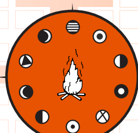
BRIEF JOINTLY PRESENTED

by the Assembly of First Nations Quebec-Labrador (AFNQL)
and
the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC)

BRIEF ON BILL 10: an act to amend the organization and governance of the health and social services network, in particular by abolishing the regional agencies

First Nations of Quebec and Labrador Health and Social Services Commission



Assembly of First Nations Quebec-Labrador

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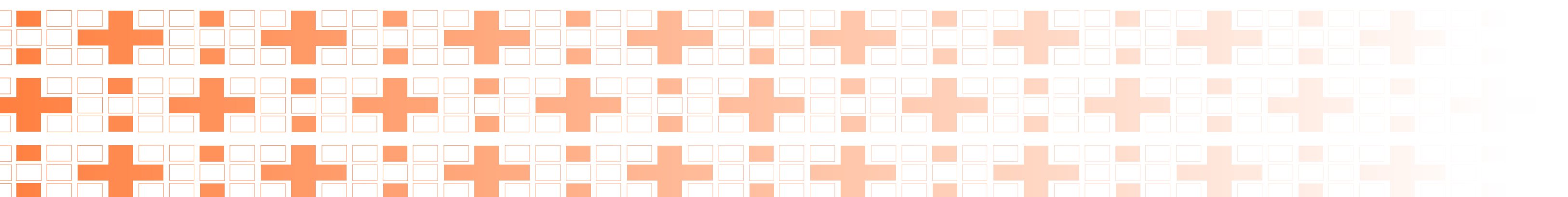


INTRODUCTION

BRIEF ON BILL 10: AN ACT TO AMEND THE ORGANIZATION AND GOVERNANCE OF THE HEALTH AND SOCIAL SERVICES NETWORK, IN PARTICULAR BY ABOLISHING THE REGIONAL AGENCIES

INTRODUCTION

On September 25, 2014, the *Ministre de la Santé et des Services sociaux*, Gaétan Barrette, tabled in the National Assembly Bill 10, *An Act to amend the organization and governance of the health and social services network, in particular by abolishing the regional agencies* (Bill 10). Special expanded consultations are being held with over forty organizations. The government has invited them to submit their views before a parliamentary committee. Among these organizations, there are several professional orders, associations of directors of institutions, organizations representing various clientele of the network, groups of caregivers, community organizations and social economy enterprises, trade unions, etc.

Once again, we must denounce the fact that the First Nations were not invited to these hearings because the government felt it unnecessary. However, the Assembly of First Nations–Quebec and Labrador (AFNQL) and the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) represent the interests of a population of over 60,000 people who will be affected by the proposed changes. These are all men, women and children who are entitled to access the Quebec network. These are people living for the most part in a difficult socio-economic context and who face specific jurisdictional conflicts already posing a barrier to equitable access to care. Why must the First Nations constantly remind the government of its duty to consult?

The AFNQL and the FNQLHSSC therefore submit this Brief to bring to the attention of the government the concerns of the First Nations with respect to this Bill.

1. DESCRIPTION OF THE ORGANIZATIONS

Founded in 1985, the AFNQL is the meeting point of the Chiefs of 43 communities in ten First Nations in Quebec and Labrador. The AFNQL addresses issues such as the defense of Aboriginal and Treaty rights and title; the policies of the federal and provincial governments that violate the customs and lifestyle of the First Nations, government policies and laws, funding levels, decisions and relationships with governments; economic development and all social, economic and cultural issues; and generally all matters relating to self-government, international relations and government relations. The secretariat of the AFNQL coordinates work on a number of priority issues and the official activities of the regional Chief. It implements the decisions taken by resolution of the Chiefs-in-Assembly, to improve the living conditions of the First Nations.

Founded in 1994, the FNQLHSSC is a non-profit organization responsible for supporting the efforts of the First Nations in Quebec and Labrador in order to, among other things, plan and deliver culturally-appropriate and preventive health and social services programs. Its mission is to promote and monitor the physical, mental, emotional and spiritual well-being of First Nations and Inuit people, families and communities. It also aims to improve access to comprehensive and culturally-sensitive health and social services programs designed by First Nations organizations that are recognized and sanctioned by the local authorities, all the while respecting their respective cultures and local autonomy.

