transfer of expertise and knowledge to meet the needs of these communities.

Despite these provisions, Quebec's Aboriginal communities have reported the persistence of factors limiting accessibility to services of the Quebec health and social services network, particularly lack of awareness of Aboriginal culture and reality and the complexity of how services are organized. As well, barriers exist between Quebec network services and the communities due to a lack of collaboration. Finally, the presence of culturally insensitive services has been reported.

This Collaboration Agreement serves as an administrative mechanism to be shared by the network institutions and the communities in order to formalize their respective commitments relative to the delivery of mental health and addiction services and the establishment of effective means of coordination and communication. The goal of the agreement is to promote the continuity and complementarity of addiction and mental health services between the community of [*name of community*] and the Centre de santé et des services sociaux of [*name of institution*].

WHEREAS a First Nations community is responsible for providing mental health and addiction services to members residing in its territory;

WHEREAS according to section 5 of the Act Respecting Health Services and Social Services "Every person is entitled to receive, with continuity and in a personalized and safe manner, health services and social services which are scientifically, humanly and socially appropriate."

WHEREAS according to section 100 of the Act Respecting Health Services and Social Services "The function of institutions is to ensure the provision of safe, continuous and accessible quality health or social services which respect the rights and spiritual needs of individuals and which aim at reducing or solving health and welfare problems and responding to the needs of the various population groups;"

WHEREAS the community of [*name of community*] and the centre de santé et de services sociaux (CSSS) of [*name of institution*] want to ensure the provision and the maintenance of quality mental health and addiction services;

WHEREAS the community of [*name of community*] and the CSSS of [*name of institution*] want to ensure the coordination of their efforts and effectively monitor clientele referred to mental health and addiction services offered by the CSSS of [*name of institution*] and the local services of the Quebec network, in order to provide a continuum of functional services in mental health and addictions;

PURPOSE OF THE AGREEMENT ON COLLABORATION:

Accordingly, the parties hereto agree as follows:

1. GENERAL PROVISIONS

1.1 The preamble is an integral part of this Collaboration Agreement and shall govern its interpretation.

1.2 This Agreement covers the services that the Community of XX and the CSSS of XX provide and the collaboration between the parties designated herein to ensure the continuity of mental health and addiction services to a common client in accordance with the specific mandate of each of the concerned parties.

2. THE MISSIONS OF THE PARTIES TO THE AGREEMENT ON COLLABORTION

This Collaboration Agreement must be carried out in respect of the autonomy, the perspectives and the responsibilities specific to each party, as stated below:

2.1 The mission of _____ is:
(Health center or nursing station of XX community)

_____
_____
_____
_____

2.2 The mission of the Centre de santé et des services sociaux

Section 79 of the Act Respecting Health Services and Social Services: "Health services and social services shall be provided by the institutions in the following centres: local community service centre; hospital centre; child and youth protection centre; residential and long-term care centre and rehabilitation centre.

Section 80, paragraph 1 of the Act Respecting Health Services and Social Services: "The mission of a local community service centre is to offer, at the primary level of care, basic health and social services, and to offer health and social services of a preventive or curative nature and rehabilitation or reintegration services to the population of the territory served by it."

Section 100 of the Act Respecting Health Services and Social Services also clarifies that the CLSCs, like other health and social service institutions, have as their function "to ensure the provision of safe, continuous and accessible quality health or social services." To do this, the institutions work in collaboration with partners

in the public and community networks. “In addition, a local authority must elicit and facilitate such cooperation.”

2.3 The mission of the Agences de la santé et des services sociaux

Section 340, paragraph 2 of the Act Respecting Health Services and Social Services gives to the agences de la santé et des services sociaux the responsibility of “facilitating the development and management of the local health and social services networks in its region;”

3. MENTAL HEALTH AND ADDICTIONS RESPONSIBILITIES

3.1 The health center or nursing station of the community of XX provides the following mental health and addiction services:

- Intake, evaluation, orientation and monitoring service;
- Crisis intervention service;
- Custody intervention service outside office hours;

3.2 Responsibilities of the mental health and addiction services of the CSSS of XX:

3.2.1. Mental Health:

The first-line mental health team is composed of professionals with knowledge and skills in mental health and who share common objectives.

