



# FIRST NATIONS IN QUEBEC HEALTH AND SOCIAL SERVICES GOVERNANCE PROJECT

## **REVIEW OF HEALTH AND SOCIAL SERVICES PROVIDED TO QUEBEC FIRST NATIONS AND INUIT**

Report produced by the First Nations of Quebec and Labrador  
Health and Social Services Commission





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ISBN : 978-1-926528-47-2

Legal deposit – 2015

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## FOREWORD

In the fall of 2012, the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) began an approach towards developing a structure for its Governance Project in terms of health and social services for the First Nations of Quebec. The FNQLHSSC hopes that the realization of this project, expected to be completed in 2016, will contribute to improving the delivery and access to health services for the First Nations of Quebec through the implementation of a governance model that promotes participation in the design, delivery, coordination and evaluation of health programs and services (FNQLHSSC, 2013 - internal document).

In Canada, only a few Aboriginal Nations have obtained, following the signing of tripartite agreements, the responsibility for the delivery and development of health services for their communities. In B.C., First Nations along with provincial and federal governments, signed a Framework Agreement that sets a new governance structure for First Nations health services. This governance structure, which was implemented in the fall of 2013, ensures that the newly created First Nations Health Authority inherits the responsibility for the planning, management, delivery and funding of health programs for First Nations in the province through Health Canada (Health Canada, 2013b).

B.C. appears to be the exception, although some Nations, such as the Inuit, Cree and Naskapi in Quebec, have signed agreements that provide a certain form of autonomy in the delivery of health and social services to their communities.

Through its work, the FNQLHSSC has sought the support of various collaborators from academic and government circles. The Aboriginal Health team from the *Institut national de santé publique du Québec* (INSPQ) was invited to conduct, under the coordination of the FNQLHSSC, the first activity for the realization of axis 1; i.e. collect information and conduct research on existing programs, services and initiatives in terms of health and social services. The drafting of a document summarizing and illustrating the delivery of health and social services to First Nations and Inuit communities in Quebec has been identified as a key element for presenting the information collected.

### **Adoption of Bill 10**

This document was drafted in the fall of 2014 and a final version was forwarded to the FNQLHSSC in December of the same year. In parallel with this work, in September 2014 the Quebec National Assembly presented Bill 10 which amends the organization and governance of the health and social services network by the abolition of regional agencies. This Bill was adopted and sanctioned in February 2015.

Originally, the document structure was built around the organization of the health and social services network in Quebec as it was before April 1, 2015. In order to reflect the organizational changes made by Bill 10, subsequent amendments were made to the content of the document. Given the transitory nature of certain provisions of the bill and the pursuit of other significant legal work that will modify the *Act Respecting Health Services and Social Services*, there is every reason to believe that updates will have to be considered.

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## **LIST OF ACRONYMS AND INITIALISMS**

|          |                                                                                                                               |
|----------|-------------------------------------------------------------------------------------------------------------------------------|
| AANDC    | Aboriginal Affairs and Northern Development Canada                                                                            |
| ASSS     | Agence de la santé et des services sociaux<br>(health and social services agency)                                             |
| NFC      | Native Friendship Centre                                                                                                      |
| JBNQA    | James Bay and Northern Quebec Agreement                                                                                       |
| CBHSSJB  | Cree Board of Health and Social Services of James Bay                                                                         |
| CH       | Centre hospitalier (hospital centre)                                                                                          |
| CISSS    | Centre intégré de santé et de services sociaux<br>(integrated centre for health and social services)                          |
| CIUSSS   | Centre intégré universitaire de santé et de services sociaux<br>(integrated university centre for health and social services) |
| YC       | Youth Centre                                                                                                                  |
| CLSC     | Centre local de services communautaires<br>(local community service centre)                                                   |
| CMC      | Community Miyupimaatissiun (health) Centre                                                                                    |
| NEQA     | Northeastern Quebec Agreement                                                                                                 |
| RC       | Rehabilitation Centre                                                                                                         |
| CPEJ     | Centre de protection de l'enfance et de la jeunesse<br>(child and youth protection centre)                                    |
| CSSS     | Centre de services de santé et services sociaux<br>(health and social services centre)                                        |
| FNQLHSSC | First Nations of Quebec and Labrador<br>Health and Social Services Commission                                                 |
| FNIHB    | First Nations and Inuit Health Branch                                                                                         |

|        |                                                                  |
|--------|------------------------------------------------------------------|
| MSSS   | Ministère de la santé et des services sociaux                    |
| NNADAP | National Native Alcohol and Drug Abuse Program                   |
| RAMQ   | Régie de l'assurance maladie du Québec                           |
| RCAAQ  | Regroupement des centres d'amitié autochtones du Québec          |
| LSN    | Local services network                                           |
| NRBHSS | Nunavik Regional Board of Health and Social Services             |
| RTS    | Réseau territorial de services (territorial network of services) |
| NIHB   | Non-Insured Health Benefits                                      |

## KEY MESSAGES

- ▶ The services offered by the Québec health and social services network are accessible to all citizens residing or traveling in Quebec, including First Nations and Inuit.
- ▶ 1<sup>st</sup> line general services are offered in all Quebec First Nations and Inuit communities.
- ▶ Certain 2<sup>nd</sup> line specialized services are provided in facilities in Nunavik, in Eeyou Istchee and in Kahnawake. 2<sup>nd</sup> line services are offered in First Nations and Inuit communities through home care programs.
- ▶ There are no 3<sup>rd</sup> line services offered in First Nations and Inuit communities.
- ▶ The provision and funding of services to First Nations and Inuit depend on their legal status and place of residence.
- ▶ The Quebec government funds the provincial services offered in Nunavik, in Eeyou Istchee and in Kawawachikamach, as stipulated in the James Bay and Northern Quebec Agreement (JBNQA) and the Northeastern Quebec Agreement (NEQA).
- ▶ The Nunavik Regional Board of Health and Social Services (NRBHSS), the Cree Board of Health and Social Services of James Bay (CBHSSJB) and the Naskapi CLSC were created during the JBNQA and NEQA. The three organizations are part of the MSSS.
- ▶ The NRBHSS, the CBHSSJB and the Naskapi CLSC are responsible for the delivery of health services and social services in Nunavik, in Eeyou Istchee and in Kawawachikamach. In addition to ensuring the delivery of provincial services, these three organizations manage the delivery of federal programs, to which the First Nations and Inuit people from these territories have access.
- ▶ At the federal level, the delivery and funding of health services and social services for First Nations and Inuit is shared between Health Canada, the First Nations and Inuit Health Branch (FNIHB), and Aboriginal Affairs and Northern Development Canada (AANDC).
- ▶ Health services and social services offered to First Nations communities located in territories not under agreement are funded from federal programs. Medical services, however, are funded by the MSSS.
- ▶ First Nations people living in communities located in territories not under agreement who require care not offered in their community are referred to the Québec network of health and social services.
- ▶ First Nations and Inuit people who reside outside the community generally do not have access to services that are available in their home community. When their health condition requires care, they consult the Québec network of health and social services institutions.

# QUEBEC FIRST NATIONS AND INUIT AT A GLANCE

## Profile of the Nations

In Quebec, the term Aboriginal specifically refers to the ten First Nations (Abenaki, Algonquin, Atikamekw, Cree, Huron-Wendat, Innu, Maliseet, Mi'gmaq, Mohawk and Naskapi) and the Inuit nation. First Nations and Inuit communities distinguish themselves from one another in terms of culture, language and geography, and vary greatly socio-economically, politically, and in terms of health regions.

Members of these eleven Nations live in one of the 55 Aboriginal communities scattered across Quebec, mainly north of the St. Lawrence River (see Appendix 1). Some communities are located near large cities and regional centres, such as Pikogan, Mashteuiatsh, Wendake, Uashat mak Maliotenam, Gesgapegiag, to name a few. Others are located in remote areas such as Manawan, Lac-Rapide and Natashquan. Finally, some are located in remote regions of Quebec and are accessible only by air or sea (or by land during winter). These are the communities of Nunavik, some communities of Eeyou Istchee<sup>1</sup>, Kawawachikamach, Matimekossh and of Unamen Shipu and Pakua Shipi both located on the Lower North Shore. The geographical position of First Nations and Inuit communities must be considered in understanding the general provision of services that is offered to these people and access to these services.

## Demography

According to data presented by the Secrétariat aux Affaires autochtones, the population of First Nations and Inuit people in Quebec in 2012 totalled 98,731, a little over 1% of the total population of Quebec (SAA, 2013). The population of most communities is low (less than 1,000 inhabitants) and young (FNQLHSSC, 2013a; NRBHSS, 2012; SAA, 2011). It is also a rapidly growing population with a high fertility rate.

## Political organization

In Canada, First Nations are subject to the *Indian Act*, a legislative framework that defines the federal government's obligations to status First Nations (registered Aboriginals) on the management of governance, taxation, land and resources, membership, culture, etc. To be recognized under this legislation, individuals must meet certain criteria and be registered in the Indian Register maintained by Aboriginal Affairs and Northern Development Canada (AANDC).

---

<sup>1</sup> In this document, the term "communities of Eeyou Istchee" always refers to Cree communities in accordance with the *Act respecting Cree, Inuit and Naskapi Native Persons*. In the health network, the Eeyou Istchee territory corresponds to the health region Terres-Cries-de-la-Baie-James (region 18).

Under the *Indian Act*, the vast majority of communities have reserve status. The political and administrative organization of First Nations communities is based on the Band Council, which governs the services that are normally provided by provincial and municipal governments elsewhere in Canada, including health care, social services, education, fire protection and public safety. Some band councils are grouped under the organization of tribal councils that act as the official representatives of the Nations and promote their rights and interests.

### **James Bay and Northern Quebec Agreement and Northeastern Quebec Agreement**

In Quebec, the James Bay and Northern Quebec Agreement and the Northeastern Quebec Agreement have attributed special status to the Cree, Inuit and Naskapi people. These two agreements provide a framework which defines the rights and responsibilities of the three Nations over resources and territories. By establishing a new governance regime, these agreements have transferred to the Cree, Inuit and Naskapi the responsibility for local and regional institutions on their territories in the areas of health, housing, education, justice, public safety and hunting, fishing and trapping (Publications du Québec, 2012).

### **Health profile**

Despite the significant improvement in the health status of Aboriginal people in Canada and Quebec, serious health disparities remain between Aboriginal and non-Aboriginal people. Marked differences are generally observed in terms of injuries (intentional and unintentional), chronic diseases (such as obesity, diabetes and cardiovascular diseases), infectious diseases (such as sexually transmitted infections and tuberculosis), and for several health indicators of young children such as perinatal and infant mortality. In addition, life expectancy of Aboriginal people is generally shorter than for non-Aboriginal people (Adelson, 2005; FNQLHSSC, 2013b; NRBHSS, 2012).

### **Psychosocial problems**

There are many First Nations or Inuit communities dealing with various psychosocial issues, such as mental health (from psychological distress to suicide), various forms of addiction (alcohol, drug addiction and gambling), as well as family violence and abuse. The living conditions that persist in many communities are still particularly difficult today, both in terms of infrastructure and housing (overcrowding and unsanitary conditions), but also the accessibility to basic services (such as access to clean water, electricity or health services and quality education) (KRG & Makivik Corporation, 2010; FNQLHSSC, 2013a; Reading & Wien, 2009). These people often have to deal with a particularly unfavorable socio-economic context marked by poverty, unemployment and low education levels (KRG & Makivik Corporation, 2010; FNQLHSSC, 2013a; Gracey & King, 2009).

## **Urban context**

An increasing number of Aboriginal people in Quebec live outside their home community. Between 2001 and 2006, Aboriginal people living in urban areas represented more than 60% of the total Aboriginal population in Quebec (Cloutier, 2011). In 2010, it was estimated that over 80,000 First Nations or Inuit people lived in Quebec cities and regional centres. The difficult living conditions in communities, obsolescence or lack of housing partly explain these departures (short or extended, occasional or frequent) to other communities or to neighbouring or distant cities. Many people are also leaving for work, to study, to join relatives or to access necessary services (Lévesque, 2003; 2011).

### **According to the Quebec First Nations Regional Health Survey – RHS 2008:**

#### ***Sociodemographic data***

The year prior to the survey:

- 53.7% of adults were earning less than \$20,000;
- 20.5% of adults were collecting employment insurance;
- 37% of adults were collecting social assistance;
- 34.2% of people were living in a household that earned less than \$20,000;
- 24.8% of adults were living with moderate or severe food insecurity;
- 31.2% of adults living with children were in a situation of moderate or severe food insecurity
- Fewer than half the adults had a high school diploma.

#### ***Residential schools***

- 26.4% of adults reported having attended a residential school during their lives;
- 32.8% of individuals having attended a residential school reported having had suicidal thoughts; 22% of them have attempted suicide.

#### ***Well-being***

- 27.5% of adults reported having experienced some form of violence or abuse during their childhood, and almost 30.0% reported having been victims of conjugal violence;
- 26.4% of adults reported having considered suicide during their lifetime.

#### ***Health***

- 33.0% of adults were overweight and 40.6% obese.

### **Urban context**

- 45.5% of individuals 18 years of age and older reported having previously lived outside their community;
- The main reasons provided to justify living outside the community are work and education; the main reasons for returning to the community are family and culture related;
- A large proportion (65.9%) of the migrants left their communities to live in a city.

Source: FNQLHSSC (2013) *Quebec First Nations Regional Health Survey – 2008. Chapters 1, 11, 15 and 18*, Québec: First Nations of Quebec and Labrador Health and Social Services Commission.



# 1 INTRODUCTION

In Quebec, as elsewhere in Canada, the government's responsibility for the delivery and funding of health services and social services for First Nations and Inuit depends on a variety of somewhat fragmented legislative and political provisions that comes from sharing jurisdiction enshrined in the Canadian Constitution (NCCAH 2011a; Lavoie, 2013; MSSS, 2007c). On the one hand, the provinces have the obligation to structure the organization of health and social services for the entire population. On the other, the federal government is responsible for the funding and delivery of services to First Nations and Inuit (INACC 2006; Chenier, 2004; Health Canada, 2012a; Health Canada, 2014). However, this obligation by the federal government varies depending on the signing of agreements with certain Nations.

In Quebec, with the signing of the James Bay and Northern Quebec Agreement (JBNQA) and the Northeastern Quebec Agreement (NEQA), the provincial government allocates funds to three organizations to manage the delivery of services to citizens in their respective regions. Although they fall within the Quebec network of health and social services, these three organizations still need to manage the funding of certain federal programs available to First Nations and Inuit people of the three territories under agreement. Elsewhere in the territories not under agreement, the situation is reversed: the funding of health services and social services in First Nations communities stems primarily from federal programs. However, as with all of Quebec's population, the citizens of these communities have access to services offered by the Québec network of health and social services.

In this review, the description of services offered to First Nations and Inuit living in Quebec is articulated around the organization of the health and social services network in Quebec<sup>2</sup>. This structure makes it easier to account for the organization of services in the territories under agreement and to establish more effective links between organizations in the health and social services network and First Nations organizations located in the territories not under agreement.

---

<sup>2</sup> Given that the collection of information and the drafting of the the summary preceded the adoption and enforcement of Bill 10 amending the organization and governance of the health and social services network by the abolition of the regional agencies, the organization of health and social services in Quebec described in this document corresponds mainly to what it was prior to April 1, 2015. The necessary changes have however been made to take into account the provisions of Bill 10.



## **2**

# **SOURCES OF INFORMATION**

The information collected is mainly from documents (consulted electronically) produced by various government bodies and certain of their affiliates, as well as Aboriginal organizations or agencies. All the documents listed and consulted were obtained as a result of research conducted by keywords in Google-like search engines and search tools from various websites.

On the provincial side, most of the information was published by the Ministère de la santé et des services sociaux (MSSS), the Régie de l'assurance maladie du Québec (RAMQ), the regional authorities (previously designated as health and social services agencies) and certain of their affiliate institutions, as well as various orders including the Ordre des infirmières et infirmiers du Québec (OIIQ) and the Collège des médecins du Québec (CMQ). Following the restructuring of the Quebec health and services network in 2003, the Ministère de la santé et des services sociaux (MSSS) had produced a variety of publications detailing the organizational structure of the network, explaining its founding principles and defining the various health and social services that should be offered by the various health institutions in Quebec. Again, in 2015, the MSSS began the dissemination of documents to popularize and explain the latest network reorganization.

On the federal side, the main sources of information were the First Nations and Inuit Health Branch (FNIHB) of Health Canada and Aboriginal Affairs and Northern Development Canada (AANDC).

Much information appearing in the document was also taken from websites of several First Nations and Inuit organizations. This information provided general details on certain aspects presented.

