Edzanèk'e Gots'ǫ
Ek'èteht sodǫ
Łegehdì Kǫ

MEETING SD 23-20-24

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

TUESDAY, AUGUST 13, 2024
DET'ANCHOGH KǪ́É - EAGLE ROOM / ZOOM
9:30 AM

AGENDA

1. Call to Order
2. Prayer
3. Review and Adoption of Agenda
4. Declarations of Conflict of Interest
5. In Camera Matters:
    a. Review of Feedback on *Mental Health Act*
    b. Confidential Correspondence:
        i. 2024-06-12 – HIV Legal Network and Harm Reduction Nurses Association
        ii. 2024-07-02 – Hon. Minister of Health and Social Services
        iii. 2024-07-11 – Hon. Minister of Health and Social Services
        iv. 2024-07-12 – Hon. Minister of Education, Culture and Employment
        v. 2024-07-22 – Hon. Minister of Education, Culture and Employment
        vi. 2024-07-22 – Hon. Minister of Education, Culture and Employment
        vii. 2024-07-25 – Hon. Minister of Education, Culture and Employment
        viii. 2024-07-26 – Hon. Minister of Health and Social Services
        ix. 2024-07-31 – Hon. Minister of Health and Social Services
        x. 2024-07-31 – Hon. Minister of Health and Social Services
    c. Housing as a Human Right Project
        i. Project Tracker Update
        ii. Scheduled Briefings/Proposed Briefings
    d. Healthcare Sustainability and Accountability Project
        i. Project Tracker Update
        ii. Proposed Briefings
    e. Draft Motion
    f. Work Plan
6. New Business
    a.
7. Date and Time of Next Meeting: Friday, August 16, 2024 at 10:30 a.m.
8. Adjournment

Briefing Note: *Mental Health Act Statutory Review* **Summary of Public Comments**

Purpose

This briefing note summarizes public feedback to Standing Committee on Social Development review of Statutory Review of the *Mental Health Act.*

The summary is intended to help Committee finalize proposed recommendations.

Committee can use this briefing to provide direction for the content of the final report.

Committee's task

Committee's task is to systematically review public comments as they are summarized in this briefing (starting on p.3). Staff will be seeking direction on whether and how to incorporate each piece of public feedback into the final report.

Options for direction include:

Make recommendation	**Reflect in text of report only**	**Combine with another comment**
Reject	**Do more research**	**Decide later**

It should be noted that because this is a review of an existing Act rather than a Bill, Committee cannot directly pursue amendments. If Committee wishes to see a clause amended, the course of action Committee can take is to make a recommendation that the Government come forward with an Act to Amend the Mental Health Act with that change reflected. Alternatively, a Member of the Committee could bring forward a private Member's bill with the change reflected.

Summary of public hearings

Date	Place	Participants	Verbal submissions
May 8, 2024	Yellowknife – Somba K'e (Mental Health Act Review Board)	2	1
June 12, 2024	Yellowknife – Somba K'e (Technical briefing from HSS)	4	1
Total			

Summary of written submissions

- Association of Psychologists of the Northwest Territories
- Royal Mounted Canadian Police – G Division
- Canadian Psychiatric Association
- Raymond Pidzamecky – Registered Social Worker
- Department of Health and Social Services - Materials to support the Legislative Assembly review of the NWT's *Mental Health Act*

Summary of themes

Staff categorized public comments into 13 themes and 63 sub-themes. The main themes are:

1	Issues with timing
2	Cultural support
3	Clarification on terms and definitions
4	Responsible custody, transfer, and detainment of patients
5	Oversight of *Mental Health Act*
6	Police resources, powers, and duties
7	Voluntary and involuntary admissions
8	Patient rights
9	Emergency treatment
10	Community Treatment Plans
11	Staffing capacity, resources, and programs available
12	Assessment, admission, renewals and discharging
13	Streamlining forms

Summary of public comments

Theme		Sub-theme	Comment	Where	Committee direction
Issues with timing	**1**	**7-day notice requirement before a hearing is very stringent, flexibility is required**	This issue presented to Committee by the MHARB is in reference to Section 70(1). Currently, the 7-day notice requirement (waiting 7 days before a hearing) to hold a hearing is very stringent, and flexibility is required. While the patient is detained (i.e. involuntary admission), time is of the essence. For most applications, a patient wishes to be heard as soon as possible. In most cases, the Board could hold a hearing sooner than 7 days from the issuance of a Notice of Hearing. MHARB: An amendment was proposed to Section 70(1) to remove the wording "give seven days" and replace it with "on consent of all parties, provide" written notice… This would give the Board flexibility to hold a hearing more quickly upon consenting within the parties. This would allow for the process to proceed at a quicker pace and make every effort to address the needs of the patient. It was also recommended by the MHARB to add a provision to deal with cases where no consent can be obtained, allowing the panel to set a hearing date and give written notice as set in the regulations. It is also recommended that in the regulations, there be a minimum wait time-period set. It is the MHARB's opinion that consent would work the majority of the time. The minimum wait time-period set in the regulations would be the exception. The Department also suggest that amendments to the legislative framework could be considered and that the issue can be addressed by amending Section 70(1)(b) to remove the seven days notice requirement and instead defer the requirement to the *Mental Health Act Review Board Regulations* (i.e. "give written notice of the date,	Presentation by the Mental Health Act Review Board (MHARB) Written Submission by the Department of Health and Social Services Technical Briefing from the Department of Health and Social Services	

Theme	Sub-theme	Comment	Where	Committee direction
		time, place and purpose of the hearing to the parties within the prescribed time period"). A shorter time period could then be set out in the regulations, with an added ability to shorten the notice period with the consent of all parties.		
	2 24 hours before a Certificate of Involuntary Assessment can be issued	This comment is in reference to Section 10(2)(2) and relates to potential timing gaps. The Section says: "A certificate of involuntary assessment of a person may not be issued under subsection (1) later than 24 hours after the examination to which it relates." RCMP: The problem for the police is if no involuntary assessment is ordered within 24 hours. The 24-hour requirement could be an issue in busier communities/nursing stations with minimal or stretched resources. CPA: Twenty-four hours seems to be excessively short: in many jurisdictions it is one week. A health professional may conduct an assessment, conclude that a person *may* meet the criteria and want more information before completing a certificate. Attempts to contact a person to obtain collateral information can easily take a few days.	Written Submission by the RCMP Written Submission by the Canadian Psychiatric Association (CPA)	
	3 *Renewal Certificate* and *Certificate of Involuntary Admission*	It is suggested that amendments to the legislative framework could be considered. Form 4 – *Renewal Certificate* can only be issued within 72 hours of the *Certificate of Involuntary Admission* or previous Renewal Certificate expiring. In other jurisdictions these can be done within 7 days of the form expiring. It is suggested that a review of similar provisions in other jurisdictions should be completed to determine the appropriate length of time before certificate expiry for issuing a renewal. This review should include an operational lens and data respecting length of admissions to inform the appropriate timelines for renewing involuntary admissions.	Written Submission by the Department of Health and Social Services Technical Briefing from the Department of Health and Social Services	

Theme		Sub-theme	Comment	Where	Committee direction
	4	**Evaluating reasons behind why hearings are being cancelled (post-cancellation file review)**	As describe by the presenters, there are many cancellations which may be due to the patients not wanting to wait out their timeframe of 7 days before a hearing. Out of approximately 70 applications that they received in the past 5.5 years, it is safe say that they have only heard from 15 and the rest have been cancelled. The Board does not know why the hearings are being cancelled. An issue presented to Committee by the MHARB is that currently, the Board has no authority to review a certificate after its cancellation. They also noted that three out of four certificates for involuntary admission are cancelled within 48 hours of the hearing date. An amendment was proposed to create authority for the MHARB to obtain a copy of medical records up to the scheduled and subsequently cancelled date of a hearing due to a certificate being cancelled. This would be to determine the purpose of the cancellation. An amendment was also proposed to create the ability for the MHARB to obtain information on re-admissions of an applicant for mental health treatment within 60 days of a cancelled hearing. The reason for these changes, especially the amendment relates to the post cancellation file review is for statistical and research purposes – for the MHARB to identify applicant trends and outcomes. The data would be used for the MHARB to report on an annual basis. Privacy of applicants would be maintained by removing any identifiable information and by aggregating data.	Presentation by the Mental Health Act Review Board (MHARB)	
	5	**Applications to the MHARB to cancel certificates**	It is suggested that amendments to the legislative framework could be considered (Section 66(1)(a) and Section 74(1)(a) and (b)). Applications can be made to the Review Board to cancel any certificate issued. This means that patients admitted under *Form 3 – Certificate of Involuntary Admission* could	Written Submission by the Department of Health and Social Services	

Theme	Sub-theme	Comment	Where	Committee direction
		potentially be required to apply to the Review Board twice within the span of only a few days if they had applied for their initial *Form 2 – Certificate of Involuntary Assessment* to be cancelled, because a review of this certificate would not result in an automatic review of their *Form 3 – Certificate of Involuntary Admission*. There have been several instances when a patient on a *Form 2 – Certificate of Involuntary Assessment* has applied to the MHARB; however, a hearing cannot be arranged due to the legislated timelines for the review as well as the short duration of the certificate. It is suggested that the ability to apply to the MHARB for a review of a Certificate of Involuntary Assessment be removed as it cannot be reasonably provided. It is noted by the Department that most jurisdictions do not allow for an application to the MHARB until a person has been involuntarily admitted under the equivalent of the NWT's Certificate of Involuntary Assessment. Multiple options to address this issue have been explored by the Department in consultation with legal counsel, but it has been determined that an amendment to the Act is required to remove the ability to apply for a review of a Certificate of Involuntary Assessment and review the timelines associated with review panel hearings. In the interim, health professionals have been asked to ensure they are clearly communicating to the individuals subject to a Certificate of Involuntary Assessment that, if they apply to the MHARB for a review of their Certificate of Involuntary Assessment, they would need to submit an additional application if they would like a review to cancel their Certificate of Involuntary Admission if they are ultimately involuntarily admitted.	Technical Briefing from the Department of Health and Social Services	
	6 **Timelines for screening applications to the MHARB are too short**	Timelines for screening applications to the MHARB are too short, especially if a weekend or holiday intervenes. This refers to Section 67(2) of the Act.	Written Submission by the Department of Health and Social Services	

Theme	Sub-theme	Comment	Where	Committee direction
		It is suggested that amendments to the legislative framework or operational changes could be considered and that further engagement with the MHARB is required to determine what, if any, changes are required to address this concern. The Act currently requires that the chairperson of the MHARB review an application within two days and either refer it to a review panel or dismiss it. However, the *Interpretation Act* provides for further requirements when interpreting time in legislation, specifying that where a time for doing anything in an Act falls on a holiday (Section 22(10)) or during office closure (Section 22(11)), the time limit is extended to include the next day that the office is open. Staff have interpreted this suggestion as the following: • Is the Department wanting the Interpretation Act to apply? OR do are they looking for a different timeline and are recommending supplanting the current provision with a new timeframe? Changes to the provision may require collaboration with the MHARB to determine a more appropriate timeline.		
7	**Timelines for the review panel to issue an order requires review**	Department suggests that changes to the legislative framework could be considered. Staff interpret this as a change to the regulations because there are no parallel requirements existing within the Act. Committee should note that the Department has the authority to change regulations. The regulations currently require that a review panel make a decision and issue a written order no later than 48 hours after the completion of a hearing. It is suggested by the Department that this regulation requirement could be reviewed with the MHARB to determine the most appropriate timeline. Consideration could be given to specifying the timeline in days, instead of hours, to allow the flexibilities afforded by the *Interpretation*	Written Submission by the Department of Health and Social Services	

Theme		Sub-theme	Comment	Where	Committee direction
			Act with respect to holidays and office closures to apply.		
	8	**Hearings need to be shorter**	Some feedback the Department received is: "Hearings need to be shorter. These are the longest hearings I have ever attended. This has an impact on psychiatrist time by also for patients and families have viewed it as burdensome as well." It is suggested that this is an operational challenge that does not require amendments to the legislative framework. Committee should not that the duration of hearings is not set out in the legislation. It is suggested that this issue can be addressed by working with the MHARB to find ways to streamline the hearing process.	Written Submission by the Department of Health and Social Services	
Cultural support	9	**Clarify role of cultural advisor**	Under Section 71(5), on request by a patient, by his or her substitute decision maker or the patient's medical practitioner, the Board shall engage an Elder or cultural advisor to a review panel. It was noted during the presentation by the MHARB that cultural advisors can make an important contribution to the patient centered approach and help the Board conduct its business in a culturally sensitive way. Currently, the role of the cultural advisor is not clearly delineated and the procedure for their standing in a hearing is not set out. Currently, the cultural advisor only "comes in" at the hearing, not at the beginning of the process. It was suggested in the MHARB presentation to modify the current wording "during the hearing" in the Act to make it more open so the panel has more flexibility. Suggested replacement wording could be "throughout all stages of the process" or "at a time deemed appropriate for patient needs". The Department also suggests clarity is required regarding the role of the Elder/cultural advisor. They suggest that the "vagueness" of the role can be addressed by expanding on Section 68(1) in the Act to clarify that the Elder/cultural advisor is to be engaged to the extent for any purpose(s)	Presentation by the Mental Health Act Review Board (MHARB) Written Submission by the Department of Health and Social Services Technical Briefing from the Department of Health and Social Services	

Theme		Sub-theme	Comment	Where	Committee direction
			requested by the patient.		
	10	**Information being provided to cultural advisor**	It is suggested that information being disclosed to the Elder/cultural advisor may be too wide; the test for disclosure means they basically get every relevant or relied upon record, which could be interpreted to be the whole chart. This disclosure may be detrimental to the patient. It is suggested that amendments to the legislative framework and operational changes could be considered. The Act currently requires that personal health information be collected, used, and disclosed in accordance with the *Health Information Act*. It is not clear where the disclosure of information fits with the cultural advisor role in the Act. Right now, the Act allows those with authorization to disclose information, to withhold information if it has been recorded in the patient's chart that disclosing that information would result in risk or harm to a person. MHARB: Suggested that a provision be added to clarify that a panel may disclose information to the extent the panel deems necessary for cultural advisors to perform their role. It is suggested by the Department that this issue can be addressed by: • Add a specific disclosure provision to the Act outlining what information may be disclosed to the Elder/cultural advisor, and that consent of the patient or substitute decision maker be required prior to disclosing information • Educating staff and MHARB members on disclosure of information provisions in the Act and processes for withholding information authorized to be disclosed	Presentation by the Mental Health Act Review Board (MHARB) Written Submission by the Department of Health and Social Services Technical Briefing by the Department of Health and Social Services	
Clarification of terms and definitions	11	**Reviewing terminology for consistency with operational language**	It was commented that some of the terminology can be quite confusing. For example, you have Involuntary Assessment and also Involuntary Admissions – Of which if somebody is under Involuntary Assessment – Operationally, they are admitted to the hospital but under	Technical Briefing from the Department of Health and Social Services	

Theme		Sub-theme	Comment	Where	Committee direction
			the Act, they are not really admitted as a patient. This tends to be very confusing. It is suggested that clarity and simplification on the definition in the Act to promote appropriate operationalization is needed.		
	12	**Definition of authorized persons**	Section 10(5) describes the authorized conveyance of the involuntary patient by a peace officer or "other authorized persons" to the receiving designated facility, or other health facility and detention and control of the patient for the purpose of conveyance. The comment from the RCMP is that there is no definition of "other authorized persons". The RCMP also mention that there is no clarification as to "authorized person" in Section 90(d).	Written Submission by the RCMP	
	13	**Definition and identification of "Designated Facilities"**	The RCMP noted in their submission that "designated facilities" should be identified within the Act. Committee should note that a list of designated facilities is listed in the Designation of Facilities Regulations and may be easier to change in Regulations versus the Act itself. The Department identifies that there are concerns regarding "Code Gridlock status", meaning bed allocation is over capacity which impacts ability to provide critical care services at Stanton. This is a barrier to transferring clients from a designated facility to receive acute psychiatric treatment at Stanton which has the only inpatient psychiatric unit in the NWT. In these cases, the physician and nursing staff have been given support through virtual psychiatric consultation. It was suggested to the Department that this is not an acceptable standard of care for inpatient psychiatric treatment. Section 23(4)(b) of the Act also includes a provision that "deems" a health facility to be a designated facility under the Act if an involuntary patient is transferred to that facility while their certificate of involuntary admission or renewal certificate is in effect. This means that a facility does not have to be "designated" in order for an involuntary patient to be	Written Submission by the RCMP Written Submission by the Department of Health and Social Services Technical Briefing from the Department of Health and Social Services	

Theme		Sub-theme	Comment	Where	Committee direction
			admitted there. Recommendation from Department: Review the suitability of Inuvik Regional Hospital and Hay River Health Centre as designated facilities under the Act and revoke their designations if necessary, particularly taking into account their fluctuating environmental and staffing capacity to keep up with best practices and standard of care. Admissions could still occur at these facilities in cases where it's appropriate, by relying on the "deemed designated facility" provision in the Act (Section 23(4)(b)). Recommendation to evaluate the consideration of different classes of designated facilities based on levels of service provision available and standards of inpatient psychiatric treatment/care as well as levels of responsibility (PEI's Mental Health Act regulations are a good example).		
	14	**Definition of "mental disorder"**	It is recommended that the definition of "mental disorder" in Section 1 of the Act be reviewed and compared against Alberta's new definition. Alberta changed their definition of "mental disorder" in March 2021 and added further clarifying language in regulations. It is suggested that these changes could be reviewed alongside other jurisdictions' definitions where recent updates have been made, to determine if updates should be made to the NWT's framework.	Written Submission by the Department of Health and Social Services Technical Briefing from Department of Health and Social Services	
	15	**Clarifying the meaning of "accept"**	This comment is in reference to Section 90(d). The RCMP note that there is no clarification as to what the meaning of "accept" is. It is the position of the RCMP that accept means that the patient has been conveyed to a designated facility and that it is up to the facility to safeguard the patient as a duty of care. However, RCMP personnel are often required to remain as the patient is not deemed to be "accepted" until they have been fully assessed. The RCMP reiterate that this is a medical situation, and the involvement of the police should end with the conveyance to a designated facility.	Written Submission by the RCMP	

Theme		Sub-theme	Comment	Where	Committee direction
	16	**Definition of health professional and medical practitioner**	In relation to sub-theme #50 and #55, amendments to the legislative framework and operational changes could be considered. There are challenges for health and social services professionals who are not authorized to complete forms under the Act in reporting mental health crises to the RCMP. Despite summary of concerns meeting criteria of involuntary assessment under the Act, RCMP assessment overrides the professionals' concerns. It is suggested that this issue can be addressed by reviewing the list in the definition for "health professional" in the Act to determine if the list can be further expanded, whether that be in the Act or in the regulations. Suggested that this would require reviewing the scope of practice of various health and social services professions to determine if it is within their scope to issue a *Certificate of Involuntary Assessment.* And reviewing whether and how other health and social services professions are able to do this in other jurisdictions, and engaging with any professions that are being considered for potential addition to the definition. It is suggested to review the current Standard Operating Procedures and scope/utilization of the Community Mental Health Nurse and/or other Registered Nurse roles in respect to implementation of the MHA. It was also noted by the Association of Psychologists of the NWT that there was some confusion over the terms "Health Professionals" and "Medical Practitioner" which it may help to clarify.	Written Submission by the Department of Health and Social Services Written Submission by the Association of Psychologists of the NWT Technical Briefing from the Department of Health and Social Services Presentation by the Mental Health Act Review Board (MHARB)	
Responsible custody, transfer and detainment of patients	**17**	**Facility-to-facility transfer**	Section 23(1) describes that the director of a designated facility, may, in writing authorize the transfer of an involuntary patient to another designated facility or to another health facility. The comment from the RCMP is that it does specify in this section who is responsible for this transport. Related to Section 23-25: The Department notes that this	Written Submission by the RCMP Written Submission by the Department of Health and Social Services	

Theme		Sub-theme	Comment	Where	Committee direction
			is an operational challenge and does not require amendments to the legislative framework: The transportation of people under the Act from Inuvik Regional Hospital (a designated facility) to Stanton Territorial Hospital (a designated facility) and/or a facility in Edmonton is reasonably common and unreasonably complex. A dedicated flow diagram for this kind of transport is recommended. It is also mentioned to ensure that flow charts are updated with operational considerations in mind when legislation/regulations are amended and that there is additional education on the Act.		
	18	**Transfer out of the NWT**	Section 24(1) describes transfers of involuntary patients out of the NWT, which defaults to the police or other authorized persons. The comment from the RCMP was that because "authorized persons" are not identified in the Act, it defaults to the police. They noted: Section 94 refers to authorized persons, but this too fails to identify who "authorized persons" would be.	Written Submission by the RCMP	
	19	**Person to take over custody**	Section 10(3)(a) describes the apprehension of the person by a peace officer and conveyance of the person by a peace officer or other authorized person to a designated facility. RCMP have noted that the Act does not state who the person should be delivered to. The RCMP have also noted that could be a provision where they turn over to a person to take over custody. They noted that other provinces have Institution Safety Officer who take over custody. It is suggested that amendments to the legislative framework could be considered. This is in reference to Section 7(3), 10(3), 11(7), 90(1)(d): The Department notes that it is unclear whether or not a peace officer remains with an involuntary patient who has been apprehended/transferred. Duties of the peace officer outlined in the Act, Regulations and Forms include apprehension, conveyance, detainment and control. No	Written Submission by the RCMP Written Submission by the Department of Health and Social Services	

Theme	Sub-theme	Comment	Where	Committee direction
		one is specified as responsible for "care" of the patient being conveyed until they have arrived at a designated facility. The Act and regulations clearly require that persons being conveyed under the Act be "supervised" by a peace officer at all times until the facility or another person (peace officer or medevac) has accepted custody of the person. An Order for Involuntary Examination and a Form 2 – *Certificate of Involuntary Assessment* only authorize "**care**… observation, examination, assessment and treatment of the person" once the person has been conveyed to the health facility or designated facility. However, in Section 8 of the *Apprehension, Conveyance and Transfer Regulations* is unclear as to who is responsible for notifying the receiving designated facility about the delay in conveyance and for providing the person being detained with an opportunity to contact family, a health professional, or other person, as no one is specifically named responsible for the "care and control" of the person as reference in the provision. Use of term "care" in this provision is misleading, as it implies the provision of health care services. In this instance, it is intended to mean providing general care to ensure the safety and well-being of the person during and pending conveyance, for which is the sole responsibility of the peace officer (e.g. food and water, a place to sleep, access to emergency medical treatment if needed, etc.) It is suggested that this issue can be addressed by amending Section 8 of the *Apprehension, Conveyance and Transfer Regulations* to clarify that the peace officer responsible for supervising the person pending or during conveyance is the one responsible for fulfilling the requirements of that section as the person responsible for conveying the person and supervising the person while they are temporarily detained pending conveyance. Any amendments being considered should be informed by engagement with the RCMP to ensure an operational lens		

Theme	Sub-theme	Comment	Where	Committee direction
		respecting apprehension, conveyance, and transfers is included. **Note from LawClerk:** The Act already specifies this and amending the regulations to specify that peace officers are responsible would align with the wording of the Act. Under Section 90(10)(b.1) of the Act, Peace Officers shall, in the event of any delay in conveying the person to a designated facility, provide the person with the opportunity to contact a family member, health professional or other person; **Note from LawClerk:** There is no definition of care in the Act and therefore the word will be interpreted with its common meaning within the context of the Act/regulations. It is implied that by 'supervising' the patient the peace officer has a level of responsibility to the patient; however, including the word 'care' could imply peace officers having a higher standard of responsibility in dealing with the patient. For example, a common definition of supervise is to keep watch over someone in the interest in their or others' security. In contrast, the definition of care has an active component that is not there in the definition of supervise.		
	20 Short term leave	This is in reference to Section 35(1): Short Term Leave. It was noted by the RCMP that there are no clearly defined roles/responsibilities for who essentially enforces lack of compliance if there is an Absent WithOut Leave (AWOL). They note that Section 47(2)(a) and 52(1) discuss this topic and place the responsibility for compliance with the police, whereas other mechanisms, such as health professionals should be the first consideration. They note that decisions to release patients rest with health professionals yet the consequences default to the police. **Note from LawClerk:** The certificate authorizes enforcement by a peace officer, this does not necessarily require it. If there are other methods of enforcement	Written Submission by the RCMP Written Submission by the Department of Health and Social Services Technical Briefing from the Department of Health and Social Services	

Theme	Sub-theme	Comment	Where	Committee direction
		available those could be considered but are not currently explicitly authorized in the certificate as it is described under the Act. There could be practical considerations in this enforcement such as the resources available to health professionals to safely ensure compliance, this is a policy decision to be discussed with health professionals. Sections 35-37: The Department also describes the issue that the current short term leave process is administratively burdensome, often requiring multiple passes to allow involuntary patients to leave the facility for short periods of time for walks, smoke breaks, etc. The current short term leave provision were designed to allow leave from the facility for up to 30 days, but do not account for shorter leaves of absence that most, if not all, patients should have for daily fresh air breaks, errands, to attend appointments, etc. It is suggested that this issue can be addressed by reviewing the current short term leave provisions and similar leave of absence provisions in other jurisdictions to reduce the administrative burden involved in allowing a patient to leave the facility regularly for short periods of time. It is suggested that amendments to the legislative framework could be considered.		
	21 Temporary detention of the person	This note from the RCMP is in reference to Section 52(1.2). They note that this section was written without consultation of the police. The default in these circumstances is the incarceration of patients in jail cells, even though they have committed no crime (in most cases), and this is strictly a medical situation. RCMP direction is to not incarcerate these patients, except in exceptional circumstances. Is it the position of the RCMP that this section should be either repealed, or reworded to emphasize that this should only occur if there are criminal circumstances associated	Written Submission by the RCMP	

