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# Exploring the potential roles of community-university partnerships in northern suicide prevention implementation research

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**ABSTRACT**

This paper discusses the lessons learned from a partnership project on suicide prevention carried out with Inuit organisations in Nunavut and Nunavik. The aim was to identify research needs, processes, and opportunities for knowledge translation to guide suicide prevention activities. Key reflections among partners regarding regional needs and the potential roles of research in suicide prevention in northern Canada are described as well as the three identified priorities: (1) focusing on community mobilisation; (2) supporting access to scientific information; and (3) supporting the adaptation of evaluation criteria and protocols of ongoing community activities. Strategies to address these priorities are presented.

**RÉSUMÉ**

Cet article présente les leçons tirées d'un projet de recherche en prévention du suicide, mené en partenariat avec des organisations du Nunavut et du Nunavik. L'objectif était d'identifier les besoins de recherche, les processus et les possibilités d'application des connaissances afin d'orienter les activités de prévention du suicide dans ces régions. Les réflexions principales des partenaires quant aux besoins régionaux et aux rôles de la recherche sont ici décrites. Trois priorités ont été identifiées: 1) la mobilisation des communautés; 2) l'accès à l'information; et 3) l'évaluation des activités en cours. Les stratégies imaginées pour répondre à ces priorités sont présentées.

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## Introduction

There is evidence of a wide range of physical and mental health disparities between the general population and circumpolar Indigenous populations. Suicide rates are recognized as among the most serious of these disparities [1–3]. Available statistics show that while Canada has a moderate rate of suicide compared to other countries, Inuit in Canada suffer from one of the highest rates of suicide in the world [4]. Youth are especially at risk. From 1994 to 2008, the rate of suicide among Inuit youth under 18 years of age was 30 times higher than that of their counterparts within the general population [5]. These high rates of suicide among Inuit are a relatively recent phenomenon. In the 1950's and 60's rates of suicide were as low as 5.2 per 100,000 [6] but steadily increased from the 1970s and 1980s [6–8]. Between 2009 and 2013, just prior to the beginning of this project, death by suicide was at 116.7 per 100,000 in Nunavut and 113.5 per 100,000 in Nunavik. During the same period, the Canadian national average was 11.3/100,000 [9]. These deaths often occur in clusters. In 2016, the community of Kuujjuaq (Nunavik), composed of 2154 inhabitants lost 5 youth to suicide over an 8-month period and there were another 85 attempts among youth from this community in the same time period [1].

While recognising the complexity of the phenomenon, many authors argue that there is a direct link between the increase in suicide rates in Northern communities and the cumulative transgenerational effects of the historical processes of colonisation, and social marginalisation [8,10,11]. Facing what they called an "unacceptable reality" Inuit regional leaders urged organisations, researchers, community members and governments to develop comprehensive and effective responses to address the situation [12].

Research on suicide in Inuit regions has focused largely on risk and protective factors associated with

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suicide [13,14], suicide trends over the past years [8,15], representations and experiences of mental health, well-being [16,17], and associations between suicidality and colonisation [2,18,19]. Much less work addresses suicide prevention and intervention for circumpolar regions. Indeed, a recent scoping literature review found that only 7 of 95 articles on suicide in the circumpolar region between 2004 and 2014 described suicide prevention interventions [20]. Five of these articles described projects conducted in Alaska, and two in Nunavut, including a community toolbox [21], a CD-ROM to train counsellors [22], a helpline [23] and an intergenerational exchange project between youth and elders [24].

Difficulty in translating research studies of risk and protective factors or demonstrations of the efficacy of interventions into action to address health disparities in global health has led to increased investment in implementation research, which aims to bridge the knowledge-action gap [25]. Researchers in implementation science are interested in how the local context and its specificities, including end-user engagement, influence the ability to implement a programme or policy, and the ways in which these programmes or policies must be adapted to ensure their uptake within a given setting [26]. Implementation research generally looks at the best practices in a given field of study and explores a set of contextual conditions that may influence the implementation including: characteristics of the target population; characteristics of the intervention; characteristics of the "inner setting" or local context (economic, political and social contexts of the specific implementation of the programme); the process of implementation; and characteristics of the "outer setting" (broader economic, political and social contexts beyond the specific place and time of implementation) [27,28].