The use of institutional sources proved essential to establish a general portrait of the delivery of health services and social services. This type of information is usually easily accessible and mostly kept up to date. However, institutional sources have the disadvantage of not providing a clear understanding of particular characteristics in certain contexts and for not accounting for local dynamics. Therefore, some parts of this review require clarification. For example, it would be interesting to have a detailed portrait of doctors and nurses working in Inuit and First Nations communities (their number, affiliation, years of practice in Aboriginal communities, etc.). It would also be important to know the various agreements binding the Quebec network and various Inuit and First Nations health organizations.

The clarification of these gray areas could be undertaken in subsequent proceedings by seeking, for example, participation by individuals working in First Nations and Inuit health institutions, the Quebec health network or federal bodies.

### **3 QUÉBEC NETWORK OF HEALTH AND SOCIAL SERVICES**

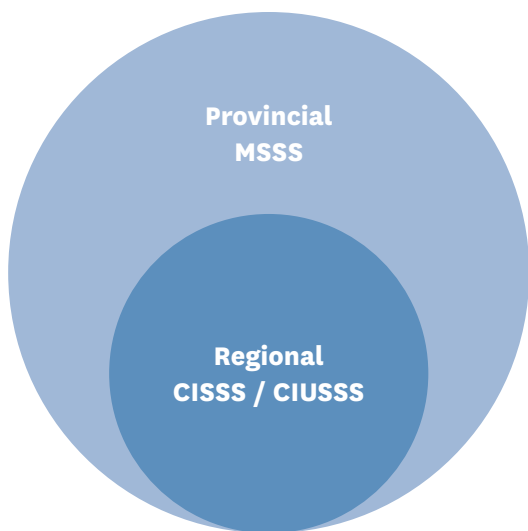
In Quebec, the *Act Respecting Health Services and Social Services* establishes the essential principles and foundations of Québec public network of health services and social services. Respecting national principles of universal accessibility and free services included in the Canada Health Act (Madore, 2005), the Quebec health and social services system's goals are maintaining, enhancing and restoring the health and well-being of people by making available a full range of health and social services (MSSS, 2007a). Since its creation in 1971, it has brought health services and social services together under the same administration.

Network services are accessible to all citizens who reside or temporarily reside in Quebec, including First Nations and Inuit under the criteria set out in the *Health Insurance Act and the Rules on eligibility and registration of persons with the Régie de l'assurance maladie du Québec* (MSSS, 2007c; Publications du Québec, 2014; RAMQ, 2014b)

The Quebec network of health and social services is based on a two-level governance structure, as well as two fundamental principles - populational responsibility and prioritization of services. Network services include three levels of access, are structured by programs, they are offered in public institutions and provided by various health professionals.

#### **3.1 GOVERNANCE STRUCTURE**

Between 2003 and March 2015, the Quebec network of health and social services was based on a three-level governance structure - provincial, regional and local - which had been developed to promote a model maximizing local vision of the organization of services (MSSS, 2004b ; 2009; 2013a). Bill 10, sanctioned in February 2015, further amended the organization and governance of the health and social services network through the implementation of a reduced two-level hierarchical management approach (MSSS, 2015a).



### **3.1.1 Provincial level**

At the provincial level, the Ministère de la santé et des services sociaux (MSSS) is responsible for policy planning and for access and quality of service standards, funding and allocation of financial resources for the regional and non-merged program-service institutions, monitoring and evaluation of the entire health and social services network (MSSS, 2004b; MSSS, 2015a).

### **3.1.2 Regional level**

At the regional level, since April 1, 2015, Quebec has 13 Integrated Centres for Health and Social Services (CISSS) and 9 Integrated University Centres for Health and Social Services (CIUSSS). A CISSS operates in each of the 13 health regions other than the region of Montreal, the Capitale-Nationale, Estrie, Mauricie and Centre-du-Québec and Saguenay-Lac-Saint-Jean (MSSS, 2015a). A CIUSSS operates in these five regions (the Montreal region has 5).

There are no CISSS or CIUSSS in Nunavik, Eeyou Istchee or Kawawachikamach. In fact, institutions in the northern regions, i.e. the Naskapi CLSC, the Inuulitsivik Health Centre (Hudson's Bay), the Ungava Tulattavik Health Centre (Ungava Bay), the Cree Board of Health and Social Services of James Bay, are not covered by Bill 10, because they were created by the JBNQA and the NEQA. These bodies are described in Section 4.1

In parallel, the Centre régional de santé et de services sociaux de la Baie-James (Region 10) is also not covered by the law, because it already had the mandate of regional facility.

The CISSS come from the merger of the health and social services agency (ASSS) and public institutions from a same region, or local community health centres (CLSCs), hospital centres (CH), residential and long-term care centre (CHSLD), child and youth protection centres (CPEJs), and rehabilitation centres (CR). (MSSS, 2015a). They differ from CIUSSS since they are in a health region where a university is located offering a full undergraduate program in medicine or operates a centre designated as a university institute in the social field (MSSS, 2015a).

The integration of services ensures that the CISSS and CIUSSS were awarded the mission of CLSCs, CHs, CHSLDs, CPEJs and CRs. These former institutions are now considered institutions or service points and are operated by the CISSS/CIUSSS. The missions are presented in Section 3.5.

Furthermore, each CISSS/CIUSSS is at the heart of the territorial network of services (RTS). Thus, they were given the responsibility to plan, coordinate, organize and provide all social and health services (including the public health aspect) of the people on their territory. By their regional scope, the CISSS and CIUSSS must assume a populational responsibility for the people on their territory and ensure simplified management of access to services. They must also establish agreements with the different partners of their RTS (MSSS, 2015a).

They must also plan the distribution of human resources in institutions and service points on their territory and provide a follow-up and report to the MSSS (MSSS, 2015a).

### **3.1.3**

#### **Territorial distribution**

From a health and social perspective, Quebec is divided into three levels: health regions, the CISSS/CIUSSS territories and the local services networks. To these territories are added those associated with the integrated university health networks (RUIS).

## Health regions

The territory of the health and social services network has 18 health regions whose boundaries resemble the territorial distribution from the administrative regions of Quebec (see Figure 1).

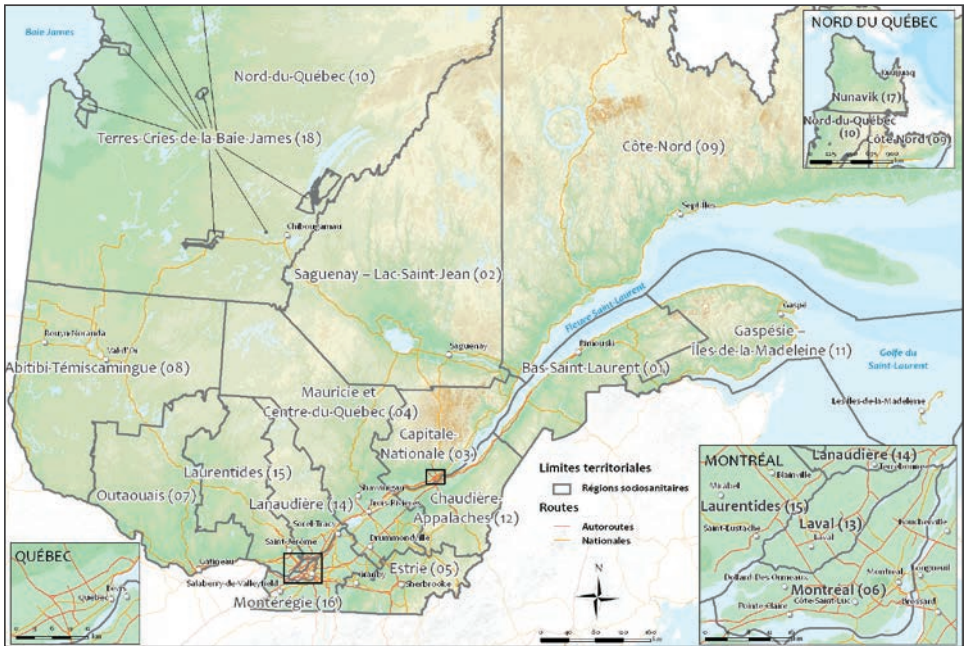


Figure 1 — Quebec health regions

Source: MSSS (2012)

## CISSS/CIUSSS territories

With the exception of the Montreal region, the Gaspésie-Îles-de-la-Madeleine region and the Montérégie region, the CISSS/CIUSSS territory corresponds to the boundaries of the health region. In the three regions being the exception, there is more than one regionally-based integrated institution because of the population density, the complexity of the organization of services, the particular geographic situation or a strong university presence (MSSS, 2015a).

### Local services network

Each of the CISSS/CIUSSS territories is divided into local service networks (RLS). These RLS were once associated with a CSSS. With the adoption of Bill 10, the RLS are maintained, although now integrated into an RTS. The number of RLS varies from one CISSS/CIUSSS territory to another. For example, as shown in Figure 2, the territory for the Abitibi-Témiscamingue CISSS is divided into 5 RLS:

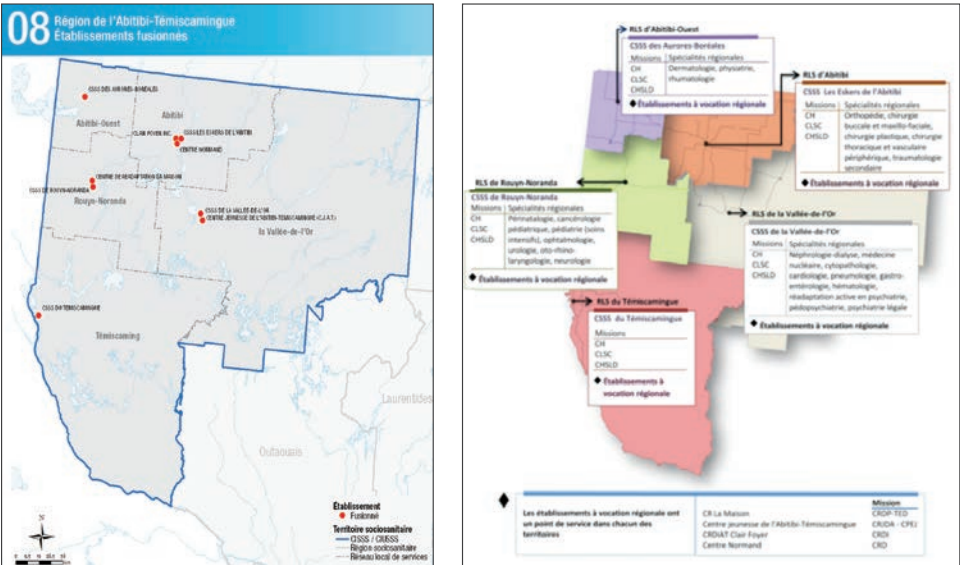
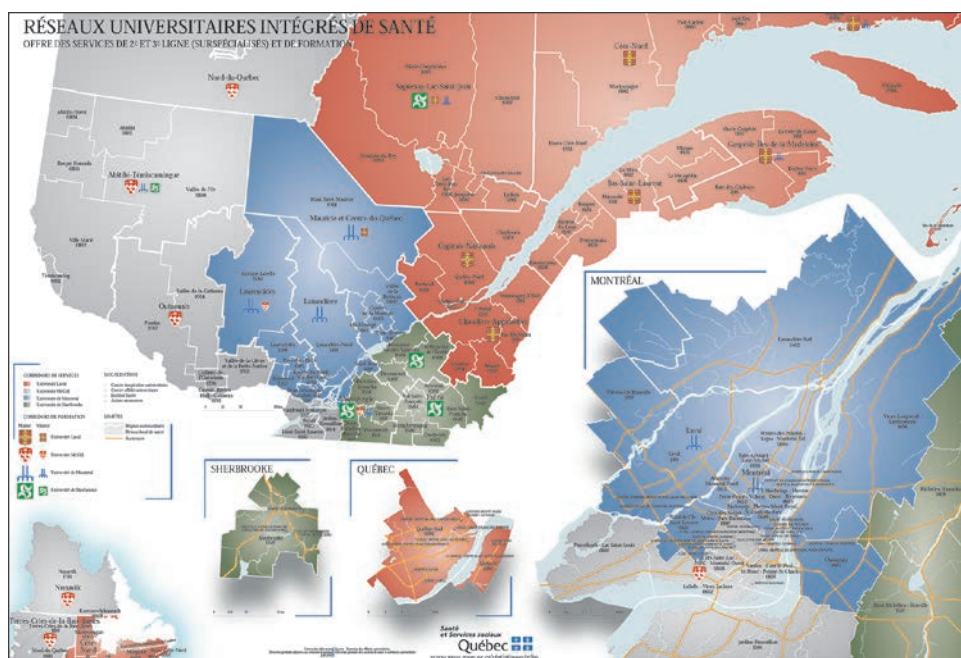


Figure 2 — Abitibi-Témiscamingue health region  
Source: MSSS (2015b)

### Integrated university health networks

The health and social services network is also divided into four integrated university health networks (RUIS) (see Figure 3). These four networks are respectively attached to the universities of Laval, McGill, Montreal and Sherbrooke. The RUIS were created to ensure the organization of specialized and highly-specialized services and ensure the development of health training in a designated territory. Service corridors are established between the CISSS/CIUSSS and the relevant RUIS following RUIS recommendations on the provision of specialized and highly specialized services to make available in the affected territory.



### Figure 3 — RUIS territories

Source: MSSS (2005)

In Nunavik and in Eeyou Istchee, relationships are ensured with the RUIS at McGill. In Kawawachikamach, as part of the CISSS de la Côte-Nord, linkages are ensured with the RUIS at Laval University.

### 3.2 BASIC PRINCIPLES OF THE NETWORK

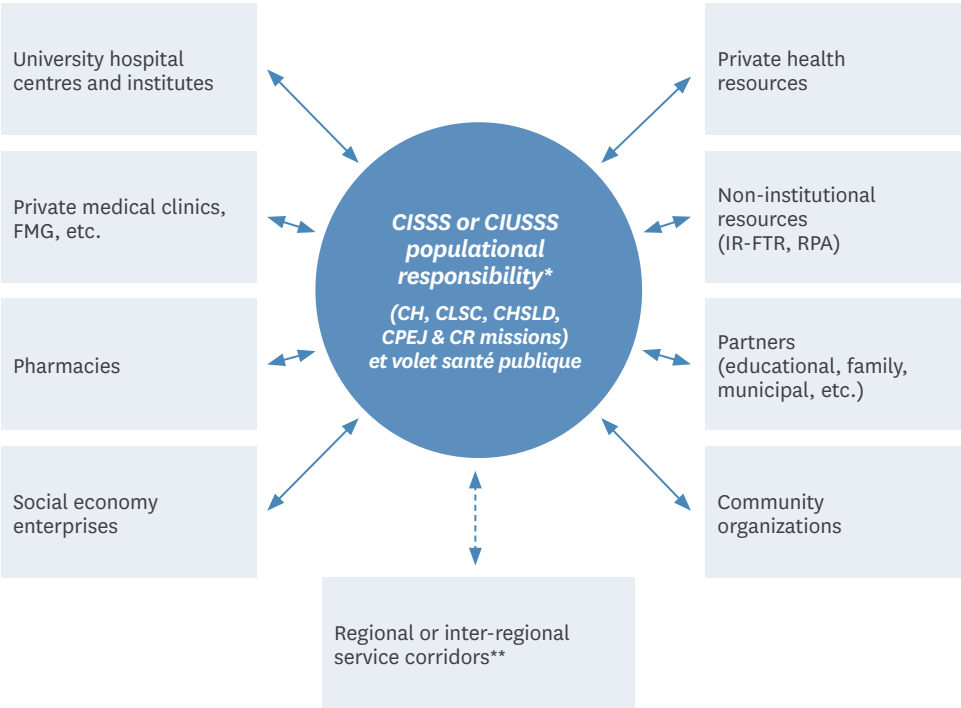
Two fundamental principles support the Quebec network of health and social services: populational responsibility and prioritization of services.