2. OVERVIEW OF THE PARTICULAR CONTEXT OF THE FIRST NATIONS IN QUEBEC[1]

The Constitution Act, 1867 confers exclusive jurisdiction with regard to Indians and lands reserved for Indians to the federal Parliament.[2] That is why the federal government works with First Nations communities in all areas of activity, including to fund and support basic health and social services, complementing the Quebec network. Provincial laws of general application (health and social services, security and safety of buildings, etc.) are valid on the territory of the reserve, provided they do not come into conflict with an existing federal law or regulation or its subsequent modifications, or that the band council has adopted rules in this area.[3] To exercise the powers conferred on them by the *Indian Act*,[4] band councils have assumed responsibility for a number of services in areas such as health and social services, public housing and infrastructure, education, public safety, etc. No municipality or city in Quebec or the rest of Canada can compare its responsibilities to those of a band council.

In the majority of First Nations communities in Quebec and depending on the funding provided, health centres primarily offer community health services and are open during office hours. Eleven "remote" communities manage nursing stations for the purpose of providing full-time services (24 hours a day, seven days a week). They offer emergency care in addition to community health programs. All of these health services, including the program of home and community care (home care nursing services and personal home care services) are funded by Health Canada, with the exception of services performed by a physician (permanent or visiting), which are reimbursed by the *Régie de l'assurance maladie du Québec*.[5] Care and complementary services (nutrition, rehabilitation, respiratory therapy, psychology, palliative care, etc.) depend on the delivery plan specific to each of the communities, in relation to its needs and the funding granted to it. Specialized services usually require a stay in a Quebec network facility, unless they are offered periodically, whenever possible, by visiting professionals.

For social services, the Department of Aboriginal Affairs and Northern Development Canada (AANDC) funds a range of programs, including adult placement services and domestic help (complementary to the Health Canada-funded home care program) and seven residential centres for people with loss of autonomy requiring less than two and a half hours of care per day. Note that the health and social services centres, as well as residential centres in communities, are not considered institutions of the Quebec network, although some of these facilities are operated under a private institution permit issued by the Quebec's *Ministère de la Santé et des Services sociaux* (MSSS).[6]

PARTNE

1 See, in particular, AFNQL and FNQLHSSC, *Access for All? Fact or Fiction...*, Brief presented to the Committee on Health and Social Services of the National Assembly of Quebec in the context of the special consultations for the White Paper on the Creation of Autonomy Insurance, FNQLHSSC, 2013, pp. 7-9.
2 *The Constitution Act*, 1867, R.S.C. 1985, Part II, no. 5, sec. 91(24).
3 See GRAMMOND Sébastien, *Aménager la coexistence – Les peuples autochtones et le droit canadien*, Établissement Émile Bruylant, Bruxelles and Éditions Yvon Blais, Cowansville, 2003, pp. 361-377; Michel DESCHÊNES, "Les pouvoirs d'urgence et le partage des compétences au Canada," 1992, 33 Les Cahiers de Droit, 1181, pp. 1203-1205.
4 R.S.C. 1985, c. I-5
5 Ministère de la Santé et des Services sociaux, 2007, *Prestation et financement des services de santé et des services sociaux.*
6 Ibid.

3. THE FIRST NATIONS AS PARTNERS: OVERLOOKED AND ALL TOO OFTEN IGNORED BY QUEBEC

The First Nations are confronted by a health care system that is more complex than the one Quebecers are used to dealing with because it constantly requires building bridges between the first-line services offered in First Nations communities and the second- and third-line services provided by the institutions of the Quebec network. Continued efforts must be made on both sides to establish and maintain a true continuum of services available to First Nations. Once established, service corridors and the linking mechanisms that surround them remain very vulnerable to changes in the structures of the Quebec network.