In this paper, we describe our process and reflections as partners in a community-university partnership project on suicide prevention implementation research carried out with Inuit organisations in Nunavut and Nunavik (Northern Quebec). The partnership was funded by a Phase I CIHR Pathways to Health Equity Implementation Research grant. The aim of the project was to identify promising interventions, research needs, and opportunities for partnerships to support the implementation of suicide prevention programmes and strategies within the regions. According the CIHR call for proposals, Phase I of the Pathways programme was meant to lead to the co-development of a proposal for a second phase in which policies and programmes would be implemented and assessed in a pilot project, followed by a third phase of scale-up. During the first phase of the partnership, we reflected on needs within the Nunangat regions and the potential roles of university partners in suicide prevention implementation programmes in northern Canada. The extensive discussions held among partners over an 18-month period allowed us to rethink the goals of implementation research and what it could look like on Inuit territory. This paper was initially written to summarise the reflections and then validated, refined and approved by partners of both Nunavut and Nunavik.

## The partnership

This project was developed in response to a 2014 call for proposals for implementation research teams as part of the Pathways to Health Equity initiative of the Canadian Institutes of Health Research, Institute for Aboriginal Peoples Health. In 2014, Nunavut Tunngavik Incorporated (NTI), responsible for social and cultural well-being in Nunavut, was ending the first phase of its Suicide Prevention Strategy Action plan and wished to expand its actions. Similarly, the Nunavik Regional Board of Health and Social Services (NRBHSS) had conducted a variety of community consultations and, with a committee composed of Inuit leaders, had developed a regional action plan for suicide prevention. During that same year, the PI of the team (LJK) was approached by an Inuit community leader, Nathan Obed, who at the time was the Director of the Department of Social and Cultural Development at Nunavut Tunngavik Inc., Iqaluit (and who later became the president of Inuit Tapiriit Kanatami (ITK), an organisation that represents all Inuit in Northern Canada) to explore promising intervention practices for suicide prevention in Nunavut and Nunavik. Together, they developed a list of potential partners. Each potential partner was contacted and invited take part in the current project as well as to add suggest other potential partners.

The initial team was composed of researchers, a coordinator, representatives of governmental institutions of Nunavik and Nunavut including both Inuit and non-Inuit actors, as well as a representative of Inuit Tapiriit Kanatami[1] (ITK). The government of Nunavut (GN) and Nunavut Tunngavik Inc[2] (NTI) represented Nunavut suicide prevention as were the Embrace Life Council[3] (ELC) and the Red Cross. To represent the

[1] https://www.itk.ca
[2] http://www.tunngavik.com
[3] http://inuusiq.com

voice of Nunavik, five individuals working for the *Nunavik Regional Board of Health and Social Services*[4] (NRBHSS) participated, including the director of mental health services, a suicide prevention agent, the community suicide prevention liaison worker, and the director of wellness workers. Finally, a representative of the comprehensive community health and social services clinic (CLSC) in Sherbrooke (Southern Québec), who had been working with the Nunavik team on suicide prevention, community mobilisation and adaptation of best practices was invited on the team.

## The process

The proposal was submitted to CIHR and evaluated favourably. Team members in Nunavut and Nunavik informed community stakeholders and linked the team to appropriate organisations and networks in the regions. In March 2015, the partners met to determine the priorities, next steps and roles. The principal investigator took the lead by proposing subgroups and actions as well as time-frames for the action plan. Four sub-groups were created to move forward with each of the priorities of the action plan. The subgroups were informed by implementation research methods, which aim to examine the process and the consequences of organising, delivering and scaling up policies and practices designed to improve the conditions of a population presenting specific health risks [29].

After the initial team meetings and division of tasks, one sub-group collated and synthesized existing literature reviews on suicide prevention to identify promising and strength-based practices and conducted further analyses on existing databases to update available statistics and knowledge regarding risk and protective factors. A second subgroup explored the pertinence of existing Indigenous (mainly First Nations) programmes to the Inuit context and essential cultural or logistical adaptations needed for potential implementation in the North. A third group had the task of developing an implementation grid with a list of the various contexts that needed to be taken into consideration when assessing the pertinence of a programme in the given context. Finally, a group was to finalise a model on cultural adaptation of programmes in order to reflect on the various ways of adapting an intervention to a given context. By the end of the timeframe, the aim was to have a list of promising programmes, ways of assessing the programmes, and frameworks to reflect on the possibilities regarding adaptation.