### 3.2.1 Populational responsibility

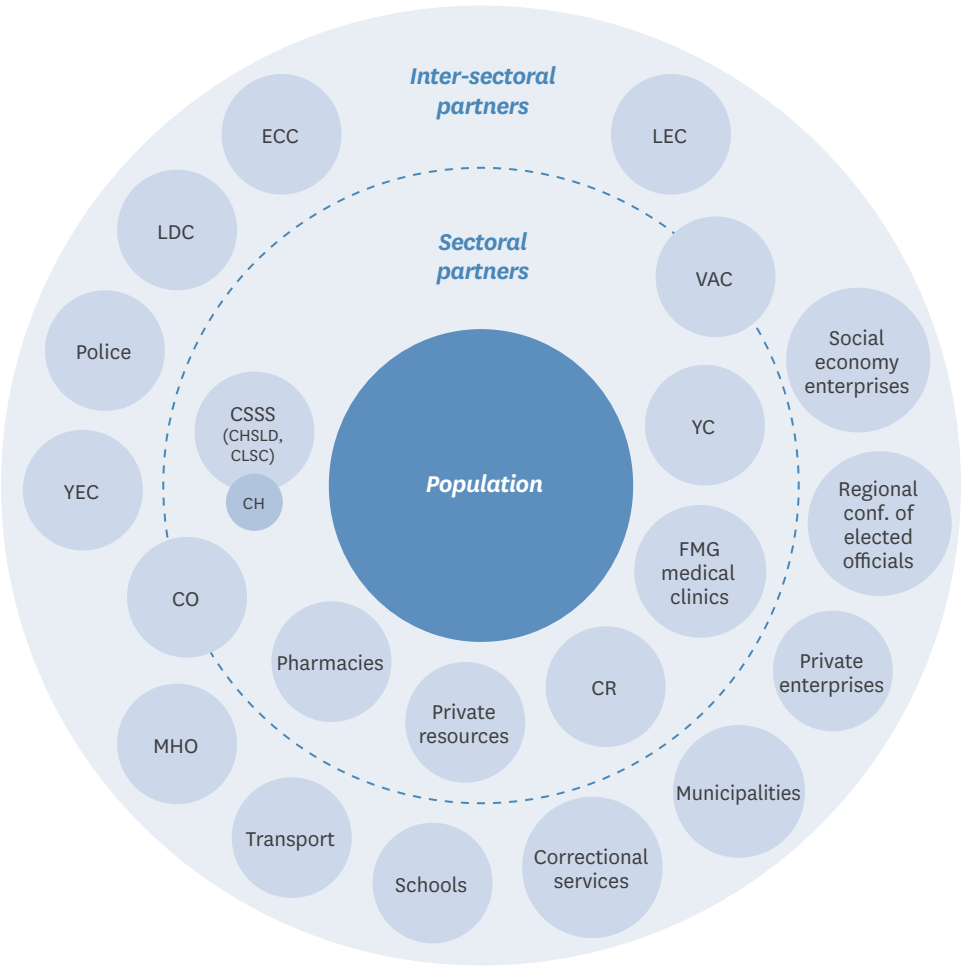
Populational responsibility involves acting on the health determinants and ensuring, on an ongoing basis, access to a wide range of health and social services and addressing the needs of the population of the CISSS/CIUSSS territories. It implies that the care providers in a given territory share a collective responsibility to improve the health and well-being

of people by making available a set of health services and social services (MSSS, 2004b). The role of the CISSS/CIUSSS is to support the collaboration between partners and organizations from different sectors of the RTS. Figure 4 illustrates the RTS and subsequently the different partners involved in populational responsibility. Among these partners there are possibly the Native friendship centres, health institutions or schools in Aboriginal communities, etc.

**RTS Réseau territorial de services (territorial network of services)**  
**Network of services within the CISSS or the CIUSSS**



# Partners involved in the PR



## Legend

ECC: Early childhood centre  
 LDC: Local development centre  
 CO: Community organization  
 MHO: Municipal housing office  
 LEC: Local employment centre

YEC: Youth employment centre  
 VAC: Volunteer action centre  
 RC: Rehabilitation centre  
 YC: Youth centre

(OQRLS & IPCDC, 2012)

Figure 4 — Territorial network of services  
 Source: MSSS (2015a)

### **Populational responsibility and First Nations communities located in territories not under agreement:**

In the deployment of their services, the CISSS/CIUSSS must consider, in consultation with their partners, the needs of all populations established in the territories they serve. They must also ensure continuity and complementarity of services when residents of First Nations communities located in territories not under agreement receive services offered by their service points.

### **3.2.2 Prioritization of services**

Prioritization of services involves improving the complementarity of services to facilitate the flow of people between service levels (1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> line), according to referral mechanisms supported by agreements or pre-established service corridors between care providers (MSSS, 2004b; 2013a).

#### **Service and collaboration agreements**

In order to ensure the continuum and prioritization of services, the CISS/CIUSSS, supported by the Minister, may enter into agreements related to services to the population, to a particular clientele, to target groups or to a user (MSSS, 2006; Publications du Québec, 2015b). These agreements can be made with local partners (community organization, a pharmacy, a private resource, a non-institutional resource, etc.) as well as with partners and regional and supra-regional institutions.

To our knowledge, there are no documents produced by the MSSS, the former ASSS or the former CSSS detailing the agreements that were signed between Quebec network of health and social services institutions and First Nations communities located in territories not under agreement. However, in an OIIQ document published in 2004, the authors indicated that partnerships had been established between First Nations health services and Quebec health network institutions, such as with the Hôpital de Sept-Îles, the Centre de santé de la Basse-Côte-Nord, the Centre de santé de Havre-Saint-Pierre, the Centre hospitalier régional de Baie-Comeau, the Centre hospitalier de Roberval, the Carrefour de santé de la Saint-Maurice, the CLSC de la Matawini and the Centre hospitalier régional de Lanaudière. All these institutions, service contracts were signed between First Nations health services and the Québec network regarding immunization (OIIQ, 2004).

In addition, there are services and collaboration agreements between First Nations communities located in territories not under agreement and youth centres (YC) in terms of child protection services. These agreements are described in Section 5.1.

### A few examples of recent agreements:

The Native friendship centres of Val-d'Or and La Tuque, in partnership with the CSSS de Val-d'Or and La Tuque<sup>3</sup> and the youth centres (YC) of their territory, have developed two clinics integrated into the LSN of the MRC in their health region (NFC of Val-d'Or, 2012; Cunningham, 2013). These clinics will provide urban Aboriginal clients in Val-d'Or and La Tuque culturally-appropriate proximity services in terms of health and social services, and the CSSS can assume their populational responsibility. It is not a matter of organizations involved having to create new services, but rather to propose new approaches to attract a clientele often unreceptive to using health institutions and social services from the Quebec network. Human resources already employed by the CSSS or YC concerned shall work in these two clinics (NFC of Val-d'Or, 2012; Cunningham, 2013; Tremblay, 2014).

In the fall of 2013, the Services de santé Masko-Siwin in Manawan and the CSSS du Nord de Lanaudière<sup>4</sup> signed an agreement to improve the accessibility and continuity of services to the Manawan people. It includes specific agreements on medical coverage in emergencies, medical support from doctors from the Unité de médecine familiale du Nord de Lanaudière, the application of common collective prescriptions, access to Info-Santé/Info-Social services, mental health care trajectory and telehealth (CSSS du Nord de Lanaudière, 2013).

## 3.3 ACCESS LEVELS

In Quebec, all health services and social services are grouped under three levels of access, commonly called lines of service.

### 3.3.1 First line

First-line services represent the first level of access to the network. They include two types of service: general services that cater to the general population and specific services for specific problems (troubled youth, intellectual impairment, addictions, chronic diseases, etc.) (MSSS, 2004a).

The main first-line services are based on soft infrastructure (CLSC or CH type service points, family medicine groups, etc.) and revolve around clinical and assistance activities, which include:

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<sup>3</sup> Since these agreements were concluded before April 1, 2015, the appointment and mission of the institutions concerned at the time of the signing of agreements have been retained for clarity.

<sup>4</sup> Idem.

- ▶ **Nursing care** (nursing interventions, on-call 24/7, sexuality interventions, basic education for people with chronic diseases, monitoring during pregnancy, breastfeeding support, etc.);
- ▶ **Diagnostic** support;
- ▶ **Nutrition** and **physiotherapy** activities;
- ▶ **Psychosocial and psychological** interventions;
- ▶ Short-term **home assistance**;
- ▶ **Interventions in emergency and disaster situations**;
- ▶ **Complete maternity care by a midwife**;
- ▶ **Medical consultations** (episodic problems or unspecified, punctual, unpredictable discomfort, requiring long-term monitoring or not, with or without an appointment, occasional minor emergency situations);
- ▶ Certain **social services**<sup>5</sup>;
- ▶ **Public health activities** (reception and information, physical health, prevention of psychosocial problems, perinatal care, childhood, youth in school environments and their parents, community interventions, interventions in emergency and disaster situations) (MSSS, 2004c).

### 3.3.2 Second line

Second-line services are, in most cases, specialized services offered primarily in CH type service points. They are intended to resolve complex social and health issues. They usually rely on an extensive infrastructure and advanced technology as well as on specialized expertise, but that remain nonetheless widespread. For the vast majority of these services, professionals provide care for individuals who are referred to them by first-line care providers (MSSS, 2004a).

Second-line services include:

- ▶ Short-term **hospitalization**;
- ▶ **Surgical and anesthesia** procedures;
- ▶ **Diagnostic, medical imaging** and **outpatient clinic** services (audiology, cardiology, dermatology, internal medicine, obstetrics and gynecology, psychiatry, etc.);
- ▶ **Direction de la protection de la jeunesse** (youth protection) services.

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<sup>5</sup> First-line social services generally offered in service points of CISSS/CIUSSS are presented in Section 5.1.

### 3.3.3 Third line

The third level of access includes third-line services and usually concern highly-specialized services. They are organized on a national basis, but they are accessible on a regional basis or, exceptionally, on a local basis. These services are accessible on referral, and are intended for individuals with very complex problems with very low prevalence. They rely on technology, expertise and sophisticated and rare equipment (MSSS, 2004a). For example, the Centre hospitalier affilié universitaire de Québec (CHA) offers trauma and burn victim programs to the citizens of the Quebec City and eastern Quebec region.

Highly-specialized services are also offered to individuals with physical impairment (motor, visual, hearing, language and speech) or to their relatives (MSSS, 2007b). In Quebec, the Institut de réadaptation en déficience physique du Québec offers such services.

The services offered in Inuit and First Nations community health institutions are mostly first-line services. Some second-line services are offered in designated institutions in Nunavik and Eeyou Istchee as well as in Kahnawake. Generally, in Inuit and First Nations communities, second-line services are offered as part of home care programs. There are no third-line services offered in Inuit and First Nations community health institutions in Quebec.

## 3.4 ORGANIZATION OF CARE AND SERVICES PER PROGRAM

Both in Quebec and federally, the provision of services is organized per program, i.e. service and activity groups (MSSS, 2004a). The program architecture of the Quebec network is divided into two main categories: service programs and support programs (for a visual representation, refer to Appendix 2) (MSSS, 2004a).

Service programs are divided into two categories depending on whether they are designed to meet the needs of the entire population or the needs of a group of individuals with specific problems (MSSS, 2004a). Service programs for the entire population include:

- ▶ **Clinical and assistance** activities included in the general service activities;
- ▶ **Public health** programs and activities.

Generally, the service programs are composed of 1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> line services. However, the general service program only includes first-line services.

Seven other service programs were developed to address specific issues. These issues include:

- ▶ **Loss of autonomy related to aging;**
- ▶ **Physical impairment;**
- ▶ **Intellectual impairment and PDD;**
- ▶ **Troubled youth;**
- ▶ **Addictions;**
- ▶ **Mental health;**
- ▶ **Physical health.**

For support programs, they are not designed to meet the needs of the population in terms of health and social services, but they are necessary for the provision of services and the operation of a facility. They include administrative and support activities for the delivery of services and the activities related to the management of buildings and equipment (MSSS, 2004a).

### **Services offered to specific clientele**

In addition to the general health and social services, health services are offered to specific clientele. These services include eye care, dental care, pharmacare, medical transportation and other services to meet special needs such as devices to help with physical impairment, hearing or visual, domestic help, housing services, etc. (RAMQ, 2014c). An overview of these services is provided in Appendix 5.

## **3.5 INSTITUTIONS OFFERING HEALTH SERVICES AND SOCIAL SERVICES**

The reorganization of Quebec's health and social services network which came into force on April 1, 2015 resulted in a reduction in the number of public institutions, from 182 to 34. These 34 institutions include:

- ▶ 13 CISSS
- ▶ 9 CIUSSS
- ▶ 7 non-merged institutions in Quebec and Montreal<sup>6</sup>
- ▶ 5 northern institutions not covered by the law<sup>7</sup>

<sup>6</sup> Thie CHU de Québec-Université Laval, the Institut universitaire de cardiologie et de pneumologie de Québec-Université Laval, the Centre hospitalier de l'Université de Montréal, the Centre hospitalier universitaire Sainte-Justine, the McGill University Health Centre, the Montreal Heart Institute and the Institut Philippe-Pinel de Montréal.

<sup>7</sup> As previously mentioned, these institutions include the Naskapi CLSC, the Centre régional de santé et de services sociaux de la Baie-James (Region 10), the Ungava Tulattavik Health Centre (Ungava Bay), the Cree Board of Health and Social Services of James Bay.

Prior to the adoption of Bill 10, Quebec included five categories of public institutions providing health services and social services to the population: local community service centres (CLSC), hospital centres (CH), residential and long-term care centres (CHSLD), child and youth protection centres (CPEJ), and rehabilitation centres (CR). With Bill 10, these institutions were merged into a regionally-based facility, i.e. CISSS/CIUSSS, which inherited the mission of CLSCs, CHs, CHSLDs, CPEJs and CRs. These missions are defined in Sections 79-87 of the *Act respecting health services and social services*, and are presented in Figure 5.

It should be noted however that the allocation of different missions to CISSS/CIUSSS has not led to a reduction in the number of network service points (CLSC, CH, CHSLC, CPEJ, CR).

| Mission of the CISSS/CIUSSS |                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CLSC                        | 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. [...] The mission of such a centre is also to carry out public health activities in its territory. (Section 80)                                                       |
| CH                          | Offer diagnostic services and general and specialized medical care. (Section 81)<br>Hospital centres belong to one or another of the following classes: <ul style="list-style-type: none"> <li>▶ General and specialized hospital centre;</li> <li>▶ Psychiatric hospital centre.</li> </ul>                                                                                                                          |
| CHSLD                       | Offer, on a temporary or permanent basis, an alternative environment, lodging, assistance, support and supervision services as well as rehabilitation, psychosocial and nursing care and pharmaceutical and medical services to adults who, by reason of loss of functional or psychosocial autonomy can no longer live in their natural environment, despite the support of their families and friends. (Section 83) |
| CPEJ                        | Offer in the region such psychosocial services, including social emergency services, as are required by the situation of a young person [...] and services for child placement, family mediation, expertise at the Superior Court on child custody, adoption and biological history. (Section 82)                                                                                                                     |
| CR                          | Offer adjustment, rehabilitation and social integration services to persons who, by reason of physical or mental impairment, behavioral disorders or psychosocial or family difficulties, or because of an alcohol, gambling or drug addiction or any other addiction, require such services, as well as persons to accompany them, or support services for their families and friends. (Section 84)                  |

### *Mission of the CISSS/CIUSSS*

- CR      A hospital centre belongs to one or several of the following classes:
- ▶ rehabilitation centre for persons with intellectual impairment or pervasive developmental disorder;
  - ▶ rehabilitation centre for persons with a physical impairment;
  - ▶ rehabilitation centre for persons with an addiction;
  - ▶ rehabilitation centre for young persons with adjustment problems;
  - ▶ rehabilitation centre for mothers with adjustment problems.

Figure 5 — Missions of the CISSS/CIUSSS

In addition to the CISSS/CIUSSS and their service points, the network relies on many organizations (advisory bodies, community organizations, external partners) and institutions (medical clinics, family medicine groups, community pharmacies and others) to provide services to the population of Quebec.

## **3.6 CARE AND SERVICE PROVIDERS**

Various care and service providers constitute the network of health and social services workforce. The health professionals remunerated by the RAMQ include doctors (general practitioners, specialists and residents), dental surgeons and specialists in oral and maxillofacial surgery, optometrists, pharmacists, midwives and nurses specialized nurse practitioners (RAMQ, 2014A). The RAMQ also remunerates various service providers (denturists, audiologists and hearing care professionals and authorized ocularists) (RAMQ, 2014a).

In addition, Quebec network services are also offered by nurses (nurse practitioners, clinical nurses (and nurse specialists), auxiliary nurses and orderlies. Other services are also offered by psychologists, social workers, nutritionists/dietitians, etc. These professional services are funded by the MSSS.

The number of physicians practicing in a region, Section 377 of the *Act Respecting Health and Social Services* (repealed by section 78 of Bill 10) requires that the Minister of health and social services must develop a regional medical staffing plan (PREM) for the different CISSS/CIUSSS territories. These PREM are prepared based on the organization plans, the number of physicians required to perform various medical activities and after having sought the opinion of the RUIS according to the territory served. The PREM provide an equitable distribution of medical personnel based on each region's needs (MSSS, 2014a).