Theme		Sub-theme	Comment	Where	Committee direction
			to a particular situation. There are medical alternatives to control unruly/intoxicated patients to await transport.		
	22	**Designated Facilities**	The Department of HSS highlights capacity issues of some designated facilities. They suggest issues can be addressed by: • Providing education to staff regarding the need to keep the Department apprised of anticipated changes in the capacity of designated facilities to assess and/or admit patients under the Act, so that the Designation of Facilities Regulations can be amended to revoke designations (temporarily or permanently) when warranted • Clarifying/standardizing appropriate psychiatric "treatment" in designated facilities and where transfers should be pursued • Review data about how many people are involuntarily admitted at Inuvik Regional Hospital and Hay River Health Centre	Written Submission by the Department of Health and Social Services	
	23	**Pediatric Unit at Stanton**	There are rooms in the Pediatric Unit at Stanton where all objects that can do harm can be removed, but those rooms do not lock. Therefore, pediatric patients being involuntarily detained under the Act can run away if the rest of the unit is busy and the nursing ratio is 2 nurses to 8-10 patients, compromising safety of the Pediatric psychiatric population. Section 2.1.(2)(c) and Section 7(2) – The Act does not require locked doors; however, the Act does provide authority for individuals being held under the Act to be detained, following the principle of using the least restrictive measures possible and taking into consideration the safety of the person and other persons. The Department suggests this can be addressed by ensuring staff education is provided regarding the following: • Review of Physician assessment and NTHSSA policy/SOPs that determine the most appropriate treatment environment and staffing levels.	Written Submission by the Department of Health and Social Services	

Theme		Sub-theme	Comment	Where	Committee direction
			Ongoing risk assessment is balanced with least restrictive and recover-oriented principles of care • Internal processes in place for staff and patients/families to appropriately address and report safety concerns		
	24	**Lack of safe and appropriate space to hold clients**	There is a lack of safe and appropriate space to hold clients during waiting periods for conveyance to a designated facility (from rural/remote communities). Committee should note that it is suggested that this is an operational challenge that does not require amendments to the legislative framework. To account for travel delays that occur when conveying a person detained under the Act from one community to another, Section 7 of the *Apprehension, Conveyance and Transfer Regulations* allows for persons to be temporarily detained at a health facility, RCMP detachment, or other location. Any location where the person is temporarily detained must be able to ensure the safety and well-being of the person. It is suggested that the challenges with temporary detention under the Act are related to human and physical resource allocation. Committee should note that these are currently being reviewed by the NTHSSA.	Written Submission by the Department of Health and Social Services	
Oversight of *Mental Health Act*	**25**	**Lack of clear oversight role**	The Department of Health and Social Services believe that the recommendation presented by the MHARB – that is plays a broader role in oversight of the *Mental Health Act* - warrants further review. This is related to *Mental Health General Regulations* Section 14. Currently, the Director of Mental Health receives copies of forms related to involuntary admissions/renewals/cancellations to keep a registry of involuntary patients. The intent of receiving forms for the purpose of an involuntary patient registry is unclear, and it is not always known if they are receiving all of the forms. There are concerns that Department staff are being made aware of sensitive personal health information when they	Written Submission by the Department of Health and Social Services Presentation by the Mental Health Act Review Board (MHARB) Technical Briefing from the	

Theme	Sub-theme	Comment	Where	Committee direction
		shouldn't be. A suggestion from the Department is that a larger oversight role could allow for more comprehensive reporting to identify trends and outcomes, identify gaps in the system, and inform future service delivery improvements. It was recommended that a cost analysis of expanding the oversight role in the Act would have to be completed before any amendments could be proposed. Note from LawClerk: The Director of Mental Health and the Director of Designated Facilities are not the same. The Director of Mental Health is appointed under Section 14(1) of the *Mental Health General Regulations.* There is no reference to the Director of Mental Health in the Act, although there are references to the 'Minister's designate' (section 56) and the Minister is authorized to make regulations in respect of this designate. Section 2 of the Act which deals with the administration of the Act does not specify a specific authority who is responsible for its oversight.	Department of Health and Social Services	
	26 Burdensome on senior administration	"I have never encountered a MHA as convoluted and unnecessarily burdensome on senior administration. The number of forms and considerations is complex to a degree that essentially guarantees it won't be workable. If us staff physicians of 5+ years still can't figure it out, the 80% of our workforce make up of locums certainly won't. The additional mental effort and time consumed trying to figure this all out is a substantial risk in the ER, where time = patient care, and unnecessarily consumed time = patient care delays = risk. Finally, if don't do things by the book, it poses medicolegal risk. In trying to be 'perfect', this Act has in fact created new risk." It is suggested that amendments to the legislative framework and operational changes could be considered. It is noted by the Department that involuntarily detaining a person under the Act infringes on a person's Charter rights in order to protect the Charter rights of others. Therefore, it is critical that any infringement of these rights	Written Submission by the Department of Health and Social Services	

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			be done so only in very prescriptive circumstances and that it be very well documented should the person with to challenge the infringement on their rights through the Courts. The Mental Health Act must balance respecting individuals' Charter rights to the greatest extent possible with the administrative and operational consideration that come with infringing upon them. This will inevitably mean extensive procedures, processed, and paperwork. It is suggested that this issue can be addressed by: • Reviewing the current forms to (directly related to sub-theme #59) • Reviewing the role of Stanton's Clinical Mental Health Coordinator and supports being provided to clinicians to determine what additional supports and/or training needs to be provided • Reviewing the duties of the Director of Designated Facility in the Act and regulations (see more details in sub-theme #27)		
	27	**Role of the Director of the Designated Facility (COO)**	It is noted by the Department that there is overall concern about the role of the Director of the Designated Facility (COO) and what roles can and cannot be delegated or shared. The rigid processes and roles may cause delays in the review of forms and is administratively burdensome. It is suggested by the Department that amendments to the legislative framework and operational changes could be considered. The Director of a Designated Facility is the person in charge of the administration and management of the facility and is typically considered to be the Chief Operating Officer (COO). Therefore, it is their responsibility to ensure that the services being provided under the Act are following legislation. The Act sets out duties for the directors of designated facilities throughout. Many of these duties are considered "shared" and can be performed by health professionals and/or medical practitioners, but the ability is provided for the director to perform these duties in the event that a health	Written Submission by the Department of Health and Social Services Technical Briefing from the Department of Health and Social Services	

Theme	Sub-theme	Comment	Where	Committee direction
		professional or medical practitioner is unable to do so. It is suggested that clarifying/streamlining the role of the Director of the Designated Facility can be addressed by: • Reviewing current processes to determine if current delegation processes can be streamlined and to determine if additional delegation can be made where they currently are not, seeking legal advice where required • Review the duties of the Director of Designated Facility in the Act and regulations and responsibilities that can be specifically delegated to determine if amendments can be made to the Act or regulations to reduce the administrative burden on this role while ensuring overall responsibility for compliance can be maintained. This could include a process for automatic transfer of Director responsibilities to an alternate position in cases of emergency, vacancy, etc. Consideration could also be given to being silent on the ability to delegate and relying on the power to delegate under Section 19(3) of the *Interpretation Act*, and instead being clear on what duties cannot be delegated (if any). It is suggested that this review should include an operational lens. **Note from LawClerk:** The Act itself does not deal with delegation of Director responsibilities, it is just contemplated as something to be dealt with in the regulations.		
	28 Statistics and data	The MHARB has requested from the Department statistics about how many people become involuntary under the At or other relevant statistics or information to help determine if the number of applications they receive seems reasonable. It is suggested that this is an operation challenge that does not require amendments to the legislative framework (related to Section 19 of the *MHARB Regulations*).	Written Submission by the Department of Health and Social Services	

Theme		Sub-theme	Comment	Where	Committee direction
			The Department has noted the need to substantiate data regarding application to the MHARB with information regarding number of admissions. It is suggested that this can be addressed by establishing processes to share admission statistics with the MHARB to inform their yearly reports to the Minister.		
Police resources, powers and duties	**29**	**Mental health calls under the Act**	Mental health calls for service require the diversion of a significant amount of police resources. Average call for serve is 4 hours which equates to 24,184 hours or 2,7 years of dedicated police resources during this time period.	Written Submission by the RCMP	
	30	**Peace officer powers and duties**	This comment is in reference to Section 90.1(b.1) whereby if there is a delay in conveying the person to a designated facility, the person can be provided with the opportunity to contact a family member, health professional or other person. The RCMP note: This section is irrelevant as it only serves to delay or complicate situations. A person has a legal right to counsel, which could serve this function. It is counsel's responsibility to advocate on behalf of the detained person, not the police. It is noted that this is an unrealistic expectation to place on the police.	Written Submission by the RCMP	
Voluntary and involuntary admissions	**31**	**Internal process to address concerns**	It was suggested to help solve the issue of patients not knowing their rights, and the processes to the Act (i.e. voluntary admission changing to involuntary admission).	Written Submission by the Department of Health and Social Services	
	32	**Parameters for monitoring change in patient status**	It was suggested that parameters are put in place for monitoring change in patient status and potential interventions, including the use of Form 1 – *Notifications of Patient Rights and Other Information* for an involuntary examination, are appropriately documented in the physician orders.	Written Submission by the Department of Health and Social Services	
	33	**Creating false narratives for patients**	It is suggested that this is an operational challenge that does not require amendments to the legislative framework. At times, the Psychiatrist will put a patient on a voluntary hold and order that the patient be placed on an involuntary	Written Submission by the Department of Health and Social	

Theme		Sub-theme	Comment	Where	Committee direction
			hold if the patient wants to leave or tries to leave. This has been expressed as an operational challenge as it creates a false narrative for these patients who think they are in control of their care. This ability within the Act is still important and the Act needs to balance the rights of individuals with acute mental health needs with the rights of others to be safe and free from harm. The Department suggests this issue can be addressed by the education of staff/patients/families (as appropriate) regarding: • Having internal processes in place to most appropriately address concerns about the Act and patient safety • Communicating patient rights upon admission • Developing parameters for monitoring change in patient status and potential interventions, including use of Form 1 – *Notification of Patient Rights and Other Information* for a voluntary examination, are appropriately documented in the physician order	Services	
Patient rights	**34**	**Right to be examined by a second medical practitioner**	This comment is in reference to Section 9.1. While unusual, this provision is good from a rights perspective. Many patients are discharged prematurely, and a case can be made for giving families more of a say in the timing of discharge and perhaps an acting substitute decision-maker could be given the same right to ask for a second opinion. The downside is at the system level, where there already are too few psychiatric beds.	Written Submission by the Canadian Psychiatric Association (CPA)	
	35	**Information and education about rights under the Act**	It is suggested that postage of information about patient rights under the Act as a permanent part of the individual space may not be appropriate, particularly for Pediatric Unit rooms designated for psychiatric admission at Stanton Territorial Hospital as they are adaptive spaces that may be utilized for acute medical treatment as needed. It is suggested that this issue can be addressed by education of staff/clients/families (as appropriate) regarding the requirement to post patient rights in client facing space on the unit.	Written Submission by the Department of Health and Social Services	

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		It is also suggested that patients know their rights upon admission. Ensuring it is communicated to the patient that, should they wish to be discharged and there are any imminent safety concerns, they may be held involuntarily for further assessment. It is also suggested by the Department that there needs to be review of the need to provide additional awareness and encouragement to staff who are responsible for providing patients with information about their rights under the Act to ensure all persons being held under the Act are being appropriately informed of their right to apply to the MHARB. There is also a suggestion to educate staff regarding internal processes (Standard Operating Procedures) to address concerns about patient rights.		
	36 Patients right to retain and instruct counsel without delay	It is suggested that it is unclear whether patients are being informed of: • Their rights to retain and instruct counsel without delay, and; • If their access to counsel is being facilitated It is suggested that this is an operational challenge that does not require amendments to the legislative framework. The Act has clear requirements for health professionals to inform patients and persons detained under the Act about their rights, including the right to instruct legal counsel. The Director of a Designated Facility is further responsible for ensuring that patients are given information about their rights in a language and manner that they understand. It is suggested that this issue can be addressed by: • Providing education to staff/patients/families (as appropriate) regarding patients held involuntarily under the Act being given a verbal explanation and copy of the Form 1 – *Notification of Patient Rights and Other Information*, outlining patient rights when the need for an involuntary assessment or admission is determined by a health or medical professional. Part of this explanation includes the right to contact and speak with a lawyer; however, restrictions may apply until any immediate safety concerns to the patient or others are resolved.	Written Submission by the Department of Health and Social Services	

Theme		Sub-theme	Comment	Where	Committee direction
			• Providing education to staff/patients/families (as appropriate) that ongoing discussion with the care team is part of the admission and treatment process, as there may be factors interfering with the patient's ability to understand information given about patient rights initially		
	37	**Independent patient rights advisor**	"I am concerned about how patient rights are explained to patients. Patients are often too upset at the doctor to understand what the doctor explains to them as their rights within a Form 1 – *Notification of Patient Rights and Other Information* when they are being told they are involuntarily detained. This responsibility often falls on the nurse to provide. Issues arise when high turnover of staff causes issues in ability to adequately provide this information. Patients often do not that this information well from a nurse they do not have good rapport with." There were suggestions to provide an independent rights advisor/neutral party who comes in to review patient rights under the Act or under Assisted Community Treatment, rather than this being done by the treating team.	Written Submission by the Department of Health and Social Services	
	38	**Reviewing Form 1 - *Notification of Patient Rights and Other Information***	It is suggested to review and amend Form 1 – Notification of Patient Rights and Other Information to simplify language and layout, and consider including information on how to access advocacy and/or legal supports. This review should include an operational lens and perspectives of persons with lived experience. There is also a suggestion to make is standard that the patient is given a copy of the patient rights poster with the Form 1. There is also a suggestion to consider using a separate form specific to patient rights (as depicted in Alberta and BC). **Note from LawClerk:** As long as the information required under the Act/regulations is included the formatting can change without changing the Act.	Written Submission by the Department of Health and Social Services	

Theme		Sub-theme	Comment	Where	Committee direction
Emergency treatment	**39**	**Second medical opinion**	This comment is in reference to Section 28(2). The CPA comments that it seems unnecessarily restrictive to require a second medical opinion before administering emergency treatment. In an emergency, even the time required to contact a second physician could result in a bad outcome. The CPA suggest that the Committee reconsider this as it is potentially problematic. Alternatively, insert the word "readily" before available.	Written Submission by the Canadian Psychiatric Association (CPA)	
Community Treatment Plan	**40**	**"Willing" seen as problematic**	This comment is in reference to Section 37(6)(d). The use of the word "willing" is very problematic. In Ontario, the working is "is able to comply". The word "willing" could suggest to clinicians that the person is consenting and that if they do not agree then they are not eligible for a CTO. If this is the intention, then the CTO has very limited function.	Written Submission by the Canadian Psychiatric Association (CPA)	
	41	**Coordinating assessment under Assisted Community Treatment**	The issue at hand is that coordinating assessments required prior to the expiry of a Certificate of Involuntary Assessment or Renewal Certificate with assessments/appointments required under Assisted Community Treatment Certificates/Community Treatment Plans and their appointment dates are needlessly cumbersome and often results in more appointments than is necessary. It is suggested that this is not patient centered and that amendments to the legislative framework and operational changes could be considered. It is suggested that this issue can be addressed by reviewing current processes and assessment requirements in the Act and Regulations for patients on leave (short term leave or assisted community treatment) to allow better coordination of timelines and required assessments, streamline information to reduce number of forms and duplication of administrative tasks, and simplify language and require information. This review should include the perspective of persons with lived experience and an operational lens.	Written Submission by the Department of Health and Social Services	

Theme		Sub-theme	Comment	Where	Committee direction
	42	**Unable to initiate Assisted Community Treatment unless the client meets criteria for an involuntary admission**	It is suggested that amendments to the legislative framework could be considered. The issue at hand is: "Unable to initiate Assisted Community Treatment unless the client meets criteria for an involuntary admission. This causes confusion for clients and families and causes moral distress for staff." The Department notes that Assisted Community Treatment is often equated with Community Treatment Orders used in the South. Assisted Community Treatment in the *Mental Health Act* is considered a form of extended leave, enabling involuntary patients to receive care and treatment while living in the community in an effort to transition them to living successfully in community once they are no longer involuntarily admitted. On the other hand, Community Treatment Orders in the south are designed for individuals who may or may not be admitted under the Act, but allows for reasonable treatments to be provided without consent of the person where it is considered less restrictive than keeping the person in hospital – it is typically used for individuals who are frequently re-admitted. It is suggested that this issue can be addressed by reviewing the legislative framework for potential amendments to the Assisted Community Treatment provisions, including consideration of expanding Assisted Community Treatment to be available to those who are no longer involuntary patients, similar to southern Community Treatment Orders. In short, it is suggested to rework the Assisted Community Treatment model to align with the Community Treatment Order model, including removing the requirement that a person be an involuntary patient. It will be important to consider the differences on the impacts of service provision in the NWT compared to southern jurisdictions, such as the number of designated facilities, rural/remote context, administration and operational requirements inevitably placed on the only designated facilities with a dedicated psychiatric unit (Stanton).	Written Submission by the Department of Health and Social Services Technical Briefing from the Department of Health and Social Services	

Theme		Sub-theme	Comment	Where	Committee direction
	43	**Supports through Assisted Community Treatment (ACT) Certificate**	This comment is in reference to Section 40(1)(b). It is suggested that amendments to the legislative framework and operational changes could be considered. For involuntary patients to be successful in community some form of housing and income must be available to them; however, what exactly is required is not immediately clear in the legislation other than that something be in place. The wording in the Act is intentionally vague to account for varying housing and income situations and what may or may not be appropriate for different patients' safety and well being while residing in community. It is mentioned that a "plan for other support, including income and housing." is confusing. The Department states the question - Do health care professionals have to ensure this support is available before a patient is eligible for ACT, and if so, what is considered adequate? How would this work for clients who have unstable housing/income? It is suggested that this issue can be addressed by: • Reviewing the legislative framework for potential amendments to the ACT provisions, including requirements for the community treatment plan, for it to better reflect the needs of the NWT population and program and services options available in more rural/remote communities • Developing SOPs, policies respecting the requirement for income/housing support and what that means	Written Submission by the Department of Health and Social Services	
	44	**Operational guidance and services in rural and remote communities**	There is not enough operational guidance for staff in communities with a designated facility to confidently manage care for clients on Assisted Community Treatment (ACT). This includes difficulty in establishing clear communication about the required processes for bed allocation at designated facilities. It is suggested that this is an operational challenge that does not require amendments to the legislative framework. It is suggested that this issue can be addressed by:	Written Submission by the Department of Health and Social Services	

Theme	Sub-theme	Comment	Where	Committee direction
		• Development of a Standard Operating Procedure for ACT, including when admission at non-designated facilities for the purpose of ACT would be appropriate (which would then "deem" that facility to be a designated facility for the purpose of the Act). • Education and engagement with external stakeholders involved in community care in an attempt to increase capacity to support Assisted Community Treatment • Review of operational challenges related to human and physical resource allocation in the health and social services system, including the use of virtual supports, assessments, etc. where appropriate The Department also highlights that most rural/remote communities do not have the required services to manage clients who would benefit from ACT (e.g. medication management services, comm unity mental health nurse or psychiatrist to monitor/assess/treat client). Therefore, ACT hasn't been effectively utilized. It is suggested that amendment to the legislative framework and operational changes could be considered.		
	45 Changes to the Community Treatment Plans	Most current community treatment plans and forms are not available for community practitioners on Electronic Medical Records (EMR), which may risk changes to medications of other aspects of the formalized plan. There is no established process to flag this for general practitioners or other health professionals in the community. It is suggested that this is an operational challenge that does not require amendments to the legislative framework. It is suggested that this issue can be addressed by the development of Standard Operating Procedures for assisted community treatment. There is also a suggestion to educate and engage with external stakeholders involved in community care in an attempt to increase capacity to support assisted community treatment.	Written Submission by the Department of Health and Social Services	

Theme		Sub-theme	Comment	Where	Committee direction
	46	**Nonadherence to required monitoring and treatment**	The issue at hand is that the nonadherence to the required monitoring and treatment would typically lead to apprehension and conveyance to the closest designated facilities for clients who reside in rural/remote communities. This may lead to overuse of emergency transportation services impacting available resources in the community for other emergencies, is costly and doesn't reflect principles of recovery-oriented care. The Department suggests that this is an operational challenge that does not require amendments to the legislative framework. The supervising medical practitioner can issue a certificate that requires the patient to return to the hospital/designated facility for an examination to determine the suitability of further community treatment – one of the criteria for issuing this certificate is that the patient must have refused or failed to attend an appointment for a psychiatric assessment. The intent of these powers in the Act are to be able to bring the patient back to the facility before they seriously decompensate or harm themselves or others. It is suggested that this issue can be addressed by: • Education and engagement with external stakeholders involved in community care in attempt to increase capacity to support Assisted Community Treatment • Education and engagement with internal and external stakeholders involved in community care to increase awareness of obligations to ensure efforts are made to inform patients of non-compliance, health the patient comply, and inform the patient of the consequence of non-compliance • Review operational challenges related to human and physical resource allocation in the health and social services system	Written Submission by the Department of Health and Social Services	
Staffing capacity, resources, and programs	**47**	**No multisystem model of service delivery**	It is mentioned by this individual that research shows that the most effective models for intervention are multisystemic in nature. He encourages the government to create a multi departmental team for children, adolescents, and families that includes membership from at least health, social services, education, and justice. This proposed team could	Written Submission by Raymond Pidzamecky (M.S.W., RSW)	

Theme		Sub-theme	Comment	Where	Committee direction
available			be used for innovative thinking for service and program development and to intervene in high-risk cases.		
	48	**Staff capacity**	There is one Mental Health Act Coordinator who reads these forms for the entire territory. She reasonably likes to go on vacation. Then on leave, the task is now the responsibility of nurses, who must explain to locum doctors who have not read the Act how and why they filled a form out incorrectly. Committee should note that this is an operational challenge that does not require amendments to the legislative framework. It is suggested that this can be addressed by ensuring coverage of the MHA coordinator responsibilities by a consistent person when on leave.	Written Submission by the Department of Health and Social Services	
	49	**Addition of a public facing navigator role for the Mental Health Act**	Related to sub-theme #56 and a lack of guidance for families and caregivers to apply for Orders, there is a suggestion to explore the addition of a public facing navigator role for Mental Health Act processes. For example, consideration could be given to adding this function to the Office of Client Experience or to the Mental Health Act Review Board Office Manager.	Written Submission by the Department of Health and Social Services	
	50	**Inclusion of Community Mental Health Nurse and Registered Nurse within the MHA**	There are concerns that there is no guidance or process in place for Community Mental Health Nurses or other health professionals designated in the Act to fill out Form 2 – *Certificate of Involuntary Assessment* and Form 10 – *Statement for Apprehension of Conveyance*. There is a lack of awareness or support for registered nurses and registered psychiatric nurses to issue these forms. This leaves gaps in facilitating emergency care in communities. It is suggested that this can be addressed by reviewing and revising the current Standard Operating Procedures and scope/utilization of the Community Mental Health Nurse and/or other Registered Nurse roles in respect to implementation of the MHA.	Written Submission by the Department of Health and Social Services	
	51	**Clarity about**	"…greater clarity about psychiatrist role in the hearing. Are	Written	

Theme		Sub-theme	Comment	Where	Committee direction
		psychiatrist role during hearings	we considered the hospital representative, or the witness called by the hospital?... have had the experience of being asked questions about the legal scope of the hearing which is beyond (the psychiatrist's) scope." It is suggested by the Department that this is an operational challenge that does not require amendments to the legislative framework. The Department notes that the psychiatrist would be considered the "attending medical practitioner" of a patient and is considered to be a party to the application. Their role in the hearing would be comparable to serving as a witness to provide information about their knowledge of the case (i.e. the patient's treatment history, information related to their professional expertise, etc). Because they are a party to the application, they are also able to call additional witnesses to help support the information they may want to present at the hearing. The Director of the Designated Facility is also a party to the hearing and is the one responsible for representing the designated facility. It is suggested that this issue can be addressed by education the MHARB, psychiatrists, and other staff regarding the role of psychiatrists/attending medical practitioners at review panel hearings.	Submission by the Department of Health and Social Services	
	52	**Wrap-around supports and Multisystemic Therapy Theoretical Framework**	A research study from McMaster University (1998) shared by Raymond Pidzamecky highlights the benefit of wrap-around supports and services for single mothers and children accessing social assistance. Raymond also presents research related to Multisystemic Therapy Theoretical Framework which provides practitioners and families with considerable emotional and clinical support. He notes that to optimize the probability of decreasing antisocial behaviour, an intervention should have the capacity to address pertinent risk factors across the youth's social network. Staff would like Committee to note that this may be beyond the scope of the *Mental Health Act*.	Written Submission by Raymond Pidzamecky (M.S.W., RSW)	