The roles assigned to the first-line mental health team are:

- Evaluate, using recognized clinical tools, the consultation requests that have been forwarded;
- Provide care and services to the client based on clinical practice guidelines and evidence-based practice in the context of first-line services, while taking into account family members;
- Provide support to partners within the CSSS and external partners, including appropriate community resources;

3.2.2. Addictions:

The Addiction Program aims to prevent, reduce and treat addictions through the deployment and consolidation of a range of services across the province. The program's clientele consists of people who display at-risk behavior, problems of

abuse or dependency issues related to alcohol, drugs, gambling or money. Some clients are systematically targeted and must be systematically considered, namely pregnant women and their spouses, parents of young children, troubled youth and persons with mental health problems. The program also includes services for families and friends of addicts. The services offered are:

- Detection and referral to appropriate services
- Early intervention to prevent worsening of the situation
- Inpatient detoxification in a hospital
- Outpatient detoxification without intensive care
- Psychosocial follow-up under treatment of a specialist
- Medical and psychosocial follow-up with substitution treatment support

4. OBLIGATIONS OF THE PARTIES TO THE AGREEMENT ON COLLABORTION

Joint obligations:

4.1 The parties agree to promote the sharing of information, in compliance with the consent obtained, to ensure the best possible service to every client.

4.2 The parties undertake to maintain an oversight committee to support the delivery of services and, where appropriate, establish ad hoc committees to support the development of services.

4.3 The parties shall jointly determine the procedures that members of the First Nations shall follow to ensure the coordination of their requests for services, referrals and monitoring.

4.4 The CSSS is committed, as able, to providing opportunities for clinical training of human resources working in the area of mental health and addiction in the communities. The training costs, unless otherwise stated, are the responsibility of the community.

4.5 The community is committed to providing workshops on awareness of the culture of (name of the Nation) to services offered by the CSSS and other partners; the training costs will be the responsibility of the institution which receives the workshop.

4.6 The parties undertake to ensure that their expertise in the areas of mental health and addiction prevention, promotion and intervention is kept up to date.

5. SAFEGUARDING AND MAINTAINING CONFIDENTIALITY, PROTECTING PERSONAL INFORMATION AND OBTAINING CONSENT

Under this Collaboration Agreement, any information concerning users must remain confidential under the Act Respecting Health Services and Social Services as it applies to institutions. The Quebec Civil Code also defines the principles of confidentiality that must be respected in employment contracts and case work. The *Frame of Reference for the Protection of Information Held By a Quebec First Nations Community or Organization,* as adopted June 12, 2012 by the Assembly of the First Nations of Quebec and Labrador in its resolution 07/2012, also forms part of the basic considerations to take into account concerning confidentiality. Information regarding users transmitted between the parties shall be with the free and informed consent (verbal or written) of the user through the aid of the attached form (Appendix XX).

The parties recognize as confidential information any documents or personal information that their staff has acquired in the course of their duties, including any information included in the user's file. As a result, the community agrees and undertakes for its professional staff and all its employees for the duration of this Agreement on Collaboration and at all times thereafter:

a) to safeguard and maintain the confidentiality and privacy of personal information and to prohibit the use of such information for any purposes other than those necessary for the execution of this Collaboration Agreement;

b) to ensure that personal information is only disclosed to members of its staff who require it, in the context of the execution of this Collaboration Agreement;

c) to take the necessary measures to prevent the disclosure or transmission of personal information to third parties, notably by developing and ensuring the application of confidentiality rules and policies, including those under the jurisdiction of the Commission d'accès à l'information, which aim to prevent any unauthorized reproduction, use or access of personal information;

d) to report, in a timely manner, to the CSSS any incident that may affect the privacy or confidentiality of personal information; to promptly notify the CSSS, if the community knows or has reason to believe that an unauthorized person has had access to personal information or of any other contravention committed by such person in respect to this confidentiality agreement;

e) to promptly notify the other party to this agreement in the event that an unauthorized person has gained access to personal information or of any other contravention committed by such person in respect to this confidentiality agreement.

6. COMMUNICATION

6.1 Exchanges of correspondence

All documents and correspondence provided for in this Collaboration Agreement shall be sent in writing to the representatives of the parties at the addresses listed below:

- _____
  (Address of the health center of the community and its representative)
- _____
  (Address of the community and its representative)
- _____
  (if applicable: Address of the agency and its representative)

6.2 Maintaining lines of communication

To facilitate the continuity of the relationship between the parties:

- The parties shall inform each other in writing and as soon as possible of any changes to the representatives holding positions related to the implementation of this Collaboration Agreement.
- Each party agrees to facilitate the participation of the other in its prevention, information, training and awareness activities through the same channels of communication.