As part of the Quebec network of health and social services, the regions of Nunavik and Eeyou Istchee must develop a regional medical staffing plan for their territory. In 2014, in Nunavik, 5 positions were available/accessible to all physicians. In Eeyou Istchee, three positions were available/accessible. Kawawachikamach is considered in the PREM of the CISSS de la Côte-Nord.

For the First Nations communities located in territories not under agreement, none of which are considered in the medical staffing plans since they are not integrated into the Quebec health network. Thus, when the Minister determines the PREM for a region, the Minister does not consider medical resource needs of First Nations communities on the territory.

### **Collective prescriptions**

Collective prescriptions are a lever to improve accessibility to services by allowing, for example, nurses to perform diagnostic tests, administer and adjust medications, perform medical treatment to particular groups and initiate diagnostic and therapeutic measures (OIIQ, 2014). Each collective prescription is issued by a physician. They are not limited to the network's health care institutions; they may be issued to other locations including clinics (OIIQ, 2014).

The use of collective prescriptions varies from one region to another and between service points in the same region. However, to promote and to help make the adjustment of medication by nurses operational, collective prescriptions have been specifically developed for high blood pressure, diabetes, anticoagulant therapy and dyslipidemia (MSSS, 2013b). In 2013, the first three prescriptions were available.

Prescriptions may also be issued for specific clients for medications, medical treatments, examinations and care services (OIIQ, 2014).

# 4

## THE ORGANIZATION OF HEALTH SERVICES IN QUEBEC FIRST NATIONS AND INUIT COMMUNITIES

With respect to First Nations and Inuit, regardless of their place of residence, the Québec government provides, as it does for the entire population, complete coverage of insured services offered by the Québec network of health and social services in its institutions and service points (MSSS, 2007c). In Inuit and First Nations communities, however, the delivery of health services and social services varies depending on the legal status and place of residence of its citizens. These features are represented in Figure 6.

Réseau québécois de la santé et des services sociaux

|                                   | <i>Entire province</i> | <i>Territories under agreement</i>                                            | <i>Territories not under agreement</i>                                                                   | <i>Outside communities</i>                      |
|-----------------------------------|------------------------|-------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| <b>Funding of health services</b> | Quebec                 | Quebec; except for certain Health Canada programs, including the NIHB         | Health Canada; except for health services                                                                | Quebec; except for NIHB funded by Health Canada |
| <b>Funding of social services</b> | Quebec                 | Quebec                                                                        | AANDC                                                                                                    | Quebec                                          |
| <b>Service planning</b>           |                        |                                                                               |                                                                                                          |                                                 |
| 1 <sup>st</sup> line              | ASSS and CSSS          | Regional entity and/or local entity in each community                         | Responsibility of communities or federal government based on whether or not service provision is covered | Receive services in Quebec network institutions |
| 2 <sup>nd</sup> line              | ASSS                   | Certain services are offered in hospital centres in Nunavik and Eeyou Istchee | Receive services in Quebec network institutions                                                          | Receive services in Quebec network institutions |
| 3 <sup>rd</sup> line              | ASSS and RUIS          | Receive services in Quebec network institutions                               | Receive services in Quebec network institutions                                                          | Receive services in Quebec network institutions |

Figure 6 — Funding and planning of services in Inuit and First Nations communities

As part of the JBNQA and NEQA, the Quebec government is responsible for funding health services and social services offered in Nunavik, Eeyou Istchee and Kawawachikamach. Inuit and First Nations residents of these regions, however, have access to certain programs funded by federal bodies. All services offered in territories under agreement are managed by regional and local bodies under the MSSS.

In First Nations communities located in territories not under agreement, the funding and delivery of health services and social services is shared between two departments, i.e. the Health Canada First Nations and Inuit Health Branch (FNIHB) and Aboriginal Affairs and Northern Development Canada (AANDC). The planning and operationalization of services falls under the communities since the Band Councils or Tribal Councils have assumed responsibility<sup>8</sup>. The federal government still assumes the planning of services for certain communities that have not entered into management agreements.

Regarding First Nations and Inuit people not residing in their home community, they generally do not have access to services and health and social programs funded by Health Canada and AANDC and offered in their community (excluding NIHB). Like all Quebec citizens, First Nations and Inuit people living outside their home community must use the services offered by the Quebec network of health and social services institutions and its partners. However, certain federal programs fund some initiatives introduced to meet the specific needs of these clients.

The organization of health services in the communities of territories under agreement and not under agreement is detailed in the following sections.

## **4.1 THE ORGANIZATION OF HEALTH SERVICES FOR TERRITORIES UNDER AGREEMENT**

### **4.1.1 Service planning**

With their regional-based mission, the NRBHSS and CBHSSJB respectively ensure the planning of health services and social services (provincial and federal) in Nunavik and Eeyou Istchee. In Kawawachikamach, the Naskapi CLSC manages the health and social services system for the Naskapi population living on the territory defined by the NEQA (the MRC of Kawawachikamach and Matimekoshe/Schefferville exclusively for Naskapi beneficiaries) (Naskapi CLSC, 2012). This local entity is included within the CISSS de la Côte-Nord.

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<sup>8</sup> In the late 1980s, the federal government approved the transfer of programs and services to Health Canada under the control of First Nations communities who requested it and who met the eligibility criteria (Health Canada, 2005). In Quebec, most communities have signed contribution agreements.

The CBHSSJB and NRBHSS (initially the Kativik Health and Social Services Council) were founded in 1978. The mandates of the two organizations are embedded in sections 14 and 15 of the JBNQA as well as in the *Act Respecting Health Services and social Services* and the *Act Respecting Health Services and social Services for Cree Native Persons*.

In Kawawachikamach, in 2000, an amendment to the *Act Respecting Health Services and Social Services* allowed the Naskapi Nation to manage its 1<sup>st</sup> line health and social services system with the implementation of a CLSC type facility (Naskapi CLSC, 2012).

Provisions in the two agreements provide that the boards of directors of each of these three organizations must be composed of Inuit, Cree or Naskapi representatives (depending on the region).

As indicated in Section 15 of the JBNQA, in Nunavik, the delivery of services is organized in two sub-regions: Hudson Bay and Ungava Bay. The Inuulitsivik Health Centre in Puvirnituk and the Tulattavik Health Centre in Kuujuaq, two multi-purpose institutions (specialized and highly-specialized hospital centres, CHSLD, CR, CPEJ), are responsible for the organization of services within seven service points in each of the two sub-regions (NRBHSS, 2013). These 14 service points are CLSC type institutions where general services are planned and offered.

In Eeyou Istchee, the Chisasibi hospital centre is the only facility to be regionally-based. At the local level, a Community *Miyupimaatisiun* (health) Centre (CMC) is present in each of the nine communities. Reporting to the CBHSSJB, these CMCs are responsible for providing services that address the needs of their people (CBHSSJB, 2013).

Furthermore, in Nunavik in Eeyou Istchee, the Module du Nord Québécois (Northern Quebec module) (MNQ) and the Services aux patients cris (Cree services to patients) (SPC) coordinate and organize the transfer of patients, whose medical condition requires it, to network service points located outside the two regions. In Nunavik, patients are usually transferred to Montreal. In Eeyou Istchee, SPCs are organized with the CRSSS<sup>9</sup> in Chibougamau, the Val-d'Or hospital centre and Montreal hospital centres (CBHSSJB, 2013; NRBHSS, 2013). The MNQ is managed by the Inuulitsivik Health Centre (NRBHSS, 2013).

#### **4.1.2 Programs**

Sections 14 and 15 of the JBNQA and Section 10 of the NEQA specify that the Quebec government agrees to fund health and social services included in provincial programs

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<sup>9</sup> Centre régional de santé et de services sociaux de la Baie-James

offered to the general population as well as some federal funded programs offered to Inuit and First Nations residents.

In **Nunavik**, in addition to managing several programs provided by the MSSS pursuant to regional priorities, the NRBHSS also manages programs funded by Health Canada (NRBHSS, 2013):

- ▶ Aboriginal diabetes initiative;
- ▶ Brighter futures;
- ▶ Home and community care;
- ▶ Fetal alcohol spectrum disorder;
- ▶ Mental health crisis management;
- ▶ Prenatal nutrition program;
- ▶ Youth suicide prevention strategy;
- ▶ Aboriginal Health Human Resources Initiative;
- ▶ Indian residential schools;
- ▶ Nutrition North Canada.

For social services, the NRBHSS also manages the Family Violence program funded by AANDC (NRBHSS, 2013).

In **Eeyou Istchee**, the CBHSSJB has consolidated the management of various programs under three large-scale services (CBHSSJB, 2013):

- ▶ *Nishiiyuu Miyupimaatisiun department* – Regional land-based healing program
  - working towards finding ways to integrate the Cree healing traditions to the social and clinical services.
- ▶ *Miyupimaatisiun department* – Being alive well
  - includes health services and social services;
  - includes the Chisasibi regional hospital centre and the network of CMCs.
- ▶ *Pimuhteheu department* – Walking side by side
  - the objective is planning, prevention, strengthening and improvement of health services and social services;
  - includes the regional public health service and the planning and regional services.

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<sup>9</sup> Centre régional de santé et de services sociaux de la Baie-James.

In **Kawawachikamach**, the Naskapi CLSC manages 1<sup>st</sup> and 2<sup>nd</sup> line health and social services as listed in the three appendices of Section 10 of the NEQA (CLSC, 2012). These services include:

- ▶ Common health services (physical health, minor emergency), nutrition;
- ▶ Perinatal and early childhood services, youth services in school and their parents;
- ▶ Common psychosocial and psychology services, school psychosocial services;
- ▶ Curative and preventive dental services;
- ▶ Support services offered to people with loss of autonomy (home care);
- ▶ Public health services.

The Naskapi CLSC also manages several Health Canada community programs:

- ▶ Aboriginal diabetes initiative;
- ▶ Fetal alcohol syndrome;
- ▶ Prenatal nutrition program;
- ▶ Home and community care program.

Finally, whether in Nunavik, Eeyou Istchee or Kawawachikamach, Inuit and First Nations people have access to the Non-Insured Health Benefits program (NIHB) funded by Health Canada (NIHB are presented in Section 4.2.2) (CBHSSJB, 2013; CLSC Naskapi, 2012; NRBHSS, 2013).

### **4.1.3 Institutions**

A CLSC type facility can be found in each community located on the territories under agreement where general 1<sup>st</sup> line services are offered. Given their geographical isolation, these institutions must also provide the institutions to stabilize patients before their transfer to other institutions in the network. In Kawawachikamach, The Naskapi CLSC is the only facility providing health services and social services.

In Nunavik and Eeyou Istchee, there are also regional hospital centres that provide general services and certain specialized services. In Nunavik, Inuulitsivik Health Centre in Puvirnituq serves seven communities located along the coast in James Bay and Hudson Bay, while the Tulattavik Health Centre in Kuujuaq serves the seven communities located along the coast of Ungava Bay. In Eeyou Istchee, the regional hospital centre in Chisasibi meets the needs of all nine communities. As there is no hospital centre in Kawawachikamach, patients who require hospital services are transferred to the CH de Sept-Îles.

Second-line health services and social services offered in the three hospital centres located on the territories under agreement are limited. Certain short or long-term care services are available, some surgical activities, obstetrical services, radiology and laboratory activities. Many of these services are provided by resources in institutions outside the two regions.

### *To sum up:*

In **Nunavik**, the NRBHSS manages (NRBHSS, 2013):

- ▶ Two sub-regional multi-purpose hospital centres: one in Puvirnituk, the other in Kuujuaq;
- ▶ each pursues their CH mission of providing general and specialized care and CHSLD.

Each hospital centre manages:

- ▶ a CLSC service point in the seven communities in its sub-region;
- ▶ a DPJ in each sub-region (including a group home in each sub-region).

The Tulattavik CH in Kuujuaq also manages:

- ▶ a nursing home in Kuujuaq;
- ▶ a day centre for the elderly in Kuujuaq;
- ▶ a birthing centre in Kuujuaq;
- ▶ a regional CR in Salluit;
- ▶ a regional advisory committee on rehabilitation services for troubled youth on a regional basis.

The Inuulitsivik CH in Puvirnituk also manages:

- ▶ A regionally-based crisis centre in Puvirnituk (2<sup>nd</sup> line services);
- ▶ A birthing centre in Inukjuak, Puvirnituk and Salluit;
- ▶ The Module du Nord québécois (Northern Quebec module).

In **Eeyou Istchee**, the CBHSSJB manages (CBHSSJB, 2013):

- ▶ A regional CH in Chisasibi;
- ▶ A CMC in each of the nine communities;
- ▶ three institutions for youth at risk;
- ▶ three liaison offices for Services aux patients cris.

#### **4.1.4 Service providers**

The care teams in the institutions of Nunavik, Eeyou Istchee and Kawawachikamach are composed of professionals from different disciplines. The number of health care and social services professionals and the range of professions represented vary greatly from one community to another, depending on the size and needs of the population. In many places, the stability of the care team is also compromised by significant staff turnover.

##### **Nurses and local workers**

At the forefront, care teams include nurses, often acting as first respondents. They are usually joined by community health workers or cultural workers, liaison officers and social workers (CBHSSJB, 2013; Naskapi CLSC, 2012; NRBHSS, 2013). In some communities, NNADAP agents are also available (the NNADAP is described in Section 4.2.2).

To facilitate the work of nurses in the region, the CBHSSJB Editorial Committee works with other regions of northern Quebec for the development of collective prescriptions (CBHSSJB, 2013). Members of the “Being alive well” program also do the same in several areas (CBHSSJB, 2013).

##### **Physicians**

In addition to these teams, there are permanent physicians working in the three regional CH, in some service points as well as at the Naskapi CLSC. These positions were authorized in the PREMs in their respective regions. In addition, many locum physicians visit at regular intervals the communities of their territory that do not benefit from permanent-basis physicians. These doctors usually offer 1<sup>st</sup> line services, but also some specialized services (cardiology, pediatrics, psychiatry, obstetrics and gynecology, ophthalmology, etc.) are offered by doctors working in hospitals.

Although some physician specialists occasionally visit certain communities in these regions, most specialized and highly-specialized services are offered by physician specialists working in CHs in Montreal, Val-d'Or, Chibougamau, Sept-Îles or Québec. This forces patients to travel and receive care in an unfamiliar environment and not culturally-appropriate. If necessary, specialists may also be available on call to support local teams remotely.

##### **Complementary resources**

Institutions on territories under agreement may also provide psychologists, therapists, nutritionists, occupational therapists, dentists, dental hygienists, pharmacists, etc. (CBHSSJB, 2013; CLSC, 2012; NRBHSS, 2013).

## Midwives

Furthermore, in Nunavik, Inuit and non-Inuit midwives work in maternity wards at a few health centres. They are “the first responsible for the pregnancy follow-up, the delivery and the post-partum care, up to 6 weeks after the birth. They also provide care outside of pregnancy, from adolescence to menopause, such as contraception, STI prevention, uterus cancer screening and self-exam of breast” (Inuulitsivik Health Centre, n.d.). The Inuulitsivik Health Centre offers a midwifery training program based on learning through practice in clinical settings.

Currently in Eeyou Istchee, women usually give birth at the CH in Val-d’Or. In 2013-2014, a pilot initiative was in development to integrate the knowledge of the elders to the information given to pregnant women, fathers and families concerning childbirth (CBHSSJB, 2013).

## 4.2

### THE ORGANIZATION OF HEALTH SERVICES FOR TERRITORIES NOT UNDER AGREEMENT

#### 4.2.1

#### Service management and planning

On territories not under agreement, programs and services management is done locally<sup>10</sup>. With few exceptions, each band council in the communities concerned has concluded transfer agreements with Health Canada which gives them more control over the management of some health institutions and programs. Band councils are responsible for the administration and management<sup>11</sup> of the delivery of FNIHB programs and services (Health Canada, 2012C). This responsibility is highly dependent on funding from Health Canada.

#### Service funding

The funding of health services is first calculated from predetermined formulas based largely on geographical distance, accessibility to health care and the size of the population. For example, in Quebec, a community located far from the network’s health and social services institutions could receive more funding than a community located closer and of comparable size. Similarly, a nursing station which must provide services 24/7 and emergency services could receive more funding than a health centre located near a regional hub.

Moreover, in Quebec, most communities have signed contribution agreements that serve as funding vehicles (Health Canada, 2012C). These agreements are classified under four funding models: predetermined, flexible, comprehensive and multi-departmental. They

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<sup>10</sup> On a larger scale, in Quebec, some tribal councils may also manage certain health services. This is primarily patient services (transportation, accommodation). Others may also manage social services.