Theme		Sub-theme	Comment	Where	Committee direction
	53	**Lack of collaboration between professionals**	Raymond notes that there is minimal collaboration between Health and Social Services and counsellors contracted or in private practice such as those employed by Health Canada, Shepell, Human Solutions, and Ceridian. He further notes that the Department has not been successful at implementing its mobile team for providing counselling in communities. Concerns regarding people not knowing they can access the Health Canada Indian Residental School Counselling program.	Written Submission by Raymond Pidzamecky (M.S.W., RSW)	
	54	**Unresponsive to Innovation**	Raymond provides examples of programs he submitted to the Department and notes the times that he received no response or no follow-up response, furthering his claim that the Department is "unresponsive to innovation". Raymond also highlights the need for a relapse prevention program in the NWT, and the need for local Indigenous governments to provide that follow-up or be willing to do this.	Written Submission by Raymond Pidzamecky (M.S.W., RSW)	
	55	**Indigenous culture as intervention in counselling and treatment**	In his submission, Raymond highlights his realization of the importance of culture in the journey of healing. Particularly, about Indigenous culture as intervention in counselling and treatment.	Written Submission by Raymond Pidzamecky (M.S.W., RSW)	
Assessment, admission, renewals, and discharging	55	**RCMP assessment overriding professional's concerns**	Related to sub-theme #16 there is a suggestion to establish a working group with RCMP and appropriate community stakeholders around implementation of the Act to discuss and address concerns. The issue at hand is that despite summary of concerns from health and social services professionals on meeting criteria of involuntary assessment under the Act, RCMP assessment overrides the professionals' concerns.	Written Submission by the Department of Health and Social Services	
	56	**Lack of guidance for families/caregivers/ practitioners**	There is a lack of guidance regarding how families/caregivers/practitioners can apply for an Order for Involuntary Assessment or Order for Assessment within the scope of the NWT justice system (e.g. there is no guidance on current position/programs that assist with this process). It is suggested that this is an operational challenge that does not require amendments to the legislative framework and that this issue can be addressed by:	Written Submission by the Department of Health and Social Services	

Theme		Sub-theme	Comment	Where	Committee direction
			• Revising the Guide to the *Mental Health Act* to include additional information and tools on how health and social services professionals can initiate this process • Adding public facing resources on the Department's webpage on how families can initiate this process • Creating a form for individuals applying for an Order to use		
	57	**Involuntary patients being discharged from the hospital**	It is noted by the Department: If involuntary patients are disagreeable to care, they are usually discharged from the hospital by Psychiatry – this is not supposed to be happening. It is suggested that this is an operational challenge that does not require amendments to the legislative framework. The Act requires the attending medical practitioner to conduct ongoing assessments of involuntary patients to determine whether the involuntary admission criteria continue to be met. Where they are not, they must cancel the certificate of involuntary admission and any renewal certificate, allowing the patient to be discharged. It is suggested that this issue can be addressed by ensuring staff education is provided regarding the following: • Per the Act and the NTHSSA Standard Operating Procedures, a patient admitted on an involuntary basis is unable to be discharged if a physician determines the client continues to meet the criteria for involuntary admission • Internal processes in place to most appropriately address an immediate safety concern with discharge	Written Submission by the Department of Health and Social Services	
	58	**Add ability to cancel a Certificate of Involuntary Assessment**	Currently, there is an inability to cancel a Certificate of Involuntary Assessment. Cases where a person being detained for Involuntary Assessment has substantially improved, they are still held to the Act. If there is no access to assessment by medical practitioner in a small community, for example, they would still need to be medivaced to get that Assessment, even though their condition has improved. It is suggested that this goes	Technical Briefing from the Department of Health and Social Services	

Theme		Sub-theme	Comment	Where	Committee direction
			against the principles of the Act and person-centered care to hold and transport a person unnecessarily based only on legislative requirements. Legal advice provided to the Department was to have medical practitioners complete virtual assessment to confirm whether it is appropriate to release or to continue transportation to the designated facility.		
Streamlining forms	**59**	**Improving the number, complexity and duplication of forms**	There is overall concern about the number and complexity of forms and duplication across forms. There are concerns when forms are not filled out correctly, they are considered invalid (Section 102 of the Act specifies that certificates issued under the Act must not be considered invalid only because of irregularities, informalities, or insufficiencies). It is noted by the Department that some of these issues may need amendments to the legislative framework can be addressed by: • Ensuring locum psychiatrists are oriented to MHA education resources (e.g. NTHSSA training, Policy and SOP, peer mentorship) • Reviewing and amending the current forms and form requirements in the legislative framework to streamline information to reduce the number of forms and duplication of administrative tasks, and to simplify language and required information. This review should include an operational lens and perspectives of persons with lived experience • Specific consideration could be considered to having “one admission certificate”, with the first authorizing the involuntary assessment and expiring after 72 hours, and the second authorizing involuntary admission up to 30 days (Alberta has a good example)	Written Submission by the Department of Health and Social Services In-Camera Comment by Dr. Orchard Technical Briefing from the Department of Health and Social Services	
	60	**Review and revision of specific forms**	There is a discrepancy between the Form 23 – *Community Treatment Plan* and the requirements for the form set out in Section 19 of the *Forms Regulations*. Currently, the Form requires the patient OR the substitute decision maker to initial in Part 3 (Patient Agreement), while the entire Form is not required to be signed by the patient where there is a substitute decision maker in place. Section 19 of the Forms Regulations specifically requires acknowledgement from	Written Submission by the Department of Health and Social Services	

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			the patient that they understand the requirements or obligations set out in Part 3. The current wording in Part 3 is not immediately clear that it is the patient's acknowledgement that is being demonstrated in this part. Form 22 – *Assisted Community Treatment Certificate* currently indicates that the signature of both the patient and a substitute decision maker (if applicable) are required. However, as per Section 17(2) of the *Forms Regulations*, where there is a substitute decision maker in place, the Form is only required to be signed by the substitute decision maker, not the patient. Where there is no substitute decision maker, the patient is required to sign the form. It is suggested that these issues require review and revision of the associated forms; amendments to the legislative framework may not be required. Committee should note that an initial review of the issue has been completed and the psychiatry team at Stanton has been advised of the discrepancy in Form 23 and of the intent of Part 3, as well as in Form 22. For Form 22 – until the Form can be amended, staff have been advised by the Director of Mental Health to indicate "N/A" on the patient signature line where a substitute decision maker will be signing the form. Amendments to both forms will be completed following the Stat Review to ensure any other form issues that are identified during the review are also addressed.		
	61	**Formatting changes to forms**	Adding the form name to the page number could be helpful to avoid mix ups when there are a lot of forms on the patient's chart. The Department highlights that this issue can be addressed by amending the forms to add the form name to each page. Formatting of Form 16 – *Short Term Leave Certificate* causes difficulty when filling out and filing. The Department notes this issue can be addressed by amending the forms to address formatting issues. The margins on the forms do not have room for a 3-hole	Written Submission by the Department of Health and Social Services	

Theme		Sub-theme	Comment	Where	Committee direction
			punch when filing. The Department notes that this issue can be addressed by amending the forms to provide wider margins. Amendments to forms will be completed following the Stat Review to ensure any form issues that are identified during the review are also addressed.		
	62	**Electronic signatures, electronic forms and verbal consent**	Getting signatures from substitute decision makers on forms is difficult and can result in delays (including delays for short term leave). It was suggested to allow for the substitute decision maker to consent verbally over the phone instead of relying on faxes or other means to obtain signatures, especially if this is in the best interest of the patient (this was also mentioned at the technical briefing). It is suggested that amendments to the legislative framework could be considered for this issue. This issue can be addressed by reviewing the forms and legislative framework to determine where verbal consent can be accepted, and what amendments to the legislation, regulations, and/or forms would be required to better facilitate substitute decision maker consents. Another issue is that forms cannot be sent electronically – this is an operational challenge that does not require amendments to the legislative framework. A paper copy of Form 10 – *Summary Statement Respecting Apprehension or Conveyance* must accompany the client to the designates facility. Has potential to extend period of involuntary assessment if another Form 2 – *Certificate of Involuntary Assessment* needs to be completed at a designated facility. This issue can be addressed by reviewing current secure file transfer (SFT) processes to enable forms issued under the Act to be SFT'ed to an authorized account at designated facilities.	Written Submission by the Department of Health and Social Services Technical Briefing from the Department of Health and Social Services	
	63	**Education to staff on forms**	On the issues above (in the "streamlining forms" theme), there were a number of suggestions for educating staff to help address of the issues. The suggestions are below: • Educating staff on use of secure file transfer as an alternative to faxing (related to the issue of getting	Written Submission by the Department of Health and Social	

Theme	Sub-theme	Comment	Where	Committee direction
		signatures) • Educating staff regarding internal procedures to address concerns about form completion (related to concerns that forms filled our incorrectly are considered invalid)	Services	

Next Steps

Engagement:
In the planning stages for the Statutory Review of the Mental Health Act, Committee had identified that it wished to hold a public hearing with the Minister of Health and Social Services once it heard public feedback on the Act to be able to ask the Minister questions based on feedback received.

Does the Committee still wish to take this approach? Or does Committee feel it has enough information to proceed with its report?

Report:
Staff will draft a report based off Committee's direction on this briefing note, for Committee review prior to the October sitting.

The report will be ready for Committee to read in to the House during the October sitting.

June 12, 2024

VIA ELECTRONIC MAIL : Committees@ntassembly.ca

Standing Committee on Social Development

Dear Committee members:

Re: Scaling up safe supply at supervised consumption services in Canada

We are pleased to share our new report *How to Innovate in an Emergency: Legal and Policy Measures to Scale up Safe Supply at Supervised Consumption Services*, detailing legal and policy measures to support access to safe supply in these settings (attached in English and French).

As you know, the ongoing and escalating nature of the toxic drug supply necessitates swift action and measures that would facilitate access to a safe supply of quality-controlled substances for those currently risking their health and lives because they are compelled to consume illegal and therefore unregulated street drugs of unknown composition, purity, and potency. At the same time, numerous researchers and people who use drugs have called for greater access to de-medicalized, community-based safe supply programming.

One such de-medicalized option for safe supply is to scale up access within supervised consumption services (SCS). SCS are rooted in harm reduction principles and are meant to provide accessible and low-barrier access to people who use drugs, often also staffed by people with lived experience of drug use. Efforts to implement prescribed safe supply at SCS are already underway at several sites, and research shows promise related to participants' willingness to consume in a monitored setting and to the co-location of safe supply programs within the low-barrier service delivery associated with SCS.

Affirming the possibilities of enhancing access to safe supply via SCS, a 2024 report from the Provincial Health Officer of B.C. recommends that "[o]pportunities for enhancing access to on-site consumption of prescribed alternatives at existing harm reduction sites, for example at overdose prevention and supervised consumption sites, should be considered and supported."

Our research involved a review of the evidence and literature regarding safe supply and SCS, a review of the legal and policy frameworks regulating both SCS and safe supply, and interviews with key informants, including prescribers, people who use drugs, frontline SCS staff, researchers, and lawyers. Based on this research, we make a number of legal and policy recommendations to federal and provincial authorities to ease barriers to scaling up safe supply at SCS.

1240 rue Bay Street, Suite/bureau 600, Toronto, Ontario, Canada M5R 2A7
Telephone/Téléphone: +1 416 595-1666 Fax/Télécopieur: +1 416 595-0094
info@HIVLegalNetwork.ca www.HIVLegalNetwork.ca
Charitable Registration/Numéro d'organisme de charité #141110155 RR0001

Our research confirms that **a diversity of tools is available for law and policymakers to eliminate barriers to safe supply at SCS** and begin to fully realize a continuum of options that are accessible and honour the autonomy and human rights of people who use drugs. As many of those tools are within the purview of your Office, we would welcome an opportunity to discuss our findings with you.

Sincerely,

Sandra Ka Hon Chu
Co-Executive Director
HIV Legal Network

Corey Ranger
President
Harm Reduction Nurses Association

FACILITY Standard Operating Procedure	
Title: Adult Psychiatric Admissions	Policy Number: 23-14-V1
Facility Name: Stanton Territorial Hospital	
Applicable Domain: Psychiatry, Mental Health and Addictions Services	
Additional Domain(s): NA	
Effective Date: 08/09/2020	Next Review Date: 08/09/2023
Issuing Authority: Stanton Territorial Hospital COO	Date Approved: 08/09/2020
Accreditation Canada Applicable Standard: 3.0 Access to services for current and potential clients, families, teams and referring organizations provided in a timely and coordinated manner.	
Accrediting Body and Standard: N/A	

GUIDING PRINCIPLE:

The Northwest Territories Health and Social Services Authority (NTHSSA) is committed to providing efficient and seamless psychiatric admissions procedures to ensure patients experiencing mental health issues have a safe and better health care experience.

This procedure shall be followed when completing a psychiatric admission for an adult patient.

PURPOSE/RATIONALE:

The purpose of this procedure is to ensure:

- Staff provide an efficient, timely, safe and seamless admissions process for the adult patient (and their family members or legal guardian, if applicable);
- Staff obtain pertinent information required to provide appropriate care during hospitalization; and
- Patient and family members or legal guardian or SDM (if applicable) are included in the admission process wherever possible.

DEFINITIONS:

Involuntary Patient: A patient admitted to the facility under the authority of a Mental Health Act Certificate of Involuntary Assessment (Form 2), Certificate of Involuntary Admission (Form 3), or Renewal Certificate (Form 4) and includes a person who is absent from the facility without authorization or absent from the facility under the authority of a Mental Health Act Short-Term Leave Certificate (Form 16).

Most Responsible Practitioner (MRP): The health professional, either Physician or Nurse Practitioner, who has responsibility and accountability for the specific treatment/procedure(s) provided to the patient and who is authorized by the NTHSSA to perform the duties required to fulfil the delivery of such a treatment/procedure(s) within the scope of their practice.

Voluntary Patient: A patient admitted to the facility who is willing to receive psychiatric care and treatment and who is not subject to a Mental Health Act Certificate of Involuntary Assessment (Form 2), Certificate of Involuntary Admission (Form 3) or Renewal Certificate (Form 4).

SCOPE/APPLICABILITY:

Compliance with this procedure is required by all NTHSSA Stanton Territorial Hospital employees, including students, volunteers and other persons acting on behalf of the NTHSSA. This procedure may be used as a guideline for Hay River Health and Social Services Authority and/or Tłı̨chǫ Health and Social Services.

PROCEDURE FOR ADMISSION TO STANTON TERRITORIAL HOSPITAL:

Pre-Admission Criteria

1. The patient must be medically evaluated and cleared:

- **1.1.** Of **medical conditions** that are not manageable in an acute in-patient psychiatric admission (i.e. IV therapy);
- **1.2.** If **at risk for moderate to severe alcohol withdrawal**. The patient must be admitted or transferred to a medical unit for observation and clearance until CIWA score is maintained under 10 for a period of 8 hours, including patients who:

1.2.1. Have scored higher than 10 on CIWA on more than 2 consecutive assessments; and

1.2.2. Admit to recent alcohol use (within the last three days) and have a history of experiencing alcohol withdrawal in the past year that includes seizures, Delirium Tremens or requiring IV rescue dosing.

2. The patient must have an Ethanol Level less than 80 mg/dL or 17.36 mmol/L.

2.1. It is anticipated that the ethanol level will decrease at a rate of 10-20 mg/dL/hr which translates to 2.2 – 4.4 mmol/L/hr. Clients do not need to be retested unless clinically indicated.

3. Goals of Care must be R1, R2 or R3.

Types of Admissions

4. For **ADOLESCENT PATIENT ADMISSIONS** (patients between 16 and 18 years of age) and for whom it has been determined that admission or transfer to the In-Patient Adult Psychiatry Unit is most appropriate by the MRP:

4.1. Facility Pediatric Mental Health Admission Standard Operating Procedure must be used to determine appropriateness of an adolescent admission to the Adult Psychiatry Unit; and

4.2. Approval must be obtained by the Area Medical Director or COO; and

4.3. RL6 must be completed.

5. For patient **ADMISSIONS FROM EMERGENCY DEPARTMENT**:

5.1. Admission is facilitated through the Patient Care Coordinator (PCC), Unit Clinical Coordinator (CC) or Charge Nurse.

5.2. The Emergency Room Physician (ERP) will:

5.2.1. Contact the Hospitalist and inform them of the patient's admission;

5.2.2. Complete the following:

- History and physical;
- Psychiatry Standing Orders (preferred) or General Hospital Orders;
- Medication Reconciliation;
- Mental Health Act Forms (if applicable);
- VTE Prophylaxis/Patient Dashboard; and
- Goals of Care

5.3. The SBAR, copy of the Physician Admission Orders and MHA forms (when applicable) are sent to the Psychiatry Unit prior to admission through the Pneumatic Tube.

5.4. The Facility Push Pull Procedure must be followed.

5.5. Patient must be changed into hospital pyjamas and have belongings searched to ensure no dangerous items.

6. For **DIRECT ADMISSIONS**:

6.1. Direct Admissions can be considered for patients being referred from outside hospitals and Medical Clinics once the patient has been medically cleared by a Physician.

6.2. Patients being directly admitted must have a patient escort accompany them.

6.3. Admissions are facilitated through the PCC, Unit CC or Charge Nurse and Med Response (where applicable).

6.4. Physicians **OUTSIDE YELLOWKNIFE** must contact Med Response to initiate the patient's transfer to the Psychiatry Unit. Med Response will secure an accepting Hospitalist and confirm bed availability with the PCC.

6.5. Physicians **WITHIN YELLOWKNIFE** must contact the:

6.5.1. PCC to confirm bed availability; and

6.5.2. Hospitalist to secure an accepting Physician.

6.6. For all direct admissions the referring Physician must:

6.6.1. Complete a history and physical exam to medically clear the patient; and

6.6.2. Provide Admissions Orders and Medication Reconciliation (if applicable) to be reviewed by the accepting physician.

6.7. The history and physical assessment, Physician's Admission Orders and *Mental Health Act* forms (if applicable) must be sent to the Psychiatry Unit prior to the patient's arrival.

6.8. The accepting MRP must review and approve or agree to the sending Physician's Admission Orders.

6.9. Patients must present to the Emergency Department if there was a change in status during transport to Stanton Territorial Hospital (e.g. when sedation for transport is necessary); the admission from ED process will be followed.

7. For a mental health patient's **TRANSFER FROM OTHER INPATIENT UNIT TO PSYCHIATRY** related to**:**

7.1. **Operational Need** (i.e. patient admitted to the Medicine Unit related to a bed shortage): A physician order for transfer and a transfer Medication Reconciliation is not required.

7.2. **Medical Concern** (i.e. overdose) or **Medical Clearance** (a different level of care): Both a transfer Medical Reconciliation and a physician order indicating the patient has been medically cleared for transfer must be completed.

8. For the **ADMISSION OF AN INVOLUNTARY PATIENT TO AN INPATIENT UNIT OTHER THAN PSYCHIATRY**:

8.1. All attempts will be made to admit involuntary patients who are 18 years or older and have been medically cleared to the inpatient Psychiatry Unit. If a bed is not available, the patient may be admitted to a Unit other than Psychiatry provided the following criteria are met:

8.1.1. A Health Care Worker will provide close or constant observation of the patient (as per Physician Orders);

8.1.2. All attempts will be made to have a Psychiatric consult completed within 48 hours of admission;

8.1.3. All admissions documentation including Risk Assessments outlined in this procedure must be completed; and

8.1.4. Steps outlined in the Admission Procedure below must be followed.

8.2. The patient will be transferred to the Psychiatry Unit as soon as a bed is available and the patient is deemed appropriate for transfer by the In-Patient Psychiatrist.

<u>Admission Procedures</u>

9. The patient must be changed into hospital pyjamas.

10. Member of health care team completes a valuables sheet and conducts search of the patient belongings with the patient present. In the event that the patient is unable to participate the health care worker may conduct the search with an RN/RPN.

10.1. All valuables or potentially dangerous items e. jewellery, scissors, glass items, money, patient identification) will be itemized, labelled and secured in a locked box (located in the locked cabinet in the medication room) during the patient's stay on the unit.

10.2. Refer to the Stanton Territorial Hospital Search of Belongings Policy.

11. Provide patient and family members or SDM (if applicable):

11.1. An opportunity to ask questions. This will help reduce anxiety and concerns related to admission;
11.2. The *Information Guide for Psychiatry* which outlines hospital routine, hospital and unit policies, patient rights and expectations for their stay.
11.3. A tour of the Psychiatry Unit and verbal overview of the Unit routine.

12. For involuntary patients:

12.1. The RN ensures all *Mental Health Act* forms are filed and appropriately distributed.
12.2. Refer to the NTHSSA Wide Mental Health Act Psychiatry Admissions Policy for specific procedures.

Admission Assessments and Documentation

13. At time of admission, the following admission documents must be completed:

13.1. NISS Admission Assessment- Mental Status Exam;
13.2. Falls Risk Assessment;
13.3. Aggression Risk Assessment;
13.4. Elopement Risk Assessment;
13.5. Medication Reconciliation;
13.6. Consent to investigate and Provide Treatment form. This must be reviewed with the patient (or SDM where applicable) and their signature obtained when agreeable and deemed competent to provide consent. In situations where the patient refuses to sign this is documented on the form.

14. The Suicide Risk Assessment must be completed within 24 hours of admission.

15. The NISS Database must be completed within 48 hours of admission.

PERFORMANCE MEASURES:
100% of Stanton Territorial Hospital staff is aware of and compliant to this Standard Operating Procedure.

CROSS-REFERENCES:

1. Stanton Territorial Hospital Pediatric and Adolescent Psychiatric Admission or Transfer Standard Operating Procedure
2. NTHSSA Wide Medication Reconciliation Policy (#10-13-V1)
3. NTHHSA Wide Mental Health Act Psychiatric Admissions Policy
4. NTHSSA Wide Suicide Risk Assessment Policy (#23-04-V1)
5. Stanton Territorial Hospital Search of Belongings Policy

ATTACHMENTS:

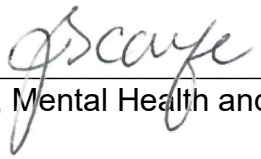
Appendix 1: Adult Suicide Risk Assessment Tool
Appendix 2: Aggression Risk Assessment
Appendix 3: Elopement Risk Assessment
Appendix 4: Falls Risk Assessment
Appendix 5: Psychiatry Standing Orders

REFERENCES:

Mental Health Act (2015, R-045). Retrieved from https://www.justice.gov.nt.ca/en/files/legislation/mental-health/mental health.a.pdf?t1536167969777

APPROVAL:

2020-08-24
Date



Director, Mental Health and Addictions Services

2020-09-08
Date

Stanton Territorial Hospital COO

Appendix 1: Adult Suicide Risk Assessment Tool

Northwest Territories Health and Social Services Authority

NTHSSA Adult Suicide Risk Assessment

This tool requires organizational training prior to use

File No.

Name	**Presentation Date** *(dd/mm/yyyy)*	**Reason for Presentation**	**Last Assessment Date** *(If Applicable)*

Gender Identification	**Sex at birth**	**Ethnicity**	**Age**
☐ Male ☐ Female ☐ Undisclosed ☐ Additional identity _____	☐ Male ☐ Female ☐ Undisclosed		

Mental Status

Oriented to: ☐ Time ☐ Place ☐ Person ☐ Self **Appearance:** ☐ Unconcerning ☐ Other _____

Speech: ☐ Normal ☐ Other _____ **Perception:** ☐ Fixed in reality ☐ Other _____

Memory: ☐ Short-term intact ☐ Long-term intact **Concentration:** ☐ Good/Attentive ☐ Distracted/Inattentive

Judgement: ☐ Good ☐ Fair ☐ Poor **Attitude:** ☐ Calm/cooperative ☐ Other _____

Mood: ☐ Good/Calm ☐ Other_____ **Affect:** ☐ Normal/Reactive ☐ Other _____

Behaviour: ☐ No unusual movements or psychomotor tics/changes ☐ Other_____

Brief Risk Assessment	**YES**	**NO**
Have you had thoughts about killing yourself?	☐	☐
Have you had thoughts of hurting or killing others (homicidal thoughts)?	☐	☐
Have you thought about hurting yourself? Why? *Describe intent/motivation:*	☐	☐

If **YES to any** of the above questions – **complete *entire Risk Assessment***
If **NO to all** of the above questions – move onto ***Safety/Protective Factors Section***

Suicidal Ideation

How long have you had thoughts of killing yourself?
I 1-2 weeks: _____
☐ 1 month ☐ 3 months ☐ Lifetime: _____

Content/details of thought:

Plan	**YES**	**NO**
Do you have a plan to hurt or kill yourself, or someone else?	☐	☐

What is your plan? *Query details of plan*

Lethality of plan: (*Actual or perceived*)

Availability of means:

Note any preparatory behaviours:
(Giving away items, suicide note, etc.)