Access to health care is a fundamental right explicitly recognized in the *Act respecting health services and social services*.[7] The First Nations, by virtue of their unique status, have the right to be consulted on such an important issue. We would point out that this reform, like those that preceded it, directly affects the institutional autonomy of the communities' health and social services in relation to first-line services, in addition to having an impact on continued access to second- and third-line services established or in the process of being established through agreements on service corridors between First Nations communities and the Quebec network. The current reforms are proceeding in the wake of a series of legislative changes that have had a significant impact on services in First Nations communities in recent years. Before going further, it is essential to cite a few examples.

Until now, First Nations Children and Family Services agencies were responsible for the management of youth protection services in the context of bipartite or tripartite agreements between the federal government, band councils and youth centres. Bill 125, *An Act to amend the Youth Protection Act and other legislative provisions* (YPA),[8] adopted in 2006, included a maximum duration for placements of children, as a result of which a large number of First Nations and Inuit children became vulnerable to being permanently placed outside their community or their village, thus losing their cultural identity and all connections with their natural environment.

In June 2009, the *Act respecting the representation of family-type resources and certain intermediate resources and the negotiation process for their group agreements*[9] came into force. This law has the effect of considerably reducing the powers previously possessed by a number of First Nations agencies. For many of them, the evaluation, accreditation, monitoring and payment of family-type resources (FTR) are responsibilities conferred to them under agreements they had signed. With the entry into force of Bill 24, the proximity host families must now be evaluated and approved by the regional health and social services agencies, whereas public facilities, under the collective agreement provisions of the law, are responsible for making FTR payments. These significant changes do not take into account the existence of First Nations agencies.

In addition to relieving the First Nations agencies of responsibilities they had previously exercised, Bill 24 will also have the effect of transforming the existing traditional relationships between members of the extended family (or those of the community) and the children they are hosting. Over time, they will be considered as contractual services relations between self-employed workers and youth centres. Thus, in addition to losing the relative autonomy they had previously exercised in protecting their children, the First Nations find that the vision of family and community support that their intervention was based on has been completely sidelined in favour of a "syndicalization" of foster care families, a system that is derived from Quebec culture and virtually non-existent in the communities. This system does not respect the governance structures put in place by local authorities and could reduce the already small pool of First Nations host families.

ERS: OVERLOOKED

7 R.S.Q. c. S-4.2, see especially sections 4-8.
8 R.S.Q., c. P-34.1.
9 R.S.Q., c. R-24.0.2 [hereafter, Bill 24].

It should be noted that Bill 24 and the application of collective agreements have resulted in a major change in the method of funding services in the communities by the federal government (AANDC). Before the entry into force of the Act, First Nations agencies received funding based on a single compensation rate for foster families. This funding method provided for the host families to be remunerated at a reasonable rate and further enabled partial funding of first-line services to organize prevention activities to reduce the rate of child placements. However, responsibility for making payments to the FTRs will be transferred to youth centres under the Act, depriving First Nations agencies of an additional source of funding for first-line services and representing a loss in their autonomy. This loss of autonomy was brought about in contradiction to the fifteen principles adopted February 9, 1983 by the *Conseil des Ministres*.[10]

Changes to the *Professional Code* brought about by the adoption in June 2009 of Bill 21,[11] although based on laudable goals, also resulted in significant consequences to the organization of services for First Nations. The increased requirements for certain categories of professionals, particularly social workers, disqualifies a high number of First Nations interveners already on the job and makes it difficult to recruit First Nations personnel in sufficient numbers.

The situation is also troubling for so-called English-speaking First Nations communities, that is, communities where the use of English is widespread, in addition to the use of the Aboriginal language. Their attempts to recruit qualified bilingual professionals have not achieved the desired results and the unilingual English professionals they hire must now join a professional order in Quebec. Consequently, they must also master the French language, unless they reside in a First Nations community.[12] This is too strict a requirement for communities that are struggling with a housing shortage. This situation accentuates the inequalities that already exist in access to care for this population and is denounced by the coalition of English-speaking First Nations communities.[13]