A workshop was held in Iqaluit (Nunavut) in November 2016. All partners were invited to review the work done to date and discuss next steps. The workshop was recorded. Throughout the workshop, many questions and tensions arose during the exchanges, requiring a deep reflection on the partners' needs and expectations regarding research.

Following the workshop, the first author and two research coordinators listened to the recordings and completed a summary. Then individual discussions (on phone or in person) were held with each partner present at the meeting to validate what the research team had heard, and two group phone conferences with all members allowed for a debriefing. The coordinators continued the individual contact with each partner via phone meetings and in person exchanges in the Montreal area. A final two-day meeting took place in Montreal to share the materials, validate our understanding of needs and explore outcomes. The meeting was recorded and transcribed. In contrast to the tension at the Iqaluit meeting, the partners felt pleased with this second phase of the project, which led to concrete decision-making within the partner organisations.

## The lessons learned: rethinking implementation research in Nunangat territory

The challenges identified during this process have important implications for ongoing work in Inuit regions but also raise broader issues for implementation research, university-community partnerships and capacity building.

1. Community mobilisation rather than implementation of programmes

Partners spoke of the variety of programmes and initiatives that have been developed over the past decade. Government funding has been made available to finance a variety of programmes. Moreover, Inuit organisations and communities have advocated for and initiated a variety of programmes independent of research teams.

> I think about suicide prevention initiatives in the territory in the past 12 months, and what we had 12 months ago is nothing like what we have now. Because of declaring a crisis. And now having the Quality of life Secretary. We released the one-year action plan in March. That had a whole bunch of initiatives that were funded. And now we're working on the next ones. So like even our office, like in a year you wouldn't even know it was the same with the programme that we're doing. I'm sure it's the same in Nunavik because the pressure is on and the momentum

[4] http://nrbhss.gouv.qc.ca/en

> is there. You can probably call me in 3 months and I can add to your new programmes on the list.

Seeing this emergence of programmes and initiatives in their regions, partners spoke of the importance of community mobilisation and of long-term development. They felt very weary of short-term research projects and the implementation of programmes developed for other populations in other contexts. Partners described the relationship with research as being at times stressful or demotivating, especially in a context where long-term funding was not guaranteed and where the intensive groundwork required for implementation was often lacking.

> We don't want a redundancy of programmes. We want to move in a direction. So if we can imagine a way, then great. If it's a programme that already exists, then awesome. We're all here for the same goal. It's not about implementing millions of programmes though. I don't see that as logical.

Moreover, there was a feeling that such "outside" programmes would not meet the unique needs of Inuit, as opposed to northern community-led initiatives. Participants spoke of a variety of initiatives that were community-driven and community specific. There was a feeling that depending on the context of each community, community members might favour certain approaches, and that this specificity could be lost if communities were encouraged to adapt predeveloped prevention programmes. One partner spoke of the child sexual abuse prevention programme being developed in Nunavut, another spoke of modifications made to housing units within a community to prevent suicide by hanging. A third partner spoke of a community that had decided not to sell alcohol. All of these efforts stemmed from ideas of community members and were implemented by Inuit.

> Because the practices are very different. That's like our Child Sexual Abuse Prevention module, it's being developed by Inuit because they know … I've learned so much. It's the first time I've been in the inner workings of creating an Inuit specific model of any kind of a training. It's going to look entirely different from anything I've seen before.

> They removed all the door locks, they removed all the curtain rods, and put [inaudible) dressers so the housing department in that community … Because the community asked for it. So nobody is walking and imposing these things on communities. They're being offered, and if you would like them, they'll help you to do those kinds of things.

> The other one I would mention as well is that some communities have chosen to be dry communities.

The idea of culturally adapting existing programmes was not viewed positively. It was described as "taking something that is not Inuit specific and transforming it." It was described as somewhat disempowering for the communities and the individuals who had been working hard at developing their own strategies. It was understood as a top-down approach despite the positive intentions of ensuring cultural safety of programmes and despite the fact that many cultural-adaptation programmes are grounded in principles of empowerment and respect for cultural ways.

> Adaptation, it's to take something and to try to arrange it to fit in the reality. And what we prefer to do is to develop something specific for the reality. Sometimes stakeholders get really hung up on their product. But it's really to create … You're taking a colonial model usually and you're adapting it. It's what you do.

> We are working since a lot so hard with the partners to take the idea from a community and to develop projects. So having a big research team presenting a project with a lot of funds it's kind of disempowering.