Intent (Extent, expectation to enact plan)

How determined are you to go through with your plan in the next week? ***Likert Rating Scale 0 to 10*** 0 ***(0 – No intent, 10 – Determined)***

Individual History of Attempts

Have you tried to kill yourself in the.... *Query nature of suicidal behaviours*

I Past month? _____ Past 3 months? _____
☐ Past 2 years? _____
I Lifetime? _____ Lethality of attempts: _____

Acute Risk Factors	**YES**	**NO**
Has anyone in your family killed themselves? *Explore how recent and impact to emotional functioning:*	☐	☐
What's making you feel stress right now? (*Legal issues, job/school crisis, financial crisis, homelessness, etc.*) *Describe:*	☐	☐
Has a doctor diagnosed any Psychiatric disorders (current/past/family history)? *Describe:*	☐	☐
Do you drink or use drugs? *Describe: (quantity/frequency)*	☐	☐

NTHSSA Adult Suicide Risk Assessment Tool (Legal Size) Page 1

File No.

Potentiating Risk Factors

What other things are making life stressful for you? ***Query as necessary and note any potentiating risk factors***

- ☐ Bullying
- ☐ Prevalence of community suicides
- ☐ Developmental disability (diagnosed or suspected)
- ☐ Erratic/Impulsive behaviour
- ☐ Hopelessness/Helplessness
- ☐ Identity struggle (sexuality, gender, cultural)
- ☐ Medical issues (incl. chronic pain)
- ☐ Recent loss/grief (incl. divorce)
- ☐ Relationships chaotic
- ☐ Risk-taking behaviour
- ☐ Severe weight loss
- ☐ Sleep disturbance (insomnia, nightmares)
- ☐ Social isolation/Social withdrawal
- ☐ Supports minimal or non-existent (can be your assessment, or from client's perspective)
- ☐ Uncontrollable/Intolerable emotions (e.g. guilt, shame, anxiety, loneliness, desperation, rage, abandonment)
- ☐ Other (*specify*)_____

Safety/Protective Factors

I'm interested in learning more about your reasons for living; could you tell me what would make you want to stay alive?

- ☐ Strong connections to family and community support
- ☐ Sense of belonging, sense of identity and good self-esteem
- ☐ Cultural belonging and connectedness (with elders, the land, language, etc.)
- ☐ Spiritual and/or religious
- ☐ Willingness to access support through ongoing medical and mental health care relationships
- ☐ Effective clinical care for mental, physical and substance use disorders
- ☐ Easy access to a variety of clinical interventions and support for seeking help
- ☐ Engages in leisure time (enjoys activities)
- ☐ Safe, consistent housing
- ☐ Identification of future goals/commitments
- ☐ Restricted access to lethal means of suicide
- ☐ Fear of death or dying
- ☐ Responsibility to children, family, pets, employer, or others;
- ☐ Cohabitation (partner, family, roommate)
- ☐ Personal aversion/belief regarding suicide
- ☐ Engaged in work or school
- ☐ Aware of and uses healthy coping skills + good judgement
- ☐ Other (*specify*) _____

Determining Risk Level and Develop Interventions to LOWER Risk Level

The estimation of suicide risk, at the culmination of the suicide assessment, relies on sound clinical judgement, presenting information and the established therapeutic rapport. Risk level does not require matching all criteria. ***For an expanded list of interventions, please refer to the NTHSSA Suicide Risk Assessment Policy***

Risk Level	Risk/Protective Factors	Suicidality	Action Plan and Next Steps
HIGH ☐	☐ Multiple risk factors with few protective factors; ☐ Severe psychiatric symptoms; ☐ Acute precipitating life event(s); ☐ Access to lethal means; ☐ Unstable mental status; ☐ Immutably bleak future outlook.	☐ Multiple warning signs, suicide ideation with intent and plan within the **past month**; or, ☐ Suicidal behaviours expressed in the **past 3 months**	- Psychiatric and/or physician evaluation ASAP for admission or Med-Evac generally indicated unless a significant change reduces risk. - 1-1 constant/close observation. - Removal of potential means on person. - Ensure all necessary safety precautions are in place for client (e.g., during transport and upon admission). See Procedural guidelines. - Reassessment prior to Med-Evac and on arrival at receiving facility. - Follow-up with Mental Health on return to community.
MODERATE ☐	☐ Risk factors, outweigh protective factors; ☐ Limited access to means; ☐ Questionable impulse control; ☐ Pessimistic, vague or negative future plans.	☐ Suicidal ideation with plan, no intent or behaviour in the **past month**; or, ☐ Suicidal behavior more than **3 months ago**	- Consider admission/close observation. - Brief interventions: e.g. coping skills, stress management. - Develop safety/crisis plan (with family or support person(s) where possible) and provide individual with a copy. - Referral to Mental Health for ongoing evaluation and treatment planning. - Provide emergency contacts. - Book follow-up for within 24 hrs. - NB: If individual is unwilling to participate in safety planning, consider assigning a higher risk level.
LOW ☐	☐ Modifiable risk factors; ☐ Strong protective factors; ☐ Good self-control; ☐ Future commitments and goals.	☐ Expressed wish to die without a plan, intent or behaviour; or ☐ Suicidal ideation **more than 1 month ago**	- Provide information about warning signs. - Create support plan (with family or support person(s) where possible) and provide individual with a copy. - Where possible, warm hand-off to Mental Health professional for ongoing evaluation and treatment planning. - Book follow-up for within 48 hrs.

File No.

Actions Taken and Additional Comments *Include consultation recommendations and any actions taken to reduce risk level.*

☐ **Safety Plan Completed? –** *If yes, provide copy to individual and attach a copy to file*
☐ **For Med Evac's, Transfers, and Return to Community – Relevant documentation sent to receiving facility/unit?**

Assessment Completed by

Printed Name	Signature	Date	Time

Appendix 2: Aggression Risk Assessment

NORTHWEST TERRITORIES
Health and Social Services Authority

STANTON TERRITORIAL HOSPITAL
PSYCHIATRY UNIT

AGGRESSION RISK ASSESSMENT

(PATIENT ID)

All Patients should be assessed **on Admission**. Patients scoring **Moderate or High** should be **re-assessed every 48 hours** or until score is re-assessed as a **Low Risk**.

		1	2	3	4	5	6	7
Please check the most appropriate reason for assessment.	**Admission**							
	Change in status							
	Periodic review							
	Discharge							
RISK FACTORS		**SCORE: YES = 1**			**NO = 0**			
Chronic or co-existing medical condition								
Intoxicated, recent illicit drug use (within 72 hours) or non-compliance to prescribed medications								
History of mental health diagnosis (Psychosis, mood disorder, personality disorder, organic brain)								
Involuntary status (Certified under Mental Health Act)								
Prior history of violence or easily angered								
Violence during current ER visit or within 72 hours								
Risk for impulsivity								
Altered mental status (Experiencing delirium, delusions or hallucinations)								
Non-therapeutic relationship with staff								
Does not agree to treatment and hospitalization								
TOTAL SCORE: **Low Risk: 0-3** **Moderate Risk: 4-7** **High Risk: 8-10**								
DATE/TIME								
INITIAL								

Continue To Page 2 for Interventions

STHA# 6120-092-20

Page 1 of 2

NORTHWEST TERRITORIES
Health and Social Services Authority

STANTON TERRITORIAL HOSPITAL
PSYCHIATRY UNIT

AGGRESSION RISK ASSESSMENT

(PATIENT ID)

Date, time and **initial** the interventions completed. If interventions are **not applicable, mark as N/A.** Refer to the individual care plan for additional interventions.

Scoring and Interventions:	**1**	**2**	**3**	**4**	**5**	**6**	**7**
0 – 3 Low Risk:							
• Close observation: q15min for 48 hours then reassess • Routine observation = N/A							
Reassess following a change in presentation, transfer to another unit and prior to discharge. If Aggression Risk changes, follow interventions accordingly.							
4-7 Moderate Risk: Re-assess q48h or until Low Risk							
• Close Observation (q15min checks) • Routine Observation = N/A							
• Produce a quiet and calm environment							
• Communicate with empathy to the person to facilitate a better understanding of his or her current needs							
• Initiate "Behaviour Tracking Log" to monitor aggression triggers and intervention effectiveness							
• Ensure a safe space, free of objects that could be potentially used as weapons							
8-10 High Risk: Re-assess q48h or until Low Risk							
• Close Observation until score is Moderate Risk							
• Produce a quiet and calm environment • Communicate with empathy to patient to facilitate a better understanding of their current needs							
• Initiate/continue "Behavior Tracking Log" to monitor aggression triggers and intervention effectiveness							
• Ensure a safe space, free of objects that could be potentially used as weapons							
• Provide medication if appropriate according to MAR and prn MAR							

STHA# 6120-092-20

Page 2 of 2

Appendix 3: Elopement Risk Assessment

NORTHWEST TERRITORIES
Health and Social Services Authority

STANTON TERRITORIAL HOSPITAL
PSYCHIATRY UNIT

ELOPEMENT RISK ASSESSMENT

(PATIENT ID)

All patients should be assessed **on admission**.

		1	2	3	4	5	6	7
Please check the most appropriate reason for assessment.	**Admission**							
	Change in status							
	Periodic review							
	Discharge							
RISK FACTORS		**SCORE: YES (1) NO (0)**						
Age 35 years or younger								
Lack of insight into hospitalization								
Co-morbid substance use or drug cravings								
History of mental illness (Psychosis, Mood Disorder, Personality Disorder)								
Involuntary status (certified under *Mental Health Act*)								
Prior history of elopement								
High risk for impulsivity								
Non-therapeutic relationship with staff								
Concern for safety of persons or belongings (Minor children; belongings at home; living situation)								
Reduced mental capacity (Dementia, cognitive impairment, organic brain syndrome)								
TOTAL SCORE **Low Risk (1-3) Moderate Risk (4-6) High Risk (7-10)**								
DATE/TIME								
INITIALS								

Patients assessed as **High Risk** for elopement require a completed physical description inventory.

Height:	Weight:	Hair Colour:	Hair Length:	Ethnicity:
Physical Identifiers: (i.e. tattoos, scars)	Jacket Description:	Shoe Description:	Next of Kin:	Other:

Page 1of 1

Appendix 4: Falls Risk Assessment

STANTON TERRITORIAL HEALTH AUTHORITY
FALL RISK ASSESSMENT

(PATIENT LABEL)

Reason Key: A = Admission C = Change in Condition R = Periodic Review F = Post Fall D = Discharge	**Date/Time**												
Number of assessments:		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Reason for assessment:													
History of Falls (within 3 months) No: **0** Yes: **5**													
Secondary Diagnosis (Dx): No: **0** 1 point for each secondary Dx to max of: **5**													
Ambulatory Aids: None: **0** One person assist: **1** Two person assist: **2** Cane/Crutches/Walker: **3** IV Pole/Mobile medical equipment/Foley: **4** With use of furniture/Refusing aides: **5**													
Gait: Normal: **0** Wheelchair: **2** Gait weak/Impaired: **3** Bed rest: **4**													
Mental Status: Knows own limits: **0** Over-estimates/forgets limits: **3** Symptoms of ETOH withdrawal/on Clinical Institute Withdrawal Assessment: **4**													
Medications: Not on medication causing fall risk: **0** Alpha-Blockers/Anticholinergics/Antihistamines Anti-Emetics/Anticonvulsants/Cardiac medications/Muscle relaxants/ Parkinson medications: **3** Sedatives/Hypnotics/Anxiolytics/ Antidepressants/Psychotropics/Neuroleptics: **5**													
Impairments: No impairment (Using Glasses/Hearing Aides) : **0** Visual/auditory/cognitive/sensory impairment: **4**													
Ability to rise from a chair: In single movement: **0** Pushes up from chair in one attempt: **2** Multiple attempts but successful: **3** Unable without assistance: **4**													
TOTAL SCORE:													
INITIALS:													

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STANTON TERRITORIAL HEALTH AUTHORITY FALL RISK ASSESSMENT	(PATIENT LABEL)

Planning/Implementation: Date and initial the applicable section once action completed.

Re-assessment: Re-assess status following; a change in condition, on transfer to another unit, and/or prior to discharge.

Number of assessments:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
0 - 9 Low Risk: reassess q24h & prn Provided "SAFE" environment												
10 – 19 Moderate Risk: reassess bid & prn Place a "Fall Risk" armband on patient												
Inform patient of their risk for falls.												
Notify family of fall risk status.												
Place fall precaution labels on chart, care plan and over patient bed.												
Initiate individualized care plan.												
20 – 36 High Risk: reassess tid & prn Place a "Fall Risk" armband on patient												
Inform patient of their risk for falls.												
Notify family of fall risk status.												
Place **2** fall precaution labels on chart, care plan and over patient bed, to signify higher risk.												
Initiate individualized care plan.												

SAFE = **S-** Safe Environment, **A-** Assist with Mobility, **F-** Fall Risk Reduction, **E-** Engage Client and Family

STHA# 6050-002-16

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Appendix 5: Psychiatry Standing Orders

NORTHWEST TERRITORIES
Health and Social Services Authority
STANTON TERRITORIAL HOSPITAL
DEPARTMENT OF PSYCHIATRY

PATIENT ID

PHYSICIAN STANDING ORDERS FOR: GENERAL PSYCHIATRY ADMISSION

ALLERGIES: ☐ NKA ☐ YES, SEE CAUTION SHEET.

DATE: TIME:

1. **Admit to (MRP):** _____
2. **Consult Psychiatry**
3. **Admitting Diagnosis:** _____
4. **Goals of Care:** (Choose A or B)
   - A. ☐ Full Code (R1)
   - B. ☐ Alternate Goal of Care (See Goals of Care Physician Order Form)
     Alternate Levels of Care should be considered if the patient's clinical condition is such that death within the year would not be considered unexpected
5. **VTE Prophylaxis:** (Choose A or B)
   - A. ☐ VTE Risk Assessment Form attached
     VTE Prophylaxis orders: _____, or ☐ None
   - B. ☐ VTE Prophylaxis Assessment not required
     (Pediatric patient under 18 years of age or patients on therapeutic anticoagulation only)
6. **Medication Reconciliation:** (Choose A or B)
   - A. ☐ Patient is NOT on medications at home – Admission Medication Reconciliation not required
   - B. ☐ See Best Possible Medication History (BPMH) for Medication Reconciliation Orders
7. **Voluntary or Involuntary Status** (Choose A or B)
   - A. ☐ Voluntary admission
   - B. ☐ Involuntary admission: Form:_____ (specify Form number)
8. **Diet:** ☐ DAT ☐ Other: _____
9. **Activity:** ☐ AAT ☐ Other: _____
10. **Vital Signs:** ☐ Routine (Weekly) ☐ Daily ☐ Other: _____
11. **Observation:** (Choose one)
    - A. ☐ Close (q| 5min) for 48 hours, then reassess
    - B. ☐ Routine observation (q1h)
    - C. ☐ Other _____
12. **Passes:** (Choose A or B)
    - A. ☐ Fresh air breaks escorted by staff for 48 hours, then reassess
    - B. ☐ No passes until assessed by MRP on Psychiatry

_____
PHYSICIAN SIGNATURE

STHA# 6000-327-17 CPAC Approved: 03 AUGUST 2017
Top Copy – Chart Bottom Copy – Pharmacy
Page 1 of 2

Health and Social Services Authority
STANTON TERRITORIAL HOSPITAL
DEPARTMENT OF PSYCHIATRY

PATIENT ID#

PHYSICIAN STANDING ORDERS FOR: GENERAL PSYCHIATRY ADMISSION

ALLERGIES: ☐ NKA ☐ YES, SEE CAUTION SHEET.

DATE: TIME:

13. **Investigations:**
- ☐ CBC & differential ☐ Electrolytes ☐ TSH
- ☐ Lipid panel (Cholesterol, HDL, LDL, triglycerides)
- ☐ Renal panel (Sodium, Potassium, Chloride, CO_2, BUN (Urea), Creatinine)
- ☐ Liver panel (Total bilirubin, ALT, AST, ALP, GGT, Total Protein, Albumin)
- ☐ Fasting glucose Or: ☐ Random glucose
- ☐ Urine pregnancy screen, ☐ Urine drug screen
- ☐ Drug levels (Please List- *eg: Lithium level*): _____

14. **Medications:**
- ☐ Olanzapine 5-10 mg ODT p.o. bid prn for psychosis or agitation **Max Dose 20 mg per day**
- ☐ Haloperidol 2.5-10 mg p.o./IM q2h prn for severe agitation or psychosis **Max Dose 20 mg per 24hr**
- ☐ Lorazepam 1-2 mg IM/p.o./sublingual q6h prn anxiety or agitation **Max Dose 12 mg per day**
- ☐ Benztropine Mesylate 1-2 mg IM/p.o. bid prn for extrapyramidal symptoms
- ☐ Trazodone 50-100 mg p.o. qHS prn sedation
- ☐ Zopiclone 3.75-7.5 mg p.o. qHS prn sedation
- ☐ Acetaminophen 500-1000 mg p.o. q6h prn pain or fever
- ☐ Nicotine Inhaler prn for cigarette cravings **Max Dose 12 cartridges per day**
- ☐ Nicotine Gum 2-4 mg prn for cigarette cravings **Max Dose 80 mg per day**

15. **See Additional Standing Orders:** _____

16. **Other Orders:** _____

PHYSICIAN SIGNATURE
"ORIGINAL SIGNED"
TERRITORIAL CLINICAL LEAD

"ORIGINAL SIGNED"
AREA MEDICAL DIRECTOR

STHA# 6000-327-17 **CPAC Approved: 03 AUGUST 2017**
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Government of
Northwest Territories

July 11, 2024

PLEASE KEEP THE CONTENT OF THIS DOCUMENT CONFIDENTIAL BUT THE FACT THAT THE GNWT IS PARTICIPATING IN NEGOTIATIONS IS NOT CONFIDENTIAL

JANE WEYALLON ARMSTRONG
CHAIRPERSON
STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Inuvialuit Coordination Agreement and Information Sharing Agreement

In accordance with Provision 4 of the "Process Convention on Communications between the Executive Council, Ministers, Standing Committees and Regular Members," I am writing to share a copy of the draft Inuvialuit Coordination Agreement and Information Sharing Agreement for information sharing purposes. Once signed, the Inuvialuit Regional Corporation (IRC) will determine whether these documents are made public.

On November 24, 2021, the IRC passed the *Inuvialuit Qitunrariit Inuuniarnikkun Maligaksat* (Law) and made a request under the federal *Act respecting First Nations, Inuit and Métis children, youth and families* (Federal Act) to enter into a Coordination Agreement. The Department of Health and Social Services, on behalf of the Government of the Northwest Territories (GNWT), has been participating in Coordination Agreement discussions with the IRC and the federal government to identify how it can support the successful implementation of the Law in the Northwest Territories (NWT).

The *Inuvialuit Qitunrariit Inuuniarnikkun Maligaksat* or "*Maligaksat*", a not-for-profit corporation that will implement the Law, will be assuming responsibility and accountability for voluntary support services from the GNWT. Voluntary support services agreements are a prevention service offered when there are no concerns for the safety of the child(ren). Consistent with the GNWT's approach to financing self-government implementation, the GNWT is responsible for providing the budgeted costs for this program to Inuvialuit beneficiaries of the IRC, which totals $209,391 annually.

At the request of the IRC, the GNWT will maintain responsibility for all protection services, as well as emergency services, to ensure the safety, security and well-being of Inuvialuit children and youth. The Coordination Agreement identifies several areas where the IRC, Maligaksat, and the GNWT have made commitments to collaborate with respect to the provision of protection services.

.../2

The Coordination Agreement includes information sharing commitments. The GNWT will disclose child and family services information with Maligaksat and the IRC for the purposes of meeting the commitments under the Coordination Agreement, such as areas of collaboration and for the transfer of voluntary support services from the GNWT to Maligaksat. The Coordination Agreement requires that an Information Sharing Agreement is signed prior to sharing any information.

It is anticipated the Coordination Agreement will be signed in the near future. This will be the first time an Indigenous government in the NWT has exercised jurisdiction over a social envelope jurisdiction. This is also the first Coordination Agreement finalized under the Federal Act in the NWT and the first for and by an Inuit government in Canada. It is a significant milestone for inherent rights in the NWT and in Canada.

If Standing Committee would like more information on the Agreements, Minister Semmler along with representatives from the Department of Health and Social Services are available to provide a briefing and answer any questions Members may have.

Sincerely,

Lesa Semmler
Minister, Health and Social Services

Attachments

c. Members of the Legislative Assembly
Principal Secretary
Deputy Secretary, Premier's Office
Secretary to Cabinet/Deputy Minister, Executive and Indigenous Affairs
Deputy Minister, Health and Social Services
Clerk, Standing Committee on Social Development
Advisor, Standing Committee on Social Development
Committee Members, Standing Committee on Social Development

This Agreement, dated for reference the 27th day of February, 2024.

INUVIALUIT COORDINATION AGREEMENT

between

INUVIALUIT
as represented by the Inuvialuit Regional Corporation
(referred to as the "**IRC**")

and

INUVIALUIT QITUNRARIIT INUUNIARNIKKUN MALIGAKSAT SOCIETY
as represented by the Chair of the Board of Directors
(referred to as "**Maligaksat**")

and

THE GOVERNMENT OF THE NORTHWEST TERRITORIES
as represented by the Minister of Health and Social Services
(referred to as the "**GNWT**")

and

HIS MAJESTY THE KING IN RIGHT OF CANADA
as represented by the Minister of Indigenous Services
(referred to as "**Canada**")

TABLE OF CONTENTS

IN CONSIDERATION OF the mutual promises made herein, the Parties agree as follows:

ARTICLE 1 – INTERPRETATION

Definitions

1.1 In this Agreement and the schedules attached hereto, the following capitalized terms and expressions have the following meanings:

(a) "***Access to Information and Protection of Privacy Act***" means the *Access to Information and Protection of Privacy Act*, S.N.W.T. 1994, c. 20;

(b) "**Agreement**" means this Inuvialuit Coordination Agreement;

(c) "**Care Provider**" means a person who has primary responsibility for providing the day-to-day care of an Inuvialuk Child or Youth, other than the Inuvialuk Child or Youth's parent or Foster Parent, including in accordance with the customs or traditions of Inuvialuit and any other Indigenous group, community, or people to which the Inuvialuk Child or Youth may be connected;

(d) "**CFS Standards**" means the standards, directives, resources, forms, and information that form the GNWT's Child and Family Services Standards and Procedures Manual, as may be amended or replaced from time to time;

(e) "***Child and Family Services Act***" means the *Child and Family Services Act*, S.N.W.T. 1998, c. 1;

(f) "**Child Protection Worker**" has the same meaning as set out in s. 1 of the *Child and Family Services Act*;

(g) "**Collaboration Committee"** means the committee described pursuant to s. 15.13 (Collaboration Committee) of this Agreement;

(h) "**Coordination Committee**" means the committee established pursuant to s. 15.8 (Coordination Committee) of this Agreement;

(i) "**Cultural Plan**" means a detailed written document identifying the cultural supports for an Inuvialuit child or youth who is receiving services from the Director;

(j) "**Designate**" includes an authorized person (as that term is defined in s. 1 of the *Child and Family Services Act*), a foster care and adoption worker, or supervisor/manager designated by the Director;

(k) "**Director**" means the Director of Child and Family Services, as defined in s. 1 of the *Child and Family Services Act*;

(l) "**Effective Date**" means the date of the last signature to this Agreement, upon which this Agreement comes into effect;

(m) "**Federal Act**" means *An Act respecting First Nations, Inuit and Métis children, youth and families,* S.C. 2019, c. 24;

(n) "**Financial Contributions**" means transfer payments or other forms of financial support related to child and family services as agreed to in Fiscal Arrangements;

(o) "**Fiscal Arrangements**" means agreements and other mechanisms related to the provision of child and family services by IRC and Maligaksat which Financial Contributions are made available either directly or through third parties to the ISDP by Canada and the GNWT, including the Inuvialuit Child and Family Services Fiscal Agreement, dated _____;

(p) "**Fiscal Year**" means the period that commences on April 1st of a calendar year and ends on March 31st of the following calendar year;

(q) "**Foster Parent**" means an individual providing a placement service on behalf of the Director pursuant to s. 62 of the *Child and Family Services Act* but does not include an extended family placement;

(r) "**Good Faith**" means the Parties will, among other things:

(i) make a genuine attempt to reach a mutually acceptable outcome;

(ii) explain its views, interests, and positions on any subject or matter being discussed;

(iii) provide information relevant to the discussion to the other Parties on a timely basis;

(iv) give full and fair consideration to proposals from the other Parties, and provide supporting rationale for areas of disagreement;

(v) respond to proposals from the other Parties on a timely basis, but does not include an obligation to reach agreement on any subject or matter that is being reviewed and discussed; and

(vi) act consistently with the standard of good faith as articulated in the common law.

(s) "**IGB**" means an Indigenous governing body, as defined in s. 1 of the Federal Act;

(t) "**Inuvialuit Settlement Region**" has the same meaning as in the *Inuvialuit Final Agreement*;

(u) "**ISDP**" means the Inuvialuit Social Development Program;

(v) "**Law**" means *Inuvialuit Qitunrariit Inuuniarnikkun Maligaksat*, Inuvialuit Regional Corporation, 2021;

(w) "**Major Service Change**" means a regulation passed under s. 51 of the Law, which may include the expansion of jurisdiction to include child protection services;

(x) "**Notice of Significant Measure**" means a notice of Significant Measure provided in accordance with Article 6 (Notice of Significant Measures) of this Agreement;

(y) "**Plan of Care Agreement**" has the same meaning as set out in s. 1 of the *Child and Family Services Act*;

(z) "**Plan of Care Committee**" has the same meaning as set out in s. 1 of the *Child and Family Services Act*;

(aa) "**Service Provider**" means any person, government, or other entity providing child and family services. For the purposes of this Agreement, Service Provider does not include Maligaksat or the GNWT;

(bb) "**Significant Measure**" has the meaning set out in s. 6.2 (Definition of "Significant Measure") of this Agreement; and

(cc) "**System**" means the Child and Family Information System (CFIS), MatrixNT, and any preceding or successor information and data management systems (electronic or otherwise) maintained by the GNWT in the provision of child and family services.