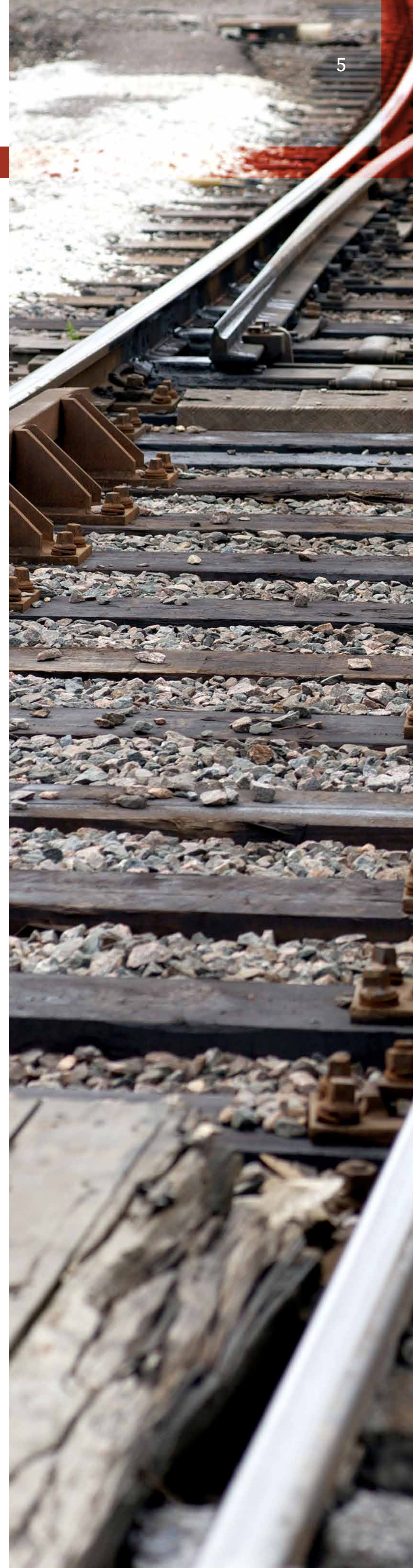
4. THIS REFORM: OBSTACLE OR OPPORTUNITY FOR QUEBEC FIRST NATIONS?

The first chapter of the draft Bill 10 specifies three objectives that can be summarized as follows:

- Facilitate and simplify public access to services.
- Contribute to improving the quality and safety of care.
- Increase the efficiency and effectiveness of the network.

To achieve this, the Bill proposes first to integrate health and social services in each health region by creating expanded institutions through the amalgamation of regional health and social services agencies (ASSSs) and all other public health institutions in the region, with the exception of Montreal. Each regional facility, to be known as a *Centre intégré de santé et de services sociaux* (CISSS), will ensure the organization and complementarity of services throughout the region by hospitals (CHs), local community health and social services centres (CLSCs), nursing homes and long-term residential care (CHSLDs), child and youth protection centres (CPEJs), rehabilitation centres (CRs) and public health departments. The merger of the institutions and the disappearance of regional agencies is intended to simplify the decision-making structure of the current system through the creation of a two-tier management structure: local management at the regional level provided by the CISSS and system-wide management throughout Quebec provided by the MSSS.

10 See, Secrétariat aux affaires autochtones (SAA), in reference to the fifteen principles that constitute the basis for government action in relation to Aboriginal nations.
11 An Act to amend the Professional Code and other legislative provisions in the field of mental health and human relations, S.Q. 2009, c. 28.
12 Another consequence, this time legal; this has the effect of allowing the Charte de la langue française to apply on the “reserves,” even though the Charter explicitly exempts them.
13 “In April of 2012, the English-speaking First Nations communities began working together to address access issues. The Coalition, made up of directors and key individuals from First Nations health and social services organizations, identified that there is a lack of existing health, social and related services accessible for First Nations in the English language: as such, English-speaking First Nations do not have the same level of access to services as that of the mainstream Quebec population.” From CHAMBERLIN, Amy, *Portrait of the Situation for English-speaking First Nations: Accessing Health and Social Services in English in the Province of Québec*, Final Research Report, Onkwata’karitahtshera and the Coalition of English-speaking First Nations of Quebec, October 21, 2013. 100 pages.