The concerns voiced by community partners indicated scepticism about the value or acceptability of adapting interventions developed in other settings. Rather than advocating for a single approach, we provided regional agents with a table of best practices and programmes developed or adapted in Indigenous communities, with contact information for each. This allowed agents to have access to the information without imposing any programme or approach.

### 2. Accessing and sharing information

The second major theme in discussions was having access to scientific information and spaces for connecting with others around mental health and suicide, and more specifically about research conducted in northern Canada. Partners deplored still having difficulty accessing data and synthesized knowledge from past research. In addition, when results or published articles are physically accessible, there was a feeling that the type of information shared was often problematic because it was overly focused on difficulties rather than on strengths and solutions.

> Yeah, stop telling us what we're doing wrong and tell us what we're doing right. A researcher made a comment like that when she had her lecture. She said that she's very tired of having that. I think it's going to be very different for someone who works as a programme implementer or facilitator. It would be interesting to have those facts, suicide prevention strategies maybe more suitable for the actual community members who are

> affected be by these high rates. Things that can helpful not necessarily just based on suicide high rates.

There was also a concern that the format and the concepts used in available knowledge transfer tools were not always clear and concise. Moreover, there was a recognition that communities might require specific information based on their local realities in order to ensure relevance and application of results. One partner explained that a researcher could go into a community and enquire:

> What's happening in your specific community? So, not a global research but a very specific one to those communities. Then the idea is to take that information and provide programme.

This information could be simplified and accompanied by questions for reflection that would allow community members or policy makers to make sense of the information in relation to their own context and identify ways to apply this information to developing specific strategies and actions.

> If the community asks for that type of information, then fact sheets are a bit of information and then you work with the community asking questions. "What does that mean to you? Here are the risk factors. Do you think that those risks or protective factors, it's true for the community?" Like it's more like a trigger for conversation or … Like the whole PC-Cares of Lisa Wexler is very interesting.

Here the participant referred to a recently developed community mobilisation approach to a Community of Practice in which "bite-size" pieces of information are shared with community members during their mobilisation workshops to ignite action-oriented discussions [30]. Another partner spoke of the challenges of reading and making sense of statistical data:

> So I think this is the biggest challenge with statistics. It's to try to do … to write what is the implication for the practitioners. For me just statistics like that, that doesn't help. (…) we have to describe what is the action we want them to do with the information.

Participants clearly felt that accessing information and having a place and time to reflect on it was very pertinent to their processes of programme development and community mobilisation.

> But how do we best develop people's capacity? Or they don't feel like they're qualified to do it. Or they don't … Like there's any number of reasons where people are going to come out and say run on afterschool peer leadership programme. Like it's just … So it's how can we best build our communities so that they are capable and competent. To give themselves what they want. The knowledge is all there. It's getting to the next level.

Based on the requests made by the partners, the research team worked on different methods of knowledge transfer in order to explore with partners that would be most pertinent. knowledge transfer methods included: (1) developing a bibliography of relevant articles; (2) preparing one-page resumes of articles in different formats; (3) writing a text that integrates results from different articles all pertinent to circumpolar realities and integrating stories of elders that illustrate some of the concepts; and (4) Creating a table or grid for mapping and evaluating suicide prevention strategies to ensure comprehensive multi-layered suicide prevention.

### 3. Support in evaluating what people are already doing

The third key theme was the desire for support in evaluating the initiatives that are currently being developed in northern Canada.

> Just to provide further examples of culturally based interventions, there was a huge study done on a programme for young men. So not huge but I mean of fourteen participants, young men who went hunting, had to come back and share the catch, had to work with the elders … from step one right to the end of their project. So that took place over months. It was successful. They went from whatever their number of suicides to zero. That year that they ran the programme, they had no suicides. Then they lost their funding. Because what we need are the data in order to support. So Health Canada says "Where's your data, that this is going to work? Then we'll fund you". But you need to do the trials in order to get the data, in order to prove that that funding is relevant. So that's what we're referring to here. That's why it's so important to have that research.

Responsibility for the evaluation of programmes often was assigned to government agents who were not trained for the task and who were in charge of a great variety of files, often quite urgent and complex. The ITK National Inuit Suicide Prevention Strategy [10] identified key priorities which can provide a basis for evaluating the impact of interventions.

Evaluation in the field of suicide prevention for the general population poses distinct methodological challenges [31]. In northern regions, geographical, historical, political and cultural considerations add to the complexities of developing rigorous and relevant evaluation protocols that respect community knowledge and local context (Pollock et al., 2018a). Crucially, partners spoke of the importance of adapting evaluation methods to Indigenous knowledge.

