Investigation into child and youth protection services
in Ungava Bay and Hudson Bay

NUNAVIK

Report, conclusions of the investigation and recommendations

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des droits de la personne
et des droits de la jeunesse
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REPORT ADOPTED BY DECISION OF THE INVESTIGATIONS COMMITTEE,
AT THE 285TH SESSION HELD ON FEBRUARY 15, 2007

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TABLE OF CONTENTS

1. PURPOSE OF THE INVESTIGATION

1.1 The Commission's mandate

In accordance with the provisions of the *Youth Protection Act* [1], the Commission des droits de la personne et des droits de la jeunesse (hereinafter referred to as the Commission) must, upon an application or of its own motion, investigate any situation where it has reason to believe that the rights of a child or of a group of children have been encroached upon by persons, institutions or bodies. As part of its mandate, the Commission may carry out systemic or individual investigations.

1.2 Complaints

On March 25 and April 4, 2002, two complaints were filed with the Commission concerning the situation of thirteen children who were allegedly not receiving adequate services from the two Directors of Youth Protection in Nunavik, one for Ungava Bay and the other for Hudson Bay (hereinafter referred to as "Director of Youth Protection" or "DYP"), or from certain other organizations in the region.

The complaints described major problems in the way social services for children were delivered in Nunavik, at all stages of the process set out in the *Youth Protection Act.* The Commission was also informed that the situation of many children had been repeatedly reported but that no action had been taken, or that the services needed to correct their situation had not been provided.

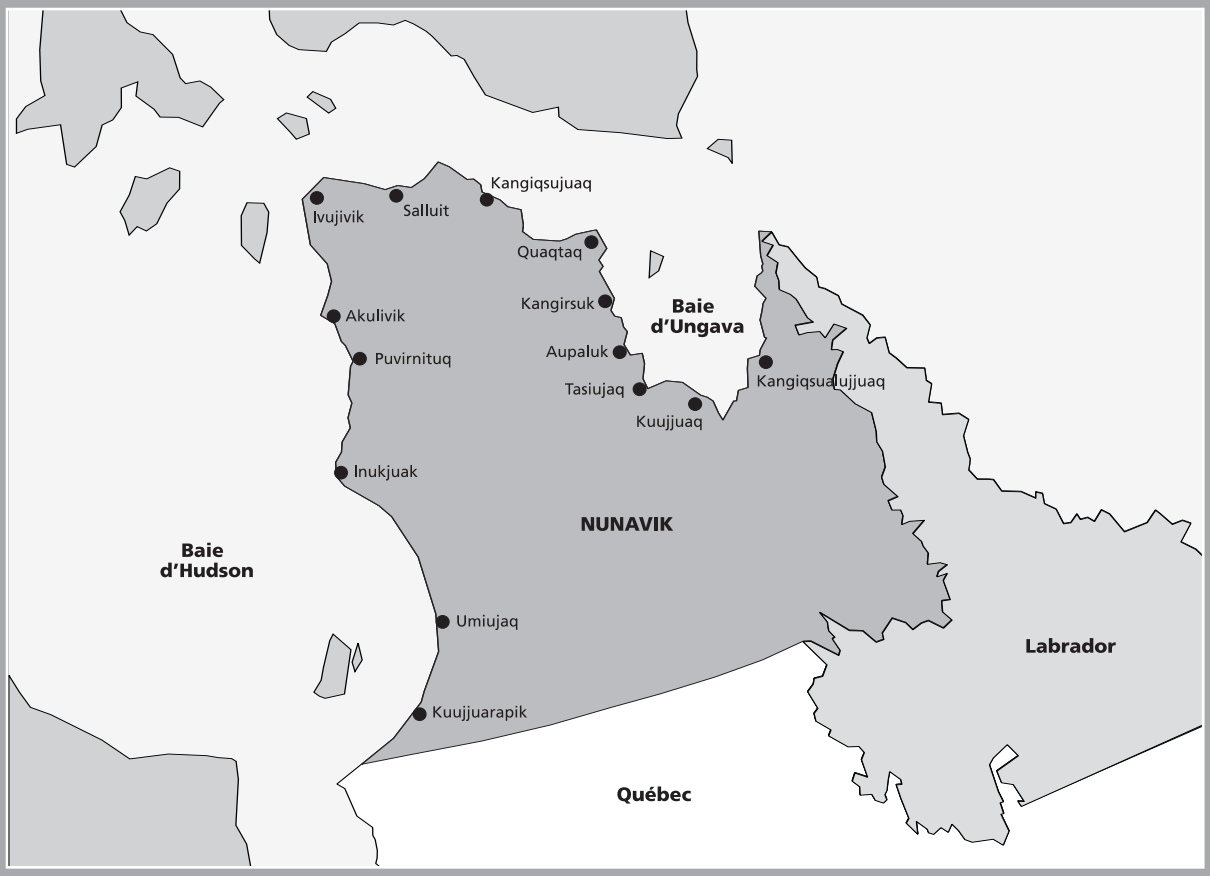
The applicants also stated that the Youth Protection case workers were poorly trained, and lacked the tools and support they needed to perform their duties properly. Because of this situation, the Youth Protection Service had an unusually high turnover of staff.

1.3 The subject of the investigation

Mr. Pierre Marois, the President of the Commission, authorized the Commission to undertake an investigation, on its own initiative, in order "to establish facts and circumstances in the situations reported for each of the children concerned, and for any other children, and if necessary to make recommendations to restore their rights".

The investigation was systemic in nature, and focused on the entire range of services provided for children by the two Directors of Youth Protection in Nunavik.

1 R.S.Q., c. P-34.1.



Nunavik is inhabited by about 10,000 permanent residents scattered over an immense area. Distances between villages are considerable. Although it is not heavily populated, Nunavik is undergoing exceptional demographic growth. The Nunavik workforce has a poor choice of economic activity. Unemployment is high.

The Commission notes that the children whose cases were studied all experienced extensive health and social problems.

Their situation is unfortunately typical for the people of Nunavik, who have been forced to undergo major changes within a very short period of time, and are currently experiencing severe social problems and general distress.

The problems include poverty, suicide, high teen pregnancy rate, neglect and sexual abuse of children, behavioural difficulties, family violence (often linked to alcohol abuse), drug and alcohol addiction, and mental health problems.

2. METHODOLOGY

2.1 Choice of cases

The files of 139 children were selected to examine the application of the *Youth Protection Act*, representative of the fourteen villages served by either one of the two Directors of Youth Protection. They were selected by the Commission's investigators in March 2003 for Ungava Bay, and in May 2003 for Hudson Bay.

For Ungava Bay, 62 files were selected, making up 25% of the 251 children's files that were active at the Youth Protection Service in March 2003. For Hudson Bay, 77 files were selected, making up 20% of the 382 children's files active in May 2003. Moreover, during the investigation, the Commission regularly received other complaints concerning the services provided by the Hudson Bay DYP, and intervened on numerous occasions to restore young people's rights.

With regard to the application of the *Young Offenders Act* — in force at the time of the investigation but replaced on April 1, 2003 by the *Youth Criminal Justice Act* [2] — 21 files were selected for examination, 14 in Ungava Bay, accounting for 54% of the files opened by the DYP, and the all 7 files existing in Hudson Bay.

2.2 People interviewed and documents consulted

During their various trips to Nunavik, the investigators met and interviewed around 120 people, representing the following categories and organizations:

- children, families and foster families;
- the Directors of Youth Protection for Ungava Bay and Hudson Bay, and their staff;
- hospital staff;
- representatives of the Nunavik Regional Board of Health and Social Services;
- staff members and young people housed at the Sapummivik Rehabilitation Centre (Salluit);
- staff members and young people housed at the Saturvik Group Home in Kuujjuaq and the Puvirnituq Group Home;
- staff members and physicians at the Tulattavik Health Centre and Inuulitsivik Health Centre;
- staff members at the Local Community Service Centre (CLSC);
- teachers and other staff from the Kativik School Board;
- police officers from the Kativik Regional Police Force;

2 R.S.C., c. Y-1.5.

- judges from the Court of Québec;
- lawyers;
- the mayors of villages;
- representatives of the Module du Nord from the Montreal Children's Hospital;
- a representative of the Québec Registrar of Civil Status;
- other individuals, including case workers from other regions of Québec and former residents of Nunavik.

The investigators also consulted approximately sixty documents, reports and websites.

Finally, the Commission staff met with Mr. Bernard Saladin D'Anglure, an anthropologist specializing in the Inuit people. The information provided by Mr. Saladin D'Anglure helped strengthen their knowledge and understanding of the various facets of Inuit society.

3. LIVING CONDITIONS IN NUNAVIK

3.1 The major changes of recent decades and their impact on families

In the space of a few years, the Nunavik population have experienced a numerous of changes that have overturned their traditional lifestyle and triggered a series of social problems that have had serious consequences for some of children.

Traditionally, the Inuit of Nunavik were a semi-nomadic people with a subsistence-based economy. Despite the harsh climate, a somewhat hostile environment and isolation, they lived in relative comfort and developed a rich cultural life. The Inuit lifestyle remained generally unchanged until the 20th century, with the arrival of the trading posts and the growth of the fur trade.

Increased contact with the outside world led to epidemics in the early 20th century, coinciding with a natural decline in traditional foodstuffs. In the 1940s and 1950s, the end of the fur trade left Nunavik economically and socially dependent on the outside world.

Government assistance designed to help the Inuit eventually destroyed their semi-nomadic lifestyle and led the population to settle in villages where their subsistence economy was no longer viable. As a result, most Inuit were forced to depend on the government for their survival.

Changes in lifestyle, language, economy, the move from schooling in English to schooling in French, and the influence of people with different cultures and ways of thinking from other regions, caused rifts between the generations. Inuit people over the age of 65 have generally not received any formal education. Some younger people were sent away from their community to receive schooling, thereby cutting ties to their family and roots. The younger population have been educated in schools that were obliged to conform to the Québec education model, with another mentality and culture. They have learned another language and no longer practice the traditional way of life except in their free time.

Currently, the major changes affecting the communities make it difficult for elders to guide their children as they become parents in a society that has been completely transformed.

The introduction of government-run social services has set aside the traditional methods of support for people experiencing difficulty, but the services have failed to adapt to Inuit culture and realities.

3.2 Political organization

The political structure of Nunavik as we know it today results from the *James Bay and Northern Québec Agreement* (JBNQA), signed on November 11, 1975. The Agree-

ment organizes and regulates lands, economic issues, government, health and social services, education, police forces, and legal and correctional services. In terms of government responsibilities, the Québec government was entrusted with the management of several existing Federal government programs in the North. The institutions created under the Agreement, such as Mativik Corporation [3] , the Kativik Regional Government [4] , the Kativik School Board and the Nunavik Regional Board of Health and Social Services, report to the corresponding Québec government departments.

The Federal government nevertheless remains a major player in the Nord-du-Québec region. It subsidizes many services that are now provided by local Aboriginal governments and the Québec government.

In November 1999, following an agreement between Makivik Corporation, the Québec government and the Federal government, the Nunavik Commission was asked to propose a form of government. On June 26, 2003, a framework agreement was signed that will eventually lead to the merging of certain institutions and the creation of a new form of government in Nunavik. The process is still being negotiated.

3.3 Economic, cultural and social overview

Nunavik is inhabited by about 10,000 permanent residents scattered over an immense area. Distances between villages are considerable.

Although it is not heavily populated, Nunavik is undergoing exceptional demographic growth. Its population curve is the opposite of that for Québec as a whole. In 1996, 46% of the population was under 18 years of age, and 41% was composed of children aged 0-14. Teenage mothers are steadily increasing.

The Nunavik workforce has a poor choice of economic activity. According to the 2001 census, the main areas of employment are health care and social assistance (which provide jobs for 21% of the Nunavik workforce), public administration (19.5% of the workforce) and teaching (18% of the workforce). Unemployment is high.

The average household income is lower in Nunavik than in Québec as a whole. However, figures alone do not provide the full picture and the differences need to be considered in light of certain factors such as the number of people per household in Nunavik, higher consumer prices and transportation costs, as well as the fact that certain health and housing services are subsidized.

Inuktitut is still the language most widely spoken in Nunavik. All children are taught in Inuktitut from kindergarten to grade 3.

In many cases, the language barrier complicates communication between the Inuit and non-Inuit population, especially in the social services field. For example, a psychologist dispensing family therapy to young children or parents who do not speak much French or English must use a translator. The cases studied during the investigation

3 As specified in sections 5 and 8 of the *Act Respecting the Makivik Corporation* (R.S.Q., c. S-18.1), the objects of the corporation are, among other things,
- to receive, administer, use and invest the part, intended for the Inuit, of the compensation provided for in the *James Bay and Northern Québec Agreement;*
- to relieve poverty and to promote the welfare and the advancement of education of the Inuit;
- to foster, promote, protect and assist in preserving the Inuit way of life, values and traditions;
- to initiate, expand and develop opportunities for the Inuit to participate in the economic development of their society;
- to exercise the functions vested in it by other acts or the Agreement;
- to develop and improve the Inuit communities and to improve their means of action;
- to assist in the creation, financing or development of businesses, resources, properties and industries belonging to the Inuit.

4 The Kativik Regional Government provides support, management and technical assistance services in several areas, such as municipal administration, recreation, the environment, civil security, land planning, etc.

confirmed this difficulty; some families need services that are simply not available in Nunavik, and the language barrier is a significant problem.

The family structure in Nunavik is based on the "extended family", which includes grandparents, uncles, aunts, cousins and soon, all of whom maintain interdependent relationships. The structure also differs from that in the rest of Québec because more than 28% of all dwellings house more than one family.

In traditional Inuit culture every child belongs to the community, and the entire community is responsible for that child. In the interviews, however, many people said that because of sedentarization and the ensuing social problems, the Inuit had preserved "extended family" values but were no longer structured in a way that enabled them to maintain them. Many adults were no longer prepared to look after children who had been left to their own, even if they were nephews, nieces, grandchildren or neighbours.

During the investigation, it became clear that the way in which traditional adoption is practised and overcrowded housing had an impact on the children whose cases were examined.

Adoption

Today, traditional adoption is by far the most frequently used form of adoption in Nunavik. It is extremely common — one-quarter of the children born in Nunavik between 2000 and 2004 have since been adopted. Following a resolution made by the Kativik Regional Government and the Nunavik Regional Board of Health and Social Services concerning traditional adoption [5], the adoption of children of Inuit descent by non-Inuits can never be considered as an adoption under Inuit custom. Most Inuits consider that adoptions by non-Inuits has removed many children from their culture and caused them to lose contact with their roots.

The Registrar of Civil Status acknowledges traditional adoptions in Nunavik without a prior evaluation of parenting skills. Parents wishing to give their child up for adoption must go to the municipality and provide the names of the biological parents, the child's date and place of birth, the names of the adoptive parents, their place of residence and their dates of birth. The biological family and the adoptive family then sign the adoption document. If the document is duly completed and approved by the appropriate municipal official, the Registrar confirms the adoption and issues a birth certificate.