<sup>11</sup> It should be noted, in a community for example, band councils may appoint an organization to manage their community health component (accounting, health facility employee management, etc.).

are distinguished by their degree of support, flexibility, level of authorization, their duration and their requirements in terms of reporting and accountability (Health Canada, 2012C). The predetermined funding model is the least flexible for communities in their program management. This flexibility increases in other models. Details of these funding models are presented in Appendix 3.

### **Service planning (programming)**

Service planning depends on the funding model chosen by the communities. The models offering greater flexibility require more planning. For example, for the comprehensive funding model, communities must identify their health priorities, develop a health plan accordingly and establish their health management structure (Health Canada, 2012c).

Several partners assist in identifying health and well-being priorities and plan the delivery of programs and services that address the needs of local people. These are health centre directors and nursing stations, staff members of these institutions, representatives of schools and early childhood centres, community workers, citizens and other persons concerned with health.

In addition, communities that so desire can count on FNIHB support in their planning as well as the support and expertise of the FNQLHSSC. The Commission's mission "is to promote and ensure the physical, mental, emotional and spiritual well-being of the First Nations and Inuit individuals, families and communities while fostering access to comprehensive health and social services programs that are culturally-appropriate and designed by First Nations organisations that are recognised and sanctioned by the local authorities while respecting the cultures and the local autonomy. The FNQLHSSC also helps the communities that so desire to set up and promote health and social services programs and services that are adapted and designed by First Nations organisations" (FNQLHSSC, 2011).

#### **4.2.2 Programs**

The architecture of program activities provided by the FNIHB includes three main activities: Primary Health Care, Supplementary Health Benefits and Support for health infrastructure (FNIHB, 2011). Each of these activities includes programs (initiatives, strategies, and services) that can be mandatory or optional, permanent or temporary. Among these, some are frequently renewed by the FNIHB while others are subject to a call for projects.

Within the framework of this document, we shall focus on programs grouped into seven components of the *Primary Health Care activity* and the *Non-Insured Health Benefits* program associated with the *Supplementary Health Benefits activity*. All information

presented is from the Program compendium 2011/2012 published by the FNIHB (FNIHB, 2011). For a schematic representation of the architecture of the FNIHB program activities, refer to Appendix 4.

## **Primary health care**

The *Primary health care* activity is available in three axes, which includes Health promotion and disease prevention, Public health protection and primary care. These axes are grouped under seven main components, namely: Healthy child development, Mental wellness, Healthy living and, identified as mandatory, Communicable disease control and management, Environmental public health, Clinical practice and client care, and finally Home and community care. These four components are identified as mandatory as they have a direct impact on the health and safety of the population (FNIHB, 2011).

The programs associated with this activity, grouped by axis, include:

### **Health promotion and disease prevention**

#### **► Healthy child development**

- Aboriginal Head Start on Reserve Program
  - Funds early childhood intervention strategies that support the health and development needs of First Nations children from birth to age six, and their families. This program can be presented through projects in centres, outreach and home visiting services, or a combination of these methods.
- Canada Prenatal Nutrition Program
  - Associated activities: nutrition screening, education and counseling; maternal nourishment; breastfeeding promotion, education and support.
- Fetal Alcohol Spectrum Disorder
  - Associated activities: Support the development of prevention and early intervention programs; support capacity building and training of community workers and professional staff, development of action plans and prevention, education and awareness activities; implement prevention programs through mentoring projects (includes home visits); implement intervention programs through case management and community coordination to facilitate access to diagnosis, and to help families connect with multi-disciplinary diagnostic teams and other support and services.

- Maternal child health
  - Associated activities: Screening and assessment of pregnant women and new parents to assess family needs; reproductive and preconception health promotion; home visits by nurses and community-based workers (support and education).
- Children's oral health initiative
  - Designed for children from birth to age 7, as well as their parents, caregivers and pregnant women. Activities associated with this program include prevention of oral diseases, the promotion of good oral hygiene habits and basic clinical services.

## ► Mental wellness

- Mental health and suicide prevention
  - Brighter futures: Aimed at improving the quality and accessibility of community services in terms of mental health, child development, and injury prevention in the community. It also includes the *Healthy babies* and *Parenting* components.
  - Building healthy communities: Aimed at helping communities prevent and manage mental health crises, such as suicide and substance abuse.
  - National Aboriginal youth suicide prevention strategy: Aimed at increasing protective factors and reducing risk factors in terms of youth suicide. This program includes activities aimed at promoting mental health and risk reduction, supporting community-based approaches, increasing the effectiveness of interventions in crisis situations) and finally, developing knowledge on the best solutions in terms of suicide prevention among Aboriginal youth.
- Substance abuse prevention and treatment
  - National Native Alcohol and Drug Abuse Program (NNADAP) – treatment program and community program: Aimed at supporting Inuit and First Nations communities to develop and deliver programs against the abuse of alcohol, other drugs and solvents. It is composed of three main categories of activities: prevention activities (public awareness campaigns, school programs, news media work, etc.), intervention activities (recreation activities for youths, discussion groups and social programs, Native spiritual and cultural programs) and aftercare activities (counseling, sharing circles, support groups, support visits, treatment or service referrals) (Health Canada, 2013a).

In Quebec, NNADAP agents work in First Nations communities located on territories not under agreement and in Nunavik, Eeyou Istchee and Kawawachikamach.

As part of the activities in the NNADAP, Health Canada supports in Quebec six treatment centres against alcohol and drug abuse which are generally open to male and female clientele (see Table 1). Some of these centres may also provide anger management and domestic violence therapies. The approaches generally include group activities and individual meetings conducted in a closed environment varying over a few weeks. In addition, some centres may also offer external monitoring services in communities.

**Table 1**  
**Alcohol and drug abuse treatment centres**

| <i>Name of the facility</i>    | <i>City</i>              | <i>Region</i>                 | <i>Funding</i> |
|--------------------------------|--------------------------|-------------------------------|----------------|
| Onen'to:kon Treatment Services | Kanehsatake              | Laurentides                   | Health Canada  |
| Centre Miam Uapukun            | Maliotenam               | Côte-Nord                     | Health Canada  |
| Centre de réadaptation Wapan   | La Tuque                 | Mauricie                      | Health Canada  |
| Mawiomi Treatment Services     | Gesgapegiag              | Gaspésie-Îles-de-la-Madeleine | Health Canada  |
| Wanaki Centre                  | Kitigan Zibi             | Outaouais                     | Health Canada  |
| Waseskun House                 | Saint-Alphonse-Rodriguez | Lanaudière                    | Health Canada  |

- Indian residential schools Resolution health support program
  - This program provides culturally appropriate support services in mental and emotional health to eligible former Indian residential school students and their families before, during and after their participation in Settlement Agreement processes. It also includes professional counselling and transportation when support services are not available locally.

## ► Healthy living

- Chronic disease prevention and management
  - Aboriginal diabetes initiative: Aimed at contributing to the promotion of healthy lifestyles and environments and at reducing the prevalence and incidence of type 2 diabetes. The different program components include activities that focus on promoting a healthy lifestyle (diabetes awareness, healthy eating and physical activity), screening for diabetes complications, training of community workers as well as research, monitoring, evaluation and supervision of prevention and awareness initiatives.
- Injury prevention
  - Community health promotion and injury/illness prevention: In collaboration with various national and regional partners, the program is aimed at identifying trends in injury; promoting best practices; identifying priorities for the knowledge development, dissemination and exchange; and contributing to the development of tools to help Aboriginal communities.

## Public health protection

### ► Communicable disease control and management

- Communicable disease control
  - Immunization Program: Aimed at ensuring access to newly recommended vaccines, improving the coverage rates of routine immunizations and improving the development of knowledge and skills of workers as well as monitoring, data collection and evaluation.
- Blood borne diseases and sexually transmitted infections
  - HIV/AIDS program: In respect of BBDSTI and HIV/AIDS, the program is aimed at improving access to diagnostic services, care, counseling, support and quality treatment, improving education and public awareness, developing capacities and facilitating access to health professionals and finally, increasing monitoring and data collection and evaluation activities.
- Respiratory infections
  - Tuberculosis program: Aimed at reducing the incidence of tuberculosis in communities, detecting and diagnosing tuberculosis cases early, providing treatment via directly observed therapy, supporting health workers in the prevention and control of TB and strengthening TB research

through collaboration with various partners. In general, the program is operated through the primary care services in communities.

- Communicable disease emergencies initiative
  - Influenza pandemic: Aimed at supporting communities in preparing for an influenza pandemic by supporting the configuration, development, testing and revision of community plans.

#### ► **Environmental health**

- Environmental health
  - Environmental public health program: Carried out by certified environmental health officers, this program is aimed at identifying and preventing public health risks that could affect the health of community residents and recommending corrective action to reduce these risks. The program covers activities on drinking water, health and housing, food safety, facilities inspections, environmental communicable disease control, emergency preparedness and response, solid waste disposal and wastewater. Because this is a mandatory program, communities are required to report on drinking water monitoring activities.
- Environmental health research program
  - Focuses on research on environmental hazards and risks - physical, chemical, biological and radiological - that affect the health. The personnel of this program helps Inuit and First Nations communities in developing capacity to work with various partners concerned with environmental health. The program provides funding for community-based research programs, research work, monitoring and surveillance, as well as laboratory and field studies related to environmental health. Funding which is based on contributions for community research is allocated following a competitive request for proposal process.

### **Primary care**

All of this component's programs are mandatory.

#### ► **Clinical and client care**

This program includes essential health services, urgent and non-urgent, for First Nations people, including residents of remote and isolated communities. As these are mainly 1<sup>st</sup> line services, they are delivered by health teams, predominantly nurse led.

The components covered by the *Clinical and client care* services are:

- Urgent care
  - Immediate assessment of a seriously injured or ill client to determine the severity of the condition and the type of care needed. It may involve treatment with stabilizing measures and arranging for immediate transport to a tertiary care centre, or keeping the client under observation. Where available, this is done in consultation with a physician. In isolated/remote communities, this is done by the nursing staff often in consultation with a physician by telephone or internet.
- Non-urgent care
  - Assessment, identification of problem(s) and generation of a plan of management for a client who is seeking non-urgent care.
- Coordination and case management
  - The linkages with other services may include other health, social and education programs available both within the community and outside of the community (therapeutic services, hospital services, specialized services, etc.).
- Access to medical equipment, supplies and pharmaceuticals
  - Provision of necessary medical equipment, supplies and pharmaceuticals.
- System of record keeping and data collection
  - Develop and maintain a client record and an information system that enables program monitoring, ongoing planning, reporting and evaluation activities.
- Continuous quality improvement process
  - Capacity to review and continuously improve the delivery of clinical and client care in a safe and effective manner.

► **Home and community care**

This program includes home and community-based health care services for citizens with disabilities, chronic or acute illnesses and the elderly. The program is primarily provided through contribution agreements. Services are provided primarily by home care registered nurses and trained and certified personal care workers.

Essential service elements include:

- Client assessment;
- Home care nursing;

- Case management;
- Home support (personal care and home management);
- In-home respite;
- Linkages and referrals, as needed, to other health and social services;
- Provision of and access to specialized medical equipment and supplies for care;
- A system of record keeping and data collection.

Additional supportive services may also be provided, depending on the needs of the communities and funding availability. Supportive services may include:

- rehabilitation and other therapies;
- adult day care programs;
- meal programs;
- in-home mental health services;
- in-home palliative care;
- specialized health promotion, wellness and fitness activities.

## Supplementary health benefits

The Non-Insured Health Benefits (NIHB) program is a national program that provides registered First Nations and Inuit people, regardless of their residency, a range of medically required health-related goods and services that are not provided through other private or provincial/territorial plans. As NIHB are used to compensate for services that are not covered by the provinces, the rules on what is covered may vary from one region to another (Health Canada, 2012b).

The NIHB Program provides benefit coverage for vision care, dental care, pharmacy, medical transportation, in addition to short-term crisis intervention and approved health services outside of Canada. Other services to meet special needs are also available (Health Canada, 2012b). An overview of these services is provided in Appendix 5.

The provision of these services is administered through NIHB headquarters for drug benefits and orthodontic care, through Health Canada regional offices for dental care, medical transportation, vision care, medical supplies and equipment, and short-term crisis intervention mental health counseling, through contribution agreements for specific services.

### 4.2.3 Institutions

In Quebec, for First Nations communities located on territories not under agreement, the FNIHB funds three types of health institutions; health centres (15), nursing stations (11) and rehabilitation centres (5 alcohol and drug abuse rehabilitation centres and 1 First Nations youth rehabilitation centre (Health Canada, 2011).

- ▶ Health centre: Usually located in non-isolated communities, it has at least one community health nurse and staff to perform preventive and health promotion activities. The provision of primary and urgent care is provided by physicians (Health Canada, 2011).
- ▶ Nursing stations: Facility, often located in isolated, semi-isolated or remote communities, with a staff composed of at least one community health nurse, support workers and medical staff. Primary and emergency care (24 hours a day, with some exceptions) and patient care when admitted for short periods. In addition, there are personnel responsible for the promotion of public and community health. Consultation with a physician is available on call and when visits are planned in communities (Health Canada, 2011).
- ▶ Rehabilitation centre: Facility that provides culturally appropriate inpatient and outpatient care in terms of alcohol and substance abuse (Health Canada, 2011).

Some communities are still lacking health institutions; generally these communities do not have reserve status. The citizens of these communities requiring care and health services must therefore use Québec network service points nearby.

The Kateri Memorial Hospital Centre in Kahnawake is the only hospital run by a First Nation in Quebec. The agreement for the construction and operation of a hospital centre in Kahnawake was made in 1984 between Mohawks and the Quebec government. Under the *Act respecting health services and social services*, the Kateri Memorial hospital centre is considered a private institution under agreement<sup>12</sup>. In 2012, the National Assembly passed a law that allowed the expansion of the institution. It includes short or long term services, laboratory, prevention and control of infections activities, physiotherapy services. Traditional medical services should be offered in the future.

<sup>12</sup> Private institutions under agreement are subject to all laws and regulations of organization and administration of the health network institutions. They are distinguished from public centres of the same vocation by their funding and financial accountability methods. General rules relating to the funding of activities provided by private institutions under agreement determine the budget allocation parameters for institutions and subsequently funding is determined between each institution and their regional health and social services agency (AEPC, 2012).

In some communities, there are also other types of institutions such as senior residences and centres, rare transition houses from hospital to home (FNQLHSSC, 2013c), community pharmacies or shelters for female victims of conjugal violence (these housing resources are presented in Section 5.2). Schools and daycare centres, for example, can also develop programs funded by Health Canada.

The *Iakhihsohtha Lodge* (Home for the Elderly) in Kanesatake is a residential facility for short or long term periods for frail elderly or convalescents. Services are organized to meet the psychological, social, emotional and spiritual needs of residents and their families (Mohawk Council of Akwesasne, 2014).

#### **4.2.4 Service providers**

The composition of the care teams working in First Nations community institutions located on territories not under agreement is similar to that described for communities under agreement. Care teams are primarily based on the presence of versatile nurses, community health representatives and social workers (Quebec Regional Advisory Committee, 2011). These professionals often act as first responders to provide care but also to respond to emergencies and social crises.

Other resources can join these teams, such as nutritionists, psychologists, psychoeducators, specialized educators, community organizers, dentists, speech therapists, etc. Sometimes rare physical therapists and traditional healers may also be consulted by the resident population in some communities (FNQLHSSC, 2013c).

For emergency situations, a few communities can also rely on an ambulance service and others, on an emergency response team (FNQLHSSC, 2013c).

#### **Physicians**

In some First Nations communities located on territories not under agreement, general practitioners make visits on a periodic basis or provide 24/7 telephone care service to respond to emergencies, discuss cases or confirm prescriptions (fax transmission) (OIIQ, 2004). However, the presence of doctors in communities located on territories not under agreement is not based on a formal structure as is the case for the Quebec network. Health centres in these communities are not considered Quebec institutions within the meaning of the law and have no right to PREMs. Doctors who visit communities do so on a voluntary basis with the approval of the facility or service point with which they are affiliated.

Moreover, according to the results of the RHS 2008, the vast majority of health professionals working in First Nations communities are not First Nations (FNQLHSSC, 2013d).