4.1 Agreements between the communities and institutions in the youth protection network

Under the current system, First Nations communities are situated on the periphery of the organization of health and social services. At the local level, they must establish corridors of access to care to overcome this distance and must do so while taking into account the cultural and linguistic differences that exist among their populations. In regards to these differences, they are often deliberately ignored or simply misunderstood by the interveners and decision makers of the institutions of the Quebec network.

To overcome this "distance," both institutionally and culturally, many communities have entered into agreements for the protection of youth with institutions of the Quebec network and are currently negotiating other agreements that seek the establishment of mechanisms permitting interveners themselves to exercise other delegated responsibilities. Negotiations are also underway to allow communities to create their own youth protection regimes under chapter 37.5 of the YPA in order to enable more effective interventions adapted to the cultural context and socio-economic reality that exist in First Nations communities.

According to the draft Bill 10, "the provisions of any text applicable to a public institution also apply, with the necessary modifications and unless the context indicates otherwise, to a regional or supraregional institution."[14] As the power to enter into agreements is vested in the *Directeur de la protection de la jeunesse* (DPJ) under chapters 32 and 33 of the YPA, Bill 10 should not have any effect on current agreements. Bill 10 stipulates, in chapter 6, that the regional institution succeeds the public institutions and that it enjoys all the rights and assumes all the obligations of these institutions. The CISSS therefore assumes the responsibilities of the youth centres provided for under the bipartite agreements. This creates some uncertainty as to the administrative structure that will be implemented within the CISSS to enable the continuation of the CPEJ's mission. Who has the status and powers (CISSS, DPJ or the Minister) to ensure that resources are available and organized to enable the effective implementation of the agreements?

In the event that the bipartite agreements are renegotiated, it should be done with the DPJ in recognition of the responsibilities it carries under chapters 32 and 33 of the YPA, but also with the CISSS for other aspects of the agreement. In the current model, negotiations are undertaken with the youth centre in light of the realities concerning the protection of youth in the First Nations. Negotiations with the CISSS could mean a loss of autonomy for First Nations communities due to a lack of sensitivity to their unique characteristics and the history of collaboration with the youth centres. The sensitivity provided by the youth centres is important in concluding these agreements.

Since the entry into force of Bill 24, a new system of payment for FTRs was established. To be paid, the FTR needs to be registered in the province's family-type and intermediate resources information system (*système d'information sur les ressources intermédiaires et de type familial*—SIRTF). Only youth centres have access to this system and First Nations communities want to negotiate an agreement with them to also have access to the system. With the passage of Bill 10, SIRTF will be transferred to the Minister "with all the related rights and obligations."[15] This change would create additional uncertainties for the First Nations as to the duration and the results of such negotiations. On the other hand, Bill 10 could also create new relationships and opportunities for the First Nations to gain access to SIRTF and to be designated as FTR payers.

14 Sec. 42(1).
15 See sec. 162, part 2.

The numerous delays that have taken place since the entry into force of Bill 24 place FTRs of the First Nations who are not registered in SIRTF in a situation of uncertainty about the retroactive remuneration due to them. The FNQLHSSC, MSSS and AANDC are working to find solutions to avoid penalizing those FTRs who, it must be pointed out, are families entitled to an amount equivalent to that of other FTRs registered in SIRTF. If Bill 10 is adopted, they should not suffer further delays caused by the transition, and the Minister should ensure a resolution to this situation as soon as possible.

Bill 10 provides that the CISSSs respect existing agreements between the institutions and partners of the network. However, it offers no guarantees regarding the transitional measures needed to avoid disturbing agreement negotiations currently in process. The work done so far in collaboration with network institutions may be undermined by this reform. During the transition period, youth centres may lose their decision-making powers because of the merger, while CISSSs may not yet be fully functional. Given their coordination role and their proximity to public institutions in their area, agencies play a key role in the negotiation and implementation of agreements under section 37.5 of the YPA. Their abolition implies the devolution of functions to the Minister, who would be playing an increased role in the negotiation of agreements. With the reform, institutions yield this decision-making power to the CISSS and at the same time, lose their ability to renew expiring agreements on their own.