Traditional adoption is a key element in Inuit culture and tradition, and allows Inuit parents to place a child in the care of a member of the immediate or extended family who will then treat the child as their own. During the investigation the Commission observed that adoption practices go well beyond this objective since, in reality, any interested person may adopt a child. The Commission heard numerous testimonies

5 Kativik Regional Government, Résolution 1995-14; Nunavik Regional Board of Health and Social Services, Résolution 1995-36.

on the subject of traditional adoption, the vast majority in favour of maintaining it. However, many of the people interviewed also felt that traditional adoption should be supervised by Social Services staff, who would then be responsible for ensuring that the adoptive family offers a healthy living environment for the child.

The following problems were identified in some cases:

- some families agree to adopt children even though they do not really want to do so. For example, this may be the case for grandparents who dare not refuse the honour when a child is offered;
- some families force the mother to give her child for adoption even if she would rather kept the child;
- children may be transferred from one family to another for the sake of expediency: even though the adoptive family is known to be inadequate, the biological parents do not want to harm their reputation and hand over the child;
- if difficulties arise, the biological parent may have the child adopted by another family. In some cases, the same child is adopted repeatedly;
- some of the professionals interviewed during the investigation said that generally speaking, the adopted children are the ones that experience the most difficulty in the adoptive family. They are the family's "whipping boys". Some of the medical staff interviewed said adoptive parents were less concerned about the health of a child they had adopted than about the health of their other children. In addition, grandparents who adopt children often feel very tired and would have preferred not to adopt;
- in the Ungava Bay investigation, 19 of the 62 children whose cases were studied (30% of the total sample) had been adopted. In the Hudson Bay investigation, 20 of the 77 children in the sample (26%) were adopted. Almost one third of the children whose situation was examined were adopted. Thirteen of the Hudson Bay children, or 65% of the adopted children in the sample, had been moved from one place to another. For example, they might have been given back to the biological parent, then transferred to another adoptive parent, handed back again, and then taken back by the original adoptive parent. Generally speaking, the Commission note that adopted children are often transferred several times.

Housing

Everyone interviewed during the investigation said that Inuit homes are overcrowded. For example, two or three families will often live in the same house. This means 12 to 15 people, from three or even four generations, including aunts, uncles and cousins, will live together in a single dwelling.

The Commission's investigation revealed the negative impacts of overcrowding on the lives of the children, the care they receive and the abuse they may suffer. The Commission made the following observations:

- overcrowding creates conditions conducive to the emergence of social problems and makes it more difficult to eradicate them;
- the lack of privacy exacerbates tension. Homes are noisy and people who are less tolerant may lose their temper. Children, from a very young age, will often witness sexual acts or conflicts between adults;
- over half of all children live in an environment where at least one family member living under the same roof drinks or is violent. Their living conditions may be affected, and the risk of abuse is greater;
- some families who do not themselves have particular problems live with other people who do, meaning that their children are exposed to other people's problems on a daily basis;
- abusers awaiting trial or released from prison, when they return to their own communities or are sent to another community, often live in homes where there are children;
- the fact that all housing is overcrowded makes it difficult to place children;
- the housing shortage also makes it harder to recruit case workers. For example, it may be impossible for the DYP to hire a specialist case worker in a small village, or transfer a case worker from another village, simply because no housing is available;
- at the present time, approximately 500 families in Nunavik (25.5% of the total) are on the waiting list for housing.

On June 27, 2005, a new agreement was signed by the Québec government, the Federal government and the Makivik Corporation for the implementation of a five-year program to construct 275 homes. Annually, the program will add around fifty homes, meeting 11% of needs. For this reason, the DYP in Hudson Bay considers that the agreement will not improve the situation, but merely maintain the *status quo*.

3.4 Social problems

The Commission notes that the children whose cases were studied all experienced extensive health and social problems, a similar finding to previous studies.

Their situation is unfortunately typical for the people of Nunavik, who have been forced to undergo major changes within a very short period of time, and are currently experiencing severe social problems and general distress.

The problems include poverty, suicide, a high teen pregnancy, neglect and sexual abuse of children, behavioural difficulties, family violence (often linked to alcohol abuse), drug and alcohol addiction, and mental health problems.

Case workers are not immune to these problems, and during the investigation some of them mentioned that they themselves were the victims of conjugal violence and had a problem with alcohol.

We were told by police officers that when intoxicated, many men and sometimes women become extremely violent. "This is not ordinary violence. […] They unleash violence that has been bottled up for years. They hate the whole world."

Studies conducted in 1996 in the Nunavik population revealed that family violence was ten times higher than the Canadian average [6]. They also showed that 10% of young people aged 15 to 19 used cocaine and inhaled solvents.

In a major report on youth protection in Nunavik in 1998 [7], the Nunavik Task Force on the Application of Youth Protection and Young Offenders Services in Nunavik, on behalf of the Regional Health and Social Services Board, pointed out that the large youth population means that youth issues are an ever-present reality in Nunavik and represent a significant challenge. The Task Force identified the principal problems experienced by youth in Nunavik as follows:

- the suicide rate is one of the highest in Canada. The rate of sexual and physical abuse, and the number of cases of severe neglect, is so high as to be discouraging for case workers. Behavioural problems with teenagers, such as refusing to accept parental authority, not attending school, threatening to commit suicide and drinking heavily, are widespread. In this context, the caseload of a case worker is enormous compared to their counterparts in the south;
- families are large. Signalling a child might result in the placement of the siblings, since the parent's lifestyle generally endangers the security and development of all their children;
- since resources are scare, rehabilitation services are always used to capacity. The few foster families that exist are in constant demand.

According to the Task Force, the youth population of Nunavik is in a state of crisis, and there is an urgent need to improve the services provided for children in difficulty:

> *The consequences [of an inadequate application of the Youth Acts] are quite simple: the services have nearly no effect on the crisis within the youth population; nothing changes. The problems that were identified 25 years ago are still present and their frequency has increased, more violence, more suicides, more sniffing, more damages.*

6 Hodgin's, *Health & Well Being Challenges in Nunavik* (1996); also consulted a study by Puvirnituq social services in 1996.

7 Regional Board for Health and Social Services — *Youth Protection Act, Young Offender's Act, An in-light review of their problematical application in Nunavik*, Resolution 1998-68, passed July 15, 1998.

4. ORGANIZATION OF SERVICES

4.1 Regional Board and the health centres

The Nunavik Regional Board of Health and Social Services covers two territories: Ungava Bay and Hudson Bay. Its offices are located in Kuujjuaq, in Ungava Bay. It is administered by a board of directors composed of representatives from each of the communities in its territory, the two health centres, users and the Kativik Regional Government.

The Regional Board runs two health centres: the Tulattavik Health Centre (Ungava Bay) located in Kuujjuaq, and the Innulitsivik Health Centre (Hudson Bay) located in Puvirnituq. The two health centres are responsible for the health services and social services normally offered by a local community service centre (CLSC), a child and youth protection centre (CPEJ), a short-term hospital, a long-term residential care centre (CHSLD) and a rehabilitation centre for youths with adjustment difficulties (CRJDA).

This type of service structure was preferred because of the area's sparse population and to facilitate partnerships between the various organizations, thus limiting the need for service agreements. In 1998, however, in its report on social services in Nunavik, the Regional Board called this structure into question, noting that it was difficult for a single board of directors to pursue so many different missions, and that recent experience tended to show that social services would always be the poor relation in the system, overshadowed by health services.

4.2 The CLSCs

The mission of a CLSC is set out in section 80 of the *Act Respecting Health Services and Social Services* [8]. At the primary level of care, it provides basic health and social services of a preventive or curative nature, as well as rehabilitation or reintegration services. It assesses the needs of the population to ensure that the required services are dispensed in its facilities, in homes, or in schools and workplaces.

In Ungava Bay, the CLSC is responsible for offering residential rehabilitation to young people. The services are provided by the Sapummivik Rehabilitation Centre in Salluit, which serves the whole of Nunavik, and the Saturvik Group Home in Kuujjuaq. In addition, the CLSC, working with the DYP, deals with some of the calls for help received by the emergency social services.

The CLSC in Ungava Bay has two psychologists, based in Kuujjuaq, and one social worker and one social assistant in each community. Last, in the school system, the CLSC provides services through a student counsellor.

At the time of the investigation, the CLSC in Hudson Bay had two psychologists located in Puvirnituq. However, both were laid off subsequently, due to budget cutbacks.

8 R.S.Q., c. S-4.2.

The CLSC also has one Inuit social assistant per community, and five social workers, located in Kuujjuarapik, Inukjuak, Puvirnituq, Akulivik and Salluit.

For Nunavik as a whole, the Commission notes that the CLSC offers no regular social services for the population under the age of 18.

4.3 The Director of Youth Protection in Ungava Bay

The Director of Youth Protection in Ungava Bay reports directly to the Tulattavik Health Centre. She is responsible for applying the *Youth Protection Act* and for recruiting foster families. She also acts as Provincial Director for the purposes of the *Youth Criminal Justice Act*.

During the investigation, the DYP in Ungava Bay employed two social workers in Kuujjuaq, one acting as a coordinator, plus a few social assistants in Kuujjuaq and one social assistant per community

4.4 The Director of Youth Protection in Hudson Bay

The Director of Youth Protection in Hudson Bay reports directly to the Inuulitsivik Health Centre. She is responsible for the application of the *Youth Protection Act* and the recruitment of foster families. She also acts as Provincial Director for the purposes of the *Youth Criminal Justice Act*. In Hudson Bay, the DYP is responsible for the accommodation services offered by the Puvirnituq Group Home.

At the time of the investigation, the DYP employed one social worker in Puvirnituk, acting as a coordinator, and three community workers.

In Kuujjuarapik, the DYP employed one social worker and three community workers for the four other villages.

Since 2005, the DYP has apparently employed five social workers for the six villages.

4.5 Specialized resources

> The *Youth Protection Act* states that the Director of Youth Protection must intervene in a certain number of situations in which the security or development of a child is in danger. The Director's mandate is part of a set of health and social services designed to prevent difficult situations from deteriorating, or to allow for the implementation of the measures deemed necessary to correct a situation that has been taken in charge pursuant to the Act.

Generally speaking, the people interviewed for the investigation criticized the lack of specialized programs and services to help children and their families. For example:

- there are no rehabilitation resources for children aged 6 to 12;

- youth assistance programs are virtually non-existent. There are no programs for young victims of abuse, young abusers, community educators or disintoxication programs, except at the Inukjuak group home, and no activities aimed at preventing bullying and extortion;
- there are no resources in the North for children with mental health disorders or mental impairment. Given the prevalence of problems relating to alcohol and the inhalation of gasoline, growing numbers of children suffer from foetal alcohol syndrome or have neurological damage that requires highly specialized treatment that has been shown to be effective. The usual treatment offered by the Rehabilitation Centre is insufficient in such cases;
- in Hudson Bay in particular, the parents of children with mental health problems are reluctant to accept medical explanations and treatments involving medication. Many believe instead that the child is "possessed" and seek traditional treatments (healing sessions) or consult their religious representative;
- the psychiatrists who travel to Nunavik for consultations do not provide follow-up for young mental health patients. When psychiatric assessments are ordered, the children are sent to the Douglas Hospital in Montreal, or to the Montreal Children's Hospital (Module du Nord);
- according to the judges and lawyers interviewed, the DYPs in the North tend to base their court cases on behavioural problems rather than abuse, to avoid having to provide psychological follow-up;
- in Ungava Bay, there are only two psychologists working at the Kuujjuaq CLSC, meaning that no therapy or psychological follow-up is provided in the other villages. There are no psychologists at all in Hudson Bay;
- according to the DYP in Hudson Bay, mentally handicapped youngsters and youngsters with mental health problems should have access to a special group home. Such a resource could be located in the South, but would be open exclusively to Inuit children;
- in schools, children who are hyperactive or suffering from foetal alcohol syndrome, and those who are bullies or victims of bullying, do not receive the services they need. The only specialist resource available in schools is the student counsellor. In Kuujjuaq, at the time of the Commission's investigation, this job was performed by an educator working for the CLSC;
- tools exist in French, English and Inuktitut, but they are not used. For example, the Commission notes that the CLSCs in both Ungava Bay and Hudson Bay have access to awareness and prevention material on parenting skills, child development and bullying. Radio capsules are also available on problems such as suicide, drinking and drug use, and neglect. During the investigation, the Director of the

Health Centre in Hudson Bay and the CLSC Manager both said they did not have the money available to carry out prevention programs;

- parents and adults in general have access to very few resources to deal with drug addiction, violence, mental health or suicide, to find out more about child development and improve their parenting skills, or to solve personal problems. Since the investigation, an improvement has been noted in the programs offered to develop parenting skills. In its comments on the Commission's factual report, the Nunavik Regional Board informed the Commission that a program to improve parenting skills for parents under the age of 20 had been launched in Hudson Bay. In addition, an early detection program for children aged 0 to 5 has been set up by the CLSC.

4.6 Training for case workers

The case workers employed by the Youth Protection Service currently receive the training planned by the National Training Program and offered by the Association des centres jeunesse du Québec (ACJQ), like all other case workers in Québec.

During the investigation, CLSC case workers in Hudson Bay said they had asked their superiors for analysis and assessment grids for neglect, behavioural problems and abuse, but had never received them. These tools already exist and are in use elsewhere in Québec.

The investigation also revealed that the DYPs do not use the tools and guides for youth protection promoted by the ACJQ.

4.7 The administration of justice

Under the *James Bay and Northern Québec Agreement,* the judicial district of Abitibi includes the entire territory of New Québec.

Nunavik is served by the Itinerant Court, whose office is located in Amos. It comprises a judge, a clerk, a prosecutor, a Legal Aid attorney, the Sûreté du Québec liaison officer, a probation officer, an interpreter and a travel coordinator.

The Court sits in the courthouses of the three largest communities, namely Kuujjuaq, Puvirnituq and Kuujjuarapik. In the other communities, it sets up in a school gymnasium or community hall.

The Court travels to Kuujjuaq and Puvirnituq approximately once a month, and is in session for several days. From time to time the Court also goes to the other communities, depending on need and weather conditions. There is no resident judge.

The Itinerant Court hears cases brought under the *Youth Protection Act* and the *Youth Criminal Justice Act*.

During the investigation, the Commission noted that the small number of hearing days organized by the Itinerant Court created a number of problems. For example, if the Itinerant Court is not sitting and an emergency hearing is required under the *Youth Protection Act*, complicated and extensive travel arrangements must be made. The families and all the other people involved must appear before the court in Amos, meaning that they must fly to Kuujjuaq or Puvirnituq, and then transit through Montreal to Val-d'Or, from where they are driven by taxi to Amos. They then return to Nunavik following the same route.

In addition, the current organization of the Itinerant Court means that cases are often postponed, and multiple hearings are held concerning temporary measures which therefore last far longer than prescribed by the *Youth Protection Act*. Besides the expensive travel costs, inefficient use of resources and reliance on short-term solutions for children and their families, this system gives the court only a glimpse of each child's situation, creating uncertainly and frustration for all involved. A plan to use videoconferencing was being studied at the time of the investigation.

5. APPLICATION OF THE *YOUTH PROTECTION ACT* IN UNGAVA BAY

5.1 The situations examined

The 62 children whose files were selected to examine the application of the *Youth Protection Act* had been signalled to the Youth Protection Services a total of 403 times [9], an average of 6.45 times per child.