Undefined Terms

1.2 Undefined capitalized terms have the same definitions as set out in the Law.

1.3 For greater certainty, where the terms Child or Youth are capitalized, they have the same meaning as set out in the Law. Where the terms child or youth are in lowercase, they have the same meaning as set out in the *Child and Family Services Act*.

Interpretation

1.4 For the purposes of this Agreement:

(a) where the use of the word "will" or "shall" denotes an obligation that must be carried out by one or more of the Parties and, when no time frame is set out, the obligation shall be carried out as soon as is reasonably practicable after the Effective Date or the event which gives rise to the obligation;

(b) unless it is otherwise clear from the context, the use of the word "including" means "including, but not limited to" and the use of the word "includes" means "includes, but is not limited to";

(c) the use of the singular includes the plural and the use of the plural includes the singular, unless a different meaning is otherwise clear from the context;

(d) the word “or” is used in its inclusive sense, meaning A or B, or both A and B; and the word “and” is used in its joint sense, meaning A and B, but not either alone;

(e) there will be no presumption that any ambiguity in the terms of this Agreement is to be resolved in favour of, or against, a particular Party;

(f) headings and sub-headings are for convenience only and in no way affect the scope or meaning of any provisions of this Agreement;

(g) reference to a federal, territorial, or Inuvialuit law or statute includes every amendment to, every regulation made under, and any law enacted in replacement of that statute; and

(h) a reference in this Agreement to a department or a position holder in a department of Canada, or to a department or a position holder in a department, agency, or other entity of the GNWT, includes a successor to that department or position holder.

ARTICLE 2 – APPLICATION

Nature of the Agreement

2.1 This Agreement is a coordination agreement within the meaning of s. 20 of the Federal Act that provides a foundation for an ongoing relationship amongst Inuvialuit, Maligaksat, GNWT, and Canada in relation to the provision of child and family services to Inuvialuit Children and Youth. The Parties commit to the following in support of the evolution of this Agreement:

(a) the ongoing evolution of the fiscal relationship and Fiscal Arrangements;

(b) the amendment provisions set out in s. 15.35 (Amendment);

(c) the periodic review provisions set out in s. 15.23 (Periodic Review); and

(d) other processes as agreed to by the Parties.

Purpose and Principles

2.2 The purpose of this Agreement is to establish an ongoing relationship between Inuvialuit, Maligaksat, the GNWT, and Canada, in order to support the successful and ongoing implementation of the Law. In carrying out their obligations under this Agreement, the Parties shall be guided by and shall work towards the following:

(a) coordinating to achieve cultural continuity for each Inuvialuk Child and Youth;

(b) enhancing the supports available to enable Inuvialuit families to thrive, reducing the need for intervention;

(c) improving information sharing for fully informed service provision, advocacy, and decision making; and

(d) supporting the increased exercise of Inuvialuit jurisdiction in child and family services at Inuvialuit's own pace and in Inuvialuit's own way.

2.3 In respect of Inuvialuit Children receiving or in need of child and family services pursuant to the Law, the IRC and Maligaksat will ensure that Inuvialuit Children have avenues to express themselves and ask for assistance; and to the extent that Inuvialuit Children are able to understand and express views and preferences about decisions that directly affect them:

(a) those views and preferences will be considered by the IRC and Maligaksat; and

(b) Inuvialuit Children who wish to exercise their rights of review are given assistance and representation.

Scope

2.4 The commitments in this Agreement apply where the Parties are exercising jurisdiction in respect of child and family services in relation to an:

(a) Inuvialuk Child or Youth that is residing in the Northwest Territories; or

(b) Inuvialuk child or youth who is in the temporary or permanent custody of the Director but may be receiving services outside of the Northwest Territories.

Statutory Obligations Regarding Programs and Services

2.5 Where the GNWT is responsible for the practical management and direction of programs and services, the Parties acknowledge that the commitment to collaborate shall not fetter, frustrate, or interfere with, the Director's statutory obligations, including the duties and powers of the Director as set out under ss. 51(2) and (3) of the *Child and Family Services Act*. Nothing in this Agreement affects the decision-making authority of the Director while the GNWT is responsible for the practical management and direction of programs and services.

2.6 For greater certainty, while the GNWT is responsible for the practical management and direction of programs and services, the *Child and Family Services Act* applies, and nothing in this Agreement affects the inherent jurisdiction of the Courts of the Northwest Territories over proceedings commenced under the *Child and Family Services Act*.

2.7 Where Maligaksat is responsible for the practical management and direction of programs and services, the Parties acknowledge that the commitment to collaborate shall not fetter, frustrate, or interfere with IRC and Maligaksat's statutory obligations and decision-making authority under the Law. Nothing in this Agreement affects the full decision-making authority of Maligaksat while Maligaksat is responsible for the practical management and direction of programs and services.

Term of the Agreement

2.8 This Agreement commences on the Effective Date and shall continue, unless terminated pursuant to the provisions of this Agreement, or until the Federal Act has been repealed and not replaced. For greater certainty, termination of this Agreement does not impact the legal validity of the Law.

Binding on Parties

2.9 This Agreement is binding upon and enures to the benefit of each of the Parties hereto and their respective successors and assigns.

Paramountcy

2.10 If there is any conflict or inconsistency between this Agreement and the *Inuvialuit Final Agreement*, the *Inuvialuit Final Agreement* prevails to the extent of the inconsistency or conflict.

Non-Derogation and Without Prejudice

2.11 As soon as reasonably practicable after a Party provides notice under s. 15.25 (Non-Periodic Review of Agreement), the Parties agree to conduct a non-periodic review, pursuant to s. 15.28(f) (Non-Periodic Review of Agreement), to address the paramountcy of laws, including conflict provisions, having regard to the decision rendered by the Supreme Court of Canada in Reference re *An Act respecting First Nations, Inuit and Métis children, youth and families*, 2024 SCC 5.

2.12 Subject to any consequential amendments made to this Agreement as a result of the non-periodic review contemplated in s. 2.11 (Non-Derogation and Without Prejudice), the GNWT and IRC agree:

(a) that nothing in this Agreement will derogate from the statutory authority of each Party;

(b) that this Agreement is without prejudice to the Parties with respect to the issue of paramountcy in cases where the Law and the *Child and Family Services Act* conflict or are inconsistent; and

(c) to the greatest extent possible, will endeavour to make the Law and the *Child and Family Services Act* operate concurrently.

2.13 This Agreement reflects a negotiation between Canada, GNWT, IRC, and Maligaksat and is not a precedent for the negotiation, implementation, or interpretation of any coordination agreement and fiscal arrangements involving any other IGB.

2.14 Canada, GNWT, IRC, and Maligaksat enter into this Agreement without any admission of facts or liability.

Conflict with other Indigenous Laws

2.15 If there is any conflict or inconsistency between the Law and another Indigenous law, the IRC shall enter into discussions with the appropriate IGB to attempt to resolve the conflict or inconsistency.

Provision of Services in Cases of Conflict

2.16 Where there is a conflict or inconsistency between the Law and a territorial or Indigenous law, the Party delivering the relevant child and family services shall continue to provide such services until the conflict or inconsistency has been resolved.

2.17 Where neither the GNWT nor Maligaksat provide a service, and it is unclear under the Law and the *Child and Family Services Act* which Party is responsible for providing that service, the GNWT and Maligaksat agree to refer such conflict or inconsistency to the Collaboration Committee.

Self-Government Agreement

2.18 Any conflict or inconsistency between the Law and any law made pursuant to an Inuvialuit self-government agreement shall be addressed through the non-periodic review process, in accordance with s. 15.28(b) (Non-Periodic Review of Agreement).

Section 35 Rights

2.19 This Agreement does not abrogate or derogate from the Aboriginal or treaty rights recognized and affirmed by s. 35 of the *Constitution Act, 1982*.

2.20 For greater certainty, this Agreement is not a treaty within the meaning of ss. 25 and 35 of the *Constitution Act, 1982*.

Other Programs

2.21 Subject to s. 2.22, this Agreement does not affect the ability of IRC, Maligaksat, or Inuvialuit:

(a) to participate in or benefit from any federal or territorial program for Inuit or Indigenous people in accordance with general criteria established for that program in effect from time to time; or

(b) to participate in or benefit from any federal or territorial program, other than a program referred to in s. 2.21(a) above, or to receive any public service in accordance with general criteria established for that program or public service in effect from time to time.

2.22 IRC, Maligaksat, and Inuvialuit are not eligible to participate in or benefit from any program or to receive any public service from Canada or the GNWT to the extent that funding to

support that program or public service or a substantially similar program or public service has been included in any Fiscal Arrangement.

2.23 Notwithstanding s. 2.22 above, eligibility of Inuvialuit or any person providing services to Inuvialuit for health, social and educational products, services and supports pursuant to Canada's Inuit Child First Initiative is not affected by this Agreement, unless stated otherwise in any Fiscal Arrangement.

2.24 Where Canada makes new programs or services available to Inuit with respect to child and family services or replaces or modifies Canada's Inuit Child First Initiative, Canada will engage with IRC and Maligaksat to discuss potential amendments to this Agreement as appropriate.

All Parties

2.25 This Agreement will be interpreted and administered in accordance with the principle of substantive equality so that a jurisdictional dispute does not result in a gap in child and family services.

ARTICLE 3 – REPRESENTATIONS AND WARRANTIES

Inuvialuit

3.1 The IRC confirms that pursuant to para. 6(1)(a) of the *Inuvialuit Final Agreement* and the inherent right of self-government, the Inuvialuit Regional Corporation:

(a) represents Inuvialuit and their rights and benefits; and

(b) for the purposes of this Agreement and any Fiscal Arrangement, the Inuvialuit Regional Corporation:

(i) is the IGB of Inuvialuit;

(ii) has the authority to make and enact the Law;

(iii) has directed the ISDP to be responsible for the management, administration, and delivery of the child and family services under any Fiscal Arrangement; and

(iv) has legislated the establishment of Maligaksat to, amongst other things, deliver child and family services.

ARTICLE 4 – CULTURAL CONTINUITY

Identification of Inuvialuit

4.1 The GNWT will take all reasonably practical steps to identify Inuvialuit Children and Youth among existing clients, including adjusting its intake process to include the identification

measures set out in ss. 6 to 9 of the *General Regulation* (Reg. 2021-1) enacted pursuant to the Law.

(a) Where required by the *Child and Family Services Act*, the GNWT shall seek the consent of the client to share information with third parties in order to meet the identification measures set out in ss. 6 to 9 of the *General Regulation* (Reg. 2021-1) enacted pursuant to the Law. Where consent is not obtained to share such information with third parties, the GNWT shall refer the client to Maligaksat for support in exploring, discussing, and otherwise confirming their identity.

(b) Where there is a dispute about which community, group, or people the Child or Youth belongs to, the GNWT shall not be responsible for determining the identity of a Child or Youth, including for the purposes of s. 8 of the *General Regulation* (Reg. 2021-1) enacted pursuant to the Law.

4.2 The GNWT shall conduct an internal review of all files that are active in the System as of the Effective Date, to identify Inuvialuit Children and Youth who are receiving services under the *Child and Family Services Act* as of the Effective Date, and disclose the results of this review with the IRC in accordance with Article 8 (Information Sharing).

4.3 The Parties acknowledge that s. 4.2 above is subject to the list of Inuvialuit registrants and Beneficiaries being provided by the IRC to the GNWT.

Access to information related to Inuvialuit Children and Youth who received services prior to the Effective Date

4.4 Access by the IRC and Maligaksat to information and records of information related to Inuvialuit Children and Youth who received services prior to the Effective Date is beneficial for its current and future delivery of child and family services. The GNWT recognizes this as one of the benefits to information sharing where its discretion for the use and disclosure of such information and records of information is authorized under the *Access to Information and Protection of Privacy Act* and the *Child and Family Services Act*.

4.5 The IRC may make requests to access GNWT records related to Inuvialuit Children and Youth who received services under the *Child and Family Services Act* prior to the Effective Date.

4.6 Subject to resourcing, and receiving a request under s. 4.5, the GNWT shall conduct an internal review of its records related to Inuvialuit Children and Youth who received services under the *Child and Family Services Act* prior to the Effective Date in accordance with the *Access to Information and Protection of Privacy Act*.

4.7 Any disclosure resulting from a request under s. 4.5 must be made in accordance with Article 8 (Information Sharing).

Registration

4.8 For the purposes of ss. 4.9 to 4.15 below, "**registration**" means the process of registering an Inuvialuk Child with the IRC for the purposes of, among other benefits, obtaining access to IRC

children's programs, eligibility for federal programs, and recording the Inuvialuk Child's eligibility for enrollment as a Beneficiary when such Child turns eighteen (18) years of age.

4.9 The IRC and the GNWT agree that registration is an important part of implementation of the *Inuvialuit Final Agreement* and is an important measure in promoting cultural continuity and providing access to resources for Inuvialuit Children.

4.10 Subject to ss. 4.11 and 4.14 below, where an Inuvialuk Child is in the permanent custody of the Director, the Director will actively advocate with the family for the registration for such Child, where the Child's family is willing and able to participate in the registration process. The opinions of the Child's family will be considered when:

(a) the Director makes a decision concerning the application for registration of the Child; and

(b) the IRC makes a decision concerning the registration of the Child.

4.11 Where a Child has attained twelve (12) years of age, the Director shall ascertain the Child's views on their registration. These views will be considered when:

(a) the Director makes a decision concerning the application for registration of the Child; and

(b) the IRC makes a decision concerning the registration of the Child.

4.12 When an Inuvialuk Child that was in the permanent custody of the Director has been registered and is reunited with their parent(s) and/or Care Provider(s), the IRC shall provide to the Director, information and other materials to be shared with the parent(s) and/or Care Provider(s) to inform them that the Child was registered.

4.13 Where the GNWT is providing child and family services to an Inuvialuk Child, but the Child is in the temporary custody of the Director or the Director does not have legal custody over such Child, the GNWT will contact the IRC to initiate a registration discussion with the Child's family and provide the family with information on registration.

4.14 Where a Child is believed to be eligible for enrolment pursuant to another comprehensive land claim agreement in Canada, the Director shall inform IRC. IRC will discuss with and obtain written confirmation from the applicable IGB that there are no concerns with respect to the Child's registration. When a Child is enrolled in another comprehensive land claim agreement, this will be considered when:

(a) the Director makes a decision concerning the application for registration of the Child; and

(b) the IRC makes a decision concerning the registration of the Child.

4.15 The IRC is responsible for providing the Director with the appropriate information and registration forms, including contact information for the appropriate IRC staff.

Cultural Continuity Planning

4.16 The GNWT shall conduct an internal review of all files that are active in the System as of the Effective Date in order to identify those Inuvialuit children and youth for which a cultural plan has been completed, and disclose the results of this review and the cultural plans with Maligaksat in accordance with Article 8 (Information Sharing).

4.17 Maligaksat shall, in collaboration with the GNWT, review and update cultural plans completed for such files that are active in the System as of the Effective Date.

4.18 Maligaksat shall develop a template for cultural plans and any further materials and resources to be used in the development, review, and assessment of cultural plans.

4.19 On receipt of an initial Notice of Significant Measure concerning an Inuvialuk child or youth, Maligaksat will initiate the process set out in s. 4.20 below to develop a cultural plan, in collaboration with the GNWT, pursuant to the timelines prescribed in the CFS Standards and *Child and Family Services Act*.

4.20 Maligaksat, the GNWT, and any applicable parties, including the Care Provider for the Inuvialuk child or youth, shall:

(a) meet to develop a cultural plan using the template provided by Maligaksat;

(b) discuss the steps and activities to be included in the cultural plan to support cultural continuity in the care of the Inuvialuk child or youth;

(c) determine how each element of the cultural plan will be resourced and implemented; and

(d) come to a shared agreement on the contents of, and sign, the cultural plan.

4.21 For greater certainty, Maligaksat and the GNWT agree to develop cultural plans that are consistent with s. 11 of the Law, recognizing that Maligaksat and the GNWT will continue to meet their statutory obligations under the Law, the Federal Act, and the *Child and Family Services Act*.

ARTICLE 5 – CUSTOM ADOPTION

ACARA Commissioners

5.1 The IRC shall work collaboratively with Custom Adoption Commissioners appointed under s. 6 of the *Aboriginal Custom Adoption Recognition Act*, S.N.W.T. 1994, c. 26 ("***ACARA***").

ARTICLE 6 – NOTICE OF SIGNIFICANT MEASURES

Notices of Significant Measure

6.1 The GNWT shall provide Notice of a Significant Measure to the following individuals and entities:

(a) Maligaksat;

(b) person(s), other than the Director, who has or have lawful custody of a child or youth;

(c) the Care Provider(s); and

(d) any other applicable IGB.

Definition of "Significant Measure"

6.2 A "**Significant Measure**" includes any of the following:

(a) the receipt of a report by a Child Protection Worker or Designate for which a protection investigation is anticipated or required, or that contributes to an existing protection investigation;

(b) when a Child Protection Worker or Designate establishes a Plan of Care Committee;

(c) the proposed creation, review, amendment, reassessment, renewal, extension or termination of:

(i) a Plan of Care Agreement; or

(ii) any other plan or agreement with a parent, care provider, or youth that may be permitted under the *Child and Family Services Act*;

(d) where a reassessment is conducted in accordance with s. 16(3) of the Federal Act;

(e) when a Child Protection Worker or Designate considers or becomes aware of a potential or actual change to where the child or youth lives, including:

(i) when a Child Protection Worker or Designate apprehends an Inuvialuk child;

(ii) when a Child Protection Worker or Designate is placing the Inuvialuk child or youth in an out-of-home living arrangement, starting a new placement, or changing the placement;

(iii) when a Child Protection Worker or Designate is placing an Inuvialuk child or youth in a voluntary interim placement thirty (30) days after a permanent custody order is granted for the purpose of adoption; or

(iv) reunification (return of the Inuvialuk child or youth to parent(s)) following any of the measures listed under this s. 6.2;

(f) decisions by the Director made pursuant to ss. 35(2), 37(3.1), and 47(2) of the *Child and Family Services Act*, a change in access, or any new event or change in the life of the Inuvialuk child or youth as may be agreed to by the GNWT and Maligaksat and set out in the CFS Standards;

(g) when a Child Protection Worker or Designate makes an application for a court proceeding, including:

(i) to confirm an apprehension;

(ii) for a child or youth protection order pursuant to ss. 24 or 29.2 of the *Child and Family Services Act*;

(iii) for an extension of a child or youth protection order; or

(iv) to discharge a child or youth protection order;

(h) when a Child Protection Worker or Designate withdraws from a court proceeding;

(i) a change in the Child Protection Worker or Designate assigned by the Director or GNWT to an Inuvialuk child or youth, or Inuvialuit family;

(j) where the child is in the custody of the Director and:

(i) the child is placed for the purposes of adoption; or

(ii) the Director consents to an adoption;

(k) consideration of a file transfer to another External Protection Authority, or consideration of potential closure of file or end or termination of services;

(l) notice of a serious incident involving an Inuvialuk child or youth receiving services under the *Child and Family Services Act*, including confirmed or suspected abuse or maltreatment, serious criminal conduct, significant injury, self-harm, missing person, or death, and including anything that requires immediate reporting of an incident to the Director within the CFS Standards;

(m) a complaint filed in accordance with CFS Standards relating to child and family services provided to an Inuvialuk child, youth, or family; or

(n) any other measure agreed to by the IRC and the GNWT and set out in the CFS Standards.

Timing of Notice

6.3 A Notice of Significant Measure provided under s. 6.1 (Notices of Significant Measure) will be made within the applicable timeframes set out in s. 1 of the *General Regulation* (Reg. 2021-1) enacted pursuant to the Law.

6.4 Where the timing for a Notice of Significant Measure is not indicated in the Law, the default notice period shall be the applicable notice period in the *Child and Family Services Act* if indicated, or otherwise ten (10) days from the Significant Measure.

6.5 Where information giving rise to a Significant Measure is not made known to the GNWT in time for the GNWT to provide a Notice of Significant Measure within the prescribed timelines, the GNWT shall notify Maligaksat immediately upon learning of such information.

Process for Providing Notice

6.6 The GNWT shall provide Notices of Significant Measure in a manner and form mutually agreed upon.

6.7 For Notices of Significant Measure relating to court proceedings, the GNWT shall also satisfy the requirements set out in the Territorial Court *Civil Claims Rules*, R-122-2016, the *Child and Family Services Act,* and CFS Standards.

6.8 The IRC shall maintain a twenty-four (24) hour phone line for emergency Notices of Significant Measure and other urgent contact from the GNWT.

6.9 The GNWT shall record how and when each Notice of Significant Measure was provided.

Response to Notice of Significant Measure

6.10 The IRC or Maligaksat shall respond to a Notice of Significant Measure by:

(a) acknowledging receipt of the Notice of Significant Measure as soon as practicable, or otherwise within twenty-four (24) hours; and

(b) subject to Article 7 (Inclusion and Participation), as soon as practicable, or otherwise within three (3) working days, responding to the GNWT on whether and to what extent the IRC or Maligaksat will participate in matters relating to the child or youth.

ARTICLE 7 – INCLUSION AND PARTICIPATION

Collaboration with GNWT

7.1 Subject to the requirements set out in Article 8 (Information Sharing), the IRC, Maligaksat, and the GNWT intend to collaborate through ongoing communication.

Coordination on Investigations

7.2 Once Maligaksat receives a Notice of Significant Measure on a matter falling under s. 6.2(a) (Definition of "Significant Measure"), Maligaksat and the GNWT shall work collaboratively to support the participation of Maligaksat in investigations.

7.3 Maligaksat's role when participating in investigations is to:

(a) represent Inuvialuit interests and support Inuvialuit families in the delivery of child and family services;

(b) assist and support culturally-informed risk assessment and decision-making in investigations; and

(c) mitigate any miscommunication or misunderstanding, or mediate, as needed, between a Child Protection Worker or Designate and an Inuvialuit family.

7.4 Attendance by and the level of participation of Maligaksat in investigations shall be at the sole discretion of Maligaksat, provided that any attendance and participation is:

(a) able to be carried out in a timely manner, within the required timeframe under the *Child and Family Services Act*; and

(b) in the best interests of the child.

7.5 The IRC or Maligaksat shall work collaboratively with the GNWT to develop CFS Standards relating to the nature of Maligaksat's inclusion and participation in investigations.

7.6 Standards relating to the nature of Maligaksat's inclusion and participation in investigations must be finalized prior to Maligaksat participating in investigations with the GNWT.

7.7 The GNWT shall disclose the outcome of an investigation in relation to an Inuvialuit child or youth to Maligaksat.

Case Planning and the Creation of Agreements or Plans

7.8 The IRC, Maligaksat, and the GNWT agree that the participation of Maligaksat in a Plan of Care Committee is beneficial for the development of a Plan of Care Agreement for Inuvialuit children and youth.

7.9 Pursuant to s. 15(3.1)(b) of the *Child and Family Services Act*, a majority of the members of a Plan of Care Committee may agree to invite Maligaksat to become a member of the Committee where they believe Maligaksat may be of assistance in developing and entering into a Plan of Care Agreement.

7.10 The GNWT commits to advocating for the participation of Maligaksat in the Plan of Care Committee prior to its establishment, mediation, and alternative dispute resolution with:

(a) the parent(s) or person(s) with lawful custody of an Inuvialuit child; and

(b) the Inuvialuit child, if the child is twelve (12) years or older.

7.11 Nothing prevents a child or youth's family from inviting the participation of Maligaksat at any point in the Plan of Care Agreement process set out under the *Child and Family Services Act*.

7.12 Maligaksat and the GNWT shall jointly develop messaging to the parent(s) or person(s) with lawful custody of an Inuvialuit child or youth with respect to the perspective and assistance that Maligaksat can offer through its participation and involvement in a Plan of Care Committee, mediation, and alternative dispute resolution. This may include a development of a form specific to supporting the notification and involvement of Maligaksat in the Plan of Care Committee.

Status in Legal Proceedings

7.13 The GNWT shall provide Maligaksat with notice pursuant to the *Child and Family Services Act* regarding legal proceedings within or connected with child and family services involving Inuvialuit children or youth.

Emergency Services

7.14 The GNWT will continue to provide emergency services to ensure the safety, security and well-being of Inuvialuit children and youth.

ARTICLE 8 – INFORMATION SHARING

Data Definitions

8.1 For the purposes of this Article 8 (Information Sharing), the following terms have the following meanings:

(a) "**Aggregate Information**" means:

(i) high-level compiled or collected data; and

(ii) any research or best practices derived from s. 8.11 (Pilot Projects);

in a form that contains no Personal Information and cannot be used or manipulated in any manner to identify any individual.

(b) **"Department of Indigenous Services"** means the department, established in s. 3 of the *Department of Indigenous Services Act*, S.C. 2019, c. 29, s. 336, including all of its agents and assigns.