> So we're looking at how do we incorporate Inuit or indigenous knowledge, which would be like story based evaluations where there's actually a value to a community who is doing the research in a way that … So most significant change

> through a story as opposed to scientific collection of data, creating a space for that.

Following the request, we developed a list of individuals and organisations that can conduct evaluations and are familiar with northern realities. We also developed a short introduction to evaluation in suicide prevention with an evaluation framework and references.

### 4. Developing a Community of Practice (CoP)

As the partnership evolved, various partners spoke of a particular benefit of the implementation team: the research process encouraged participants to set aside time to share experiences and expertise. They felt that the partnership should continue and be formalized as a CoP for regional agents working in the field of suicide prevention.

Although CoP is a fairly new concept in implementation science [32], it refers to a process that occurs naturally in social groups and that is consistent with Inuit community practices of knowledge sharing. CoP is an informal regrouping of people with a shared domain of interest (e.g., suicide prevention) for the purpose of collective learning [33,34]. CoPs can occur in person or online, synchronously or asynchronously and can be facilitated through various formal methods of network building and animation. In implementation research and practice, CoPs provide a way of sharing knowledge and creating new knowledge around a given subject of practice by supporting reflexivity among its members. CoPs must offer a safe environment to help foster a feeling of belonging and equality within the community. CoPs are recognized as a promising approach in health, education and social services and, more specifically, in mental health promotion and suicide prevention [30,35].

Partners spoke of the importance of having a safe space to talk about the challenges experienced by people who are living the same or similar realities as those they seek to help. Addressing the challenge of this personal impact was also a major reason for advocating for this CoP.

> And I really think if we're gonna see a difference we need to work together. It's heavier because when you're working in suicide prevention and there's still suicides happening in the middle of your work, sometimes because of the lack of relationships between the services and the people, it's hard to go in that direction. It really is. I would have so much hope working with my people than to have hope working with governments that are funding us. Because we have this mutual understanding.

> Because I remember last year during a crisis in our community, I mean I always had hope but it went way down for a while, it was really tough. And just having that hope and that support from other regions that can say to me "You're going through a hard time right now but we went through this 3 years ago and look at what we did and this is what we did and this is how we got through it". I think that would make a world of difference as far as doing our work and just continuing to do our work. So we can exchange on challenge.

Partners also saw the potential for advocacy by creating this type of network. They felt that together they would have a stronger voice when making funding requests or speaking to provincial and federal governments and organisations.

> We're also gonna be able to have a common language, like to be able to better understand each other. When there's going to be like the next symposium in mental health or whatever, we have to present what we've done as a community of practice, then it's gonna have more weight like for our decision makers to be able to say "Okay, we hear you now". We're speaking as a Nation, we're not just speaking as Nunavummiut. So this is going to be something that's really going to help us.

Potential challenges of building a CoP were mentioned; in particular, identifying who would coordinate it given that many potential facilitators already had heavy demands on their time. Concerns about lack of time and human resources, sustainability, and political support were highlighted in partner discussions. Potential solutions to these challenges were also identified.

To move ahead, partners chose to coordinate the meetings themselves and divided the organisation tasks. They chose four themes to discuss over the ensuing months: (1) On the land activities; (2) protective factors regarding addictions; (3) healing practices; and (4) suicide safe broadcasting. Monthly teleconferences were arranged and guests with knowledge and perspectives relevant to the CoP were invited to these meetings.

The research team contributed short, focused literature reviews in lay language to contribute scientific perspectives on the subjects. The research team also supported the group by offering information on CoP, including information on developing terms of reference.

## Discussion

The Pathways to Health Equity Implementation Research Team on Suicide Prevention for Inuit Youth aimed to support the development of partnerships between a variety of actors, identify promising practices that correspond to the realities of community partners, which could be adapted, implemented, and assessed. At the launch of the funding

programme, government agencies were actively searching for partnerships that would allow concrete actions to be taken to respond to the suicide crisis in Inuit communities. However, by the time the team was funded and work began, much had changed within communities in Nunavik and Nunavut. As a result, the research needs changed and the team had to rethink the collaborative process and goals. We expect the research needs will continue to change as the context evolves.