Thirteen (13) files had been signalled to the Youth Protection Services between 3 and 9 times, 15 between 10 and 13 times, and six 14 times or more.

The most common reason for reporting a child to the Youth Protection Services was neglect and the behaviour or lifestyle of the parents (214 times out of 403, concerning the situation of 45 children). The second most common reason was behavioural problems (111 times out of 403, concerning the situation of 22 children) [10].

In the situations examined by the Commission, 29 children were placed for over 30 days by the Director of Youth Protection. Twenty-five of these children, or 84%, were transferred three or more times. Of these twenty-five children, 13 were placed in at least 5 foster families and 8 in at least 7 foster families. One child was placed in 10 different foster families, and two children changed foster families 14 times. In one the latter cases, the child concerned was under the age of 10.

The situations examined by the Commission illustrate the amplitude and gravity of the problems experienced by the children whose situation was reported to the DYP, as summarized below.

5.2 Families in severe difficulty

In most of the signalements made to the Youth Protection Direction for neglect, family violence was also a factor. Similarly, family violence accounts for a significant percentage of the crimes committed in the community. Forty-five of the files selected include conjugal or intra-family violence, in other words 73% of all the files. In four of these, one of the parents had been imprisoned for events involving conjugal or family violence. In several of the files examined by the Commission, the community workers refuse to meet the parents in their home or to confront them, for fear of violence.

Alcohol and drug consumption

Most of the young people interviewed by the Commission in the Rehabilitation Centre stated that they used alcohol and drugs.

The families of the 62 children whose situation was examined by the Commission all included at least one member with an alcohol or drug abuse problem.

9 Originally, there were 383 cases reported and 20 situations that should have been reported. 403 situations were therefore examinned by the Commission.

10 Several reasons can be given in a single report.

The judges of the Court of Québec have noted that most of the files brought before them include neglect as a factor, connected to chronic alcohol or drug abuse. Lawyers dealing with the files of young offenders or major delinquents also stated that in most cases, alcohol and drugs were a factor.

Serious behavioural difficulties

As specified above, of the 403 signalements to the Youth Protection Service that were examined, 111 concerned serious behavioural difficulties, involving drug or alcohol consumption or violent behaviour. The 111 signalement concerned 22 children, in other words over one-third of the children.

Mental health problems

The 62 files selected for examination by the Commission included those of 8 children with a parent experiencing mental health problems. Three of the children whose files were examined were themselves diagnosed with mental health problems.

Suicidal behaviour and self-mutilation

Of 62 files dealt with under the *Youth Protection Act*, 13 included a reference to self-mutilation, suicide threats or attempts, or actual suicides, mainly by the young person concerned, but also by a parent.

Sexual abuse of children and teenagers

Thirty-three (33) of signalements examined during the Commission's investigation involved situations of sexual abuse against 14 children, in other words 23% of the files examined.

5.3 Reception and processing signalements

The situations of the 62 children in the sample generated 403 signalements, 192 of which were retained for evaluation. As shown below, they were dealt with in various ways.

Situations potentially requiring protection measures but not considered to be signalements

The files examined showed that, in fifty-seven situations, some of the information forwarded to the Director of Youth Protection about children who were already known to the Service should, according to the standards in force, have been considered as signalements within the meaning of the *Youth Protection Act*. A decision should therefore have been made on whether or not they should be retained for evaluation, or on whether existing protection measures should be reviewed.

Signalements that should have been retained but where the file was immediately closed

The Commission noted that many situations were not retained for evaluation, even though action should have been taken. The cases examined revealed several instances in which situations brought to the attention of the Director of Youth Protection led to no action being taken, for reasons that were not connected to the actual situation of the child. These included reasons such as:

- the parents refused any intervention by the DYP;
- there were no accommodation resources available for the child;
- the mother threatened kill herself if her child was taken away;
- in the past, the parents had refused an offer from the DYP to place the child.

Other signalements brought to the attention of the DYP were not retained for evaluation, due to a misunderstanding of the Act and the role of the Director of Youth Protection:

- in some cases in which physical or sexual abuse was signalled, no action was taken on the sole grounds that there were no marks or medical proof of the abuse;
- some signalements in which neglect was signalled in connection with the behaviour and lifestyle of the parents were not retained because a relative (often the person who made the signalement) took care of the children during the family crisis or because the child, even at a young age, obtained protection by going to sleep at a friend's house;
- some signalements were not retained because the child was related to a member of the Youth Protection staff, or because the family was friendly with the DYP; these allegations are, however, denied by the DYP for Ungava Bay in her comments on the Commission's factual report.

Application of urgent measures

> A Director of Youth Protection who decides to retain a signalement must assess whether the child is in imminent danger and determine whether or not urgent measures are required. Sections 45 and following of the *Youth Protection Act* clearly state how this type of measure is to be applied.

The Commission notes that, in several cases, no urgent measures were taken although the facts reported tended to show that the child was in imminent danger.

In most of the cases, the DYP took urgent measures, but did not subsequently retain the signalement for evaluation.

5.4 Evaluation of signalements

After retaining a signalement for evaluation and before making a decision concerning the security and development of a child, the Director of Youth Protection must, under the *Youth Protection Act*, verify the facts brought to his or her attention and analyse the child's situation on the basis of various factors.

By evaluating the child's situation, the DYP gathers the information needed to offer social services adapted to the child's needs and prevent placing the child in danger. The information focuses, in particular, on the child's general behaviour and family history, the parenting skills of the parents and the resources available in the child's environment.

Of the 403 signalements retained by the DYP, 192, or 48%, actually led to an evaluation within the meaning of the Act. In 112 of these cases, the child's security and development were found to be in danger.

However, 56 signalements were considered unfounded, and twenty-four signalements were assessed but led to no decision by the DYP that there was any harm to the child.

Files closed with no evaluation

In 68 cases, after retaining a signalement for evaluation, the DYP did not actually carry out an evaluation. The Commission noted the following reasons for the lack of an evaluation:

- lack of sufficient resources;
- oversight;
- the parents refused to see the Youth Protection staff;
- kinship between the DYP or a staff member and the child, the parents or the abuser.

Signalements that were not evaluated, but where a decision was made concerning the child's security and development

Although in several cases the DYP did not evaluate a signalement, she nevertheless made a decision concerning the safety or development of the child concerned.

On this subject, during the interviews made by the Commission, it became evident that because of the small size of the communities, the DYP was able to conclude that a child's security or development was in danger without assessing the whole situation, since she or her employees already knew the family.

Signalements that were evaluated, and where a decision was made concerning the child's security and development

When an evaluation was conducted as required by the Act, it was generally expeditive. This statement is based on the following observations:

- an interview was not always conducted with the parents, and rarely with the child or significant people in the child's environment;
- the parenting skills of the parents, and their willingness to correct the situation, was not assessed;
- the vulnerability of the child was never assessed;
- events appear were considered in isolation, and were not linked to past events or their possible re-occurrence;
- the DYP did not concern herself with the situation of the brothers and sisters of a child whose security or development appeared to be in danger;
- in situations of physical or sexual abuse, the evaluation basically involved having the child undergo a medical examination. The lack of marks or physical traces led to a decision that the child was not in danger.

Decisions made in connection with the security and development of a child

Once a child's situation has been evaluated, the DYP must decide whether there are grounds for believing that the child's security and development are in danger.

The Commission observes that:

- the DYP concluded that the security or development of a child was in danger only when there was a major recurrence of the events;
- several situations in which the DYP terminated intervention following an evaluation, should have been taken in charge;
- in some cases, the DYP changed the decision concerning the security or development of a child and closed the file after the parents refused to receive social services.

5.5 Orientation

Under the *Youth Protection Act*, the Director of Youth Protection, after observing that the security or development of a child is in danger, must implement measures to correct the situation effectively, with or without the agreement of the parents.

According to the Director's assessment of the child's overall situation, the Act requires the DYP to either propose the application of voluntary measures, or to take the case before the Court.

An agreement on voluntary measures must specify the most appropriate measures to bring to an end the situation placing the child in danger, and prevent its reoccurrence. The duration and renewal of a voluntary agreement are specified by sections 52 and following of the Act.

Orientation of a child's situation

The DYP concluded that the security or development of the 62 children in the sample was in danger in 56 cases. Some of these situations led to an intervention that involved closing the file.

The Commission makes the following observations on the orientation of situations which were founded by the DYP:

- in nineteen signalements in which the situation brought to the attention of the DYP was founded, no decision was made concerning the orientation of the child's situation;
- in the other situations that were founded, most led to the signing of an agreement on voluntary measures, despite the fact that the parental capacities had not been assessed during the evaluation of the signalements;
- in some files, voluntary measures were signed, even though the child's parent no longer wanted to look after the child;
- in four files, instead of referring the case to the tribunal, the DYP ended the intervention on the grounds that the child's parent refused to sign the agreement on voluntary measures that was proposed.

Agreements on voluntary measures

The examination of the agreements on voluntary measures signed with parents, and with the child concerned if over the age of 14, showed that:

- some agreements have no connection with the reasons for which the security or development of the child was considered to be in danger;
- some agreements failed to mention the basic facts founded by the DYP to justify the fact the child's situation is taken in charge;
- in files where the parent admitted that the child's security or development was in danger, the admission was rarely mentioned in the agreement;
- most of the agreements contained no commitment by the parents to correct the situation, except the general indication "collaborate with the Director of Youth Protection", even when the parent admitted that the child's security or development was in danger;

- most of the young people placed in the Rehabilitation Centre were there under voluntary agreements. The fact that they ran away or failed to respect the rules at the Centre on an ongoing basis did not lead to a re-assessment of the use of this type of measure;
- several agreements were not filed in the children's case files or were not signed. In the files examined by the Commission, 16 agreements were made verbally, and although they were written, were not signed;
- most of the files contained two or more successive agreements on voluntary measures, which was prohibited by section 53 of the *Youth Protection Act* as it applied at the time of the investigation.

Judicial intervention

In 17% of the files examined, the Youth Division of the Court of Québec had declared that the child's security or development was in danger.

The Commission observes that the overall situation of the child was seldom presented to the Court, which was generally only informed of the child's behavioural difficulties.

5.6 Taking charge of a child's situation (Prise-en-charge)

The *Youth Protection Act* specifies the responsibilities of the Director of Youth Protection and the actions that the Director must take when a child's situation is taken in charge. They include:

— ensuring that an intervention plan and service plan is drawn up;

— ensuring that the child receives the required social, educational and health services, as specified in the voluntary agreement or court order;

— periodically revising the situation of each child.

The testimony gathered during the Commission's investigation basically revealed that the DYP, to protect the children whose situation was taken in charge, ensure their development, improve the parenting skills of their parents and prevent the reoccurrence of the situation that led to the application of the *Youth Protection Act*, had no specific service agreement with the CLSC, the school or any other institution, except as regards accommodation services. If the child was under 18, the DYP intervened alone.

However, the DYP was poorly equipped to take on this responsibility. There are no support programs for parents and children, meaning that the only solution is often to place the child.

It is hard for the DYP to get access to psychological services. However, there was an agreement with the Module du Nord of the Montréal Children's Hospital for young people who needed hospitalization or an in-depth assessment.

The situation of 46 of the 62 children (74%) whose files were examined during the Commission's investigation was taken in charge at one or several times.

Services delivery when the child's situation is taken in charge

The Commission's investigation revealed serious deficiencies in the way in which the situation of children whose security or development is considered to be in danger is taken in charge. In several of the situations examined, the child whose situation was taken in charge continued to suffer abuse or neglect, whether in the child's natural or foster family.

The deficiencies noted in the files examined were essentially as follows:

- except in one case, no intervention plan or service plan was drawn up by the DYP in the files examined during the investigation;
- there was minimal or no social follow-up. In the application of the 69 measures, the children and their natural or foster families received no follow-up;
- the type of social services offered to the family often depended on the wishes expressed by the child's parents, who do not seem to have been asked to deal with their own difficulties or address their own lack of cooperation;
- the opinion of children over the age of 14 when they were consulted was seldom taken into consideration, and younger children were never consulted.

Review of a child's situation

In general, the investigation highlights the fact that, despite the legal requirement that Directors of Youth Protection review the cases of all children whose situation is taken in charge, the DYP rarely does so. Barely 10% of the files were reviewed and contained a written report.

In almost all the files, new reports or information pointing to the fact that the specified protection measures were not being applied, or were inappropriate or insufficient, did not lead to a review of the child's situation.

Most of the files were closed once the Voluntary or Court-Ordered Measure had expired, even if the initial situation that placed the child in danger still existed.

5.7 Foster family placements

In the situations examined by the Commission, 29 children were placed for over 30 days by the DYP. Several children were placed with a foster family during the time their situation was taken in charge, and some were moved repeatedly.

The Commission notes major deficiencies in the evaluation, the follow-up and the training of foster families. In general, there were no guidelines, since there were no

assessment grids or model contracts. Intervention and service plans were, in practice, non-existent. Despite this, several foster families provided the children with excellent services, but were over-utilized as a result.

The foster family members interviewed during the investigation confirmed that they did not know what was expected of them, except that they had to offer the child shelter. None of them had received any information or training on child development. Some foster families asked for a child to be moved because they felt overwhelmed and received no support, even after asking for help. Others stated that they could have fostered more children, but did not have enough room. The case workers, in turn, stated that the families did not need to be supervised, because they were known to be stable and trustworthy. They also explained the absence of any information on the child's situation by the fact that they were required to keep the files confidential.

The examination of the situations involving foster family placements led to the following observations:

- several transfers were requested by the foster families because they felt overwhelmed and received no support in difficult situations, such as when threatened by the child's parent or when the child disturbed the other children in the family;
- only one of the files studied contained an intervention or service plan intended for the foster family;
- the examination of the children's situations revealed many other problems concerning the foster families: some foster parents were related to the child's parents, received threats, or retained to be foster families because they did not want to fall out of favour with their family; others did not have the basic skills needed to foster a child, or were themselves dealing with problems of conjugal violence or alcohol abuse. Some families acted as foster families even though their own children were considered to be compromised;
- some children fell victim to abuse and neglect in their foster families. They did not have enough food or clothing. Some had no mattress or blankets.

6. APPLICATION OF THE *YOUTH PROTECTION ACT* IN HUDSON BAY

6.1 The situations examined

The 77 children whose files were selected by the Commission to examine the application of the *Youth Protection Act* were the subject of 255 signalements, for an average of 3.3 signalements per child.

Thirty-five (35) children were reported between three and nine times, four were reported between 10 and 16 times, and three were reported between 18 and 22 times.

By far the two most common reasons given for the signalements were the parents' behaviour and lifestyle, including lack of basic care and medical care (187 signalements) and serious behavioural difficulties (177 signalements), followed by physical abuse (42 signalements), sexual abuse (37 signalements), abandonment or serious emotional rejection (37 signalements) and disproportionate workload (1 signalement) [11].

In the situations studied by the Commission, 28 children were placed for over 30 days by the Director of Youth Protection. Sixteen (16) of them were transferred more than three times, 11 were transferred between four and six times, and five were transferred more than seven times. Two children were transferred from one home to another on 17 occasions.