(c) "**Information Sharing Agreement**" means a written record of understanding that outlines the terms and conditions under which Personal Information is shared between the parties.

(d) "**Personal Information**" means information which is, in respect of:

(i) Canada, personal information as defined in the *Privacy Act*, R.S.C., 1985, c. P-21;

(ii) the GNWT, personal information as defined in the *Access to Information and Protection of Privacy Act*; and

(iii) the IRC, personal information as defined in s. 20(a) of the Law.

Sharing of Aggregate Information

8.2 At the request of:

(a) the IRC, the Department of Indigenous Services or the GNWT, shall provide the IRC with access to Aggregate Information held or collected by the Department of Indigenous Services or the GNWT, regarding the provision of child and family services to Inuvialuit Children and Youth for use to improve the lives of Inuvialuit Children and families; and

(b) the Department of Indigenous Services or the GNWT, the IRC shall provide the Department of Indigenous Services or the GNWT with access to Aggregate Information held or collected by the IRC regarding the provision of child and family services for use to improve the lives of children and families in other communities.

Information Sharing Agreements

8.3 The IRC, Maligaksat, Canada, and the GNWT acknowledge that Information Sharing Agreements, either bilateral or multilateral, are required prior to sharing any Personal Information.

8.4 The IRC, Maligaksat, and the GNWT acknowledge that Information Sharing Agreements, either bilateral or multilateral, are required prior to the GNWT sharing any information or record of information received, obtained, or retained under s. 71(1) of the *Child and Family Services Act*.

8.5 Nothing prevents the GNWT and the IRC from disclosing information under an Information Sharing Agreement, even if the disclosure of that information is not set out in this Agreement.

8.6 Each Party shall collect, retain, and dispose of Personal Information in accordance with their respective privacy legislation, regulations, policies, standards, and practices, as replaced or amended from time to time.

8.7 Any unintentional disclosure of Personal Information by any Party shall not constitute a breach of the Agreement.

8.8 The IRC may enter into an Information Sharing Agreement with any federal department, body, or corporation set out in any of Schedules I to III to the *Financial Administration Act*, R.S.C. 1985, c. F-11, for the provision of Personal Information or Aggregate Information relating to the provision of child and family services by the IRC and Maligaksat to Indigenous children.

Disclosure of Information related to Inuvialuit Children and Youth who received services prior to the Effective Date

8.9 The GNWT is authorized by and relies on s. 71(2)(j) of the *Child and Family Services Act* in relation to information-sharing and disclosure under the Federal Act and other laws and statutes. Consistent with this approach, the GNWT may, in accordance with s. 71(2)(j) of the *Child and*

Family Services Act, disclose child and family services information or records of information related to Inuvialuit Children and Youth who received services prior to the Effective Date.

8.10 The Minister will seek advice from the IRC and Maligaksat prior to determining whether to disclose, in accordance with s. 71(2)(j) of the *Child and Family Services Act*, records from a review conducted pursuant to s. 4.6 (Access to information related to Inuvialuit Children and Youth who received services prior to the Effective Date).

Pilot Projects

8.11 The IRC, in its sole discretion, may participate in any pilot projects to which Canada or the GNWT invites the IRC related to child and family services data collection, sharing, and reporting that will help provide a better understanding of the situation of, and challenges faced by Indigenous children, youth and families across Canada. Such projects may include developing common data elements or data-sharing agreements in support of a multi-jurisdictional data and reporting strategy to improve the lives of children and families.

Limitations on the Provision of Information

8.12 The provision of Aggregate Information by Canada in ss. 8.2 (Sharing of Aggregate Information) and 8.8 (Information Sharing Agreements), and the provision of Personal Information by Canada in s. 8.8 (Information Sharing Agreements):

(a) are restricted to individuals from whom information is collected that were informed by notice that the information is being collected to be shared with IGBs;

(b) do not apply where access to information requires a warrant or other judicial pre-authorization, unless the party controlling the information consents or a prior warrant or judicial pre-authorization is obtained; and

(c) is not required to be shared, if the sharing of the information is not permitted by federal law, the Law, or under any privilege at law, or where the sharing of such information is limited by the terms of another agreement entered into by either the IRC or Canada.

8.13 The Parties acknowledge their respective ability to share information, or any obligation on their part in this Agreement, may be limited by applicable laws including: *Department of Indigenous Services Act,* S.C. 2019, c.29, s. 336; *Privacy Act,* R.S.C., 1985, c. P-21; *Access to Information Act,* R.S.C., 1985, c. A-1; *Access to Information and Protection of Privacy Act*; and the *Child and Family Services Act*.

8.14 The Parties acknowledge that for the purpose of this Article, the GNWT does not collect or record any information on Inuvialuit Youth in receipt of child and family services once they reach twenty-three (23) years of age.

ARTICLE 9 – SOCIAL SUPPORTS

Priority of Preventive Care

9.1 Where the GNWT is providing child and family services in relation to an Inuvialuk child or youth, the GNWT shall refer the family to Maligaksat as soon as practicable to coordinate the provision of services to meet family needs in support of the best interests and cultural continuity.

Maligaksat to Provide Support Services

9.2 As of the Effective Date, Maligaksat shall assume responsibility and accountability to provide Support Services to Inuvialuit Children, Youth, and families in the Northwest Territories, and assisting Inuvialuit Children, Youth, and families in obtaining Support Services outside the Northwest Territories. For greater certainty, this includes Support Services for expectant parents.

9.3 "**Support Services**" include, in respect of any Inuvialuk Child or Youth or Inuvialuit family:

(a) voluntary services agreements entered into by the Director pursuant to s. 5(1) of the *Child and Family Services Act*;

(b) support services agreements entered into by the Director pursuant to s. 6(1) of the *Child and Family Services Act*; and

(c) extended support services agreements entered into by the Director pursuant to s. 6.3(1) of the *Child and Family Services Act*.

Transfer of Support Services and Agreements

9.4 As soon as practicable after the Effective Date, the GNWT shall transfer responsibilities for Support Services to Maligaksat and disclose information with respect to active Support Services and agreements provided to Inuvialuit Children and Youth.

9.5 The transfer of responsibilities for Support Services and agreements from the GNWT to Maligaksat and the disclosure of information with respect to active Support Services and agreements provided to Inuvialuit Children and Youth pursuant to s. 9.4 above shall include services outside the Northwest Territories.

9.6 For greater certainty, the GNWT is responsible for administering the services referred to in ss. 10(1)(b) and 11(3)(b) of the *Child and Family Services Act*.

Collaboration on Service Requests

9.7 Where a person requests Support Services from the GNWT in respect of an Inuvialuk Child or Youth following the Effective Date, the GNWT shall:

(a) refer the request to Maligaksat in a timely manner; and

(b) communicate to such persons requesting Support Services from the GNWT, using messaging developed by Maligaksat, that all requests for Support Services be directed to Maligaksat.

Support Services Information

9.8 Where the GNWT is required to complete a statement of alternatives in accordance with s. 12.1(5) of the *Child and Family Services Act*, the GNWT shall request, and Maligaksat shall provide within forty-eight (48) hours of this request, particulars of the Support Services provided to an Inuvialuk child in a form determined by the GNWT. For greater certainty, the provision of this information does not represent Maligaksat's support for how this information may be used, nor shall it preclude Maligaksat from relying on this information differently where Maligaksat participates in the associated legal proceedings.

Support Services to Non-Inuvialuit

9.9 The IRC may enter into agreements with the GNWT that provide for the delivery of Inuvialuit Support Services to non-Inuvialuit, in specified locations or situations, where the GNWT would otherwise provide such services.

Additional Transitional Services

9.10 Subject to s. 9.2 (Maligaksat to Provide Support Services), Maligaksat and GNWT may collaborate on the delivery of any additional programs and services to Inuvialuit Youth in the Northwest Territories.

Access to Independent Legal Counsel for Parents

9.11 When IRC establishes an independent legal counsel program, the GNWT shall facilitate access of the parent(s) or person having lawful custody of an Inuvialuk child receiving protection services from the GNWT to IRC's independent legal counsel program.

9.12 The IRC is responsible for providing the GNWT with the information necessary in order for the GNWT to make a referral to the IRC's independent legal counsel program.

Housing Continuity

9.13 When the number of individuals living in a public housing unit is affected because an Inuvialuk child or youth has been separated from their home in that public housing unit due to a protection service provided by the GNWT, the GNWT commits to working with Maligaksat to promote housing continuity by supporting families in retaining a same-sized public housing unit for up to twenty-four (24) months while the child or youth is in protection services.

9.14 Notwithstanding s. 9.13, the GNWT will continue to meet its obligations and exercise its rights under the *Residential Tenancies Act*, R.S.N.W.T. 1988, c. R-5, to ensure the rights and safety of all other tenants and the quality of public housing units.

Family Supports

9.15 Subject to the commitments set out in this Agreement, the GNWT and IRC acknowledge the provision of family supports is in the interest of avoiding family separation and promoting reunification where family separation has occurred. The GNWT and the IRC confirm they will continue to offer programs that support this which are in place from time to time without imposing any additional financial obligation on the GNWT. For greater certainty, nothing in this Agreement relieves the GNWT of existing legal obligations under the *Child and Family Services Act* and the Federal Act.

9.16 The IRC may supplement family supports provided by government with its own programs and services. For greater certainty, this does not alter the level at which the GNWT provides programming in support of families.

ARTICLE 10 – STANDARDS AND COMMUNICATIONS

Development of CFS Standards

10.1 The IRC shall work collaboratively with the GNWT on an ongoing basis to review and revise impacted CFS Standards identified by the GNWT to support the successful implementation of the Law.

Communication to Frontline

10.2 The Director shall send out official communications, developed in consultation with the IRC where applicable, to communicate information about the commitments in this Agreement and ancillary agreements and related changes to the CFS standards to individuals and organizations providing a service on behalf of the Director under the *Child and Family Services Act.*

ARTICLE 11 – OTHER MATTERS

Placements in the Northwest Territories

11.1 Where Maligaksat identifies that it is in the best interests of an Inuvialuk Child or Youth residing outside of the Northwest Territories to be placed in the Northwest Territories, Maligaksat shall work in collaboration with the relevant authority in the Inuvialuk Child or Youth's originating province or territory and the GNWT to effect such placement.

11.2 GNWT's responsibilities shall be carried out in accordance with the *Child and Family Services Act* and the *Provincial/Territorial Protocol on Children, Youth and Families Moving Between Provinces and Territories* (April 1, 2016), as amended from time to time or replaced.

Notifications of Jurisdiction and Amendment

11.3 The IRC will provide GNWT and Canada with one (1) months' notice of any amendment to the Law for the purposes of correcting a clerical omission, mistake, or manifest error, or to make other minor amendments to the Law which IRC has determined will not change the scope, intent, or substance of the Law.

11.4 The IRC will provide the GNWT and Canada with three (3) months' notice of any substantive amendment or change to the Law, including an expansion of jurisdiction over child and family services.

Services delivered outside of the Northwest Territories for children and youth in the care and custody of the Director

11.5 The GNWT shall collaborate with Maligaksat on the following:

(a) the consideration to move an Inuvialuk child or youth outside of the Northwest Territories for the receipt of services, treatment, or programs that are not available within the Northwest Territories;

(b) the consideration of the appropriate treatment model and Service Provider for the Inuvialuk child or youth; and

(c) planning for the transition of the Inuvialuk child or youth both out of the Northwest Territories and on return to the Northwest Territories.

Provinces, Territories, and IGBs

11.6 The IRC will provide information about the Law to other IGBs directly.

11.7 Where an IGB of a community with an Inuvialuit population intends to assert jurisdiction over child and family services, the IRC and the GNWT may enter into multilateral discussions to discuss the coordination of jurisdiction, service coverage, and other related matters.

ARTICLE 12 – DISPUTE RESOLUTION

Service-Level Disputes

12.1 The GNWT, IRC, and Maligaksat shall make best efforts to resolve Service-Level Disputes through the Collaboration Committee, established pursuant to s. 15.13 (Service-Level Collaboration Committee).

12.2 For the purposes of s. 12.1, a "**Service-Level Dispute**" is any dispute, disagreement, conflict, or claim that arises relating to any aspect of the administration and delivery of child and family services to Inuvialuit Children and Youth by the GNWT, IRC, or Maligaksat.

Agreement Disputes

12.3 No Party shall commence legal proceedings in respect of any dispute, conflict, or disagreement arising out of the interpretation, application, or implementation of this Agreement (an "**Agreement Dispute**") without first complying with the dispute resolution process set out in ss. 12.4 to 12.15 (Dispute Resolution Process).

Dispute Resolution Process

12.4 For the purposes of this dispute resolution process, "**Participating Party**" means one of those Parties involved in the dispute.

12.5 A Party shall provide written notice to the Coordination Committee of any Agreement Dispute. On receipt of such notice, the Coordination Committee shall first attempt in Good Faith to resolve any Agreement Dispute set forth in the notice by negotiation and consultation between the Participating Parties. In the event that the Agreement Dispute is not resolved on this informal basis within thirty (30) days of written notice of the Agreement Dispute, or within such other timeframe as may be agreed to in writing by the Participating Parties, the Coordination Committee may refer such Agreement Dispute to mediation on the written consent of each of the Participating Parties. If there is no consent, the Participating Parties are deemed to have complied with the dispute resolution process for the purposes of s. 12.3 (Agreement Disputes), and any Participating Party may commence legal proceedings after ninety (90) days of the notice set out in this s. 12.5, or within such other timeframe as may be agreed to in writing by the Participating Parties.

12.6 Where the Agreement Dispute is referred to mediation, the Agreement Dispute shall be submitted to a mutually agreed upon mediator. Where the Participating Parties are unable to agree on a mediator, the Participating Parties shall apply for a mediator to be appointed by the Supreme Court of the Northwest Territories.

12.7 Where an Agreement Dispute is referred to mediation, the Participating Parties shall:

(a) participate in Good Faith in the mediation process, on a without prejudice basis; and

(b) bear their own costs of the mediation and, unless otherwise agreed, share equally all other costs of the mediation.

12.8 If the Agreement Dispute is not settled through mediation, the Participating Parties may refer such Agreement Dispute to arbitration on the written consent of each of the Participating Parties. If there is no consent, the Participating Parties are deemed to have complied with the dispute resolution process for the purposes of s. 12.3 (Agreement Disputes), and any Participating Party may commence legal proceedings after ninety (90) days of the notice set out in s. 12.5, or within such other timeframe as may be agreed to in writing by the Participating Parties.

12.9 Where the Participating Parties agree to refer the Agreement Dispute to arbitration, the Parties shall jointly appoint one (1) arbitrator. Where the Participating Parties are unable to agree on an arbitrator, the Participating Parties shall apply for an arbitrator to be appointed by the Supreme Court of the Northwest Territories.

12.10 Prior to commencing arbitration, the Participating Parties may agree, on unanimous written consent, that the decision of the arbitrator shall be binding. Where there is no such consent, the Participating Parties shall proceed with the arbitration on the understanding that the decision of the arbitrator shall be non-binding.

12.11 The Agreement Dispute shall be resolved by a single arbitrator who, unless the Participating Parties otherwise agree:

(a) shall decide the process and procedures for the arbitration;

(b) shall decide the issues submitted to arbitration;

(c) shall determine questions of law or jurisdiction or may refer such questions to the Supreme Court of the Northwest Territories;

(d) shall determine all questions of fact and of procedure, including the method of giving evidence;

(e) may provide interim relief;

(f) may provide for the payment of interest and costs;

(g) may subpoena witnesses and order production of documents;

(h) shall administer oaths or affirmations to witnesses; and

(i) shall correct clerical errors in orders and arbitration awards.

12.12 Unless otherwise agreed by the Participating Parties or ordered by the arbitrator, each Participating Party shall bear its own costs of the arbitration and an equal share of the other costs of the arbitration.

12.13 In resolving the Agreement Dispute, an arbitrator may not question the validity of, amend, or delete any provision of this Agreement. Where the Participating Parties have agreed prior to the commencement of arbitration that the decision of an arbitrator is final and binding on the Participating Parties, such decision shall not be challenged by appeal or review in any court except on the grounds of procedural fairness, or that the arbitrator erred in law or exceeded their jurisdiction.

12.14 An appeal or an application for review of a non-binding decision of the arbitrator, or a binding decision of the arbitrator on the grounds set out in s. 12.13 above, shall be heard by a court of competent jurisdiction.

12.15 For greater certainty, at any time after the commencement of arbitration, but before an award is issued by an arbitrator, the Participating Parties may settle their dispute in which case the process is concluded.

IRC's Dispute Resolution Jurisdiction

12.16 For greater certainty, nothing in this Article 12 shall affect any other dispute resolution process set out in the Law, including the IRC's authority to make regulations on dispute resolution pursuant to Part 9 or s. 70 of the Law.

ARTICLE 13 – TRANSITIONAL PROVISIONS

On Transition

13.1 The IRC and the GNWT agree to undertake active communication and coordination to ensure that there is certainty with respect to, and continuity in, the delivery of child and family services to Inuvialuit Children and Youth, including:

(a) on the coming into force of the Law;

(b) on the Effective Date of this Agreement;

(c) a Major Service Change; and

(d) on the exercise of jurisdiction by IRC and the administration of certain child and family services by Maligaksat;

each of the above constituting an anticipated "**Transition Period**".

13.2 The IRC and the GNWT shall work collaboratively to support a Transition Period by:

(a) identifying and addressing any gaps in the delivery of child and family services to Inuvialuit Children and Youth that may result from the transition of such services;

(b) finalizing the necessary training and CFS Standards for the successful implementation of changes agreed to within this Agreement that require changes to the delivery of child and family services to Inuvialuit Children and Youth; and

(c) finalizing any communications and materials required to be distributed to frontline workers and Service Providers on any changes to the delivery of child and family services to Inuvialuit Children and Youth.

Workshops and Information on the Law

13.3 As soon as practicable after the Effective Date, Maligaksat shall provide workshops, in collaboration with the GNWT, on the commitments made under this Agreement and ancillary agreements. This may include information on the Law.

13.4 As soon as practicable after the Effective Date, Maligaksat shall, in consultation with the GNWT, provide training to the appropriate territorial officials on the commitments made under this Agreement and ancillary agreements. This may include information on the Law.

Cultural Competency Training

13.5 Until Maligaksat establishes a cultural competency training program pursuant to s. 41 of the Law, the IRC and the GNWT shall work collaboratively to develop guidelines on cultural competency for training purposes.

13.6 When Maligaksat develops a cultural competency training program, Maligaksat will deliver the program directly to Service Providers in the Northwest Territories in consultation with the GNWT.

ARTICLE 14 – FISCAL ARRANGEMENTS

Fiscal Relationship

14.1 The Parties acknowledge that the relationship created by this Agreement may include inter-governmental fiscal relationships that will be implemented through Fiscal Arrangements.

14.2 The Parties agree to work together to develop Fiscal Arrangements in accordance with this Agreement and as contemplated by para. 20(2)(c) of the Federal Act.

14.3 Subject to the terms set out in any Fiscal Arrangement, the Parties are committed to the principle that Inuvialuit have complete authority and discretion over the expenditure of the Financial Contributions.

14.4 The Parties are committed to the principle that the Fiscal Arrangements remain reasonably stable and predictable over time, while providing sufficient flexibility to address changing circumstances.

14.5 Canada and the GNWT are committed to the principle that neither of them shall cause financial responsibility for the support of child and family services to be transferred between them without mutual consent.

14.6 The obligation of IRC to provide child and family services under any Fiscal Arrangement is contingent on the IRC receiving the Financial Contributions.

14.7 The recognition and affirmation of IRC's legislative authority in this Agreement or in the Federal Act, the exercise of the IRC's legislative authority, or the manner in which IRC exercises its legislative authority does not create or imply any financial obligation or service delivery obligation on the part of Canada or the GNWT, except to the extent that the Parties have agreed to such obligations under this Agreement or under any Fiscal Arrangement.

14.8 In the event of a conflict between the terms of this Agreement and any Fiscal Arrangement, the terms of this Agreement will prevail.

14.9 Canada will not consider the own-source revenue of the IRC, when determining the Financial Contribution to be provided by Canada pursuant to any Fiscal Arrangement.

14.10 Fiscal Arrangements will not affect federal or territorial funding for the IRC or ISDP for matters other than those addressed by this Agreement and Fiscal Arrangements and will not affect the ability of the IRC, wholly-owned Inuvialuit community corporations as defined in s. 6 of the *Inuvialuit Final Agreement*, or the IRC service population to participate in or benefit from any federal or territorial program for matters other than those addressed by this Agreement and Fiscal Arrangements in accordance with the criteria for the program.

Financial Contributions

14.11 Any Financial Contribution required for the purpose of meeting Canada's financial obligations in a Fiscal Year under any Fiscal Arrangement will be subject to an appropriation of funds by the Parliament of Canada for that Fiscal Year.

14.12 Any Financial Contribution required for the purpose of meeting the GNWT's financial obligations under any Fiscal Arrangement is subject to an appropriation of funds from the GNWT Legislature.

Amendments to Fiscal Policy

14.13 Where Canada proposes to amend or replace their respective prevailing fiscal policy in respect of child and family service coordination agreements in a manner that may impact any Fiscal Arrangement, Canada will provide notice to the IRC along with details of the proposed changes, and:

(a) if there is a national or regional engagement process established by Canada to review and consider changes to that policy, IRC will be notified and will have a right to participate in that process; or

(b) if there is no national or regional engagement process in place, IRC will have the right to request a meeting with Canada, as the case may be, within thirty (30) days and make its views known on the proposed amendment or replacement prior to a decision to amend or replace the policy being made.

ARTICLE 15 – GENERAL PROVISIONS

Limitation of Liability

15.1 The IRC and Maligaksat will not be liable for acts or omissions of Canada or the GNWT, or any person or entity authorized by Canada or the GNWT to act in relation to Inuvialuit child and family services prior to the Effective Date.

15.2 Canada will not be liable for acts or omissions of IRC, Maligaksat, or any person or entity authorized by IRC or Maligaksat to act in relation to Inuvialuit child and family services upon the Effective Date.

15.3 GNWT will not be liable for acts or omissions of IRC, Maligaksat, or any person or entity authorized by IRC or Maligaksat to act in relation to Inuvialuit child and family services upon the Effective Date.

Indemnification

15.4 The IRC and Maligaksat will indemnify Canada for all damages, losses, and expenses arising directly or indirectly from claims by third parties relating to:

(a) a challenge to the validity of the Law, or the authority of the IRC to administer or enforce the Law, including a challenge to the constitutionality of the Law or IRC's authority to enact the Law, whether or not the allegations relating to the challenge are groundless, false or fraudulent; or

(b) the administration or enforcement of any provision of the Law.

15.5 The indemnity set out in s. 15.4(a) above does not apply to the extent that any challenge to the validity of the Law arises from an allegation that the Federal Act is beyond federal jurisdiction or contrary to the *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c. 11, s. 91(24).

15.6 The GNWT shall indemnify and hold harmless IRC and Maligaksat against any and all damages, losses, and expenses arising directly or indirectly from:

(a) any breach or non-fulfilment of any of the covenants to be performed by the GNWT pursuant to this Agreement;

(b) the negligence or wilful misconduct of the GNWT or its employees in the delivery of child and family services to Inuvialuit Children and Youth;

(c) claims by third parties relating to child and family services provided by the GNWT to Inuvialuit Children and Youth; or

(d) any failure by the GNWT and its employees to comply with the Federal Act, the *Child and Family Services Act*, and any other applicable laws and regulations in the performance of its obligations under this Agreement.

15.7 The IRC and Maligaksat shall defend, indemnify and hold harmless the GNWT, its Ministers, officers, employees, servants and agents from and against any and all damages, losses, and expenses arising directly or indirectly from:

(a) any breach or non-fulfilment of any covenants to be performed by the IRC or Maligaksat pursuant to this Agreement;

(b) the negligence or wilful misconduct of the IRC or Maligaksat or its employees in the delivery of child and family services to Inuvialuit Children and Youth;

(c) claims by third parties relating to child and family services provided by the IRC or Maligaksat to Inuvialuit Children and Youth; or

(d) any failure by the IRC or Maligaksat and its employees to comply with the Federal Act, the *Child and Family Services Act*, and any other applicable laws and regulations in the performance of its obligations under this Agreement.

Coordination Committee

15.8 A Coordination Committee shall be established consisting of at least one (1) designated representative each from IRC, Maligaksat, the GNWT, and Canada.

15.9 The Coordination Committee shall meet a minimum of once per year or more frequently if so determined by the Coordination Committee.

15.10 The Coordination Committee shall be responsible for:

(a) negotiations and consultations with respect to any Agreement Dispute, in accordance with s. 12.5 (Dispute Resolution Process);

(b) any dispute referred to the Coordination Committee within any Fiscal Arrangement;

(c) periodic reviews of this Agreement in accordance with s. 15.23 (Periodic Review of Agreement);

(d) non-periodic reviews of this Agreement in accordance with s. 15.27 (Non-Periodic Review of Agreement); and

(e) addressing Force Majeure Events in accordance with ss. 15.36 to 15.38 (Force Majeure).

15.11 The Coordination Committee shall be guided by the spirit and intent of this Agreement and seek to carry out its responsibilities in a non-adversarial manner to the extent reasonably possible, guided by and consistent with the best interests of Inuvialuit Children and Youth.