**4.2.5**  
**Linkages with the quebec network**

Generally, First Nations communities have access to the network’s health and social services institutions and service points by following the service corridors established by the CISSS/CIUSSS to which they are affiliated. In Abitibi-Témiscamingue (see Table 2), for example, this affiliation would look like this:

**Table 2**  
**Affiliation of First Nations communities**  
**located in the health region of Abitibi-Témiscamingue**

*o8 – Abitibi-Témiscamingue*

| <i>Communities</i>         | <i>CISSSAT</i>        |                               | <i>RUIS</i> |
|----------------------------|-----------------------|-------------------------------|-------------|
|                            | <i>CSSS*</i>          | <i>CH*</i>                    |             |
| Kebaowek / Eagle Village   | CSSS du Témiscamingue | Pavillon Sainte-Famille       | McGill      |
| Hunter’s Point / Wolf Lake | CSSS du Témiscamingue | Pavillon Sainte-Famille       | McGill      |
| Timiskaming                | CSSS du Témiscamingue | Pavillon Témiscamingue-Kipawa | McGill      |
| Winneway / Long Point      | CSSS du Témiscamingue | Pavillon Témiscamingue-Kipawa | McGill      |
| Pikogan                    | CSSS Les Eskers       | Hôtel Dieu d’Amos             | McGill      |
| Lac-Simon                  | CSSS Vallée-de-l’Or   | CH Vallée-de-l’Or             | McGill      |
| Kitcisakik                 | CSSS Vallée-de-l’Or   | CH Vallée-de-l’Or             | McGill      |

*\* As a result of Bill 10, the CSSS and CH were merged with the CISSS Abitibi-Témiscamingue.*

The distribution of health regions in the Quebec network does not take into account the territorial organization of communities located on the territories not under agreement. Therefore, some Nations have communities affiliated to different health regions. Thus, upon reading the annual management reports from the related former health and social services agencies, we note that:

- ▶ unlike all other Innu communities that are located in the Côte-Nord health region, Mashteuiatsh is located in the Saguenay-Lac-Saint-Jean health region;
- ▶ unlike Opitciwan and Wemotaci, two Atikamekw communities, which are located in the Mauricie-et-du-Centre-du-Québec health region, Manawan is included in the Lanaudière health region;
- ▶ unlike the other Algonquian nations located in the Abitibi-Témiscamingue health region, Kitigan Zibi and Lac-Rapide are located in the Outaouais health region.
- ▶ unlike Kahnawake and Akwesasne (the portion in Quebec) of the Mohawk Nation which are located in the Montréal health region, Kanasatake is located in the Laurentides health region.

### 4.3

#### **SERVICES OFFERED TO FIRST NATIONS AND INUIT LIVING OUTSIDE OF THE COMMUNITIES**

In Quebec, First Nations and Inuit people residing outside the community must usually use institutions of the Quebec network of health and social services to receive care.

However, federal funding for certain programs was developed with the intent to meet the needs of First Nations and Inuit living outside of the communities. The majority of these programs are grouped under the Improved Urban Aboriginal Strategy, and fund the Native friendship centres. The Public Health Agency of Canada funds the Aboriginal Head Start in Urban and Northern Communities program.

#### **Improved Urban Aboriginal Strategy – AANDC**

The AANDC Improved Urban Aboriginal Strategy includes two major programs - Urban Partnerships and Community Capacity Support - all prior programs that were previously addressed to urban Aboriginal people. The first, Urban Partnerships, supports projects that aim at promoting the participation of urban Aboriginal people in the economy. The second, Community Capacity Support, provides funding to urban Aboriginal community organizations (such as Native friendship centres). For the realization of the various projects, the Urban Aboriginal Strategy fosters collaboration among a plurality of stakeholders, such as the municipality, other federal departments, provincial government or even a private company (AANDC, 2014).

In Montreal, the Montreal Urban Aboriginal Community Strategy Network (NETWORK), funded in part by the Improved Urban Aboriginal Strategy was established to promote exchanges and partnerships between organizations that directly or indirectly serve First Nations and Inuit people in the Montreal area. It consists of Aboriginal service providers in the Montreal region, First Nations and Inuit people living in urban areas,

representatives of municipal, provincial and federal bodies, as well as non-Aboriginals. Its activities are organized around six priority areas of intervention: arts and culture; communications; employability-training-education; health; social services; youth (NETWORK, n.d.).

### **Services provided by Native friendship centres (NFC)**

In Quebec there are 10 Native friendship centres:

- ▶ Eenou NFC in Chibougamau (CAEC)
- ▶ NFC of Sept-Îles (CAASÎ)
- ▶ NFC of Val-d'Or (CAAVD)
- ▶ NFC of Québec (CAAQ)
- ▶ NFC of La Tuque (CAALT)
- ▶ NFC of Lanaudière (CAAL)
- ▶ NFC of Montréal (CAAM)
- ▶ NFC of Saguenay (CAAS)
- ▶ NFC of Senneterre (CEAAS)
- ▶ Point de services pour les Autochtones de Trois-Rivières (PSATR)

Native Friendship Centres (NFC) work to improve the quality of life of urban Aboriginals and to build bridges between peoples. NFC funding comes mainly from a funding program granted by AANDC. The Regroupement des centres d'amitié autochtones du Québec, an organization that represents the interests of NFC, manages this program for six NFCs (RCAAQ, 2014). NFC activities are also supported (financially and otherwise) by community organizations in their region.

The provision of services varies from one centre to another, but generally includes services that address early childhood and youth as well as adults and elders (RCAAQ, 2014). For example:

- ▶ For youth: homework assistance for elementary school students, child care, day camps, “youth centre” type institutions.
- ▶ For adults and elders: assistance/transportation services during medical visits, health programs, community development programs, personal development (AA/gamblers programs, drug awareness, suicide prevention) and economic development (employment assistance, work integration assistance).

- For vulnerable clientele: housing services and affordable services (meals, housing, clothing), street patrols for homeless or at-risk clientele).
- For Aboriginal and non-Aboriginal people: cultural and awareness activities in terms of Aboriginal realities.

As presented in Section 3.2.2, the NFC of Val-d'Or and La Tuque have set up in partnership with the CSSS in their respective regions, two health clinics in their institutions. Through these clinics, NFC and their partners hope to reach a greater number of clients and provide services that are culturally safe and appropriate to Aboriginal needs. A summary profile of these two clinics is presented in Table 3.

**Table 3**  
**Profile of the Minowé and Acokan clinics**

|                    | <i>Minowé<sup>13</sup> clinic</i>                                                                                                                                                                    | <i>Acokan<sup>14</sup> clinic</i>                                                        |
|--------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| Institutions       | NFC of Val-d'Or                                                                                                                                                                                      | NFC of La Tuque                                                                          |
| Affiliation        | Integrated to the RLS de la Vallée-de-l'Or                                                                                                                                                           | Integrated to RLS du Haut-Saint-Maurice                                                  |
| Governance         | Ensured by the CSSSVO, the CJAT, the CAAVD                                                                                                                                                           | Ensured by the CAALT and CSSSHSM                                                         |
| Associate partners | ASSS de l'Abitibi-Témiscamingue, Health Canada, Fondation Avenir d'Enfants, RCAAQ, DIALOG, ODENA                                                                                                     | N/A                                                                                      |
| Service providers  | A nurse, a local worker, an administrative coordinator, doctor (collection prescriptions)                                                                                                            | A nurse from the CSSSHSM                                                                 |
| Services           | 1 <sup>st</sup> line: Reception, assessment and referral<br>Children, youth, family<br>Addictions treatment<br>Mental health<br>Physical health (chronic diseases)<br>Liaison role CSSSVO-CJAT-CAAVD | Proximity services <sup>15</sup><br>tailored to the Aboriginal needs<br>Chronic diseases |
| Clientele          | Pregnant women, youth 0 to 18 years of age and their families                                                                                                                                        | Aboriginal people living or staying in La Tuque                                          |

<sup>13</sup> Native Friendship Centre in Val-d'Or, *The Minowé Clinic: a resource integrated to the Vallée-de-l'Or local network*, Val-d'Or: Native Friendship Centre of Val-d'Or.

<sup>14</sup> Tremblay, A. (2014). Une clinique pour les Autochtones, *Le Nouvelliste*, published February 20, 2014.

<sup>15</sup> There will be no new services created at the Acokan clinic; The objective is rather to facilitate access to services already available.

Moreover, the Montreal NFC offers clients nursing and physician care through support from Médecins du Monde. A nurse is present in the NFC one day a week and a physician is present one day a month (NFC of Montréal, n.d.).

### **Aboriginal Head Start in Urban and Northern Communities – Public Health Agency of Canada**

The Aboriginal Head Start in Urban and Northern Communities (AHSUNC) Program is a community-based children's program that focuses on early childhood development (ECD) for First Nations, Inuit and Métis children and their families living off-reserve. It addresses general health concerns in vulnerable populations and works to benefit the health, well being and social development of Aboriginal children. It focuses on six program components: Aboriginal culture and language, education and school readiness, health promotion, nutrition, social support and parental involvement (Public Health Agency of Canada, 2013).



## 5 SOCIAL SERVICES

In Quebec, social services are integrated within the same public health services system and are offered to the entire population or, as appropriate, to specific clientele. As with health services, social services are organized around the service programs presented in Section 3.4, are orchestrated by the same hierarchy (service lines) and provision of these services is done in the public institutions and their service points presented in section 3.5. The social component of CISSS/CIUSSS revolves mainly around their mission of rehabilitation centre (CR) and youth centre (YC). Moreover, in Quebec, community organizations are actively involved in providing services that contribute to the promotion of social development and the improvement of living conditions through action on the factors that are central to the well-being.

At the federal level, AANDC funds the provision of social programs that are developed and implemented in Inuit and First Nations communities. Signed the *James Bay and Northern Quebec Agreement* and the *Northeastern Quebec Agreement*, Inuit, Cree and Naskapi communities also have access to certain social programs funded by AANDC. Social programs funded by AANDC are designed to support the needs of low-income individuals as well as employability, to meet the needs of the elderly, the needs of adults with chronic diseases and the needs of youth and adults living with disabilities. Other programs are aimed at ensuring the protection of children and families and to help prevent and reduce child poverty. For its part, Health Canada funds eligible activities under the *National Native Alcohol and Drug Abuse Program (NNADAP)*. This program is presented in Section 4.2.

### 5.1 SOCIAL SERVICES OFFERED BY THE QUEBEC NETWORK

Six general first-line social services may be offered (MSSS, 2013a). As with health services, general social services include prevention and promotion activities as well as clinical and assistance activities.

#### 5.1.1 First-line services

First-line social services include the following activities:

- ▶ **Reception, analysis, guidance and referral**
  - Point of entry; social or psychological services

► **Telephone psychosocial consultation 24/7 (811)**

- Three types of intervention:
  1. Information;
  2. Prevention-education;
  3. Crisis
- Not yet available in all regions

► **Crisis intervention 24/7**

- Immediate, brief and direct intervention; stabilize the condition of the individuals or their human environment

► **Social consultation**

- Social intervention activities and conjugal and family intervention activities; aimed at improving the social functioning of individuals
- Short-term approach (maximum 12 meetings)

► **Psychological consultation**

- Offered to individuals with a one-time or situational psychological functioning
- Includes psychotherapy and clinical interventions activities
- Service offered by appointment (maximum 12 meetings)

► **Psychosocial component in a civil security context**

- Represents the psychosocial component of the “health” mission in terms of civil security
- Four specific activities:
  1. Identification;
  2. Psychosocial evaluation and monitoring;
  3. Telephone consultation;
  4. Counselling activities

### **5.1.2**

#### **Second-line services: services offered by rehabilitation centres (CR)**

In addition to the services offered in the CLSC service points, services are offered in separate institutions, to clientele with specific needs. For example, a range of services is offered in rehabilitation centres (CR)<sup>16</sup>. As presented in Section 3.5, the mission of a CR is essentially to provide specialized adaptation and rehabilitation services, social integration

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<sup>16</sup> Rehabilitation centers are operated by the CISSS/CIUSSS

and support services as well as family support services. On referral, the services offered by the CR are for individuals with either physical or intellectual disabilities, who have behavioural psychosocial or family issues, or who are living with any addiction (to alcohol, drugs, gambling, etc.). Some services are provided on an outpatient basis while others are inpatient. Often, the CR services are complementary to interventions in sectors beyond the Quebec network of health and social services, i.e. in school environments and early childhood services, workplaces or recreational institutions, etc. CRs are regionally-based, but service points allow for a more local access; their number varies from one health region to another.

In Quebec, there are:

- ▶ 20 centres for disability rehabilitation and pervasive development disorders (*centres de réadaptation en déficience intellectuelle et en troubles envahissants du développement*) (FQCRDITED, 2014)
- ▶ 21 physical rehabilitation centres (*centres de réadaptation en déficience physique*) (CRDP) distributed into 108 service points (AÉRD PQ, n.d.)
- ▶ 16 addiction rehabilitation centres (*centres de réadaptation en dépendance*) (CRD) (ACRDQ, 2014).

In Nunavik, the two health centres ensure the CR mission. In addition, the Inuulitsivik Health Centre manages the Inukjuak Reintegration Centre, a regional resource that provides services to adults with severe and persistent mental health problems and/or intellectual impairment (Inuulitsivik, n.d.).

In Eeyou Istchee, the mission of the regional services for special needs (*Services régionaux pour des besoins spéciaux*) (SRBS) is to “who require assistance to meet their basic needs due to a long-term, chronic condition that affects their capacity to achieve their full potential intellectually, physically, cognitively and/or socio-emotionally” (CBHSSJB, 2013). These services are offered in collaboration with Community *Miyupimaatisiun* (CMC) and other organizations and agencies located in the communities.

In Kawawachikamach, CR services are managed by the Centre de protection et de réadaptation de la Côte-Nord which was introduced as a result of the merger between the youth centre, the rehabilitation centre for physical disabilities, intellectual disabilities and pervasive developmental disorders and the addiction rehabilitation centre (CPR de la Côte-Nord, 2013). The head office is located in Baie-Comeau, but a service point is available in Schefferville. The Naskapi CLSC also offers common psychosocial and psychology services.

## Services offered to children, youth and their families

Several services have been developed to meet the needs of children, youth and their families. For example, protection services and specialized assistance to children and youth who are in danger or experiencing serious difficulties are offered in youth centres<sup>17</sup> (YC). The YC are institutions that operate both a child and youth protection centre (CPEJ) and a rehabilitation centre for young persons with adjustment problems or a rehabilitation centre for mothers with adjustment problems (Section 87.1 *Act respecting health services and social services*). YC are governed by the *Act respecting health services and social services*, the *Youth Criminal Justice Act*, and the *Civil Code* (ACJQ, n.d.).

In Quebec, there are:

- ▶ 16 YC;
- ▶ 3 multi-purpose centres serving the northern territories: the two health centres in Nunavik and the hospital centre in Chisasibi (ACJQ, n.d.).

Specifically, YC usually offer psychosocial and rehabilitation services built around prevention and intervention programs developed according to the age of children and youth and the needs to be met. Services are offered on an outpatient or inpatient basis, i.e. group homes or rehabilitation centres.

### Territories under Agreement

In **Nunavik**, youth protection services are provided by two health centres. A youth protection director is associated with both sub-regions (CDPDJ, 2007). They are responsible for a regional rehabilitation centre for youths with adjustment problems in Salluit and two group homes, one in Puvirnituk and the other in Kuujuaq (NRBHSS, 2013). The centre in Salluit has room for 14 individuals, while the capacity in the group homes is 8 individuals.

In **Eeyou Istchee**, the youth protection director reports to the CBHSSJB. The regional youth protection service (SPJ) operates the Upaachikush group home in Mistissini and the Weesapou group home in Chisasibi. They also operate the youth healing services reception in Mistissini (CBHSSJB, 2013). In addition, a new regional phone number is available for individuals wishing to report a threatening situation for the safety of a child. At the local level, in every community, youth protection teams can intervene, if necessary, in emergency situations.

In **Kawawachikamach**, 2<sup>nd</sup> line social services offered to youth and their families are provided by the North Shore youth protection director.

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<sup>17</sup> Youth centres are operated by the CISSS/CIUSSS

**Territories not under agreement**

For territories not under agreement, First Nations communities must sign agreements with the YC in their region to determine the terms involving the provision and funding of certain social services (MSSS, 2007c). These agreements can be bipartite or tripartite depending on whether the communities involved have accepted responsibility or not for the provision of their social services. Through bipartite agreements, YC invoice the band councils or tribal councils for the services provided to citizens residing in the communities. Communities that have not accepted responsibility for the provision of social services must sign an agreement with the YC of their region and AANDC. The YC invoices AANDC for the services provided in these communities (MSSS, 2007c).

The First Nations of Quebec and Labrador Health and Social Services Commission has documented the list of communities or groups of communities that have concluded such agreements. This information is shown in Table 4.