The situations studied by the Commission clearly illustrate the amplitude and gravity of the problems experienced by the children whose situation was reported to the DYP, as summarized below.

6.2 Families in severe difficulty

In almost half of the situations (37 out of 77) examined by the Commission, the children lived in a home where one or more people behaved violently.

Alcohol and drug consumption

Thirty-nine (39) of the children in the Commission's sample lived with parents or relatives who were alcoholics or drug addicts.

Twenty-eight (28) of these children (70%) were themselves alcoholics or drug addicts. One-third of them were under 12 years old.

One child in the sample suffered from foetal alcohol syndrome.

Gambling addiction

Five (5) of the children in the sample lived with adults who were addicted to gambling.

11 Several reasons can be given in a single signalement.

Serious behavioural disturbances difficulties

The 177 signalements for serious behavioural difficulties involved 42 of the 77 children in the sample.

Thirty-two (32) of the children had been reported in the past for other reasons, including sexual abuse, physical abuse, the behaviour or lifestyle of their parents, or neglect. In no case had they received treatment or therapy, other than placement in certain cases.

Of the ten children whose situation had never been reported before, four had a brother or sister whose situation had been reported on the grounds of mistreatment or neglect.

The very high percentage of children reported for behavioural problems when their family environment had already been brought to the Director's attention for abuse or neglect (86%) raises serious questions about the appropriateness of the protection services offered to those families in the past.

Adoption-related problems

Twenty (20) of the 77 children in the Commission's sample had been adopted. Thirteen (13) of them, or 65% of the adopted children in the sample, had been moved from one family to another; for example, they had been handed over to a biological relative or foster family, transferred to another adoptive parent, placed, and ultimately taken back by their original adoptive family.

Lack of housing

In five of the Commission's sample cases, the child's parents had no home, forcing the DYP to place the children in foster homes.

Mental health problems

In nine cases, the children lived with a parent or family member who had been diagnosed with mental health problems.

Suicide

Suicide was a major problem in the files studied. The situations of 28 children in the sample were reported on the grounds of suicidal ideation (18 signalements) or attempted suicide (10 signalements).

In addition, information in the possession of the DYP shows that 19 of the children in the sample had a relative who had committed suicide, and seven had friends or relatives who had tried or threatened to commit suicide.

Bullying

Five of the children in the sample had been bullied at school or in the village.

6.3 Reception and processing of signalements

The situations of the 77 children in the sample generated 255 signalements, 224 of which were retained for evaluation. As shown below, they were dealt with in various ways.

Situations potentially requiring protection measures but not considered to be signalements

The files examined showed that, in eighty-one situations, some of the information brought to the attention of case workers under the authority of the DYP about children who were already known to the Service should have been considered as signalements within the meaning of the *Youth Protection Act*. A decision should therefore have been made on whether or not they should be retained for evaluation, or on whether existing protection measures should be reviewed. The investigation revealed that similar information had previously been received as a signalements by the same case workers

Signalements that should have been retained but where the file was immediately closed

The Commission notes that eight signalements were not retained for evaluation, even though the nature of the facts reported suggested that the security or development of these children was in danger. In several files the DYP, after checking or talking to the parent or the child, simply terminated the intervention, on the grounds that the mother or the child denied the facts or did not want help. In one situation, the child's grandmother said her daughter retaliated against her (the grandmother) whenever the DYP intervened, which led to the closure of the file.

No decision made, even after several signalements

Twenty-three (23) signalements received by the DYP did not give rise to a decision concerning their admissibility for evaluation. It was not possible to decipher why a decision was not made; either on the child's age, the grounds to determine whether a child is in danger or the type of applicant.

Application of urgent measures

When the Director of Youth Protection decides to retain a signalements, he or she must immediately decide whether or not the child is in danger, and whether urgent measures are required. Sections 45 and following of the *Youth Protection Act* clearly set out the terms and conditions applicable to this type of measure.

In several situations — at least a dozen — the Commission notes that urgent measures were not taken even though the facts reported suggested that the child was in immediate danger.

On the other hand, as noted above, on several occasions case workers were given information or new facts that they did not treat as signalements under the *Youth Protection Act*. When the information concerned a dramatic and urgent situation, the DYP would intervene, sometimes in a form that could be construed as an urgent measure under the Act. Once the crisis was over or the child was placed, the situation was not reviewed in more depth.

Concerning the receipt of signalements, the DYP underlines the confusion reigning in the region's organizations. As a result, she sometimes received signalements that should have been processed in a different way. For example, she told us that the school had no drop-out prevention program or student support program, and did not meet with parents to explain why their children should attend school. When a child did not attend school, the school simply signalled the situation. Similarly, according to the DYP, the school also reported all situations involving assault, rather than treating them as criminal acts and calling the police. The children were then expelled from school, forcing the DYP to provide a shadow before they could return.

The DYP also pointed out that the CLSC did not provide programs or services for families or schools, with the result that all difficult situations ultimately landed on her desk.

6.4 Evaluation of signalements

After retaining a signalement for evaluation and before making a decision concerning the security and development of a child, the Director of Youth Protection must, under the *Youth Protection Act*, verify the facts brought to his or her attention and analyse the child's situation on the basis of various factors.

By evaluating the child's situation, the DYP gathers the information needed to offer social services adapted to the child's needs and a reoccurrence of the situation. The information focuses, in particular, on the child's general behaviour and family history, the parenting skills of the parents and the resources available in the child's environment.

Of the 224 signalements that the DYP considered to be admissible for evaluation, only 88 (39%) were actually evaluated within the meaning of the Act.

The DYP made a decision concerning the child's security and development in 59 cases. In most of these cases (46 in all), the DYP concluded that the signalements was founded. However, in 29 cases, no decision was made concerning the child's security and development.

Generally speaking, the examination of how signalements were processed revealed that similar situations were sometimes treated in very different ways, for no apparent reason. For example, a signalement would be retained by one case worker but not by another, in similar circumstances. Sometimes the same case worker would reach different conclusions in similar contexts. As the following observations show, the process differs from one file to the next.

Files closed without evaluation

In 27 cases, after accepting the signalement for evaluation, the DYP did not in fact carry out the evaluation, and no further intervention took place because the child's parents refused to allow it.

The Commission notes that in virtually all the files it examined for the investigation, one or sometimes several of the signalements retained for evaluation appear to have been forgotten. This occurred in several villages, in cases assigned to different case workers; however, children exhibiting behavioural problems whose situations were reported by their school made up a large percentage of these cases.

Signalements that were not evaluated, but where a decision was made concerning the child's security and development

For 80 of the 224 signalements, the DYP made a decision concerning the security or development of the child without actually evaluating the situation first. In 77 cases she decided that the child's and development were in danger. Although it was impossible for the Commission to see why the Director took this approach, the following circumstances appear to have been a factor in some of her decisions:

- the parent reported the child's situation, on the grounds that the child had behavioural problems. The DYP decided that the child's security or development was in danger and agreed with the parent on the duration of the placement;
- the signalement claimed sexual abuse by a third party. In cases such as this, the Director usually decided that the child's or development was in danger, but did not offer services and did not check either the context in which the abuse took place or the parents' ability to help the child.

According to the case workers interviewed during the investigation, the DYP may be able to decide that a child's security and development are in danger without evaluating the overall situation, because either she or her employees are already familiar with the family.

Signalements that were followed by intervention, but where no decision was made concerning the security and development of the child

Several signalements retained for evaluation were not evaluated as such. Instead, the DYP intervened with the parents, for example by instructing them to take the child to hospital, or asking them to watch out for sexual abuse by a third party. This type of intervention was wrongly referred to as a "final intervention".

In other cases the DYP began an evaluation of the child's situation, and the evaluation continued until she obtained a short-term reassurance. At the end of this process, she did not make a decision concerning the child's security and development, and this, too, was described as a "final intervention".

In a few cases, after a full evaluation that seemed to confirm that the child's security or development was in danger, the DYP did not make any decision. In some of these cases the parent refused the proposed assistance, and in others the DYP found a solution that protected the child in the short term.

In nine cases the signalements were evaluated but no decision was made as to the child's security and development. There were no apparent reasons for this; the files simply seem to have been forgotten.

In eight cases, even though the evaluation confirmed facts reported under the *Youth Protection Act*, the child was placed under the *Act Respecting Health Services and Social Services*, thus terminating the protection intervention. The Commission was unable to decipher the reasons for proceeding in this way, since other similar situations were processed under the *Youth Protection Act.*

Signalements that were evaluated, and where a decision was made concerning the child's security and development

In general, the Commission notes that most of the signalements examined for the investigation were evaluated in a very summary manner, omitting some of the elements required to understand the child's overall situation and offer appropriate social services where necessary. None of the evaluations involved the use of evaluation tools recognized by the Association des centres de jeunesse du Québec.

The Commission notes that only nine signalements were evaluated in what it considers to be a complete way.

An examination of all the evaluations carried out by the DYP reveals the following points:

- evaluations tended to focus on verification of the facts reported, and did not consider the child's overall situation;
- the child's parents, and especially the father, were not always interviewed by the case worker carrying out the evaluation. The children themselves, and the people of significance to them, were rarely interviewed;
- fathers or extended family members suspected of sexual assault were virtually never interviewed;
- general parenting skills were not evaluated, nor were the parents' willingness and ability to correct the situation. The child's vulnerability was never evaluated. Psychosocial evaluations of the child's situation were not carried out, except in conjunction with a psychological assessment;
- events tended to be examined in isolation, with no consideration of their connection to past events or possible recurrence. For example, the Director did not take into consideration the siblings of a child whose security or development was in danger, even where parenting skills were at issue;
- evaluations of abandonments appear to be particularly difficult, in that the Director tended to intervene basically at the parent's request. For example, she would place the child without evaluating the impacts of the placement;
- the Commission notes that, in seven situations, the Director asked for a psychological assessment to clarify the roots of the child's problems or the measures that might help. However, the assessments were not then considered in subsequent decisions;
- finally, the question of the confidentiality of information obtained pursuant to the Act at the evaluation stage was mentioned on numerous occasions during the interviews.

Decisions made in connection with the security and development of a child

> Once the child's situation has been evaluated, the Director of Youth Protection must decide whether or not the child's security and development are in danger, and state the reasons for that decision.

The Commission observes that:

- decisions concerning the child's security and development focused on the facts reported, regardless of other potential grounds that may have been revealed during the evaluation. This approach was particularly clear in the case of children with severe behavioural problems who had also been abused or neglected;

- as described earlier, in several cases the DYP ruled that a child's security and development were in danger on the basis of the facts reported, without evaluating the child's situation first;
- the Director ruled that the child's security or development is in danger when there is a major recurrence of the indicators that led to believe that the child's security or development is in danger;
- based on the information contained in the children's files, several signalements judged inadmissible should in fact have been taken in charge;
- as was the case for the evaluation process as a whole, the parents' wishes appear to have been a key factor in many protection interventions. For example, the Director would sometimes alter her decision concerning the child's security and development, and actually close the file, if the parents refused social services.

6.5 Orientation

Under the *Youth Protection Act,* the Director of Youth Protection, after observing that the security or development of a child is in danger, must implement measures to correct the situation effectively, with or without the agreement of the parents.

According to the Director's assessment of the child's overall situation, the Act requires the DYP to either propose the application of voluntary measures, or to take the case before the Court.

An agreement on voluntary measures must specify the most appropriate measures to bring to an end the situation placing the child in danger, and prevent its reoccurrence. The duration and renewal of a voluntary agreement are specified by sections 52 and following of the Act.

Orientation of a child's situation

In the sample cases, the DYP ruled that the safety and development of 77 children were in danger on 123 occasions. In some of these cases, interventions led to the files being closed.

The DYP decided on the orientation of the child's situation, as stipulated in the *Youth Protection Act*, in 63 cases. Forty-nine (49) agreements on voluntary measures were concluded, and 14 cases were taken to court.

The Commission makes the following observations concerning the orientation process:

- in many cases where signalements were retained, no decision was made concerning the orientation of the child's situation. The reasons for this are unclear. In three cases, no decision was made concerning the orientation because the child's parents refused the proposed measures;

- in most cases where signalements were retained, the orientation selected was the signing of an agreement on voluntary measures, even though the parental capacity had not been assessed during the evaluation process;
- in some cases, voluntary measures were selected as the orientation, even though the child's parents clearly said they no longer wanted to look after the child;
- cases were taken to court only in exceptional circumstances, and usually to obtain a placement outside Nunavik;
- although some situations clearly called for the appointment of a tutor for the child, the Director never asked for this to be done. In one particular situation where she herself was the tutor, the Director still attempted to contact the child's mother and have her sign the agreement on voluntary measures.

Agreements on voluntary measures

The examination of the agreements on voluntary measures signed with parents, and with the child concerned if over the age of 14, showed that:

- all the agreements on voluntary measures included placement, and in many cases this was the only measure implemented to help the child and the family;
- some agreements did not mention the basic facts on which the Director had based her decision to take charge of the child's situation;
- most of the agreements did not include steps to be taken by the parents to correct the situation, even where the parents admitted that the child's security and development were in danger (this was rarely mentioned in the agreements);
- the type of social services offered to the family often depended on the wishes of the parents, who did not seem to be asked to address their own problems or lack of cooperation. In 24 situations, our analysis clearly showed that the parents themselves decided on the type and limits of services to be offered;
- two agreements were not signed by the child, even though he or she was 14 years old or over;
- most Rehabilitation Centre placements were made under agreements on voluntary measures. The fact that the children ran away or reacted negatively to the placement did not cause the Director to question the use of voluntary agreements;
- several files contained more than two successive agreements on voluntary measures, a situation that is not consistent with section 53 of the *Youth Protection Act* as it applied at the time of the investigation.

Judicial intervention

Only a small percentage of the files examined for the investigation (14 in all) were taken before the Youth Division of the Court of Québec for a motion of protection.

The Commission notes that it was rare for the child's overall situation to be presented to the Court, which was often informed only of the child's behavioural problems.

6.6 Taking charge of a child's situation (Prise-en-charge)

The *Youth Protection Act* specifies the responsibilities of the Director of Youth Protection and the actions that the Director must take when a child's situation is taken in charge. They include:

- ensuring that an intervention plan and service plan is drawn up;
- ensuring that the child receives the required social, educational and health services, as specified in the voluntary agreement or court order;
- periodically revising the situation of each child, in the manner prescribed by regulation.

In the same way as in Ungava Bay, the testimony gathered during the investigation basically revealed that the DYP, to protect the children whose situation was taken in charge, ensure their development, improve the parenting skills of their parents and prevent the reoccurrence of the situation that led to the application of the *Youth Protection Act*, had no specific service agreement with the CLSC, the school or any other institution, except as regards accommodation services. If the child was under 18, the Director of Youth Protection intervened alone.

However, the DYP in Hudson Bay has very few means at her disposal to help her shoulder this responsibility. There are no support programs for parents or children, with the result that placement is often the only available solution. In addition, access to psychological services is extremely difficult. The Director does, however, have an agreement with the Module du Nord at the Montreal Children's Hospital for children who are hospitalized or require a more detailed assessment, and she has made an agreement with Douglas Hospital.