Recommendation 1:

That, on the coming into force of this Bill and for the transition period that follows, the Minister delegates a representative with a mandate to support the progress of negotiations of agreements in process and those still be to negotiated between the DYP and the First Nations communities.

4.2 Continuum of services

In relation to addictions and mental health, Quebec recognizes the responsibility of First Nations communities to set up their own services independently. Among these are intake, assessment, referral and follow-up; the crisis intervention services and on-call intervention services provided by the team of interveners in the community outside of regular hours. For their part, the network institutions cannot assume populational responsibility for non-treaty communities, but need to offer First Nations clientele who come to their doors the same services as those offered to all citizens of Quebec, whether they require first-line or specialized services. Quebec recognizes a responsibility for the continuity and complementarity of services with non-treaty communities. It does so in particular by ensuring the availability of appropriate referral mechanisms when residents of these communities require services in the institutions of the Quebec network and by facilitating the transfer of expertise and knowledge to meet the needs expressed by these communities.

First Nations communities in Quebec, however, have reported the existence of factors limiting access to health and social services of the Quebec network, including lack of awareness about what services are available and the complex organization of these services. In addition, barriers still exist between the services of the Quebec network and the communities due to a lack of collaboration. A lack of sensitivity to cultural differences persisting in certain network services has been reported.

Negotiations have been undertaken to establish administrative agreements between the communities and some CSSSs to formalize their respective commitments for the provision of mental health and addiction services and to establish mechanisms for coordination and communication. A protocol has been created to promote the continuity and complementarity of addiction and mental health services between the signatory community and the CSSS that serves it. These agreements will allow the clientele to be directed to the appropriate network services in consultation with the professionals of the community. The CSSS would ensure first-line mental health and addiction services in support of the community teams as well as second-line emergency psychiatric services and psychiatric services for children and teenagers. The CSSSs also undertake to provide clinical training to community interveners, while the latter would provide cultural awareness sessions to CSSS staff.

Since the introduction of Bill 10, questions have emerged about what will happen to these negotiations. A slowdown is already being felt, and one wonders who will be at the table representing the network. For the First Nations, the rapid resumption of these negotiations remains a priority. However, in the opinion of some groups of professionals in the field, there is reason to fear that the mental health programs will not receive the attention they deserve.[16]

16 Mental health programs will lose their priority according to the Fédération des médecins spécialistes du Québec; see Mémoire sur le projet de loi no 10 par la Fédération des médecins spécialistes du Québec présenté à la Commission de la santé et des services sociaux (Assemblée nationale du Québec), October 20, 2014, p. 6.

Recommendation 2:

The Minister officially commit to actively support the negotiations underway between First Nations communities and institutions of the Quebec network for the conclusion of agreements on the establishment of a continuum of services in mental health and addictions.

Notwithstanding the disappearance of the ASSSs which will be merged into the new regional institutions called CISSSs, the First Nations wish to continue building partnerships to improve access to services offered by the network. Given the size of the new CISSSs, the First Nations are concerned that issues important to them will be marginalized in relation to the many other issues facing CISSS policy makers regionally.

The wide geographic dispersion of First Nations communities, many of which are located in remote or isolated areas, contributes to their fear of being further removed from the concerns that will guide CISSS decision makers. Proximity and continuity of services could be compromised for the population of very large territories. The replacement of local health care organization with regional organization, and local network services (RLS) with regional network services (RRS) will have a significant impact on the First Nations. Reducing the number of service agreements within the RRS, with the underlying motivation of reducing and then possibly further streamlining services at the regional level, could foster increased centralization of services in urban areas where the clientele is concentrated at the expense of small communities located far out at the periphery.

Under the logic of regional centralization, in particular in order to increase the efficiency and effectiveness of the network (one of the objectives of chapter 1 of the Bill),[17] local services destined for certain communities situated near a peripheral CSSS could be gradually centralized into the new structure (CISSS). Certain specialized services, such as oncology and hemodialysis, could be potentially returned to the CISSS. Here's what the Collège des Médecins wrote about it: "It seems to us that the temptation for some centres to specialize and the fragmentation of services in the territory may be the main side effects of the proposed reform, *preventing the promotion and simplification of access to services for the population.*"[18]

This possible movement of services to regional urban centres could have a serious impact on First Nations clientele in some regions (e.g., the North Shore and Abitibi-Témiscamingue), including increased transportation costs, extending stays away from the community, extended absences from work and additional delays in obtaining care or increased duration of certain treatments.