15.12 Each Party shall be responsible for the costs of the participation of its representatives on the Coordination Committee.

Service-Level Collaboration Committee

15.13 There shall be continued a service-level Collaboration Committee consisting of at least two (2) designated representatives from Maligaksat and at least two (2) designated representatives from the GNWT.

15.14 The Collaboration Committee shall meet at least quarterly, either virtually or in person, with Maligaksat and GNWT each responsible for its own costs.

15.15 The Collaboration Committee shall be responsible for:

(a) identifying services that lead to culturally-informed child and family services;

(b) streamlining information sharing pertaining to Inuvialuit Children, Youth, and families receiving child and family services;

(c) identifying concerns related to child and family services delivered to Inuvialuit Children, Youth, and families; and

(d) discussing service-level disputes that may arise pursuant to s. 12.1 (Service-Level Disputes).

15.16 The Collaboration Committee shall develop a terms of reference.

Notices

15.17 Sections 15.18 to 15.20 below govern all notices required under this Agreement except for Notices of Significant Measure, which shall be provided in accordance with Article 6 (Notice of Significant Measures).

15.18 Except as provided herein, any notice, request, consent, or other written communication required or permitted to be given under this Agreement shall be given as follows:

(a) If to the IRC:

Inuvialuit Regional Corporation
ATTN: Chief Administrative Officer
3rd floor, 107 Mackenzie Rd
Bag Service 21
Inuvik, NT X0E 0T0

Email: cao@inuvialuit.com

(b) If to Maligaksat:

Inuvialuit Qitunrariit Inuuniarnikkun Maligaksat
ATTN: Executive Director
1st floor, 107 Mackenzie Rd
Bag Service 21
Inuvik, NT X0E 0T0

Email: childadvocate@inuvialuit.com

(c) If to GNWT:

Director of Policy, Legislation and Intergovernmental Relations
Department of Health and Social Services
P.O. Box 1320
Yellowknife NT X1A 2L9
Phone: 867-767-9052, ext. 49023

Email: stacy_ridgely@gov.nt.ca

(d) If to Canada:

Assistant Deputy Minister, Child and Family Services Reform Sector
10 WELLINGTON ST
Gatineau, Quebec K1A 0H4
Canada
Mail Stop 960
Building LES TERRASSES DE LA CHAUDIÈRE

Email: sefreforme-cfsreform@sac-isc.gc.ca

15.19 A notice is deemed to have been given:

(a) when delivered personally (with written confirmation of receipt) or by courier (with all fees prepaid, receipt requested);

(b) on the date sent by fax or e-mail (with confirmation of transmission) if sent during normal business hours of the recipient, and on the next business day if sent after normal business hours of the recipient; or

(c) when the postal receipt is acknowledged by the addressee, if mailed by prepaid registered post (return receipt requested).

15.20 A Party may register a change of its address for delivery of a notice on thirty (30) days' written notice to all other Parties.

Governing Law

15.21 This Agreement is governed by and construed in accordance with Inuvialuit, federal, or territorial law as the context requires.

Assignment of Agreement

15.22 No Party to this Agreement may assign any of its rights and obligations under this Agreement without the prior written consent of each of the other Parties.

Periodic Review of Agreement

15.23 The Coordination Committee shall conduct a periodic review of this Agreement every five (5) years after the Effective Date.

15.24 If a Party wishes to amend aspects of the Agreement as a result of the periodic review, the Party shall notify the other Parties in accordance with the process set out under, ss. 15.29 to 15.34 (Review Protocol).

Non-Periodic Review of Agreement

15.25 A Party to this Agreement may, at any time, request a review of part of or all of this Agreement by notice in writing to the other Parties. The notice shall include the reasons for requesting the review and may include proposed amendments to this Agreement.

15.26 The Parties shall consider in Good Faith a request for review, and within sixty (60) days of the date of request for review, shall respond in writing to the other Parties by:

(a) agreeing to the review; or

(b) refusing the request for review and providing reasons for the refusal.

15.27 Where the Parties agree to a request for review, and unless otherwise agreed to by the Parties, the Coordination Committee shall conduct a review of the Agreement. If a Party wishes to amend aspects of the Agreement as a result of the non-periodic review, the Party shall notify the other Parties in accordance with the process set out under, ss. 15.29 to 15.34 (Review Protocol).

15.28 Notwithstanding s. 15.26 above, if a Party requests a non-periodic review under s. 15.25 based on:

(a) the coming into force of any Inuvialuit self-government agreement;

(b) any conflict or inconsistency with any Inuvialuit self-government agreement;

(c) substantial changes to the Federal Act, *Child and Family Services Act*, or the Law, including where the IRC proposes a Major Service Change that may impact a Fiscal Arrangement;

(d) a decision of a Canadian court on a matter related to the inherent right of self-government, including jurisdiction in relation to child and family services;

(e) substantial changes to the provision of child and family services by the IRC or Maligaksat in the Northwest Territories; or

(f) the decision rendered by the Supreme Court of Canada in Reference re *An Act respecting First Nations, Inuit and Métis children, youth and families*, 2024 SCC 5;

the other Parties must agree to the non-periodic review.

Review Protocol

15.29 As a result of a periodic or non-periodic review of this Agreement, a Party may provide notice to the other Parties of a request to amend this Agreement.

15.30 On receipt of such notice, the Parties shall negotiate with a view to reaching a consensus on potential amendments to this Agreement. The Parties shall consider all proposals in Good Faith.

15.31 No Party is required to agree to amend this Agreement as a result of a periodic or non-periodic review.

15.32 Where the Parties do agree to amend this Agreement, the Parties will give effect to the amendment(s) in accordance with s. 15.35 (Amendment).

15.33 During any periodic or non-periodic review, each Party must participate in the discussions and negotiations, including negotiations on potential amendments, in Good Faith.

15.34 Any Party may, after one hundred and twenty (120) days after the commencement of a periodic or non-periodic review, refer the question of whether a Party has failed or is failing to participate in the review and subsequent negotiations (if any) in Good Faith, to the dispute resolution process set out in ss. 12.4 to 12.15 (Dispute Resolution Process). For greater certainty, a Party may refer a matter to the dispute resolution process set out in ss. 12.4 to 12.15 (Dispute Resolution Process) whether the periodic or non-periodic review is ongoing or has ended.

Amendment

15.35 This Agreement may only be amended by an agreement in writing executed by all Parties.

Force Majeure

15.36 No Party shall be liable or responsible to the other Parties, or be deemed to have defaulted under or breached this Agreement, for any failure or delay in fulfilling or performing any term of this Agreement, when and to the extent such failure or delay is caused by or results from acts beyond the affected Party's reasonable control, including, without limitation, strikes, lockouts, fires, floods, tempests, acts of God, or any other cause (whether similar or dissimilar to those enumerated) (a "**Force Majeure Event**").

15.37 An affected Party shall give notice to the other Parties of the Force Majeure Event, indicating the period of time the occurrence is expected to continue. On receipt by the other Parties of notice of a Force Majeure Event, the Coordination Committee shall convene to discuss, determine, and recommend to the Parties, the best course of action to mitigate the impact of the Force Majeure Event, consistent with the best interests of Inuvialuit Children, Youth, and families.

15.38 For greater certainty, the affected Party shall use diligent efforts to end the failure or delay and ensure the effects of such Force Majeure Event are minimized. The affected Party shall resume the performance of its obligations as soon as reasonably practicable after the removal of the cause.

Termination

15.39 This Agreement may be terminated:

(a) by consent in writing of all the Parties; or

(b) by any Party on notice to the other Parties, if another Party materially breaches any provision of this Agreement and either the breach cannot be cured or, if the breach

is not cured by the breaching Party within ninety (90) days after the receipt by the breaching Party of written notice of such breach.

15.40 The termination of this Agreement, for any reason, shall not release any of the Parties from any liability to the other Parties.

15.41 The provisions of Article 3 (Representations and Warranties), ss. 2.10 (Paramountcy), 2.19 to 2.20 (Section 35 Rights), 2.21 to 2.24 (Other Programs), 12.1 to 12.2 (Service-Level Disputes), 15.1 to 15.3 (Limitation of Liability), and 15.4 to 15.7 (Indemnification), as well as any other provision that must survive in order to give proper effect to its intent, shall survive the termination of this Agreement.

Severability

15.42 If any term or provision of this Agreement is invalid, illegal, or unenforceable in any jurisdiction, such invalidity, illegality, or unenforceability will not affect any other term or provision of this Agreement or invalidate or render unenforceable such term or provision in any other jurisdiction.

Entire Agreement

15.43 This Agreement is the entire agreement among the Parties in respect of the subject matter of this Agreement and, except as set out in this Agreement, there is no representation, warranty, collateral agreement, condition, right, or obligation affecting this Agreement.

No Agents

15.44 This Agreement does not create any agency, association, partnership, joint venture, or employer-employee relationship between Canada and IRC, ISDP, or Maligaksat.

Counterparts

15.45 This Agreement may be executed in counterparts, each of which is deemed an original, but all of which together are deemed to be one and the same agreement. A signed copy of this Agreement delivered by facsimile, email, or other means of electronic transmission is deemed to have the same legal effect as delivery of an original signed copy of this Agreement.

Independent Legal Advice

15.46 Each of the Parties acknowledges that they have had the opportunity to obtain their own independent legal advice with respect to the terms of this Agreement prior to its execution.

[Remainder of page left intentionally blank; Signature page follows]

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be executed.

INUVIALUIT REGIONAL CORPORATION

Per: _____ _____

Duane Ningaqsiq Smith
Chair and Chief Executive Officer

Date

INUVIALUIT QITUNRARIIT
INUUNIARNIKKUN MALIGAKSAT
SOCIETY

Per: _____ _____

Chair of the Board of Directors

Date

GOVERNMENT OF THE NORTHWEST TERRITORIES

Per: _____ _____

Minister of Health and Social Services

Date

HIS MAJESTY THE KING IN RIGHT OF CANADA

Per: _____ _____

Hon. Patty Hajdu
Minister of Indigenous Services

Date

CHILD AND FAMILY SERVICES INFORMATION SHARING AGREEMENT

BETWEEN:

THE GOVERNMENT OF THE NORTHWEST TERRITORIES
as represented by the Minister of Health and Social Services
(referred to as the "GNWT")

AND:

INUVIALUIT
as represented by the Inuvialuit Regional Corporation
(referred to as the "IRC")

AND:

INUVIALUIT QITUNRARIIT INUUNIARNIKKUN MALIGAKSAT SOCIETY
as represented by the Chair of the Board of Directors
(referred to as "Maligaksat")

(hereinafter referred to collectively as the "Parties" and individually as a "Party")

THE PARTIES AGREE AS FOLLOWS:

1. DEFINITIONS

1.1 In this Agreement, unless the context otherwise requires, or unless expressly stated:

"ATIPPA" means the *Access to Information and Protection of Privacy Act*, S.N.W.T. 1994, c.20, and any regulations made thereunder, as may be amended from time to time.

"Agreement" means this Child and Family Services Information Sharing Agreement, including all Appendices attached hereto;

"An Act respecting First Nations, Inuit and Métis children, youth and families" means *An Act respecting First Nations, Inuit and Métis children, youth and families*, S.C. 2019, c. 24, as may be amended from time to time.

"CFSA" means the *Child and Family Services Act*, S.N.W.T. 1998, c.1, and any regulations made thereunder, as may be amended from time to time.

"Child and Family Services" means services to support children and families, including prevention services, early intervention services, and child protection services.

"disclose" in relation to Information means to release Information or make Information available in any manner, including verbally or visually, to a person or organization and "disclosed" has a corresponding meaning.

"**Historical file**" refers to Information related to individuals who have received Child and Family Services but are not actively receiving Child and Family Services.

"Individual" means a natural person, whether living or deceased, unless the context indicates otherwise.

"Information" includes all information or Records of information received, obtained, or retained under s. 71(1) of the CFSA or the *Inuvialuit Qitunrariit Inuuniarnikkun Maligaksat*.

"*Inuvialuit Qitunrariit Inuuniarnikkun Maligaksat*" means the *Inuvialuit Qitunrariit Inuuniarnikkun Maligaksat*, Inuvialuit Regional Corporation, 2021, and any regulations made thereunder, as may be amended from time to time.

"Inuvialuit Coordination Agreement" means the coordination agreement, dated XXXXXXX entered into between IRC, Maligaksat, the GNWT, and Canada, pursuant to s. 20(2) of An Act respecting First Nations, Inuit and Métis children, youth and families.

"Record of information" means a record as defined in ATIPPA, but which was received, obtained, or retained under s. 71(1) of the CFSA or the *Inuvialuit Qitunrariit Inuuniarnikkun Maligaksat*.

"use" in relation to Information, means to handle, deal with, or apply Information for a purpose, including to reproduce or transform it, but does not mean to collect or disclose Information.

1.2 These definitions shall apply equally to both the singular and the plural forms of the terms defined, and words of any gender shall include each other gender when appropriate.

2. PURPOSE OF THE INFORMATION SHARING

2.1 The purpose of this Agreement is to provide for the collection, use, disclosure, and protection of Child and Family Services Information in a manner that recognizes both the right of Individuals to access and protect their information and the need of Parties to collect, use, and disclose Information to provide Child and Family Services to Inuvialuit children, youth, and families in accordance with the commitments set out in the Inuvialuit Coordination Agreement.

2.2 For greater certainty, the collection, use, disclosure, and protection of Child and Family Services Information may extend to Information related to Inuvialuit children and youth who received services prior to the effective date of the Inuvialuit Coordination Agreement.

2.3 The GNWT may collect Information from, and disclose Information to, the IRC and Maligaksat, solely for the purposes set out in s. 2.1.

2.4 The IRC and Maligaksat may collect Information from, and disclose Information to, the GNWT, solely for the purposes set out in s. 2.1.

2.5 The Parties may use Information only for the purposes in which it was disclosed.

2.6 The Parties shall not use or further disclose Information provided by the other Party except in accordance with the purposes set out in this Agreement.

3. DISCLOSURE OF INFORMATION

3.1 The GNWT is authorized to enter into this Agreement and to disclose Information described in this Agreement under s. 71(2)(j) of the CFSA. Requests for access to information by the IRC and disclosure of this information by the GNWT shall be considered on a case-by-case basis, consistent with the Inuvialuit Coordination Agreement.

3.2 The IRC is authorized to enter into this Agreement as the entity responsible for representing Inuvialuit and their rights and benefits, in accordance with s. 6(1)(a) of the *Inuvialuit Final Agreement*.

3.3 Maligaksat is authorized to enter into this Agreement in accordance with s. 86 of *Inuvialuit Qitunrariit Inuuniarnikkun Maligaksat*.

4. INFORMATION TO BE DISCLOSED

4.1 The Parties shall disclose Information as set out in the Appendix, which may be amended from time to time in accordance with s.11.

4.2 The Parties shall disclose Information in accordance with the timelines established under the CFSA and the *Inuvialuit Qitunrariit Inuuniarnikkun Maligaksat* to provide Child and Family Services or as otherwise agreed to by the Parties.

4.3 The Parties shall not collect, use, or disclose identifiable Information if non-identifiable Information would be adequate for the intended purposes of the collection, use, or disclosure.

4.4 The Parties shall not collect, use, or disclose more Information than is reasonably necessary to meet the purpose of the collection, use, or disclosure.

5. COSTS INCURRED BY PARTIES

5.1 The IRC and Maligaksat, as appropriate, are responsible for paying any incremental costs incurred by the GNWT in order to meet the Information sharing requirements under this Agreement.

5.2 The GNWT will identify the estimated incremental costs required to meet the Information sharing requirements under this Agreement and provide those costs to IRC and Maligaksat for written approval prior to such costs being incurred. If the IRC or Maligaksat have concerns with the estimated incremental costs, the concerns will be identified and discussed with the GNWT prior to being incurred by the GNWT. If the estimated costs vary throughout the Information collection and sharing process, the GNWT will notify the IRC and Maligaksat immediately.

5.3 The IRC and Maligaksat are not responsible for the GNWT's incremental costs associated with providing notice under s.12 of an *Act respecting First Nations, Inuit and Métis children, youth and families* and Article 6 of the Inuvialuit Coordination Agreement.

6. SECURITY AND CONFIDENTIALITY OF INFORMATION

6.1 The Parties agree that each shall retain Information received from the other in strictest confidence. Each Party agrees to treat any Information received from the other Party with the same degree of care as it treats its own; and in any case, to safeguard the Information against accidental or unauthorized access, disclosure, use, modification, and/or deletion.

6.2 The Parties are responsible for ensuring that administrative, technical, and physical safeguards are in place to secure and protect the privacy and confidentiality of the Information.

6.3 The Parties agree that they will not use, copy, disseminate or otherwise release such Information except for the purposes of, or as permitted under the terms of, this Agreement.

6.4 Where a Party receives non-identifying Information, the receiving Party shall not:

a) manipulate the Information in any manner or by any means, electronic or otherwise, to create, render, or extract information;

b) match, merge, or link the Information with personal data in order to produce further personal information; or

c) use the Information for the purpose of identifying Individuals.

6.5 The Parties agree that they may disclose Information received from the other Party to those employees or contractors of the receiving Party who have a bona fide need to know such information for the purposes of this Agreement provided that the receiving Party shall remain responsible for any breach of these confidentiality provisions by such employee or contractor.

6.6 The Information covered under this Agreement will be securely collected, used, retained, destroyed, and disposed of in accordance with the applicable laws of the Northwest Territories and Inuvialuit.

6.8 All Information submitted to the GNWT are in the custody or under the control of the GNWT and thus subject to the protection and disclosure provisions of ATIPPA and CFSA. IRC and Maligaksat acknowledge that the GNWT may be required to release, in whole or in part, the Agreement and any other Information or documents in the GNWT's possession or control relating to this Agreement pursuant to ATIPPA and CFSA. Where such release may be required, the GNWT shall provide prior written notice of this release to the IRC and Maligaksat.

6.9 The Parties will ensure that all and any Information related to the affairs to which the Parties become privy as a result of this Agreement is confidential and will be treated as confidential for the duration of the Agreement and after termination of the Agreement, and shall not be divulged, released, or published without prior written approval of the Party for whom the Information relates.

6.10 Upon becoming aware of any actual collection, compilation, access, use, change, disclosure, or disposal of Information other than in accordance with this Agreement or by an unauthorized person ("**unauthorized usage or disclosure**"), the disclosing Party shall give notice to the other Party and shall include in the notice:

a) a detailed description of the Information subject to the unauthorized usage or disclosure;

b) the date and time and circumstances of the unauthorized usage or disclosure;

c) actions taken or planned, if any, to contain and prevent a similar unauthorized usage or disclosure from occurring in the future;

d) the measures taken to notify Individuals (to whom the Information or Record of information applies) of the unauthorized usage or disclosure; and

e) an assessment of the implications of the breach.

7. LIMITATION OF LIABILITY AND INDEMNITY

7.1 The IRC and Maligaksat shall defend, indemnify and hold harmless the GNWT, its Ministers, officers, employees, servants and agents from and against all claims, actions, causes of action, demands, costs, losses, damages, expenses, suits or other proceedings brought by whomever made, brought or prosecuted in any manner based upon or related wholly or partially to the acts or omissions of the IRC and Maligaksat in their performance of this Agreement.

7.2 The GNWT shall defend, indemnify and hold harmless the IRC and Maligaksat, their directors, officers, employees, servants and agents from and against all claims, actions, causes of action, demands, costs, losses, damages, expenses, suits or other proceedings brought by whomever made, brought or prosecuted in any manner based upon or related wholly or partially to the acts or omissions of the GNWT in its performance of this Agreement.

7.3 Notwithstanding section 7.1, whenever Historical files are disclosed by the GNWT to the IRC and Maligaksat, the IRC and Maligaksat agree to defend, indemnify and hold harmless the GNWT, its Ministers, officers, employees, servants, and agents from and against all claims, actions, causes of action, demands, costs, losses, damages, expenses, suits, or other proceedings, however brought or prosecuted, based upon the fact of disclosure of Historical files by the GNWT to IRC and Maligaksat. For greater certainty, IRC and Maligaksat will not be liable for the acts, omissions, or negligence of the GNWT in relation to the delivery of Child and Family Services prior to the effective date of the Coordination Agreement, including where such acts, omissions, or negligence are revealed through the disclosure of Historical files by the GNWT to IRC and Maligaksat.

8. TERM OF INFORMATION SHARING AGREEMENT

8.1 This Agreement shall come into effect on the date of the last signature to this Agreement and shall remain in effect for two (2) years. Three (3) months prior to the expiry of the Agreement or any subsequent extension period, the Parties may mutually agree in writing to renew or extend the Agreement.

8.2 Where the Parties agree to renew the Agreement, the terms and conditions of the Agreement shall continue to apply until the earlier of:

a) the effective date of the renewed information sharing agreement, as agreed to by the Parties in writing; or

b) six (6) months after the expiry of this Agreement.

8.3 Where the Parties agree to extend this Agreement:

a) the Parties shall agree in writing on the term of the extension period; and

b) the terms and conditions of this Agreement shall be the same as the terms and conditions in effect immediately prior to such extension.

8.4 If the Parties do not agree on renewing or extending the Agreement, the Parties shall terminate this Agreement in accordance with s. 9.

9. TERMINATION

9.1 The Parties may terminate this Agreement on mutual consent.

10. COMMUNICATIONS AND ADMINISTRATIVE CONTACTS

10.1 Every request, notice, delivery or written communication provided for or permitted by this Agreement shall be in writing and delivered to, or mailed, postage prepaid, or emailed to the Party to whom it is to be given, at the address set forth in:

For the GNWT:

Director of Child and Family Services
Department of Health and Social Services
Government of the Northwest Territories
P.O. Box 1320
Yellowknife, NT X1A 2L9
Email: **TBC**

For the IRC:

Inuvialuit Regional Corporation
ATTN: Chief Administrative Officer
3rd floor, 107 Mackenzie Rd
Bag Service 21
Inuvik NT
X0E 0T0
Email : cao@inuvialuit.com

For Maligaksat

Inuvialuit Qitunrariit Inuuniarnikkun Maligaksat
ATTN: Executive Director
1st floor, 107 Mackenzie Rd
Bag Service 21
Inuvik NT
X0E 0T0
Email: childadvocate@inuvialuit.com

11. AMENDING PROCEDURES

11.1 This Agreement may be amended upon written agreement by the Parties.

11.2 Notwithstanding s. 11.1, any person duly authorized by the IRC and Maligaksat may provide the written agreement of those Parties to any amendment to the Appendix.

11.3 The Parties agree to review this Agreement and make such amendments as are necessary to address the paramountcy of laws, as soon as reasonably practicable following the non-periodic review required under s. 2.11 of the Inuvialuit Coordination Agreement.

12. DISPUTES

12.1 Disputes arising out of the interpretation, application, or implementation of this Agreement shall be referred to the service-level Collaboration Committee, in accordance with s. 12.1 of the Inuvialuit Coordination Agreement.

13. COUNTERPARTS

13.1 This Agreement may be signed in counterparts and each counterpart shall constitute an original including a signature delivered in a Portable Document Format (PDF) file delivered by electronic mail.

[Remainder of page left intentionally blank; Signature page follows]

IN WITNESS WHEREOF this Agreement has been signed on behalf of the GNWT by:

Minister of Health and Social Services

Witness

Date

IN WITNESS WHEREOF this Agreement has been signed on behalf of the IRC by:

[NAME](Authorized representative)

Witness

Date

IN WITNESS WHEREOF this Agreement has been signed on behalf of Maligaksat by:

[NAME](Authorized representative)

Witness

Date

Appendix
Information to be Disclosed

Disclosed by GNWT:

Information (content)	Article under CA	Purpose

Disclosed by IRC:

Information (content)	Article under CA	Purpose

Disclosed by Maligaksat:

Information (content)	Article under CA	Purpose

Government of
Northwest Territories

July 12, 2024

THIS IS PUBLIC INFORMATION

JANE WEYALLON ARMSTRONG
CHAIRPERSON
STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Response to SCOSD Letter Requesting Minimum Wage Data

I am writing in response to your letter dated July 05, 2024, requesting data pertaining to minimum wage earners.

The Department of Education, Culture and Employment receives data from the Northwest Territories (NWT) Bureau of Statistics annually on the distribution of hourly wage earners by selected socio-economic characteristics. This data can be accessed on their website, here:

https://www.statsnwt.ca/labour-income/earnings-and-wages/.

In 2023, workers in the NWT who made under $17.00 per hour were more likely to live in Yellowknife, be aged 15 to 24 years old, be female, and have less than high school graduation as their highest level of educational attainment. These workers were also more likely to be living with their parents.

Out of the approximately eight hundred (800) employees in NWT who earned less than $17.00 per hour in 2023, around five hundred (500) of them were aged 15 to 24 years old.