On the other hand, the Director feels it is not her responsibility to provide services for parents. Parents are usually referred to the CLSC, but they are free to accept or refuse the referral. The CLSC, too, may refuse to provide services. No steps are ever taken to ensure that parents receive the required services, or to verify the impact of the services on their parenting skills. Case workers employed by the Director of Youth Protection do not coordinate their interventions with their counterparts at the CLSC, the school or the hospital.

The Nunavik Regional Board of Health and Social Services, in its comments on the Commisssion's factual report, mentioned that a program to improve parenting skills for parents under the age of 20 had been launched in Hudson Bay following the investigation. In addition, an early detection program for children aged 0 to 5 has been set up by the CLSC.

Lastly, the information gathered during the investigation shows that the Director of Youth Protection, when taking charge of a child's situation or before, does not act with the authority conferred upon her by law to protect the children. There appear to be a number of reasons for this, including the small size of the communities, and the situation is complicated by the fact that the Director and her staff are sometimes prevented from proceeding in accordance with the Act by political pressure. At least, this is what some of the people interviewed for the investigation suggested.

Given that some of the 49 agreements on voluntary agreements and 14 court orders applicable to children in the sample were extended during the investigation period, the Commission studied the services offered in the case of 68 voluntary agreements and 19 court orders.

In 29 situations, the Director chose to offer services under the *Act Respecting Health Services and Social Services*. These cases were also examined as part of the investigation.

Services delivery when the child's situation is taken in charge

The investigation revealed serious deficiencies in the way in which the situation of children whose security or development is considered to be in danger is taken in charge. In several of the situations examined, the child continued to suffer abuse and neglect, whether in the child's natural or foster family.

The deficiencies noted in the files examined were essentially as follows:

- there were virtually no intervention or service plans; only two of the files examined contained such a plan. However, children placed in the Group Home received intervention plans prepared by the Home itself;
- social follow-up was usually minimal. For example, the mother and child were interviewed on a regular basis, but only for the first or last month of the agreement. In other cases, only the mother received follow-up, or a single visit was made to the foster family, or a single call was made to the CLSC to ensure that follow-up was being provided for the mother;
- the social follow-up provided was often highly superficial. Case workers simply asked how things were progressing. It was rare, for example, to see a case worker checking the family's budget, the amount of food available or the child's attendance at school;

- the Director did nothing to ensure that the parents complied with any undertakings they had made, and did not check on their progress (if any). There was little contact with schools;
- where social follow-up was provided, it was usually not initiated by the Director. The Commission notes that in many cases interventions were sought either by the parents themselves, by an institution (often the school), or by the foster family;
- when the Director placed a child with a foster family, she did not ask them to provide anything other than shelter and food. The children were usually not visited in their foster homes, unless the foster parents asked for them to be moved;
- the opinions of children aged 14 or over were rarely considered - if, indeed, the children were consulted at all. Young children did not appear to be listened to;
- some files were closed when a voluntary agreement or order was still in force;
- as was the case for signalements, many of the people we interviewed criticized the lack of confidentiality of the information;
- the *Youth Protection Act* does not provide for services to be dispensed under the *Act Respecting Health Services and Social Services*. Even so, this was done in the case of 14 children, 11 of whom were placed outside their families. In no case was the child's situation taken in charge. Moreover, the placement ended when the parent decided it should end.

Review of a child's situation

Generally speaking, the investigation highlighted the fact that, despite the Director of Youth Protection's legal obligation to review all situations taken in charge, she did not in fact perform reviews.

The analysis of the files revealed the following elements:

- the DYP had no review form or model review report;
- only 24 of the 88 measures that terminated during our investigation were reviewed;
- most of the reviews were not written up, and in many cases the information required by regulation was not obtained. The reviews consisted in reading the file and occasionally engaging in discussions with the DYP. There were no meetings with the family or school;
- if the child or parents withdrew from the agreement on voluntary agreement, the case was usually not brought before the courts, unless the child exhibited significant problems;

- in virtually every case, the child's situation was not reviewed even if a signalement or information was received to the effect that the protective measures were not being applied, or were inappropriate or insufficient;
- most of the files were closed at the end of the voluntary measure or order, even if the situation that had originally endangered the child's security and development still persisted. For example, a child who had been placed outside the family environment would be sent back home without follow-up, even though the parents had received no social services during the placement.

6.7 Foster family placements

Twenty-eight (28) of the 77 children in the sample were placed for periods exceeding 30 days. Numerous children were placed in foster homes during the time their situation was taken in charge, and some were moved several times.

The Commission notes, as it did for Ungava Bay, that nobody at the Youth Protection Service was responsible for the evaluation, the follow-up and the training of foster families. In her comments on the Commission's factual report, the DYP stated that a position with responsibility for all these duties was vacant, but that she had no housing available for a professional worker. Generally speaking, there were no guidelines for these activities, no evaluation grids and no model contracts. In practice, service and intervention plans were simply not provided for foster family placements. Despite this, some foster families served the children well, and were overused as a result.

The foster family members interviewed during the investigation confirmed that they did not know what was expected of them, except that they had to offer the child shelter. None of them had received any information or training on child development. Some foster families asked for a child to be moved because they felt overwhelmed and received no support, even after asking for help. Others stated that they could have fostered more children, but did not have enough room. The case workers, in turn, stated that the families did not need to be supervised, because they were known to be stable and trustworthy. They also explained the absence of any information on the child's situation by the fact that they were required to keep the files confidential.

The examination of the situations involving foster family placements led to the following observations:

- some foster families did not feel committed to the children they fostered. They did not treat foster children in the same way as their own children, and were quick to ask for them to be transferred if problems arose. As a result, children were often moved several times, with no prior preparation;
- some children were abused and neglected by their foster families. They did not have enough food or clothes. Some had no mattress or blankets. Ten (10) foster

families exhibited major problems that triggered action under the *Youth Protection Act*;

- in no case was a service or intervention plan prepared for the foster family;
- in several cases the foster families themselves requested that children be withdrawn from their homes because they were unable to cope and did not receive support when things became difficult - for example, if they were threatened by the child's parents, or if the child disturbed their own children;
- generally speaking, the most stable placements were those that involved the child's grandparents, provided they had proper parenting skills;
- the examination of the children's situations revealed numerous other problems with foster families. For example, some foster families were related to the child's parents, and were threatened or did not want to fall out with their relatives; others did not have the basic capacity to look after a child, or had their own problems with alcohol abuse or conjugal violence. Some families were used as foster families when their own children's security and development were considered to be in danger;
- some children had to be placed outside their home village because foster families were simply not available;
- thirteen (13) adopted children were moved from one home to another. They were given back to a biological parent, handed over to another adoptive parent and then, taken back by the adoptive parent. When this happened, the DYP paid a foster allowance to the biological or adoptive family.

7. REHABILITATION SERVICES IN NUNAVIK

7.1 Organization of rehabilitation services

Inuit children in Nunavik have access to one rehabilitation centre and three group homes: one in Ungava Bay, and two in Hudson Bay, one of which is privately-run. All these facilities receive adolescents who are placed under the *Youth Protection Act* or under an open custody order pursuant to the *Youth Criminal Justice Act*.

Although these resources offer different services and facilities, in reality the Directors of Youth Protection use them according to availability.

The Directors of Youth Protection have no residential facility for children under 12 years of age who need special rehabilitation services.

Young people subject to secure custody orders under the *Youth Criminal Justice Act* are necessarily sent to rehabilitation centres outside the region, generally operated by the Batshaw youth and family centre in Montreal for Anglophones, or L'Étape in Val-d'Or for Francophones, if there is room, because there is no agreement as such for Francophone Inuit children. Children with severe mental health problems can be sent to Montreal's Douglas Hospital.

For all other client groups, it has become extremely difficult to obtain youth placements outside the region since the Rehabilitation Centre was opened in the North. Those requests for placement outside the region that are retained are for short periods only.

7.2 The Saturvik Group Home in Kuujjuaq

Ungava Bay has a single group home, with 8 beds, in Kuujjuaq for children of both sexes aged 12 to 18. It is under the authority of the Director of Community and Rehabilitation Services at the CLSC. The group home is located in a house that is scheduled for renovation [12].

The Group Home is an intermediate resource with a strong community focus. The teenagers go to school or work in Kuujjuaq. They have a lot of free time, and are free to move around the village as they like.

The Group Home has no isolation room. According to the information obtained during the investigation, since the Group Home and the Rehabilitation Centre are several hundred kilometres apart, a teenager housed in the Group Home who needs to be isolated cannot generally be transported to the Rehabilitation Centre in time. To get around this difficulty, an agreement has been signed by the Kativik Regional Police Force, the Director of Youth Protection and the Tulattavik Ungava Hospital, to allow the cell at the police station to be used, when needed, to isolate a teenager [13]. However, in their comments on the Commission's factual report, the Director of Community

12 The comments forwarded by the Director of Community and Rehabilitation Services mention several improvements made in the services provided. These improvements are presented in Section 10 of this report.

13 Under section 11 of the *Youth Protection Act*, no child may be placed in a house of detention or in a police station.

and Rehabilitation Services and the coordinator of the Group Home stated that the police station is not actually used to isolate teenagers; on one occasion, a particularly violent young person was arrested by the police after he ran away.

Teenagers who display suicidal behaviour, threaten to kill themselves or who are intoxicated are sent to the Hospital for assessment and hospitalization if they represent a danger to themselves.

The Group Home has no specialized programs, for example to help young addicts or teenagers who have difficulty controlling their emotions.

The Group Home has ground rules, based on respect for oneself, for others and for property. The main disciplinary measures involve reducing a teenager's free time.

In the situations examined by the Commission, 11 young people were sent to the Saturvik Group Home, most of them under an agreement on voluntary measures.

7.3 The Inukjuak and Puvirrnituq group homes

The Hudson region has two group homes for teenagers of both sexes aged 12 to 18. The Inukjuak Group Home is privately-owned, whereas the Puvirnituq Group Home is under the authority of the Director of Youth Protection for Hudson Bay. The Inukjuak Group Home has been closed and reopened several times. The following information refers mostly to the Puvirnituq Group Home, which was the only one open during the Commission's investigation.

The Puvirnituq Group Home is an intermediate resource with a strong community focus. The teenagers go to school or work in Puvirnituq. They have a lot of free time, and are free to move around the village as they like. Residents receive support from a designated educator, known as a key worker, with whom they carry out activities outside the Home. All the residents meet with the key worker at least once a week, to talk about the progress they are making.

The Group Home has an isolation room. The police told us that, when the Group Home manager is absent, they are sometimes called in to help place a resident in the isolation room.

The Puvirnituq Group Home does not offer special programs to help youngsters with substance abuse or self-control problems. According to our findings during the investigation, the Inukjuak Group Home did offer programs for addicts, anger management and abuse. Some of the parents we interviewed said the programs were well-structured and tailored to the Inuit culture.

The Puvirnituq Group Home has its own ground rules, based on respect for oneself, for others and for property. Disciplinary measures normally involve cutting back on free time and room confinement. The duration and conditions of disciplinary measu-

res are not specified. According to the testimony received, they vary according to the individual worker and the circumstances. Some residents may remain in isolation for several hours — up to 24 hours in some cases — before being sent to their rooms.

Residents whose behaviour constitutes a danger to themselves or to others are taken to hospital by a police officer. The police station cells appear to be used as a means of calming residents down in some cases, at the request of the Group Home staff.

7.4 The Rehabilitation Centre

The Sapummivik Rehabilitation Centre is located in Salluit. It has 14 places, seven for each Bay. The Centre comes under the authority of the Director of Community and Rehabilitation Services at the CLSC.

The creation of the Rehabilitation Centre in Salluit was intended to enable Inuit youngsters to receive rehabilitation services adjusted to their culture, within their own environment. This was certainly not the case when they were sent to Val-d'Or.

Rehabilitation Centre residents are educated on site. They have less free time than Group Home residents, and the community's infrastructures (youth centre, gymnasium) are used for group activities.

When the Commission's investigators visited the facility, the teacher had 13 youths in seven different grades, some studying in French and others in English. She admitted that her job was virtually impossible, especially in view of the short duration of the placements and the turnover of residents.

During the investigation, disciplinary measures at the Rehabilitation Centre were applied in accordance with a code written in March 2001 and revised in April 2002. The usual punishments included separation from the group, loss of privileges or free time (e.g. computer access), and room confinement. In its comments in the Commission's factual report on Ungava Bay, the facility said it had introduced new rules for the application of disciplinary measures.

The Centre has a written procedure and forms for the removal and isolation of residents.

In the files examined by the Commission, ten cases involved placement at the Rehabilitation Centre. Most of the youngsters were placed under agreements on voluntary measures. During the investigation, Rehabilitation Centre residents said they felt they were being punished for having been abused; some said they had been placed because their parents were tired of them. Only one girl felt her placement had helped her take back control over her life.

Since it gathered the information for its investigation, the Commission has been informed by the Director of Community and Rehabilitation Services at the CLSC that many improvements have been made to the Rehabilitation Centre.

7.5 Observations on rehabilitation services

The Commission makes the following general observations:

- at the time of the investigation, Nunavik did not have any community educators. This is due partly to the shortage of suitable housing. At the same time, the Youth Centre does not have services to help parents interact with children who have serious behavioural difficulties;
- the files revealed several instances of children being incarcerated at the police station, particularly in Hudson Bay, for example when they were drunk, on drugs, out of control or suicidal. One youth who was afraid of his parents when they were drunk had to spend the night at the police station because it was too cold to sleep outside and he had nowhere else to go. The police officers regard the police station as a temporary shelter for emergency cases, rather than a prison;
- two children under the age of 12 were placed in the Rehabilitation Centre, although its operating permit does not allow this;
- there is very little difference between the behaviour of youngsters sent to the Rehabilitation Centre and those sent to a group home. In both Ungava Bay and Hudson Bay, several children whose cases were examined during the investigation were not able to be housed at a group home, as required;
- some residents at a group home or at the Rehabilitation Centre had problems that were far too serious for the existing facilities and the level of training of the staff, especially in the absence of rehabilitation programs;
- the Rehabilitation Centre and group homes still do not have the staff they need. At the Rehabilitation Centre, at the time of the Commission's investigation, the psychologist had just returned after a one-year absence, during which he was not replaced. A psychoeducator and an educator were on staff, but had been hired only recently;
- neither the Saturvik and Puvirnituq Group Homes nor the Rehabilitation Centre offer specific programs for substance abuse, for sexual abusers, or for the victims of sexual abuse or violence;
- at all the residential facilities, the staff is unaware of the internal rules governing the application of disciplinary measures. Residents may be punished differently for the same offence;
- despite the initial intention, the Rehabilitation Centre offers few rehabilitation activities adapted to Inuit culture;

- at the Rehabilitation Centre, the isolation procedures are generally in compliance with the position adopted by the Commission. However, the procedures were not followed in several cases where children were sent to their rooms for long periods, which resembled an isolation measure;
- most of the teenagers at the Saturvik Group Home do not have an intervention plan, except when there is a psychoeducator on the staff;
- although some of the teenagers at the Saturvik Group Home are there because of addiction problems, there is no procedure to limit or supervise their free time in the village. As a result, in many files, young people are reported as returning back to the Group Home intoxicated;
- when the investigators of the Commission visited the Saturvik Group Home, a young aggressor and his victim were among the residents. In this case, the only protective measure applied was to assign the victim a bedroom close to the staff office;
- the residents at the Puvirnituq Group Home had intervention plans;
- one teenage girl was sexually assaulted by two youths at the Inukjuak Group Home. Another was sexually assaulted by a night security officer upon her arrival; according to police, this was not the man's first offence. The adolescent involved in this latter incident received very little support after the assault;
- one resident of the Inukjuak Group Home was kept in isolation for six hours, even though he had calmed down, without being interviewed. He was wearing under-shorts.