7. TERM, RENEWAL AND MONITORING OF THIS COLLABORATION AGREEMENT

7.1 Term of the Collaboration Agreement

This Collaboration Agreement takes effect on the date of its signature by all parties and shall remain in force until _____.

Upon this date, it will be automatically renewed on a yearly basis for a period of one year unless either party sends a written notice of at least 30 days indicating their desire to terminate or modify this Collaboration Agreement.

7.2 Monitoring of this Agreement

It is agreed that _____
(institution)

will convene an annual mid-term review of this Agreement. Each party agrees to designate a representative to monitor the Collaboration Agreement and will provide the name of such representative to the other party in writing.

8. TERMS RELATED TO NONCOMPLIANCE WITH THE COLLABORATION AGREEMENT

To be defined

9. SIGNATURES

At _____, this _____ day of the month of _____
(city)

in the year of 20_____.

_____ _____
Signature of the community's representative ***Signature of the institution's representative***

_____ _____
Name (please print) ***Name (please print)***

Appendix 2. Performance Measurement Plan

Expected results	Elements to be evaluated	Indicators	Objectives/targets	Sources/collection methods	Baseline	Frequency of measurements	Responsibility for data collection
Increased capacity of partners and interveners involved in the mental health and addiction services of First Nations communities to collaborate in the integration of mental health and addiction services	Establishment of partnerships	Number of partnerships established	A partnership established for each of the communities	Mental health advisor/interview	0	Once, at the end of the project	FNQLHSSC research agent
	Negotiation process	Number of negotiation meetings conducted	Sufficient number of meetings for negotiations	Communities and CSSS/written questionnaire	0	Once, at the end of the project	FNQLHSSC research agent
		Satisfaction of the communities and the CSSSs in relation to the negotiation process	All the partners are satisfied with the negotiation process	Communities and CSSS/written questionnaire	n.a.	Once, at the end of the project	FNQLHSSC research agent
	Support provided by the FNQLHSSC to assist the establishment of partnerships	Satisfaction with the support provided for establishing partnerships	Support was appreciated and helpful for the communities	Communities/ written questionnaire	n.a.	Once, during the project	FNQLHSSC research agent
	Awareness of the actors from the provincial network to the reality of the First Nations	Number of awareness workshops	An awareness workshop offered to each CSSS concerned	Mental health advisor/interview/ document review	Yes in Abitibi, no on the Côte-Nord	Once, after the workshops were provided	FNQLHSSC research agent
		Number of workshop participants	All the interveners involved in services for First Nations	Mental health advisor/interview/ document review	Yes in Abitibi, no on the Côte-Nord	Once, after the workshops were provided	FNQLHSSC research agent
		Satisfaction with the workshops	Workshops appreciated by all the interveners	CSSS interveners/ written questionnaire	n.a.	Once, after the workshops were provided	FNQLHSSC research agent

Improved integration of mental health and addiction services offered to First Nations communities through support for the implementation of local protocols	Local agreements developed	Number of agreements signed at the end of the project	An agreement signed for each participating community	Mental health advisor/interview	0	Once, at the end of the project	FNQLHSSC research agent
	Support provided by the FNQLHSSC for achieving agreements	Satisfaction with the support provided for the implementation of agreements	Support was appreciated and helpful for the communities	Communities/ written questionnaire	n.a.	Once, at the end of the project	FNQLHSSC research agent
Improved access and continuity of mental health and addiction services for the First Nations of Quebec	Short-term impacts of the project on the services offered	Decrease in the number of problems encountered by First Nations clients attending their CSSS after the signing of agreements	Fewer users experiencing problems receiving CSSS mental health and addiction services	Communities/ written questionnaire	Not known	Once, at the end of the project	FNQLHSSC research agent
		Satisfaction of the communities in the collaboration with the CSSS after the signing of agreements	Improved collaboration between communities and the CSSSs	Communities/ written questionnaire	n.a.	Once, at the end of the project	FNQLHSSC research agent
	Sustainability of partnerships	Number of still active partnerships after the signing of agreements	Active partnerships maintained after the signing of the agreement	Communities/ written questionnaire	0	Once, at the end of the project	FNQLHSSC research agent