**Table 4**  
**Communities having entered into an agreement with a YC**

| <i>Nations</i> | <i>Communities</i>                                                  | <i>Type of agreement</i> |
|----------------|---------------------------------------------------------------------|--------------------------|
| Abenaki        | Grand Conseil Waban Aki Wôlinak / Odanak                            | Bipartite                |
| Algonquin      | YC Abitibi-Témiscamingue / Timiskaming / Eagle Village / Long Point | Tripartite               |
|                | YC Abitibi-Témiscamingue / Kitcisakik / Lac Simon / Pikogan         | Bipartite (YC-AANDC)     |
|                | YC Outaouais Barrière Lake                                          | Bipartite (YC-AANDC)     |
|                | Kitigan Zibi                                                        | Bipartite                |
| Atikamekw      | Atikamekw Nation Council Manawan / Wemotaci                         | Bipartite                |
|                | Opitciwan                                                           | Bipartite                |
| Hurons-Wendat  | Wendake                                                             | Bipartite                |
| Innu           | Betsiamites                                                         | Bipartite                |
|                | Essipit                                                             | Bipartite                |
|                | Mamit Innuat (Pakua Shipi / Unamen Shipu / Ekuanitshit)             | Bipartite                |

| <i>Nations</i> | <i>Communities</i>        | <i>Type of agreement</i> |
|----------------|---------------------------|--------------------------|
| Innu           | Mashteuiatsh              | Bipartite                |
|                | Matimekosh / Lac-John     | Bipartite                |
|                | Nutashquan                | Bipartite                |
|                | Uashat mak Mani-Utenam    | Bipartite                |
| Mi'kmaq        | Gesgapegiag               | Bipartite                |
|                | Listuguj                  | Bipartite                |
| Mohawk         | Akwesasne                 | Bipartite                |
|                | YC Laurentides Kanesatake | Tripartite               |
|                | Kahnawake                 | Bipartite                |

### **Youth Protection act**

The *Youth Protection Act* establishes the general principles of intervention in respect of a child and the parents to put an end to and prevent the recurrence of a situation in which the security or development of the child is in danger. According to Section 38, the security or development of a child is considered to be in danger if the child is abandoned, neglected, subjected to psychological ill-treatment or sexual or physical abuse, or if the child has serious behavioural disturbances. Youth protection directors appointed for each facility operating a child and youth protection centre (CPEJ), as well as the Commission des droits de la personne et des droits de la jeunesse (CDPDJ)<sup>18</sup> are responsible for youth protection. It is thus the responsibility of youth protection directors to decide whether a report must be accepted and in this case, determine whether the security or development of a child is in danger.

When a report is accepted, immediate protective measures for a period of 48 hours can be issued (Section 46 of the Act). These measures may be to remove the child from his present environment; entrust the child to a CR or CH, to one of the child's parents, to a person who is important to the child, to a foster family, to an appropriate body or to any other person. Following an evaluation, the concerned youth protection director determines whether or not there are any sources of risk for the child (voluntary or judicial).

<sup>18</sup> The responsibilities of the CDPDJ are listed in Section 23 of the Youth Protection Act. The CDPDJ can, for example, on request or on its own initiative, investigate any situation where it has reason to believe that the rights of a child or of a group of children have been encroached, take the legal means it considers necessary to remedy any situation, prepare and implement information and educational programs, make recommendations to the ministers involved in the health and well-being of children and youth, and ultimately carry out or cause to be carried out studies and research on any question related to its competence.

In 2006, the Youth Protection Act was amended to introduce maximum placement periods and, therefore, the notion of permanent life project for each child in care. These core elements are intended to rule quickly on the situation of each child who must be removed from their family environment and to avoid unnecessary and prolonged placement. The reform imposes deadlines determined by age of the child, after which a permanent life project must be implemented for the child whose development and security are considered at risk (Goubau, 2012). Although the maintenance or child's return to his family environment is considered to be privileged, the concept of life project also includes the placement with a person who is important to the child, with a foster family or in a rehabilitation centre, adoption, guardianship (Goubau, 2012).

### **Section 37.5**

In 2001, a new section was introduced in the Youth Protection Act to grant Inuit and First Nations communities greater responsibilities related to youth protection. Section 37.5 governs the content and implementation of agreements between the Government of Quebec and Inuit and First Nations communities to entrust the signatory communities responsibilities normally assigned to the youth protection directors (MSSS, 2007c).

#### **Youth Protection Act – Section 37.5**

In order to better adapt the application of this Act to the realities of Native life, the Government is authorized, subject to the applicable legislative provisions, to enter into an agreement with a first nation represented by all the band councils of the communities making up that nation, with a Native community represented by its band council or by the council of a northern village, with a group of communities so represented or, in the absence of such councils, with any other Native group, for the establishment of a special youth protection program applicable to any child whose security or development is or may be considered to be in danger within the meaning of this Act.

To implement a specific youth protection system, Aboriginal communities must meet certain essential conditions:

- ▶ prior take-over of 1<sup>st</sup> line social services by the communities (improved approach based on prevention);
- ▶ community support for the project;

- ▶ the identification of mechanisms for collaboration with external organizations;
- ▶ the development of practice guidelines to support interventions by social workers, etc.

A description of these conditions is provided in the *Guidelines for Establishing a Special Youth Protection Program for Native peoples* produced by the MSSS (MSSS, 2004d<sup>19</sup>).

### 5.1.3 Community organization support program (PSOC)

In 2001, the Quebec government adopted a policy that brings government departments and agencies to meet their responsibilities towards community organizations in their area (MSSS, 2014b). Historically, the MSSS has acknowledged the contribution of community organizations towards improving health and social services by creating Community organization support program (PSOC), which provides assistance, advice and information, and represents a source of funding (MSSS, 2014b). Local, regional or supra-regional organizations may submit their application for funding with the CISSS/CIUSSS in their region, with the exception of Region 18 (Terres-cries-de-la-Baie-James) where the MSSS has retained responsibility for community organizations in the region (MSSS, 2014b).

There are six types of community organizations supported by the PSOC. These types as well as examples of funded organizations are presented in Table 5.

**Table 5**  
**Types of community organizations supported by the PSOC**

| Type                                             | Example of organizations                                                                                    |
|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| Support and mutual assistance centres            | Alcoholism and other addictions; Alzheimer societies; Volunteer                                             |
| Outreach, promotion and advocacy organizations   | Mental health advocacy                                                                                      |
| Living environments and support in the community | Youth centres; Women's centres; CALACS; Resources working with violent men; Alcoholism and other addictions |
| Temporary housing organizations                  | Shelter for battered women and in difficulty; Youth shelter; Shelter for people with mental health problems |

<sup>19</sup> The updated version of these guidelines should be available in the fall of 2014.

| Type                   | Example of organizations |
|------------------------|--------------------------|
| Regional associations  |                          |
| National organizations |                          |

For example, in 2012-2013, the ASSS de la Capitale-Nationale<sup>20</sup>, as part of the PSOC, awarded a grant to the Missinak Community House, a housing and healing resource for Aboriginal women and their families (ASSS de la Capitale-Nationale, 2013).

Nunavik has several community organizations that work in partnership with the NRBHSS for various client groups, such as women, youth and drug addicts.

In Eeyou Istchee, no organization is funded under the PSOC.

In Kawawachikamach, there are no non-profit organizations (Naskapi CLSC, 2012).

## 5.2 SOCIAL SERVICES OFFERED BY FEDERAL BODIES

In First Nations communities located on territories not under agreement, funding for social services comes mainly from AANDC programs. The federal government has in fact set standards and guidelines for five major social development programs for First Nations organizations (AANDC, 2012): the Income Assistance Program, Assisted Living Program, National Child Benefit Reinvestment, Family Violence Prevention Program and finally the First Nations Child and Family Services Program. Some components of these programs are shown in Table 6.

<sup>20</sup> Since this agreement was concluded prior to April 1, 2015, the designation and mission of the facility in question at the time of signing were retained in the interest of clarity

**Table 6**  
**AANDC social programs**

*Income Assistance Program*

|                 |                                                                                                                                                                                             |
|-----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Main objectives | Support the basic and special needs of indigent residents of Indian reserves and their dependants;<br>Support access to services to help clients transition to and remain in the workforce. |
|-----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

*Assisted Living Program*

|                    |                                                                                                                                                                                                                                                                                  |
|--------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Description        | Provides funding for non-medical social support services that meet the special needs of seniors, adults with chronic illness, and children and adults with disabilities (mental & physical) with the objective of maintaining functional independence and greater self-reliance. |
| Primary components | 1. In-home care;<br>2. Adult foster care;<br>3. Institutional care;<br>4. Assisted living disabilities initiative                                                                                                                                                                |

This program has close links to Health Canada's Home and Community Care (HCC) Program.

Social services (non-medical) funded by the Assisted Living Program supports the other social programs by AANDC (Child and Family services, income assistance, specialized education).

*National Child Benefit Reinvestment*

|                 |                                                                                                                                                                                                                                                                     |
|-----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Main objectives | Help prevent and reduce the depth of child poverty;<br>Promote attachment to the workforce by ensuring that families will always be better off as a result of working;<br>Reduce overlap and duplication, and simplify the administration of benefits for children. |
|-----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

*Family Violence Prevention Program*

|            |                                                                                                                                                                                                                                         |
|------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Components | Shelters: Operational funding for family violence shelters serving First Nations communities on reserve;<br>Prevention projects: Proposal-based activities aimed at preventing family violence in First Nations communities on reserve. |
|------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

*First Nations Child and Family Services Program*

|             |                                                                                                                                                                                                    |
|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Description | Provides funding to assist in ensuring the safety and well-being of First Nations children ordinarily resident on reserve by supporting culturally appropriate prevention and protection services. |
|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Child welfare is an area of provincial responsibility whereby each province, in accordance with their legislation, delegates authority to FNCFS agencies to manage and deliver child welfare services on reserve.

In 2007, the FNCFS program adopted the Enhanced Prevention Focussed Approach (EPFA) and began reforming its funding activities for enhanced prevention and least disruptive measures.

### Shelters for Aboriginal women victim of violence

Seven shelters for Aboriginal women victim of violence operate in certain First Nations communities in the Mauricie, Gaspésie and the North Shore and in Montreal, Quebec City and La Tuque<sup>21</sup> (see Table 7). Note that there are no Aboriginal shelters in the region of Abitibi-Témiscamingue (Pharand, 2008). These shelters are usually open to women from the community or neighboring communities; shelters in Montreal and Quebec can also accommodate women from remote communities.

The services provided by these institutions vary according to the regional needs, human and financial resources, the condition of the premises or links established with other local or regional organizations (including the DPJ). Nevertheless, they generally include housing services, intervention and support for women victim of violence and their children. They can sometimes provide respite services for women with addiction problems or depression, and external services such as training, workshops, etc. (Pharand, 2008).

Most shelters receive an AANDC budget managed by band councils; the Native Women's Shelter of Montreal and the Missinak Community Home, two off-reserve resources, are an exception in that their operating budget comes from the MSSS (Pharand, 2008).

**Table 7**  
**Shelters for Aboriginal women victim of violence**

| <i>Name of facility</i>                                                        | <i>City</i>  | <i>Region</i>                 | <i>Funding</i> |
|--------------------------------------------------------------------------------|--------------|-------------------------------|----------------|
| Native Women's Shelter of Montreal / Foyer pour femmes autochtones de Montréal | Montréal     | Montréal                      | MSSS           |
| Missinak community home                                                        | Québec       | Capitale-Nationale            | MSSS           |
| Asperimowin shelter                                                            | La Tuque     | Mauricie                      | AANDC          |
| Haven House                                                                    | Listuguj     | Gaspésie-Îles-de-la-Madeleine | AANDC          |
| Maison Tipinuaikan                                                             | Uashat       | Côte-Nord                     | AANDC          |
| Maison Ashpukun Mitshuap                                                       | Matimekosh   | Côte-Nord                     | AANDC          |
| Waseya House                                                                   | Kitigan Zibi | Outaouais                     | AANDC          |

<sup>21</sup> Although located in La Tuque, the Asperimowin Shelter is considered a resource "on reserve" because it provides services exclusively for women of Wemotaci, Manawan and Opitciwan, as well as women living or staying in La Tuque (Pharand, 2008).

In 2012, the Napeuat Committee in Sept-Îles, a resource for men with violent behaviour, was included in the Réseau des maisons d'hébergement autochtones du Québec (Quebec network of Native shelters) (FAQ, 2014).

## 6 CONCLUSION

This review has shown that all First Nations and Inuit in Quebec have access to a number of health services and social services within and outside their community. A close look shows that there is significant heterogeneity in the organization of services intended for them. Thus, to understand the range of services provided to Aboriginals, it is important to determine whether or not they live in a community. If so, determine whether this community is located or not on a territory under agreement and if so, determine the conditions governing the provision of services. It is also important to take into account the geographical position of the community, whether it is considered isolated or near cities or regional hubs. It is also important to distinguish which level of government is funding the services and, within this department, distinguish whether it is health care services or social services. It is also important to determine whether the local authority is managing the provision of services alone or if this responsibility is shared with others. It will also be important to identify whether collaboration or service agreements have been made with the Quebec network of health and social services.

This diversity, which is confusing for many, is inextricably dependent on legislation and policies through the sharing of jurisdictional responsibilities and the signing of agreements. This sharing often stems from an inaccurate system marked by disparities and ambiguities where multiple procedures and decision-making mechanisms are superimposed at the expense of development services that truly address the social and health problems experienced in Inuit and first Nations communities (NCCAH, 2011a; Lavoie, 2013).

This review is not sufficient by itself to account for the entirety of the issues associated with the provision of the services offered to Inuit and First Nations people. To meet the initial mandate given, issues of accessibility, continuity and quality were deliberately set aside at this level of the project. Thus, in this review there is no description and analysis of the many barriers that can restrict people from consulting or engaging in a somewhat long-term monitoring process. One has only to think of the poverty based difficulties, social exclusion and discrimination, lack or inadequacy of infrastructure and human resources, or language and cultural barriers (NCCAH, 2011b). These many barriers are of concern to the extent that access to health services is an important determinant of health (NCCAH, 2011b).

There is also no mention of the lack of adaptation of programs and services to the needs and realities of Aboriginal communities. It does not document the failures or deficiencies in the continuity of services when, for example, patients travel back and forth between institutions in their community and those of the Quebec network. This review does not

mention the arduous steps taken by certain organizations to build bridges with the Quebec network nor does it documents the many pilot-project type initiatives, while useful, are not conducive to the stability of the service development.

Hopefully, these elements and certain gray areas will be analyzed and clarified in further work.