The Commission's investigators met all the Rehabilitation Centre staff and residents, except for two youngsters who did not want to be interviewed. At the Puvirnituq Group Home, all the staff members and all the youngsters resident in May 2003 were interviewed.

At both group home and the Rehabilitation Centre, all the youngsters and most of the staff thought that all the staff members did the same type of work. In interview, the youngsters were unable to differentiate between the roles of the psychoeducators, the educators, the guards and the animators.

Based on the interviews with rehabilitation service staff, youngsters, youth protection workers and CLSC workers, the Commission makes the following general observations:

- in the rehabilitation service, contacts and follow-up with the home environment are not formalized, but depend on the initiative of individual case workers;

- there are significant problems with staff recruitment, staff turnover, absentee rates and training, making it difficult to organize planned activities;
- despite repeated demands by staff at the Rehabilitation Centre, no team meetings are organized to talk about the dynamics of the relationship with the young people, to plan intervention and programs, and to define intervention approaches. At the Rehabilitation Centre, meetings are uncommon and address administrative questions only;
- at the Rehabilitation Centre, the physical layout is unsatisfactory and has several major deficiencies. Some bedroom doors can be locked from the inside. The layout of the corridors and bedrooms presents a clear view of all bedrooms, and it is easy for young people to go from one bedroom to another. Some windows can be opened from the inside, and several door handles are broken. Some rooms have suspended ceilings where the young people can hide forbidden objects. Some windows have been replaced by sheets of plywood. The thermostats are not protected, and have been dismantled by young people looking for mercury. The storage room is accessible, and contains naphtha. The fire extinguisher is accessible to the young people, and one young person used it to attempt to commit suicide [14];
- major dissatisfaction was expressed about the lack of training on teenage behaviour, addiction and abuse;
- many staff members admitted that they had personal addiction problems with alcohol or drugs, or were subject to conjugal violence, and did not feel prepared to counsel teenagers facing the same problems. Some said they were honestly afraid of some of the young people, and felt they lacked support and intervention tools;
- the staff at both the Rehabilitation Centre and the Group Home felt they were working in a vacuum. They criticized the social workers for not keeping in touch with the youngsters, for agreeing to all their requests without consultation, and for returning youngsters to home environments where nothing had changed, without preparation or prior consultation;
- several comments were made about the rehabilitation of clients with mental health disorders. Some found it difficult to identify mental disease, believing that it was in fact a manifestation of possession by evil spirits. Others said they did not know what to do with this type of clientele, and in some cases were afraid of them. They deplored the fact that they received no support from mental health professionals. Some said that the psychiatrists made their evaluations and handed out their pills but offered no guidelines to help the staff.

Moreover, during the investigation, the interviewed staff from the Batshaw Youth and Family Centres and the Module du Nord said they were increasingly reluctant to receive Northern clients because nothing was done to help the families during the pla-

14 As stated above, the comments made on the Commission's factual report indicate that improvements have been made at the rehabilitation centre since the time of the investigation, especially as regards physical layout.

cement. In addition, Northern case workers sent youngsters without any intervention or service plans, and did not maintain regular contact with their Southern counterparts. When the youngsters went back to their families with recommendations, the recommendations were often not applied. As a result, the service agreements were perceived as flowing in only one direction.

According to the comments made by the DYP in Hudson Bay, the situation has been corrected and cooperation with the Batshaw Youth and Family Centres is now well established and functional.

8. APPLICATION OF THE *YOUTH CRIMINAL JUSTICE ACT* IN NUNAVIK

The *Youth Criminal Justice Act* replaced the *Young Offenders Act* on April 1, 2003. As a result, the files examined during the investigation were processed under the *Young Offenders Act*, but the interviews and subsequent interventions of the Commission focused mainly on the application of the *Youth Criminal Justice Act.*

> As stipulated in the *Young Offenders Act*, the Attorney General's prosecutor informs the Provincial Director of the situation of certain youths. The Director must then decide on the need for extrajudicial sanctions. Following an agreement between the Attorney General's prosecutor and the Provincial Directors in Nunavik, the Provincial Directors have between three and six months to make a decision, depending on the prescription period for the offence.
>
> For young offenders, the Director must also authorize temporary detention, prepare the pre-decision report for the court, request custody and arrange the necessary transfers. In addition, the Director must appoint the youth workers who will be responsible for supervising the court order and assisting the youth as required.

8.1 Organization of services in Ungava Bay

In Ungava Bay, one youth worker in the Kuujjuaq office is responsible for applying extrajudicial sanctions and supervising court orders from the Youth Division. This involves meeting with the young person every week at the beginning of the probationary period, and once a month after the situation has stabilized.

Secure custody orders are applied in Montréal. The youth worker travels to the Rehabilitation Centre to help prepare the intervention plan, which is no longer under her responsibility.

When the young offender is not a resident of Kuujjuaq, the youth worker ensures that the required services are provided by the community worker in the village concerned, using the same procedures.

8.2 Organization of services in Hudson Bay

The Hudson Provincial Director has no youth worker as such, but she does have someone who was hired in January 2001 to apply the alternative measures program for young offenders. Her mandate is not clearly defined and, during the Commission's investigation, the person in question told the commission that he had recently been trained on the *Youth Criminal Justice Act* but had received very little information on how the new Act would affect working procedures.

In Kuujjuarapik and Inukjuak, the community workers themselves are responsible for their village's young offender files. They receive guidance from the extrajudicial sanctions program manager. In the other villages, young offender files are processed by case workers from the office of the Puvirnituq Director of Youth Protection.

Simultaneous application of the *Youth Protection Act* and the *Youth Criminal Justice Act*

> The application of the *Youth Criminal Justice Act* does not necessarily exclude other interventions under the *Youth Protection Act*.
>
> Before the situation of a teenager accused of an offence, and whose security or development may be in danger because of serious behavioural difficulties, is brought before the Director of Youth Protection, the problem and the motivation of the teenager and the parents to resolve the situation should be assessed. If it is clear that the parents are unwilling or unable to correct the situation, it should be dealt with under the *Youth Protection Act*.

In May 2006, the Commission was asked to intervene in the case of five young people who had committed one or more offences at school, after the Director of Youth Protection and Provincial Director for Hudson Bay had refused to retain their situation for evaluation.

The Hudson Bay DYP stated that in a case involving serious behavioural difficulties, she could only intervene under the *Youth Protection Act* if the parents were unable to correct the situation themselves.

In addition, the DYP considered that she could not apply the *Youth Protection Act* in a situation that involved a crime that had triggered the application of the *Youth Criminal Justice Act*. Despite this, in some villages the police contact her instead of using the mechanisms contained in the *Youth Criminal Justice Act*.

8.3 Observations of the services provided for young offenders

For Ungava Bay, the Commission examined 14 files opened under *the Young Offenders Act*, representing 54% of the Provincial Director's active files.

The Provincial Director for Hudson Bay had few current files. The Commission examined seven cases. Based on its examination of young offender files and its interviews on the subject of how the Provincial Directors dealt with them, the Commission makes the following observations:

- the person in Hudson Bay in charge of the extrajudicial sanctions program for young offenders is poorly trained and does not appear to know exactly what the job entails;

- in 9 out of 14 files examined, involving a variety of offences, such as breaking and entering, assault, invitation to sexual touching, theft, and dangerous driving involving an all-terrain vehicle, most in connection with excessive alcohol or drug consumption, the Provincial Director for Ungava Bay failed to make a decision concerning extrajudicial sanctions within the time limit agreed with the Attorney General's substitute. As a result, the Attorney General's substitute either had to drop the proceedings entirely, or else prosecute before the prescription deadline without giving the young offender a chance to benefit from extrajudicial sanctions;
- the same situation applies in Hudson Bay;
- the delays sometimes prevent young offenders from benefiting from extrajudicial sanctions or from facing the consequences of their actions, and may also have an impact on their subsequent willingness to cooperate;
- the monitoring of probationary periods was often deficient, and several young people on probation received no services;
- the extrajudicial measure was not always signed, and file-keeping was often deficient;
- in Ungava Bay, the files were closed as soon as the young person reached the age of 18, even if a court order was still in force. In Hudson Bay, the progress notes in the file of one young offender stated that the file would be closed when she reached full age if she did not appear as stipulated. However, the Commission cannot conclude that this is a generalized practice, since there were few files opened under the *Youth Criminal Justice Act*;
- there were not enough places for youngsters in custody;
- the Provincial Director for Hudson Bay saw no difference between extrajudicial sanctions and preventive detention;
- in both Bays, preventive detentions take place in police station cells, where youngsters cannot always be kept separate from adult prisoners.

9. COMMENTS ON THE FACTUAL REPORT FOR UNGAVA BAY

A report on the facts gathered during the investigation was sent in April 2005 to the Director of Youth Protection and Provincial Director, the Executive Director of the Nunavik Regional Board of Health and Social Services, and the director and chair of the board of directors of the Tulattavik Health Centre. The Minister of Health and Social Services also received a copy of the report. Some of the comments made on the report have been included in the factual overview sections, while others are summarized below.

9.1 Appointment of guides (accompagnateurs)

One week after receiving the factual report from the Commission, in the spring of 2005, the Minister of Health and Social Services appointed two guides to provide support for the two Directors of Youth Protection, in Ungava Bay and Hudson Bay. As specified in the letter from the Deputy Minister of Health and Social Services dated September 14, 2005, the back-ups were instructed to:

- support the two Directors of Youth Protection in performing their exclusive responsibilities under the *Youth Protection Act* and *Youth Criminal Justice Act*, to ensure that children were adequately protected at all times;
- implement measures to consolidate understanding and knowledge of the two Acts among case workers, and implement measures for training, professional supervision and clinical supervision;
- support the Regional Board in its efforts to ensure that each community recognize and take responsibility for its children, young people and families;
- examine the organization of services for young people in difficulty and propose structural solutions, such as the creation of service corridors.

9.2 Comments by the Director of Youth Protection

In a letter dated November 8, 2005, the Director of Youth Protection specified that the files examined by the Commission reflected the extent and seriousness of the situation of children monitored by social services, but not of all children in Nunavik.

The DYP questioned several aspects of the Commission's investigation. According to her, some of the complaints were unfounded from the start. She also pointed out several areas where the factual report was based on a misunderstanding. Finally, in her opinion, the Commission was wrong in its observations concerning several aspects of the investigation: for example, the fact that a file contained no notes did not necessarily mean that no action had been taken.

According to the DYP, although it is true that case workers sometimes hesitate to intervene in the families of their own relatives or friends, they then refer the file to

someone else. In this way, all situations are treated in the same way, regardless of whether or not they involve a family related to a staff member or to the DYP.

Furthermore, the DYP states that, since 2002, improvements have been made to several aspects of the protection system. She highlights the following elements:

- the introduction of new forms and the improvement of the services connected with the processing of signalements;
- an improvement in the application of voluntary measures;
- the fact that foster families receive more support and that a case worker is now responsible for recruiting foster families;
- the hiring of two back-ups from Batshaw Youth and Family Centres by the Ministry of Health Services and Social Services and the Regional Board.

The Youth Protection service can now count on the services of an assistant and two professionals, and there is more supervision, especially with respect to the making of progress notes at all intervention stages.

In addition, the DYP reports that a workshop for pregnant women on the links between infant health and alcohol and drug abuse has been scheduled, along with the services of a community educator specializing in crisis intervention.

9.3 Comments by the Director of Community and Rehabilitation Services at the CLSC (Tulattavik Health Centre)

The comments by the Director of Community and Rehabilitation Services at the CLSC in Ungava Bay, who is also responsible for the Sapummivik Rehabilitation Centre and the Saturvik Group Home, are set out in a letter dated October 27, 2005. They focus essentially on the fact that, since the filing of the complaints that led to the Commission's investigation, the rehabilitation services have improved.

Saturvik Group Home

A new coordinator was hired for the Group Home in the fall of 2003. Since then, several measures have been implemented to improve the rehabilitation services provided. For example, a “Protocol Journal” and a code of conduct and activities have been introduced.

An agreement has been negotiated with Batshaw Youth and Family Centres to borrow an educator who has been given responsibility for reviewing the current procedures and training staff. A second specialist has been asked to complete the team at the Group Home. Last, an experienced Inuit educator has been hired in Kuujjuaq. Weekly team meetings are organized to discuss the young people's situation and other topics relating to the Group Home. Training on intervention in crisis situations has been pro-

vided, and various programs on the problems faced by the young people have been set up.

Communications with case workers and the Youth Protection service are more frequent. In addition, the coordinator communicates regularly with the young people's parents.

Several sports and traditional activities have been developed by the Group Home, which now has additional equipment and facilities.

Despite the difficulty involved in hiring a psychoeducator, intervention plans are still drawn up. Young people with addiction problems receive appropriate support.

Since the new programs have been introduced, the number of young people referred back for a second residential period has dropped.

Sapummivik Rehabilitation Centre

At the Rehabilitation Centre, the layout problems have been corrected or improved.

The Centre implemented a code of conduct in July 2005. Internal rules on the application of disciplinary measures and a progressive integration program were revised and adopted in August 2005. The staff members receive ongoing training from a specialized organization.

Since June 2005, the young people have had access to sports and educational activities.

The psychoeducator on duty ensures that less experienced educators attend regular meetings where they learn how to draw up general objectives and intervention plans. Team meetings are now part of the regular schedule at the Centre.

In terms of clinical intervention, a cooperation agreement was signed in May 2005 with the rehabilitation centre run by Batshaw Youth and Family Centres. The Rehabilitation Centre now has the tools required to draw up intervention plans, keep files, complete forms and so on. Similarly, when a client from the North is sent to a residential program in Montréal, weekly communication between the case workers in both regions ensures follow-up in the case.

The documents forwarded to the Commission present the Centre's rules and the "restricted program" that will apply at the Centre. The program has seven model schedules. The Commission notes that schedules 6 and 7 involve major restrictions of freedom. For example, schedule 7 calls for the young person to be confined to his or her room all day, except for a 10 minute break and 20 minutes to take a shower. Schedule 6 also calls for the young person to remain in his or her room for most of the time except, in the afternoon, for a one-hour period outside the room with a guard, 20 minutes for a shower and a 10 minute break with a guard in the evening.

10. COMMENTS ON THE FACTUAL REPORT FOR HUDSON BAY

A report on the facts gathered during the investigation was sent in October 2006 to the Director of Youth Protection and Provincial Director, the Executive Director of the Nunavik Regional Board of Health and Social Services, and the director and chair of the board of directors of the Inuulitsivik Health Centre. The Minister of Health and Social Services also received a copy of the report. Some of the comments made on the report have been included in the factual overview sections, while others are summarized below.