17 *Supra*, p. 5.
18 Mémoire sur le projet de loi no 10 par le Collège des médecins du Québec présenté à la Commission de la santé et des services sociaux (Assemblée nationale du Québec), October 20, 2014, p. 5.

4.3 Maintaining services in the language used by First Nations people

The changes proposed in this reform also threaten the right of several First Nations communities to receive services in their mother tongue when it is English. Sections 155 and 156 of Bill 10 stipulate that the institution that succeeds an institution that was designated as serving a predominantly English-speaking population is required in turn to make services available in English until a new program is approved. CISSSs should continue to make health and social services available in English to English-speaking people in the facilities that were designated by the government under section 508 of the *Act respecting health services and social services*.

Section 65 of Bill 10 stipulates that each institution must develop a program of access to English-language health services and social services for the English-speaking population it serves. However, the program must take account of the human, material and financial resources of the institution, be approved by the government and revised at least every three years. Since the section is not binding in regard to the level of services required in English, the latter being determined by the institution itself, it is reasonable to believe that lack of resources could be a reason used in the current context to justify the reduction of the program to a minimum.

In the absence of binding provisions in Bill 10, it may not be certain that a CISSS will include in its program the maintenance of the current level of services in English in already designated facilities and the extension of services in English to other facilities of the regional territory it serves. Will it ensure that enough bilingual staff is hired to cover all the missions it undertakes in the territory? Will it provide documentation in English in all its facilities to facilitate access of its English-speaking clients to services, even if they do not constitute the majority of the clientele?

The coalition of First Nations English-speaking communities,[19] who will be holding a conference in the near future, hopes to take this opportunity to seek clarification from the Minister's representatives who have been invited. Given the current context, a number of questions remain unanswered. There are currently very few initiatives to meet the specific cultural and linguistic characteristics of the First Nations. Some CSSSs provide the services of a liaison person from a First Nation who speaks French or English and the Aboriginal language of the communities that the facility serves (for example, the Innu and Naskapi on the North Shore). In a neighbouring region, a community located in Quebec and whose population expresses itself predominantly in the English language assures that patients staying in an institution of a neighbouring province are seen by one of the community's nurses. Will the province support and encourage more of such services?

Recommendation 3:

That the Minister commit to increasing the protection of the linguistic rights of First Nations clientele so that they can receive services comparable to those received by the general population in each of the health regions of Quebec.

In the ASSSs, there are currently some officials designated to handle issues concerning the First Nations in the territory they serve. They perform an essential role in following up with the CSSSs, ensuring that services are provided in the communities, coordinating services and acting as a liaison between the CSSSs and the communities. Will these positions be abolished or maintained? Since a new division of responsibilities will be established between the Minister and the future CISSSs, under whose authority will the people responsible for Aboriginal issues be placed?

Recommendation 4:

That the Minister agree to transfer to the CISSSs all liaison agents for First Nations communities that exist in the ASSSs, with the equivalent resources and powers.

19 *Supra*, p. 5.

DECISION

5. CENTRALIZATION OF DECISION MAKING AND CONSULTATION WITH THE FIRST NATIONS: AN OPPORTUNITY TO SEIZE

Although section 14 of the Bill stipulates that the Minister must take into account the representation of different parts of the territory covered in making an appointment to the CISSS, the proposed structure does not guarantee that the First Nations will be considered and represented throughout the process. It should be recalled that in section 100 of the *Act respecting health services and social services*, to which the CISSS would also be subject, it is said that institutions must ensure the provision of health and social services that are accessible and that respect the rights and spiritual needs of individuals, and that aim at reducing or solving problems concerning health and well-being and responding to the needs of the various population groups.