First, in our discussions with partners, we found that implementation research remained relevant for northern communities, but not necessarily, as initially planned, for finding promising programmes, adapting, implementing and evaluating promising interventions. Implementation research focuses on the process of change: the conditions that influence change, the challenges to change, and ways of assessing change. Although not always the case, it generally is grounded on the premise that previously conducted scientific research, or at times local programmes have identified promising intervention and that implementation research will allow for appropriate cultural and contextual adaptation of the intervention and its subsequent scale-up.

There were several issues with this premise. First, the regions engaged in the partnership were already mobilized and invested in many activities supporting a variety of efforts. New programmes or interventions were not positively viewed because they threatened to add to an already heavily committed and often over-burdened system.

Cultural adaptation was also viewed negatively. Implementing new programmes brought in from "the South" is very time consuming and difficult to do with geographical considerations, high turn-over, low resources, many social issues to address. Moreover, implementing and adapting existing programmes does not put forth the strengths and knowledge of communities. There seemed to be a strong desire to share northern-based knowledge on the subject rather than adapting southern programmes. As mentioned by our partners, suicide prevention programmes were being developed across Inuit Nunangat and in other northern regions, including Alaska [30,35].

Secondly, reflecting the centrality of local community in the organisation of Inuit social life and governance, there was a recommendation that, at least at this point in time, interventions needed to be more local and that researchers should not take the lead in designing or guiding these interventions, but instead act as supports to local members and institutional agents within the region. It was recognized that there would likely be exceptions to this approach, including situations where researchers were already deeply involved with long-term commitments in co-led projects. Indeed, community partners felt that partnerships with universities could be defined differently. Researchers could support community and regional agents already organising or planning interventions by sharing information on suicide and suicide prevention, and supporting critical and constructive reflections based on the available research, allowing communities to build their own strategies. Researchers' knowledge and skills regarding evaluation and report writing were recognized as valuable assets in the much-needed evaluation of ongoing community strategies. Questions concerning the nature of the evaluation process and the appropriate outcomes to be assessed remain an important line of work that needs to be undertaken to ensure that evaluations are consistent with community values and pertinent to their resources and priorities.

Partnerships with researchers can be helpful, but they also are costly in terms of time and commitment. On numerous occasions our partners expressed ambivalence about research, despite an openness to connecting and to any opportunities for knowledge building. The ambivalence stemmed from the lack of resources and doubt about the practical relevance of the partnership. Researchers must be humble about their potential contributions and aware of the limitations of their work. To develop trusting relationships with organisational partners, they need to be present in meetings, check-in frequently by phone to hear about what is being done and where there are emerging needs to which they can respond. In our experience, as trust develops, and when the time is right, the organisational partners at community or regional levels may have specific requests for researchers. This responsive approach requires sustained funding so that teams can be available to collaborate when needed. This points to a different model than the time-limited grants that usually fund research. The CIHR programme that launched this team provides one model for enabling such ongoing partnerships that can respond to community needs.

## Conclusion

The discussions held throughout this project highlighted some of our own biases as researchers conducting implementation research and the importance of rethinking what implementation research can look like. A common thread throughout the discussions was the importance of self-governance and supporting community capacity so that the implementation and the research can be designed and led by community and by local or regional agencies. Qaujigiartiit Health Research Centre[5] in Nunavut and the Institute for Circumpolar Health Research[6] are two

[5]https://www.qhrc.ca/
[6]http://www.ichr.

examples of locally led research centres. Both share the mission of developing and promoting initiatives designed for and by Inuit. These two centres are extremely active and have developed multilevel projects to promote wellness across the Inuit Nunangat. According to our partners, researchers can contribute to self-governance by supporting these locally led and northern-based initiatives rather than adapting programmes from the South. Responding to this call for changes in the role of researcher can lay the foundation for more egalitarian and reciprocal community-university partnerships. Our partners also talked about the challenges to the sustainability of locally led initiatives. While more funding has been made available as a response to the high rate of suicide across Inuit Nunangat, funding opportunities are mainly short term. Along with more sustained, long-term funding for programmes implementation, our reflections underscore the need to build local capacity for implementation research in Northern communities. Given the challenges of infrastructure, that process may be facilitated by fostering communities of practice that include academic researchers and mental health practitioners as resource partners within community-led educational and intervention programmes.

## Disclosure statement

The authors have no conflict of interest to declare.

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## Geographical location

Nunavik and Nunavut are vast territories located beyond the 55th parallel north that cover the northern peninsula of Québec and northern Canada.

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