10.1 Comments by the Director of Youth Protection

Ms. Marian Martin, interim Director of Youth Protection, made a number of general comments to the Commission concerning the analysis of children's files, and in particular noted that:

- the testimony from employees who had been recently hired or were acting as substitutes and that showed a lack of understanding of the *Youth Protection Act* did not reflect the situation of most staff members;
- several of the comments made in the testimony were in fact opinions;
- the new complaints received by the Commission in 2006 should not be covered by the same investigation; the addition of these files (bearing in particular on the simultaneous application of the *Youth Criminal Justice Act* and the *Youth Protection Act*) gives the impression that the Commission considers that the situation has not changed since 2003, which is not the case.

Despite these queries, the DYP recognizes most of the systemic problems identified by the Commission. In addition, she considers that several files clearly demonstrate poor youth protection practices prior to 2003. She admits that after receiving the factual report she reviewed the files investigated and, in several cases, took charge of the child's situation. In addition, she notes that correcting all the problems identified will require extra resources (money, human resources and material resources, especially computer equipment and housing).

The DYP drew up an exhaustive list of the elements that the Commission should take into account when making its recommendations to ensure that youth protection services in the North are brought into line with the services in other regions. We believe it is appropriate to present them here:

- reduce the workload of caseworkers, who deal on average with 41.4 files in the areas of youth protection, youth criminal justice, and front-line health and social services. It is important to note that, in some villages, there is only one case worker working half-time. A single case worker deals with the files for Akulivik and Ivujivik. His workload is 84 files, and he must travel by plane between the two villages;

- develop training programs for foster families;
- work in partnership and ensure that all intersectoral protocols are understood and applied, in particular with the police force and organizations working in Nunavik;
- obtain larger offices with more space for storing files, meeting clients and holding family meetings;
- obtain adequate computer equipment in each village in order to integrate the Youth Integration Project ("Projet d'intégration jeunesse") and train staff in its use;
- obtain support, funding and resources to draft policies and handbooks on procedure, and provide ongoing training;
- assess the viability of and funding for secure custody places and intensive supervision for young people;
- the lack of housing is a big problem for the Inuit population. According to the DYP, there would be a large drop in the number of child protection cases if there was enough housing to meet the needs of the community;
- obtain the new housing needed to hire new staff (for example, a person responsible for foster families; reviewers; a criminal justice consultant for young people; a family educator for each village; and the secretarial staff needed to ensure a minimum level of service). The DYP alleges that the agreement on new housing with the Government up to 2010 will not improve the situation but only maintain the *status quo*, which is already unacceptable;
- obtain adequate wages for youth protection staff, reflecting the difficulty of the job, the fact that all youth protection workers on the Hudson Bay coast have been subjected to assault and/or serious threats to their safety while working and even at home, and that all work alone in their respective villages during the daytime, evening and nights;
- without adequate wages, the recruitment and long-term retention of staff is very difficult. This is the only way, according to the DYP, for the Regional Board and the Government to demonstrate that social services for young people are a priority;
- the Itinerant Court does not offer enough days of hearings;
- according to the DYP, facilities are needed to treat drug and alcohol addiction;
- there are not enough police officers considering the problems encountered, and they are underpaid. Like youth protection workers, they are threatened on a daily basis. They are paid less than Native police officers on reserves elsewhere in Québec.

Finally, the DYP challenges the Commission's analysis in two situations, one concerning the simultaneous application of the *Youth Criminal Justice Act* and the *Youth Protection Act*, and the other a situation in which she claims she was right not to retain a signalement (the father and child lived in a room with a large extended family, which was unable to feed the child). She explains that this is the norm in many villages, especially Inukjuak where an average of eighteen people live in each five-room housing unit. Concerning the food situation, she claims that there is a community fridge in each village (for game meat) and that, where necessary, parents in need are referred to the Kativik Regional Government to apply for social assistance.

According to the DYP, the situation was seen through "southern" eyes, whereas reality in the North is different.

She says that she made corrections in around thirty situations brought to her attention between 2003 and the forwarding of the factual report. She also helped to correct other situations brought to her attention between 2003 and 2005.

In other comments, the DYP states that the number of signalements has been increasing constantly since 2001, from 355 signalements in 2001 to 625 in 2005-2006. The DYP received 340 signalements for the first six months of the year 2006-2007, most of them (over half) concerning situations of neglect. She specifies that the increased volume of activities has not led to any staffing increase.

Finally, despite the Regional Board's proposal that the work should be reorganized by specialty for each stage specified in the Act, she considers that there are not enough staff members to even consider this proposal, especially since there are no premises available to set up a centralized service to receive and process signalements.

10.2 Comments by the Regional Board

The Regional Board has not submitted any comments on the facts reported by the Commission. Instead, it stresses the fact that the reality described in the factual reports on both Ungava Bay and Hudson Bay has changed since the investigation.

The Board points out that since the filing of the factual report on Ungava Bay, two guides were assigned by the Ministry of Health Services and Social Services in the fall of 2005, with contracts until the fall of 2007. In addition, the Regional Board hired a consultant in 2006 to prepare a plan to reorganize youth protection services in Ungava Bay and Hudson Bay, in particular by dividing the work by stage (receipt and processing of signalements RPR evaluation- taking charge of a child's situation) with specialized staff for each stage.

The provincial training program for all workers in the field of youth protection was launched in 2004.

A program to improve parenting skills and support parents under the age of 20 has been established in Hudson Bay, along with an early detection program for children aged 0 to 5, set up by the CLSC. It will eventually be implemented in Ungava Bay too.

Workshops on parental capacities are offered to all parents in Nunavik on a voluntary basis.

Two pilot projects are currently under way that involve the school board, the police force, the CLSC, the youth centres and the municipalities, with activities focusing on bullying, self-esteem and personal wellbeing.

All front-line care workers took part in a workshop on inter-generational trauma in October 2006.

"Healing" workshops began in all communities in 2004. By February 2006, all communities had held their first workshop, and the tour of the second workshop is currently under way.

A working committee has been set up, bringing together mayors, health and social services representatives and the school board, with the objective of finding sustainable solutions that will allow young people to grow up safely in every municipality in Nunavik.

In the spring of 2007, twenty-seven housing units will be built (with financial assistance from the Ministry of Health Services and Social Services) for health and social services staff.

10.3 Comments by the Inuulitsivik Health Centre in Hudson Bay

Ms. Linda Bradshaw, director of nursing, has forwarded her comments. The Health Centre has only commented on the questions relating to the dispensing of front-line services and the difficulties in collaboration between social services and youth protection.

Long-term planning

The Health Centre denies that there is a lack of service planning and organization, since youth services are one of the priorities in the CLSC's strategic plan. The problem is rather a lack of financial and human resources.

Communication and collaboration between health services, the CLSC and the DYP

The Health Centre recognizes that there have been difficulties in collaboration and communication between the various services, but has taken corrective action:

- by increasing the frequency of the meetings bringing together the head of each service;

- by setting up a management committee in the nursing and community services departments;
- by organizing multi-disciplinary team meetings to establish integrated intervention plans for clients;
- following the Commission's investigation, there has been a considerable improvement in terms of understanding front-line services in the field of youth protection, which has improved the quality of the work performed, especially as regards suicide prevention among young people.

Specialized resources

The lack of specialized resources is known and acknowledged. New cooperative links with McGill University, the Montréal Children's Hospital and Douglas Hospital designed to offer specialized health services and team support should lighten the task of case workers in Nunavik.

Housing

The lack of housing is still a major obstacle to the hiring and retention of the required staff members. This situation undermines program continuity.

Language barrier

This problem raised by the Commission exists, especially in connection with the delivery of specialized social services such as psychological services.

Lack of prevention and support programs for families

The Health Centre has a team of community workers whose main task is to carry out prevention and support work with young parents. The program to support young parents was introduced in Hudson Bay in 2005; this is a multidisciplinary program involving the maternity department at the hospital, the school board and community organizations. The objective of the program is to teach parenting skills to young parents and to prevent incidents of violence and neglect involving young children.

It is admitted that other prevention programs are needed, especially concerning alcohol and drug abuse, and family and conjugal violence.

However, it is clearly stated that as long as Inuits continue to live 15 or 20 to a house without enough food to feed their families, they will never be able to resolve their difficulties however many prevention programs are implemented.

Influence of religion

Religion plays an important role among the Inuit, and community workers ask spiritual leaders to offer support to some of their clients when they consider it necessary.

It is accurate to say that notions of satanic possession exist in some communities, and their impact on some community workers cannot be ignored. However, the situation is known, mental health education has been and remains a priority for the CLSC, and training is provided on an ongoing basis.

Social problems

The social problems identified by the Commission are well known. It is confirmed that some community workers, having to face social problems in their own lives, are sometimes in an untenable situation when they have to intervene within their community and even within their own family.

Community health workers

Community health workers are hired using federal funding under the Health Canada program Brighter Futures (workers in the field of mental health and wellbeing). The Health Centre is currently recruiting wellbeing workers for the villages of Salluit, Purvinituq and Inukjuak, plus a team coordinator.

The Director of Nursing and Community Services and the DYP are evaluating the structure of the psychosocial services they provide to establish a bridge between front-line services and those provided by the DYP.

The Health Centre points out that the introduction of psycho-social services in schools would make a major contribution to improving youth services, and reiterates that the problem is basically a question of the availability of financial and human resources.

11. CONCLUSIONS OF THE INVESTIGATION

The gravity of the situation of children taken in charge by the Youth Protection service in both Ungava Bay and Hudson Bay, as reported in the complaints filed with the Commission, led to a major investigation focusing on the whole child and youth protection system in Nunavik. The complaints alleged serious deficiencies at several levels, involving several organizations and authorities working with young Inuits and their families.

The Commission sent three investigators on five separate trips to three villages in Nunavik: Kuujjuaq in Ungava Bay, and Puvirnituq and Salluit in Hudson Bay. During these visits, they gathered testimony from over a hundred people, including children, family members, employees and managers in the fields of social services, health care and education, elected municipal officials, police officers and judges.

Next, based on the children's files obtained on-site, the investigators analyzed around 650 cases brought to the attention of one of the two Directors of Youth Protection concerning 139 children and their families, and 21 files of children subject to the *Young Offenders Act*, which was in force at the time of the investigation.

In addition to the investigators mobilized for the investigation, the Commission asked its Research and Planning Department to conduct a major study of the historical, social, economic, cultural and political dimensions of Inuit society in Nunavik.

The facts gathered by the investigators formed the basis for two separate factual reports, which were forwarded to the two DYPs and to the establishments responsible for applying the *Youth Protection Act* and the *Youth Criminal Justice Act* to give them an opportunity to make comments.

Finally, given the similarities between the observations made concerning Ungava Bay and Hudson Bay, the Commission decided to address the situation in both Bays in a single final report. As a result, the recommendations made by the Commission apply to all the authorities in Nunavik.

A people facing deep crisis

The Commission was in a position to observe that the Inuit people is facing an identity crisis. It has suddenly lost the points of reference provided by its traditional lifestyle, and this loss has created a wide gap between the generations.

The crisis is reflected in the scope of the social problems that have emerged in recent decades in Nunavik: over-consumption of alcohol, drug addiction and suicide have become problems of alarming proportions in all age groups. Poverty adds to the difficulty of the situation, and children are often the first victims. Many children live in conditions that are quite simply unsuited to their need for protection and security. A large number of children are physically, psychologically and sexually mistreated. Some

children, despite their young age, are addicted to alcohol, drugs or other substances that cause serious physical or mental disorders. The school absence and dropout rate is extremely high, which raises questions concerning the future of these children. The situation is so bad that some children, unfortunately, resort to suicide as a way to end their suffering.

Distress among children in Nunavik

The general situation in Nunavik, as observed during the investigation, inevitably affects the whole of the youth protection system, whose mission is to respond to the needs of children and young people in difficulty. The organizations that make up the system have several deficiencies in terms of work organization that are caused, among other things, by the geography of Nunavik and its remote location. In addition, there are not enough staff members to ensure the adequate, ongoing and personalized delivery of services, which means that the organizations have to operate in continual crisis mode. The offices of the two Directors of Youth Protection are no exception. The challenges they face are enormous, with many obstacles to the everyday application of the laws under their responsibility, which are not always adapted to the realities of life in the Far North. Despite everything, they manage to intervene in crisis and emergency situations.

The lack of front-line social services, and of preventive or curative programs for children aged 0 to 18, is one of the major deficiencies that partly explains the current state of the youth protection system. The investigation also clearly demonstrated a lack of cooperation between the various organizations that affects the quality and effectiveness of the services they provide. There is also little cooperation with schools and health care establishments.

As a result of its investigation, the Commission declares that the rights of the Inuit children and young people of Nunavik, as recognized in the *Youth Protection Act* and the *Youth Criminal Justice Act*, have been infringed.

In addition, the Commission declares that the fundamental rights of the children and young people, as recognized in sections 1, 4 and 39 of Québec's *Charter of human rights and freedoms* [15], have been infringed, in particular the right to personal inviolability, to the safeguard of their dignity, and to the protection, security and attention that their parents or the persons acting in their stead are capable of providing.

15 R.S.Q., c. C-12.

Urgent need to act

The Commission is convinced that to offer a brighter future for the next generation and break the cycle of violence currently affecting children in Nunavik, the protective approach must be echoed in the community, which is in the best position to make decisions concerning the well-being of its children. There is an urgent need for the community to mobilize and make children one of its key priorities.

The ambitious project undertaken by the Inuits to establish an autonomous government in Nunavik and recover political and social control over their society, while restructuring their education and health services, must also involve taking the lead in the search for solutions to ensure the protection and security of their children.

The Commission considers that, to ensure the success of any new social blueprint in Nunavik, it is essential to make the best interests of its children a condition in all the actions undertaken by organizations that serve the population. This is especially important given the fact that almost half the population is under the age of 18.

As a result, the Commission believes that the children of Nunavik should be given a voice in the debate about the new social blueprint promoted by the authorities. In this way, they will be able to find the points of reference they need to develop while drawing strength from the traditions and values of the community.

12. RECOMMENDATIONS

12.1 Making children and families a key priority

CONSIDERING

- the extent and the gravity of the problems faced by children requiring protection;
- the urgent need to support families in distress that are unable to respond effectively to the needs of children with major problems;
- the need to identify immediate, sustainable solutions to serious problems that jeopardize children's future;
- the best interests of children, that must be a key priority in the choices made by Inuit society,

the Commission des droits de la personne et des droits de la jeunesse recommends:

RECOMMENDATION 1

THAT the Nunavik Regional Board of Health and Social Services make children and families a key priority and set up mechanisms for regional coordination and partnerships focusing, in particular, on:

— the protection and stability needed to allow children to develop;

— the prevention of situations of neglect, physical and sexual abuse, and behavioural difficulties, mental health problems and suicide prevention;

— the prevention and treatment of drug addiction;

— the improvement of parenting skills.