This provision adds that the institution should cooperate with other key players, including community organizations, to act on health and social determinants and improve the supply of services to the public. However, the section limits this obligation by the need to ensure effective and efficient management of human, material, information, technological and financial resources.

In the opinion of the FNQLHSSC, it will be very difficult for the CISSSs to accomplish such a task at the regional level, at least to accomplish it effectively with regard to specific community needs. Our experience with the CSSSs demonstrates that even at the local level, it can be challenging for First Nations to develop clinical and organizational projects with existing institutions of the Quebec network. The size of the CISSSs will render even more difficult the task of the First Nations to have the specificities of their populations recognized since, in the same health region, communities can be located in urban areas, be isolated or semi-isolated. For example, in the areas of the North Shore and Abitibi-Témiscamingue, six and five CSSSs respectively will be merged into one CISSS. At the same time, in each of these two regions, there will be just as many local service networks (RLS) as CSSSs that will be consolidated into one regional services network (RRS). This means the combination of a multitude of partners working in the territory of a CISSS (institutions, private medical clinics, family medical groups, superclinics, pharmacies, social economy enterprises, private health resources, intermediate resources, FTRs, community groups, etc.).

As for the CISSS boards of directors, the powers granted to the Minister by Bill 10 relative to the process of appointing members of boards of directors and top executives (CEOs and deputy CEOs) give this process a political significance. There is a risk that First Nations will not find the necessary support for their development among the leaders of the regional network.

Section 14 of Bill 10 states: "When appointing directors, the Minister must take into account adequate representation of the various parts of the territory served by an institution and consider the sociocultural, ethnocultural, linguistic and demographic composition of the user population." It is essential that, in certain areas where they are numerous, First Nations communities are ensured a seat on the CISSS board of directors.

Recommendation 5:

That the board of directors of the CISSS of each region have at least one representative of the communities of the First Nations of the region among its independent members and that they are designated in collaboration with the communities..

It is also possible to anticipate that during the restructuring of the system, which will take a few years, a great deal of energy will be absorbed by the process of change and the mobilization of the workforce, rather than being directed towards the improvement of services. We are already experiencing an increased reluctance to undertake initiatives with the First Nations since the tabling of this Bill. The current environment is filled with uncertainties, and the establishment of partnerships has already been affected.

The adoption of Bill 10 could have a significant impact on current projects during the transition period that its implementation will require. It is therefore important that the First Nations ensure that the exercise of their rights and the progress they have made in collaboration with their partners in the network are not compromised.

For this reason, First Nations must be consulted before bills and government policies are tabled. The AFNQL and FNQLHSSC would like to take advantage of this Brief to remind the Government of Quebec that it has adopted fifteen principles to guide its policy towards Aboriginal people.[20] Here is one example:

"The Aboriginal nations have the right to have and control, within the framework of agreements between them and the government, such institutions as may correspond to their needs in matters of culture, education, language, health and social services as well as economic development."

In connection with this important principle, the AFNQL and FNQLHSSC offer the following recommendation:

Recommendation 6:

That an item be added to the general interpretation provisions of the Bill to ensure that the organization of services within a regional network of services and the conclusion of agreements with First Nations respect their cultural, linguistic and geographical uniqueness and promote the exercise of their right to autonomy.

A second principle says: "Were the Government to legislate on matters related to the fundamental rights of the aboriginal nations as recognized by Québec, it pledges to consult them through mechanisms to be determined between them and the Government."

In further respect of this principle, the AFNQL and FNQLHSSC offer the following recommendation:

Recommendation 7:

Take advantage of the reform to bring about a significant change for the First Nations in Quebec: the creation of an AFNQL/MSSS consultation table to discuss decisions and issues that affect First Nations in health and social services before they are finalized.

CONCLUSION

The First Nations are following the debate regarding the determination of what constitutes the best form of organization of health and social services for Quebecers in general. In fact, the First Nations want to work with the Minister to find lasting solutions to the best way of harmonizing the services, and, to ensure the best possible access to a continuum of services while preserving their institutional autonomy.

20 Source: Secrétariat aux affaires autochtones (SAA), in reference to the fifteen principles that form the basis of government action in relation to Aboriginal nations.