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# Nations autochtones du Québec

**INUITS**

- Ivujivik
- Salluit
- Kangiqsujuaq
- Quaqtaq
- Kangirsuk
- Aupaluk
- Tasiujaq
- Kangiqsualujuaq
- Kuujuuaq
- Umiujaq
- Kuujuarapik
- Kawawachikamach
- Matimekush

**ABÉNAQUIS**

**ALGONQUINS**

**ATIKAMEKW**

**CRIS**

**HURONS-WENDAT**

**MALÉCITES**

**MICMACS**

**MOHAWKS**

**MONTAGNAIS**

**NASKAPIS**

Whapmagoostui

Chisasibi

Wemindji

Eastmain

Nemiscau

Waskaganish

Waswanipi

Lac-Simon

Pikogan

Grand-Lac-Victoria

Mistissini

Oujé-Bougoumou

Obedjiwan

Mashteuiatsh

Wemontaci

Manawan

Rapid Lake

Kitigan Zibi

Wolinak

Odanak

Kahnawake

Kanesatake

Akwesasne

Wolf Lake

Eagle Village-Kipawa

Winneway

Timiskaming

Uashat mak Mani-Utenam

Betsiamites

Essipit

Cacouna / Whitworth

Wendake

Mingan

Natashquan

Gaspé

Gesgapegiag

Listuguj

Pakua Shipi

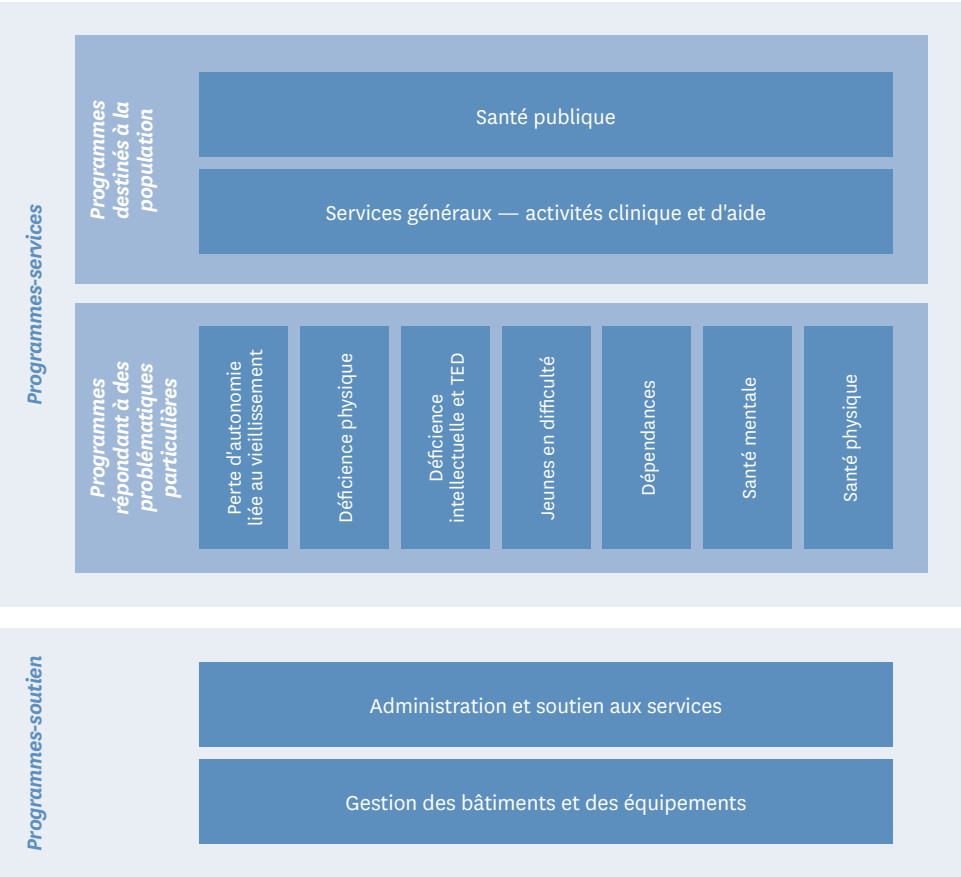
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**APPENDIX 2**  
**CONFIGURATION OF PROGRAMS**  
**IN THE QUEBEC HEALTH NETWORK**

**Configuration program**



Source: MSSS (2004a)

### APPENDIX 3 FNIHB FUNDING MODELS

Funding Model Comparison Chart

| Requirements Set      | Fixed                                                                                                                                                 | Flexible                                                    | Block                                                                                                                                                                                         |                                                                                                                                                                                                                                                                    |
|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                       |                                                                                                                                                       | (Transitional)                                              | (Flexible)                                                                                                                                                                                    | (Flexible-Transfert)                                                                                                                                                                                                                                               |
| Planning              | Recipient follows multi-year Program Plan. This plan will include: objectives, activities that will be delivered                                      | Budgetary estimate of program costs                         | Recipient establishes Multi-Year Work Plan including a health management structure. This Plan will include a budgetary plan, key priorities, objectives and activities that will be delivered | Recipient establishes a Health Plan including a health management structure. The Health Plan will include key priorities, objectives, activities, mandatory health programs and other programs and services, evaluation strategy and annual reporting requirements |
| Reallocation of Funds | Recipients only able to reallocate funds within the same sub-sub activity on written approval by the Minister within the fiscal year reporting period | No reallocation of funds                                    | Recipient able to reallocate funds in the same Program Authority                                                                                                                              | Recipients able to reallocate funds across authorities (with the exception of specifically identified programs)                                                                                                                                                    |
| Duration              | Up to 3 years                                                                                                                                         | Up to 5 years                                               | 2 to 5 years                                                                                                                                                                                  | 5 years                                                                                                                                                                                                                                                            |
| Financial Reporting   | Interim and final (year end) financial reports                                                                                                        | Interim financial report and Annual (year end) audit report | Annual year end audit report                                                                                                                                                                  | Annual year end audit report                                                                                                                                                                                                                                       |

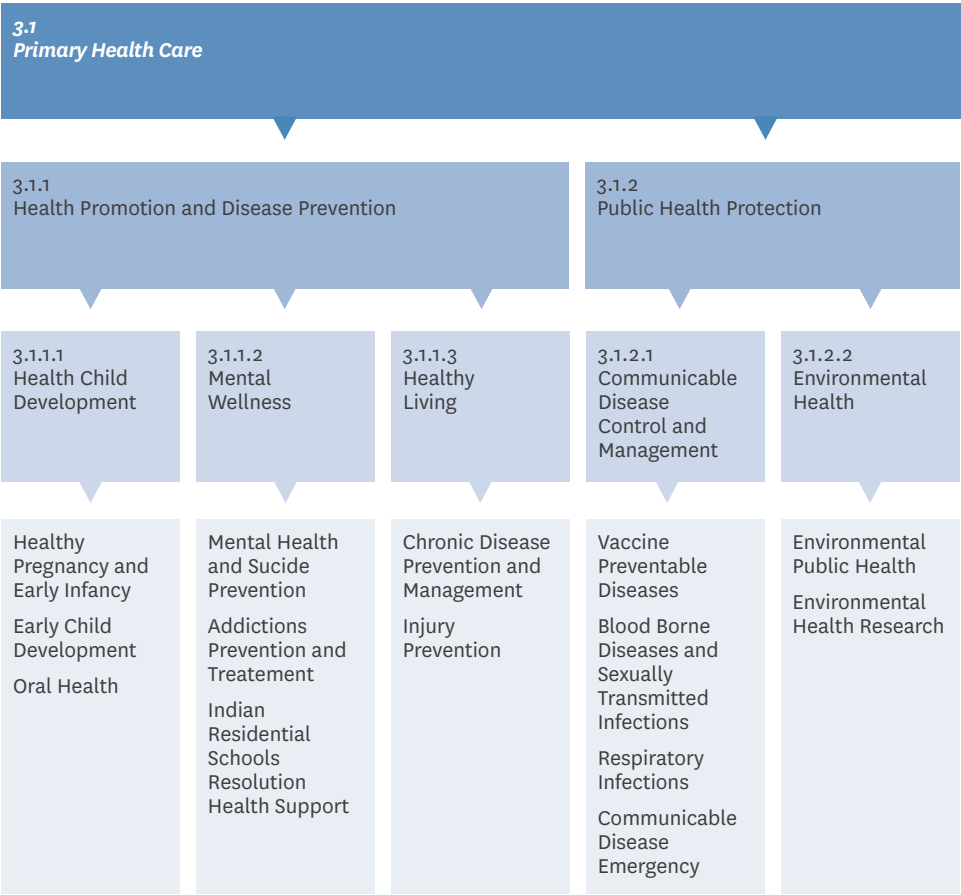
| <i>Requirements Set</i>         |                                                                                 | <i>Fixed</i>                                                                                                                                                                                                                   | <i>Flexible</i><br><i>(Transitional)</i>                                                                                                                                      | <i>Block</i><br><i>(Flexible)</i><br><i>(Flexible-Transfert)</i>                         |
|---------------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| <b>Annual Program Reporting</b> | Annual Report based on performance indicators                                   | Annual Report based on performance                                                                                                                                                                                             | Annual Report based on performance indicators                                                                                                                                 | Annual Report to recipient's members and to the Minister based on annual reporting guide |
| <b>Evaluation Report</b>        | No Evaluation Report                                                            | No Evaluation Report                                                                                                                                                                                                           | No Evaluation Report                                                                                                                                                          | Evaluation Report every 5 years                                                          |
| <b>Surplus</b>                  | No retention of surplus and no carry forward of funds into the next fiscal year | Retention of any unexpended funding remaining at the expiry of the agreement provided all objectives are met. Funds are to be used for purposes consistent with program objectives or any other purpose agreed to by the FNIHB | Recipients, with the written approval of the Minister, are able to carry forward program funding for reinvestment the following fiscal year within the same Program Authority | Recipients able to retain surpluses to reinvest in health priorities                     |

#### Must ensure the provision of all mandatory programs

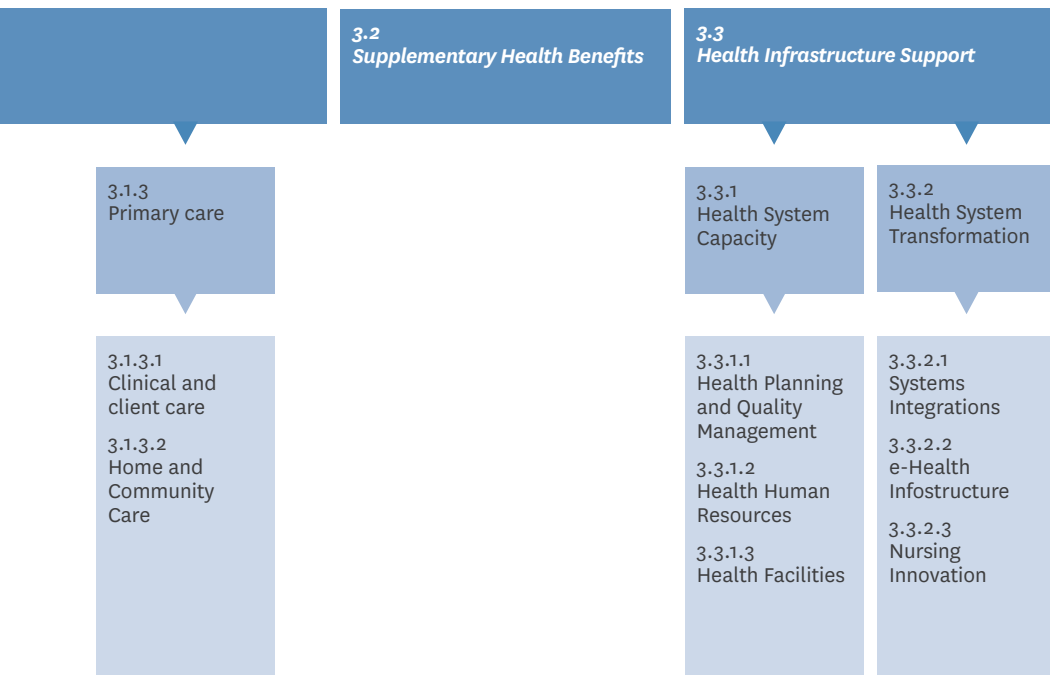
\*Exception: funds provided via capital construction contribution agreements supporting the Health Facilities sub-sub activity are only to be used for health capital projects.

Source: FNIHB (2011)

# APPENDIX 4 FNIHB CONFIGURATION OF PROGRAMS



Source: FNIHB (2011)



# APPENDIX 5 SERVICES OFFERED TO SPECIFIC CLIENTS AND NIHB

|                             | Services offered to specific clients ► Quebec                                                                                                  | NIHB ► Federal                                                                                                                                                                                                                         |
|-----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Vision care                 |                                                                                                                                                |                                                                                                                                                                                                                                        |
| Beneficiaries               | <sup>22</sup> Persons under the age of 18 or 65 or over; or persons recipient of financial assistance; or visually impaired persons            | All are covered for services not offered by the province                                                                                                                                                                               |
| Services covered            | General or specific eye examinations; Prescription of eyeglasses or contact lenses or exercises                                                | General or specific eye examinations; follow-up examinations; First pair of eyeglasses; Replacement eyeglasses/ lenses; Eyeglass repair                                                                                                |
| Dental services             |                                                                                                                                                |                                                                                                                                                                                                                                        |
| Beneficiaries               | <sup>23</sup> Children under the age of 10; Certain services are covered for persons recipient of financial assistance                         | Certain services do not require predetermination but may have frequency limits or age criteria, others require predetermination <sup>24**</sup>                                                                                        |
| Services covered            | Examinations; X-rays; Anesthesia; Fillings; Crowns; Dressings; Root canal treatment; Tooth and root extractions; Cleaning                      | Examinations; X-rays; Anesthesia; Fillings; Crowns; Dressings; Root canal treatment; Tooth and root extractions; Cleaning; Prosthetic repair; Preventive treatment; Orthodontic services; Dental prostheses; Halstrom devices          |
| Prescription drug insurance |                                                                                                                                                |                                                                                                                                                                                                                                        |
| Beneficiaries               | <sup>25</sup> Persons who are not eligible for a private plan and their children; or age 65 or over; persons recipient of financial assistance | Persons who are not covered by another program or plan                                                                                                                                                                                 |
| Services covered            | Prescription drugs that appear in the List of Medications (including exception drugs)                                                          | Prescription drugs or covered without restriction on the NIHB list; prescribed OTC medications; Medications covered without restriction; Restricted medications; Medications for patients with chronic kidney failure, palliative care |

## Medical transportation

|                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Beneficiaries</b>    | <p><sup>26</sup> Ambulance transportation: Some costs to be borne by the patient except persons: injured in a road accident; injured in a work accident; transported between two institutions of the health network; age over 65; income security beneficiaries; Signed contribution agreements with communities not under agreement, band or tribal councils can be reimbursed for expenses incurred; these expenses are a percentage not assumed by Quebec</p> <p>ÉVAQ <sup>27</sup> : Free for all people living in remote and isolated regions of Quebec</p> | <p>Ambulance transportation: All are covered for services that are not offered by the province</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Services covered</b> | <p>Ambulance transportation: Aboriginal people involved in road accidents are covered by the SAAQ and those involved in workplace accidents are covered by the CSST; When transferred between Quebec network health facilities, transportation costs are paid by the receiving facilities</p> <p>ÉVAQ: Airborne emergency services to specialized and highly specialized centres in Quebec City and Montreal</p>                                                                                                                                                 | <p>Ambulance transportation: Ground travel, water travel, air travel (Medevac when services are not provided by the province); Emergency transportation: ambulance services when required and not provided by the province (ground or air ambulance/ Medevac)</p> <p>Aid may be granted for meals and lodging; Costs of transportation, accommodation and meals of medical escorts can be included or not (authorization criteria); Travel expenses covered to travel to the nearest facility funded/designated by the NNADAP); Transportation for additional medically necessary health services (appointment with a doctor, hospital care, diagnostic tests, medical tx, etc.)</p> |

<sup>22</sup> RAMQ, Healthcare. Optometric services.

<http://www.ramq.gouv.qc.ca/en/citizens/health-insurance/healthcare/Pages/optometric-services.aspx>

<sup>23</sup> RAMQ, Healthcare. Dental services.

<http://www.ramq.gouv.qc.ca/en/citizens/health-insurance/healthcare/Pages/dental-services.aspx>

<sup>24</sup> Predetermination is a prior approval process for dental services which is applied according to NIHB Program policies, guidelines and criteria (Health Canada 2012).

<sup>25</sup> RAMQ, Prescription drug insurance. Description.

<http://www.ramq.gouv.qc.ca/en/citizens/prescription-drug-insurance/Pages/description.aspx>

<sup>26</sup> Portail santé mieux-être, Système de santé en bref. Services ambulancier.

<http://sante.gouv.qc.ca/systeme-sante-en-bref/services-ambulancier/>

<sup>27</sup> Programme national d'évacuation aéromédicales du Québec. Évacuations aéromédicales du Québec (ÉVAQ), Nos services. <http://www.evaq.ca/nos-services/index.html>

## Other services

<sup>28</sup> Devices that compensate for physical deficiencies (aids, orthopedic and prosthetic devices); Hearing aids; Visual aids; Ocular prostheses; External breastforms; Appliances for permanent ostomates; Domestic help; Public institution accommodation; Accommodation by an intermediate resource; Compression garments for lymphedema

Bathing and toileting aids; Dressing and feeding aids; Lifting and transfer aids; Mobility aids (walking aids, wheelchairs); Miscellaneous supplies and equipment; Foot orthotics and custom footwear; Audiology (hearing aids and supplies); Low vision aids; Ocular prostheses; Prostheses (breast, other); Ostomy supplies and devices; Garments and pressure orthotics (compression device and treatment of scars); Cushions and protectors; Supplies and oxygen equipment; Supplies and respiratory therapy equipment; Urinary supplies and equipment (catheter supplies and equipment, incontinence supplies); Wound dressing supplies; Interventions in short-term crisis situations (psychological support) for the community: when deemed cost-effective to provide these services in a community or in response to a crisis affecting many clients or families; Intervention for clients and families: when there is a crisis or risk situation and there is no other source of immediate funds for services; Health services approved outside Canada

\* The entire population has access to certain emergency vision care services and certain dental services or offered in hospital centres.

\*\* For a complete list of these examinations, see (Health Canada, 2012b).

<sup>28</sup> RAMQ, Healthcare. Other services.

<http://www.ramq.gouv.qc.ca/en/citizens/health-insurance/healthcare/Pages/other-services.aspx>