CONSIDERING

- the observations by the Commission that children's rights have been infringed;
- the mandate of Makivik Corporation, which includes, among others, fighting poverty, promoting welfare, progress and education of Inuits;
- the fact that most of the organizations providing health, social, and recreational and other services to children and their families do so without communicating with each other;
- the need to design solutions with local input,

the Commission des droits de la personne et des droits de la jeunesse recommends:

RECOMMENDATION 2

THAT Makivik Corporation oversee the creation of a coordination committee bringing together representatives of the Regional Board and of medical, educational, municipal, social and justice organizations, to ensure concerted interventions in the best interests of the children concerned, and to mobilize the general population around the objective of youth protection.

The Commission will require a copy of the action plan and work schedule of the committee, and of the measures implemented to assess its effect.

12.2 Application of the *Youth Protection Act*

CONSIDERING

- all the observations made by the Commission concerning youth protection services in Nunavik, namely:
  - the lack of knowledge of the provisions of the *Youth Protection Act*, and of the circumstances in which it must be enforced, among the people responsible for applying it;
  - major deficiencies at each stage in the application of the *Youth Protection Act* (processing of signalements and urgent measures, evaluation, orientation, taking charge of a child's situation and review);
  - an approach to protection based on temporary emergency measures applied in a context of ongoing crisis, with no long-term planning or intervention tools;
  - the lack of overall evaluations of children and their families;
  - differences in the application of the *Youth Protection Act*, depending on the care worker concerned;
  - the inability of the Directors of Youth Protection to act from a situation of authority;
  - the problems connected to the recruitment, training and support of foster families;
  - the inadequacy of the staff training, rehabilitation programs and building layout in rehabilitation centres, when compared to the problems of the young people placed there;
  - the lack of residential resources and the use of police stations as a substitute,

the Commission des droits de la personne et des droits de la jeunesse recommends:

RECOMMENDATION 3

THAT the Minister of Health Services and Social Services ensure that the children of Nunavik receive the protection services to which they are entitled.

RECOMMENDATION 4

THAT the Director of Youth Protection for Ungava Bay and the Director of Youth Protection for Hudson Bay specifically designate one or more experienced members of their staff to assist and advise case workers at each stage in the application of the Act to ensure that it is understood and applied in a uniform way.

For this purpose, the Commission recommends, among other strategies:

— that weekly case discussions be organized for all case workers;

— that all case workers use the appropriate tools, in particular the *Manuel de référence sur la protection de la jeunesse*.

RECOMMENDATION 5

THAT the Nunavik Regional Board of Health and Social Services, in cooperation with the Directors of Youth Protection for Ungava Bay and Hudson Bay, provide ongoing training for their staff members concerning the various stages of the Act, in particular regarding:

— the need for stability among children and attachment disorders;

— assessments of family environments and parenting skills;

— follow-up for children and families;

— the drafting of intervention and service plans;

— file-keeping.

CONSIDERING

- the inherent difficulties of the context in which the Directors of Youth Protection must exercise their responsibilities and intervene, from a position of authority, in the lives of families, in small communities;
- the need to encourage the participation of individuals and organizations working with young people, especially schools, health care establishments, CLSCs and the police force, and the role they play in implementing measures when the situation of a child is taken in charge;
- the effectiveness of the measures involved when the situation of a child is taken in charge, which depend on a concerted approach by all stakeholders and a focus on protecting the child,

the Commission des droits de la personne et des droits de la jeunesse recommends:

RECOMMENDATION 6

THAT the Nunavik Regional Board of Health and Social Services, in cooperation with the Directors of Youth Protection for Ungava Bay and Hudson Bay, create local committees of people working in the youth and family sector with the mandate of helping apply the protection measures decided by the DYP.

12.3 Front-line social services for children and their families

CONSIDERING

- the obligation of a CLSC to provide preventive and curative social services for children under the *Act Respecting Health Services and Social Services*;
- the lack of front-line social services dispensed by the Nunavik CLSC to children aged 0 to 18, as observed during the investigation;
- the large number of children in Nunavik facing difficulties for which they require such services;
- the essential nature of CLSC interventions with children;
- the lack of social services within the school system,

the Commission des droits de la personne et des droits de la jeunesse recommends:

RECOMMENDATION 7

THAT the Nunavik Regional Board of Health and Social Services:

— ensure that the CLSCs establish detection and prevention programs for the neglect of children aged 0 to 5;

— ensure that the CLSCs establish or maintain, as applicable, social services for children aged 0 to 18 and their families, as required by their mandate.

RECOMMENDATION 8

THAT the Kativik School Board, in cooperation with the Nunavik Regional Board of Health and Social Services and the Makivik Corporation, ensure that social services are introduced into the school system.

12.4 Specialized resources

CONSIDERING

- the large number of children subject to physical and sexual abuse;
- the large number of children facing mental health problems or addiction to drugs and alcohol, as early as 6 to 12 years of age;
- the lack of any specific program or treatment for the rehabilitation of these young people, as observed during the investigation;
- the urgent need to act to treat these problems and prevent their consequences,

the Commission des droits de la personne et des droits de la jeunesse recommends:

RECOMMENDATION 9

THAT the Nunavik Regional Board of Health and Social Services implement or maintain, as applicable, specialized treatment programs for drug and alcohol addiction, physical and sexual abuse and mental health.

12.5 Placement and repeated placement of children

CONSIDERING

- the repeated placements of children, which deprive them of the stable living conditions essential to their development, prevent them from forming bonds, and lead to emotional ruptures that may cause irreparable harm;
- the large number of children repeatedly placed with different families at the request of the biological or foster family, without any evaluation of their situation or of the impact of the decision on the children concerned;
- that one of the key objective of the reform of the *Youth Protection Act* is to prevent the repeated placement of children and ensure stable bonds and living conditions,

the Commission des droits de la personne et des droits de la jeunesse recommends:

RECOMMENDATION 10

THAT the Directors of Youth Protection in Ungava Bay and in Hudson Bay ensure that the family problems and specific difficulties of a child are evaluated before the child is placed, and that they seek a stable living environment and sustainable solutions for children to promote bonding.

12.6 Foster families

CONSIDERING

- the lack of any assessment procedure for foster families;
- the inadequacy of the services provided by some foster families,

the Commission des droits de la personne et des droits de la jeunesse recommends:

RECOMMENDATION 11

THAT the Directors of Youth Protection in Nunavik assess foster families and use the relevant tools to ensure that all the needs of the children concerned are met.

CONSIDERING

- the lack of training and support for foster families;
- the large number of foster families overwhelmed by the problems of the children placed with them;
- the lack of a specialized resource for children aged 6 to 12;
- the large number of children transferred without due consideration,

the Commission des droits de la personne et des droits de la jeunesse recommends:

RECOMMENDATION 12

THAT the Tulattavik Health Centre and the Inuulitsivik Health Centre, as part of their duties as child and youth protection centres, provide foster families with the tools and support they require to meet the needs of the children placed with them, in particular ongoing training and regular follow-up.

THAT the Tulattavik Health Centre and the Inuulitsivik Health Centre recruit foster families for children aged 6 to 12 with serious behavioural difficulties, and that these foster families be offered training and follow-up by specialized staff members, who could be recruited from current staff members at the Group Home or the Rehabilitation Centre.

12.7 Rehabilitation services

Since the investigation, the improvements made to the organization of the services provided by the Sapummivik Rehabilitation Centre and the Kuujjuaq Group Home, in Ungava Bay, have been brought to the attention of the Commission. These improvements appear to allow the delivery of services better suited to the needs of the young people concerned.

HOWEVER, CONSIDERING

- the use of a new seven-stage "restricted program" at the Sapummivik Rehabilitation Centre, that includes confinement measures that resemble unwarranted detention;
- section 24 of the Québec *Charter of human rights and freedoms*, that specifies that people may not be deprived of their liberty or their rights except on grounds provided by law and in accordance with prescribed procedure;
- the Commission's opinion that the use of measures that restrict freedoms, as mentioned during the investigation, contravenes the position it upholds,

the Commission des droits de la personne et des droits de la jeunesse recommends:

RECOMMENDATION 13

THAT the Tulattavik Health Centre and the Director of the CLSC for Ungava Bay together review the entire "restricted program" to ensure that the measures applied to young people at the Rehabilitation Centre are consistent with their rights.

CONSIDERING

- that the investigation revealed that, at the Puvirnituq Group Home, teenagers may remain in isolation for several hours, and even up to 24 hours;
- that section 118.1 of the *Act Respecting Health Services and Social Services* only authorizes the isolation of young people to prevent them inflicting harm upon themselves or others, and specifies that the use of such a measure must be minimal and resorted to only exceptionally, and must be appropriate having regard to the physical and mental state of the person concerned,

the Commission des droits de la personne et des droits de la jeunesse recommends::

RECOMMENDATION 14

THAT the Coordinator of the Puvirnituq Group Home use isolation only in the situations strictly authorized by law, in a manner that ensures respect for the dignity of the young person concerned, and that appropriate support be provided.

12.8 Application of the *Youth Criminal Justice Act*

CONSIDERING

- that the staff members of the Youth Protection system in Ungava Bay and Hudson Bay have not mastered the application of the *Youth Criminal Justice Act;*
- that the application of the *Youth Criminal Justice Act* to a young person does not exclude intervention under the *Youth Protection Act* for the same young person;
- that the offences, within the meaning of the *Youth Criminal Justice Act*, are committed by young people with behavioural difficulties that make them eligible for protection services under the *Youth Protection Act*;
- that any police officer who intervenes under the *Youth Criminal Justice Act* may make a signalement to the Directors of Youth Protection, who are then required to process the signalement as part of their duties,

the Commission des droits de la personne et des droits de la jeunesse recommends:

RECOMMENDATION 15

THAT the Nunavik Regional Board of Health and Social Services, in cooperation with the Directors of Youth Protection for Ungava Bay and Hudson Bay, provide training on the application of the *Youth Criminal Justice Act* for their staff, especially youth workers.

CONSIDERING

- that the time currently taken by the Provincial Directors in Nunavik to process files and decide whether to apply extrajudicial sanctions exceeds the time allowed, leading to unnecessary court cases;
- that the young people concerned are unable to benefit from extrajudicial sanctions,

the Commission des droits de la personne et des droits de la jeunesse recommends:

RECOMMENDATION 16

THAT the Nunavik Regional Board of Health and Social Services, in cooperation with the Directors of Youth Protection for Ungava Bay and Hudson Bay, take steps to ensure that young people subject to the *Youth Criminal Justice Act* benefit from the extrajudicial sanctions program under the Act, which could be harmonized with community values.

12.9 Employee assistance program

CONSIDERING

- the nature of the work carried out by staff members providing social services to children in Nunavik;
- the fact that some employees face social problems of their own, and that there is a problem with absenteeism at work;
- the impact of these problems on the quality and continuity of the services provided by the staff members,

the Commission des droits de la personne et des droits de la jeunesse recommends:

RECOMMENDATION 17

THAT the Tulattivik and Inuulitsivik Health Centres set up an employee assistance program.

12.10 Adoption

CONSIDERING

- that "traditional" adoption is widespread in Nunavik and plays an important role within families;
- that some of the testimony gathered during the investigation shows that some of the current practices should be re-examined;
- that this type of adoption is not governed by any legislation and is carried out solely at the discretion of the families concerned, without any intervention from the DYP;
- that the adoptive parents undergo no psycho-social assessment prior to the adoption;
- that in several of the situations examined, the children were repeatedly moved from their biological family to one or more adoptive families;
- that several children were placed with an adoptive family that was unable to ensure their security or development,

the Commission des droits de la personne et des droits de la jeunesse recommends:

RECOMMENDATION 18

THAT the Minister of Health and Social Services and the Minister of Justice ensure that any "traditional" adoption is assessed as a permanent lifetime decision and that a psycho-social assessment of the child and of the prospective adoptive parents is carried out prior to the adoption.

12.11 Housing

CONSIDERING

- that the investigation revealed a situation of overcrowding, and that the files of several children revealed that their security and development were in danger because their family was living with one or more other families exhibiting a range of problems;
- that overcrowding combined with violence, addiction and other forms of abuse has a direct effect on the security or development of children;
- that the lack of housing makes the recruitment of foster families and the effective organizations of social services more difficult,

the Commission des droits de la personne et des droits de la jeunesse recommends:

RECOMMENDATION 19

THAT the Minister for Native Affairs and the Makivik Corporation, in collaboration with the Federal government, propose immediate and adapted solutions to the housing problem, based on the right of children to receive protection.

RECOMMENDATION 20

THAT the Kativik Municipal Housing Bureau, in cooperation with the Directors of Youth Protection, take into consideration the greater interest of the children and their right to protection when assigning housing.

12.12 Administration of justice

CONSIDERING

- that applications to the courts under the *Youth Protection Act* in emergency situations require the children concerned to make long trips, sometimes lasting three days, while they are already experiencing trauma;
- that the trips generate major transportation and accommodation costs and unduly monopolize case worker time in a system where resources are scarce;
- that, for Hudson Bay alone, the number of protection files has doubled in recent years, without any increase in the number of court sessions;
- that restricted access to the court system prevents the DYP from taking cases to court within the time limits and on the conditions set out in the *Youth Protection Act*;
- that the current organization of the Itinerant Court leads to delays and postponements,

the Commission des droits de la personne et des droits de la jeunesse recommends:

RECOMMENDATION 21

THAT the Minister of Justice:

— take steps to limit trips by children, in particular by using videoconference technology;

— increase the number of days of hearing of the Itinerant Court;

— assess the possibility of assigning a resident judge to Nunavik.

13 FOR THE SAFETY AND DEVELOPMENT OF THE CHILDREN

13.1 A joint call to action

CONSIDERING

- the range of problems observed during the investigation with regard to the application of the *Youth Protection Act* in Nunavik, a society with unique historical, social and cultural dimensions;
- the comments made by the Commission des droits de la personne et des droits de la jeunesse in it's brief on Bill 125, in which it invites the legislator to pay particular attention to the situation of children in Native communities;
- the fact that section 37.5 of the *Youth Protection Act* provides for the adaptation of the Act to the realities of Native life, on certain conditions;
- the profound and sincere wish of the members of the community, including mothers, fathers and families, to ensure the well-being of all children in Nunavik;
- the distress of the children of Nunavik and the need to intervene to prevent any further deterioration in their situation;
- the urgent need to mobilize the community as a whole to ensure protection for its children,

the Commission des droits de la personne et des droits de la jeunesse asks the Makivik Corporation and all the authorities concerned to take the lead in bringing about the required conditions, based on the best interests of the children concerned and the realities of life in Nunavik.

13.2 Government coordination

CONSIDERING

- the responsibilities of the Premier of Québec as the minister responsible for youth;
- the *2006-2009 Youth Strategy,* which aims in particular to improve the health and wellbeing of young people, their educational success and their integration into the labour force, and to increase their influence within society and improve the support they receive;
- the gravity and extent of the problems faced by young people in Nunavik and the urgent need to prevent any further deterioration in those problems,

the Commission des droits de la personne et des droits de la jeunesse asks the Premier of Québec to take personal control of this issue and to coordinate the required actions by the Government; therefore offering to children of Nunavik hope for a better tomorrow.

13.3 The Commission's commitment

The Commission des droits de la personne et des droits de la jeunesse intends to follow up on all its recommendations and on the methods implemented to protect children, in one year's time.

March 2007