Caitlin Cleveland
Minister
Education, Culture and Employment

c. Members of the Legislative Assembly
Principal Secretary
Deputy Secretary, Premier's Office
Secretary to Cabinet/Deputy Minister, Executive and Indigenous Affairs
Deputy Minister, Education, Culture and Employment
Clerk, Standing Committee on Social Development
Advisor, Standing Committee on Social Development
Committee Members, Standing Committee on Social Development

Government of
Northwest Territories

CONFIDENTIAL/NOT FOR DISTRIBUTION

July 22, 2024

JANE WEYALLON ARMSTRONG
CHAIRPERSON
STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Notification of 2024-2025 Capital Appropriation Transfer
Reallocations to the Mezi Community School (Whatì) Barrier Free Improvement Project

As per provision 5 of the *Process Convention for Communications between Cabinet, Ministers, Standing Committees and Regular Members*, and pursuant to the requirements of *Financial Administration Manual (FAM) Policy 305 - Appropriation Transfers and FAM Interpretation Bulletin 305.01 - Transfer Criteria and Consultation,* please consider this letter as notification that the Department of Education, Culture and Employment (ECE) intends to reallocate a portion of its 2024-2025 infrastructure expenditure appropriation as follows:

Capital Project	Current Budget	Reallocation	New Budget
Mezi Community School (Whatì) Barrier Free Improvement Project	570,000	230,000	800,000
Chief Julian Yendo School (Wrigley) Fencing project	360,000	(230,000)	130,000

The effect of this reallocation in 2024-25 is for ECE to fund the construction phase of the Mezi Community School (Whatì) Barrier Free Improvement Project from projected surplus in the Chief Julian Yendo School (Wrigley) Fencing project.

The Mezi Community School (Whatì) Barrier Free Improvement Project was originally approved in the 2022-2023 Capital Estimates. This is a much-needed barrier free improvement project in Whatì. Mezi Community School is not wheelchair accessible and there are no ramps or automatic doors, which is in the scope of the project to address. The design for the project was funded from the project budget and the construction phase was directly negotiated under the Infrastructure Cooperation Agreement with the Tłı̨chǫ Government. The original tender price was significantly over budget.

.../2

ECE worked with the Department of Infrastructure and the consultant to re-design for cost savings. The contractor rebid in mid-October 2023 with overall scope decreases but was still over budget. The $230,000 to be transferred from the Wrigley project should be sufficient to complete the project.

The contractor for the Chief Julian Yendo School (Wrigley) Fencing project is mobilizing to site this month and is scheduled to complete the project this summer. A sufficient surplus is anticipated from this project's budget to allow this reallocation.

ECE would like to proceed with the reallocations identified above by July 31, 2024. Responses to this letter, if any, would be greatly appreciated by that date.

Caitlin Cleveland
Minister
Education, Culture and Employment

c. Chair, Financial Management Board
Members of the Legislative Assembly
Principal Secretary
Deputy Secretary, Premier's Office
Secretary, Financial Management Board
Secretary to Cabinet/Deputy Minister, Executive and Indigenous Affairs
Deputy Minister, Education, Culture and Employment
Clerk, Standing Committee on Social Development
Advisor, Standing Committee on Social Development
Committee Members, Standing Committee on Social Development

Government of
Northwest Territories

CONFIDENTIAL/NOT FOR DISTRIBUTION

July 22, 2024

JANE WEYALLON ARMSTRONG
CHAIRPERSON
STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Notification of 2024-2025 Capital Appropriation Transfer
Reallocations to the Chief Paul Niditchie School Parking Lot Drop Off & Turn-In Project (Tsiigehtchic) and the Chief Julius School Playground Fencing Project (Fort McPherson)

As per provision 5 of the *Process Convention for Communications between Cabinet, Ministers, Standing Committees and Regular Members*, and pursuant to the requirements of *Financial Administration Manual (FAM) Policy 305 - Appropriation Transfers and FAM Interpretation Bulletin 305.01 - Transfer Criteria and Consultation,* please consider this letter as notification that the Department of Education, Culture and Employment (ECE) intends to reallocate a portion of its 2024-2025 infrastructure expenditure appropriation as follows:

Capital Project	Current Budget	Reallocation	New Budget
Chief Paul Niditchie School Parking Lot Drop Off & Turn-In Project (Tsiigehtchic)	100,000	230,000	330,000
Chief Julius School Playground Fencing Project (Fort McPherson)		120,000	120,000
Ehtseo Ayha School Barrier Free Improvement Project (Dél̨ı̨ne)	1,000,000	-350,000	650,000

The effect of these reallocations in 2024-2025 is to replenish the budgets that were reallocated in 2023-2024 to establish a new 2023-2024 small capital project to provide immediate barrier free access improvements for a current student attending Ehtseo Ayha School in Dél̨ı̨ne. A budget of $500,000 was included in the 2024-2025 Capital Estimates to fund the Ehtseo Ayha School Barrier Free Improvement Project. However, due to the immediate need, funding was transferred from the Chief Paul Niditchie School Parking Lot Drop Off & Turn-In Project (Tsiigehtchic) and the Chief Julius School Playground Fencing Project (Fort McPherson) in an attempt to advance the project in Dél̨ı̨ne. ECE committed to reallocating funds in the 2024-2025 fiscal year to the two projects that funding had originally been reallocated from.

.../2

Planning commenced in Spring 2022 with the Department of Infrastructure (INF) and ECE funding the design for the required upgrades from within existing resources for the Ehtseo Ayha School Barrier Free Improvement Project. With the reallocated funding in 2023-2024, a construction tender was issued and closed on July 12th, 2023 with one bidder for this project.

The lone bidder was unable to fulfill the contractual obligations which caused the project not to proceed in 2023. The work was eventually split into an interior and exterior scope with the award going to two separate contractors. Work on the interior of the school as well as exterior ramp is scheduled to be completed over summer 2024.

The required funding to cover the whole scope of the Ehtseo Ayha School Barrier Free Improvement Project has exceeded the original budget of $500,000, therefore $230,000 of the originally reallocated $330,000 is being transferred back to the Chief Paul Niditchie School Parking Lot Drop Off & Turn-In Project and $120,000 of the originally reallocated $170,000 is being transferred back to the Chief Julius School Playground Fencing Project. ECE will continue to monitor these projects to ensure that the budgets are sufficient.

The Chief Paul Niditchie School Parking Lot Drop Off & Turn-In Project retained a budget of $100,000 for planning to advance the project in 2023-2024. INF was able to utilize the remaining funding for design services, a traffic study and to procure initial design documents. The current project design is currently under review by INF and internally with the Community for shared driveway access. This project has been approved to address a safety concern and has been priority-rated under Protection of People. This facility currently requires a new Parking Drop-Off/Pull In location at the front of the school. Traffic is currently not controlled, and the school has requested a safer location for student drop off and pick up.

The Chief Julius School Playground Fencing Project (Fort McPherson) is also predicated on a safety concern presented by the school. Currently community traffic is traveling through the school yard and playground. Safer property definition and fencing enclosures are required. Additionally, the existing parking lot has abandoned piles resurfacing and is an emerging hazard.

ECE would like to proceed with the reallocations identified above by July 31, 2024. Responses to this letter, if any, would be greatly appreciated by that date.

Caitlin Cleveland
Minister
Education, Culture and Employment

c. Distribution List

Distribution List:

Chair, Financial Management Board
Members of the Legislative Assembly
Principal Secretary
Deputy Secretary, Premier's Office
Secretary to Cabinet/Deputy Minister, Executive and Indigenous Affairs
Secretary, Financial Management Board
Deputy Minister, Education, Culture and Employment
Clerk, Standing Committee on Social Development
Advisor, Standing Committee on Social Development
Committee Members, Standing Committee on Social Development

Government of
Northwest Territories

July 25, 2024

PLEASE KEEP THIS INFORMATION CONFIDENTIAL UNTIL PUBLIC RELEASE SCHEDULED FOR AUGUST 1, 2024

JANE WEYALLON ARMSTRONG
CHAIRPERSON
STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Senior Home Heating Subsidy – Subsidy Enhancement

As per provision 5 of the *Process Convention for Communications between Cabinet, Ministers, Standing Committees and Regular Members*, the Department of Education, Culture and Employment (ECE) is pleased to provide the Standing Committee on Social Development (Committee) with advance notice of the changes to the Senior Home Heating Subsidy (SHHS) program. ECE will be introducing an enhancement to the subsidy rate for the 2024-2025 fiscal year to ensure seniors receive up to 80% of the estimated 2024 fuel cost associated with heating a home. With the enhancement, eligible seniors will see an increase in the amount of subsidy they receive each month.

The SHHS program provides financial assistance to Northwest Territories (NWT) seniors who own their own home or are renting a self-contained unit in the NWT and meet a financial income test. The SHHS program is a subsidy and not intended to cover all heating costs. Seniors may be eligible to receive a set amount of subsidy each month for a period of 8 months per subsidy year, depending on household income and the community in which they live. Seniors are responsible for any heating costs over the subsidy.

In April 2018, the SHHS moved from a fuel allocation system to a monetary system, where instead of receiving a set allotment of fuel, recipients would receive a set amount based on their home community/zone **(APPENDIX A)**. The amount of subsidy was based on the goal of assisting with up to 80% of the average cost of heating a home and the cost of fuel.

.../2

ECE continuously reviews the SHHS program to ensure it is meeting the needs of NWT residents. An internal assessment of the program has since revealed that with the rising cost of heating oil, the SHHS covers approximately 66% of the typical cost to heat a home in each zone. In response to this increased cost of living, and inquiries from Members of the Legislative Assembly and the general public, ECE has been able to introduce an enhancement to the subsidy for each zone for the 2024-2025 subsidy year using internal resources. The increase in subsidy rates will provide additional financial support to seniors who need assistance with heating their homes.

I wish to thank the Committee for its continued interest and look forward to any questions you may have.

Caitlin Cleveland
Minister
Education, Culture and Employment

Attachment

c. Members of the Legislative Assembly
Principal Secretary
Deputy Secretary, Premier's Office
Secretary to Cabinet/Deputy Minister, Executive and Indigenous Affairs
Deputy Minister, Education, Culture and Employment
Clerk, Standing Committee on Social Development
Advisor, Standing Committee on Social Development
Committee Members, Standing Committee on Social Development

APPENDIX A: Zones, Subsidy Amount and Income Thresholds

	Zone 1	Zone 2	Zone 3
Community	Behchokǫ̀ Dettah Enterprise Fort Providence Fort Simpson Fort Smith Hay River Kátł'odeeche Kakisa Ndılǫ Yellowknife	Fort Liard Fort Resolution Gamètì Inuvik Jean Marie River Nahanni Butte Whatì Wrigley	Aklavik Colville Lake Délı̨ne Fort McPherson Fort Good Hope Łutselk'e Norman Wells Paulatuk Sachs Harbour Saamba K'e Tsiigehtchic Tuktoyaktuk Tulita Ulukhaktok Wekweètì
Income Threshold	Up to $56,000	Up to $64,000	Up to $73,000
Current Monthly Subsidy Amount	$375	$500	$575
Subsidy Enhancement (per month)	$85	$60	$175
Total Monthly Subsidy	$460	$560	$750
Total for Subsidy Period	$3,680	$4,480	$6,000

Government of
Northwest Territories

July 26, 2024

THIS IS PUBLIC INFORMATION

JANE WEYALLON-ARMSTRONG
CHAIRPERSON
STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Follow Up to Standing Committee on Social Development Briefing on Systemic Racism in the Northwest Territories Public Health System

Thank you for your questions following the public briefing on systemic racism in the Northwest Territories public health system. The responses to the Committee's questions are attached.

I appreciate the Committee's interest in this important work and will keep you updated as we work to further build a culture of cultural safety and anti-racism across the health and social services system.

Lesa Semmler
Minister, Health and Social Services

Attachment

c. Members of the Legislative Assembly
Principal Secretary
Deputy Secretary, Premier's Office
Secretary to Cabinet/Deputy Minister, Executive and Indigenous Affairs
Deputy Minister, Health and Social Services
Clerk, Standing Committee on Social Development
Advisor, Standing Committee on Social Development
Committee Members, Standing Committee on Social Development

Response to HSS Briefing on Systemic Racism in the Northwest Territories Public Health System – Standing Committee on Social Development Follow-Up Questions

1. **What recommendations have been produced by the Indigenous Advisory Body? Can Committee receive a list of these recommendations?**

The mandate of the Indigenous Advisory Body (IAB) is to provide guidance and advice on how to incorporate Indigenous knowledge, tradition, language, culture, and healing practices within the NWT health and social services (HSS) system. This advice intends to advance actions to infuse the Indigenous worldview into all aspects of the HSS system, leading to improvements in care, health equity, and health outcomes for Indigenous people.

The IAB meets virtually on a quarterly basis and has one in-person meeting annually in each region on a rotational basis. During these meetings, the IAB provides direct feedback to the HSS system. Divisional updates from across the HSS system are also provided during their meetings, and the IAB can provide feedback and discuss improvements, needs, barriers, and gaps in the system. Each IAB meeting results in many action items for the system to address in the interim between meetings, many of which are completed or initiated in time for the following IAB meeting.

The IAB was jointly developed and established by the GNWT and participating Indigenous governments. Committee's request will be discussed at the upcoming August 2024 meeting, and additional information will be shared following that meeting if the IAB agrees.

2. **On slide 17, there was mention of centering anti-racism and cultural safety. Can the department explain what that means and what that looks like?**

Primary health care reform focuses on restructuring the foundational aspects of healthcare delivery at the community level. It emphasizes comprehensive, accessible, and equitable health services that are centered around individuals and communities. This reform aims to strengthen preventive care, health promotion, and early intervention, by involving multidisciplinary teams to address a wide range of health needs. Primary health care reform aims to transform the foundational aspects of health and social services delivery to be more holistic and community oriented. Most importantly, the unique feature of primary health care reform in the NWT is to focus on cultural safety, anti-racism, and people-centered care. Centering anti-racism and cultural safety means that employees will continuously work to understand the ways in which the health and social services perpetuates systemic racism and commits to promoting culturally safe and relationship-based care.

This also means when designing health care delivery that health and social services employees will look at new ways to address the unique needs of marginalized populations, including Indigenous people, Black people, 2SLGBTQQIA+ people, immigrants, and refugees, as well as to improve accessible care for those living in active substance use, without housing, food-insecure, and individuals struggling with their physical, emotional, mental, and spiritual wellbeing.

The primary health care reform initiative is led by the Community, Culture and Innovation division – in collaboration with the Cultural Safety and Anti-Racism division – and contributes to the achievement of the Mandate, Business Plan and primary health care reform mission. A framework will be developed as a roadmap for change that will provide guidance to achieve integrated care at all levels of the health and social services system from 2025-2028 – starting at the practice level and based on regional priorities, and scaling to the health and social services system to continue system transformation efforts.

Work currently underway includes the initiation of integrated care teams in the Yellowknife region to increase relationship-based care, dedicated physician access in the Sahtu region, and development of chronic disease management projects in the Dehcho and Tłı̨chǫ regions.

3. **Committee has concerns about the burnout of staff on the Office of Client Experience team and the Cultural Safety and Anti-Racism division. What is the work demand for the Office of the Client Experience and the Cultural Safety and Anti-Racism division versus what staffed have the capacity to provide?**

Cultural Safety and Anti-Racism Division

The Cultural Safety and Anti-Racism (CSAR) division is currently a team of 8. The team regularly engages in topics that include interpersonal and systemic racism, the intergenerational individual and community impacts of colonization, and the denial of the existence of racism. All members of the CSAR division are responsible for organizing and facilitating Cultural Safety and Anti-Racism training and quarterly Indigenous Advisory Body meetings. In addition to these tasks, the CSAR division is currently developing a tool to review HSS documents, policies, and resources from a cultural safety and anti-racism lens; developing an evaluation plan for the CSAR training; hosting workshops with other divisions; establishing a community of practice for Indigenous staff; developing Rights and Responsibilities for patients; and completing outstanding Cultural Safety Action Plan items.

Careful attention was given throughout the development of the division and staff roles to ensure that the demands of the work were clearly articulated in job descriptions and that staff are provided with holistic support to maintain their personal wellness. However, since 202, the CSAR division has offered Cultural Safety and Anti-Racism training on average 12 times/year. For a small team that is responsible for all aspects of the training, including event planning, this is causing burn out. To address this, in 2024-25 the team will offer only 6 training sessions and will conduct a review of the training. Staff are also taking advanced anti-racism facilitation training so they are better equipped to handle challenging situations. The team is also reviewing how white staff can take on more of the work in assisting other white people in understanding racism – personally and systemically – and moving from bystander to advocate.

Office of Client Experience

The risk of staff burnout in the Office of Client Experience is a concern as this work can be both mentally and emotionally draining. It is anticipated demand is likely to increase with awareness but also repeat use. People who are well served are likely to come back for further support in future if needed. Staff within the office feel the current workload is manageable. As time passes and more people become aware of the office there is concern their capacity to provide service that meets the needs of clients and families could diminish. The staff pride themselves on aiming to provide therapeutic and culturally safe interactions with those they serve. This involves being able to spend as much time as needed with clients and families to ensure their voices are heard and their concerns validated.

The Office of Client Experience was established as a pilot project to ensure good tracking and reporting as the program develops over the first few years. This includes monitoring volumes as well as information about where clients are located and the common challenges they are experiencing. This information is intended to help inform system change, as well as to substantiate any resourcing requests that may be needed as demand for the program expands over time. From the inception of the program, staff wellness has been a priority. The team has developed strategies to maintain wellness both individually and as a team. The team meets quarterly in person to check-in, revive, and share knowledge to grow stronger in their roles. Both the NTHSSA Senior Leadership and Leadership Council have expressed immense support for this program and will be kept apprised of any challenges that may hinder the team's success.

4. **Can Committee receive information on the staffing and position break-down and layout within the Office of Client Experience as well as the cultural safety and anti-racism division? To what extent are these positions GNWT-funded and/or federally funded?**

Cultural Safety and Anti-Racism Division

The Cultural Safety and Anti-Racism work has been predominantly supported by application-based third party funding through a variety of federal sources since it was initiated in 2013. This includes all of the O&M for the team, the cost of the training program, and most staff positions. Over time three positions have become core funded by the GNWT. The current breakdown of positions and funding status is as follows:

Position	Type of Position	Core or Third Party Funded	Comments
1. Director	Indeterminant	Core funded	Position filled
2. Program Coordinator	Indeterminant	Third Party	Position filled
3. Manager, Learning Initiatives	Indeterminant	Third Party	Position filled
4. Senior Advisor, Indigenous Knowledge and Wellness	Indeterminant	Core funded	Position unstaffed
5. Senior Advisor, Culturally Safe Child and Family Services	Indeterminant	Core funded	Position filled
6. Senior Project Manager	Term (2024-2026)	Third Party	Position filled
7. Specialist	Indeterminant	Third Party	Position filled
8. Specialist	Indeterminant	Third Party	Position filled
9. Specialist	Indeterminant	Third Party	Transfer Assignment from Intern position
10. Intern, Cultural Safety and Anti-Racism	Term (2023-2025)	Third Party	Unstaffed. Transfer Assignment into Specialist position
11. Intern, Indigenous Knowledge and Wellness	Term (2023-2025)	Third Party	Unstaffed

Office of Client Experience Staffing

The Office is Currently staffed with 8 positions which are filled. This includes five Senior Indigenous Patient Advocates, two System Navigators, and a Client Experience Liaison (Intake Coordinator). Of the 8 positions in the office only 5 are GNWT core funded. These includes four Senior Indigenous Patient Advocate positions and a System Navigator position. Three positions within the office, as well as O&M for the program, are not GNWT core funded and have been funded through federal Anti-Indigenous Racism funding (system navigation stream) that is set to expire March 31, 2025.

5. **Can the department confirm whether a critical incident investigation is occurring for the Mr. Kochon case?**

The NTHSSA takes all incidents seriously. We can confirm a critical incident investigation will occur to review the care and service provided to Mr. Kochon at Stanton Territorial Hospital.

6. **Committee suggests that the Department of Health and Social Services implement a professional development certificate for those that have completed their anti-racism training.**

The Cultural Safety and Anti-Racism training does not offer a professional development certificate for completion of the training due to concerns that it may be interpreted as a "checkmark" that participants have achieved anti-racist attitudes, skills and behaviours. Learning about and developing skills related to cultural safety and anti-racism is a life-long learning journey. The team is prepared to offer a "Certificate of Attendance".

The division does see value in pursing accreditation as a Continuing Education Credit (CEC). Many health professionals require a minimum number of continued education hours each year and having the training eligible for these credits may be a motivator for health professionals to prioritize completing the Cultural Safety and Anti-Racism training.

7. **Committee suggests that the Department of Health and Social Services host a wellness conference in the Sahtu within the next year.**

The Community, Culture and Innovation division administers Community Wellness Initiatives and supports Indigenous communities in achieving their health and wellness goals by implementing community development approaches, integrating the social determinants of Indigenous People's health, and advancing community identified priorities.

Indigenous communities have expressed interest in continuing discussions that took place at the Weaving our Wisdom gathering earlier in February 2024. We will engage with each community in the Sahtu region to discuss hosting a Wellness gathering or gatherings in the region.

8. **Has the department looked into establishing protocol for discharging patients exhibiting symptoms and who have not yet received treatment?**

Discharge instructions, including when to return for follow-up or reassessment, are determined as part of every physician assessment and care plan in the Emergency Department.

NTHSSA will explore the value of adding public messaging regarding returning for care if unexpected worsening or progression of symptoms occurs as a strategy to ensure that patients can feel confident returning for reassessment if they have ongoing concerns.

Community members can also call 811 to speak with a nurse to help them if they are unsure whether to seek additional care.

9. **Does the Office of Client Experience and the cultural safety and anti-racism division have plans to educate residents of small communities on what they offer in terms of healthcare support?**

<u>Cultural Safety and Anti-Racism Division</u>
The Cultural Safety and Anti-Racism division offers services internally to build a culture of cultural safety across the HSS system and build staff capacity in cultural safety and anti-racism skills as they interact with patients and clients.

The divisional work is regularly updated at each quarterly IAB meeting. IAB membership is comprised of thirteen Indigenous governments appointees who share meeting outcomes with their respective leadership.

Office of Client Experience

Since the program's inception in January 2023 conscious effort has been made to publicize and promote the Office of Client Experience throughout the NWT. This includes advertising in local newspapers, participating in requests for media interviews and going out into the communities where the teams are physically located to build community partnerships. Posters were developed and translated into all the NWT's official languages. Posters have been mailed to local Indigenous governments, organizations, and schools. In early 2024 members of the Office of Client Experience travelled to 1-2 communities in each region of the Northwest Territories to promote the Office of Client Experience. In the next year, the Office of Client Experience team members will again travel 1-2 communities in their regions to continue to promote its programs and services.

Government of
Northwest Territories

July 31, 2024

THIS INFORMATION CAN BE MADE PUBLIC AFTER PUBLICATION OF KEY ELEMENTS

JANE WEYALLON ARMSTRONG
CHAIRPERSON
STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Public Engagement on Proposed Amendments to the *Health and Social Services Professions Act*

In accordance with provision 4 of the *Process Convention on Communications between Cabinet, Ministers, Standing Committees and Regular Members*, for the information of the Standing Committee on Social Development I am writing to provide a copy of the Key Elements for proposed amendments to the Northwest Territories *Health and Social Services Professions Act*.

I must first apologize, as the Discussion Paper was posted to the HSS website prior to the advance copy being provided to Members. In the future, procedures will be in place to ensure Members are provided the advance notice required under the *Process Convention.*

The Key Elements outlines the proposed amendments. The final Key Elements document was released for public and stakeholder feedback on July 29, 2024 through the Government of the Northwest Territories' (GNWT) Public Engagement website (www.gov.nt.ca/engagements). The public engagement period will run until August 30, 2024. The feedback received will be summarized and made available on the GNWT's Public Engagement website and will inform the final amendments to the Act.

Lesa Semmler
Minister, Health and Social Services

Attachment

c. Members of the Legislative Assembly
Principal Secretary
Deputy Secretary, Premier's Office
Secretary to Cabinet/Deputy Minister, EIA
Clerk, Standing Committee on Social Development
Advisor, Standing Committee on Social Development
Committee Members, Standing Committee on Social Development
Deputy Minister, Health and Social Services

HEALTH AND SOCIAL SERVICES PROFESSIONS ACT

PROPOSED AMENDMENTS

KEY ELEMENTS

July 2024

Government of
Northwest Territories

OVERVIEW

Objective:

The Department of Health and Social Services (the Department) is seeking feedback on the proposed key elements that will inform amendments to the *Health and Social Services Professions Act* (HSSPA).

The following key elements table outlines the proposed provisions for the amendments. The proposed key elements consider the current regulatory framework and best practices for the regulation of professions across Canada, and the unique geography and small population of the Northwest Territories (NWT).

The Department encourages you to review the proposed key elements. We welcome all comments and suggestions on the proposed key elements by **August 30, 2024.** Please let us know what you think and if you have any questions.

Contact:

Attention: Comments on Proposed Amendments to *Health and Social Services Professions Act*

Policy, Legislation, and Intergovernmental Relations

Department of Health and Social Services

Government of the Northwest Territories

PO Box 1320

Yellowknife, NT X1A 2L9

Email: dhssacts_feedback@gov.nt.ca

INTRODUCTION

The *Health and Social Services Professions Act* (HSSPA) is an 'umbrella' Act that regulates different health and social services professions under one statute. The Act sets the general requirements that apply to each profession regulated under it, such as the responsibilities of the Registrar of Health and Social Services Professions, registration and renewal procedures, appeal processes, and the handling of complaints and discipline.

The profession-specific regulations cover all the specific requirements related to each profession. For example: protected titles, training, education, and continuing competency.

Together, the HSSPA and profession-specific regulations address the details associated with licensing professionals.

There are currently two regulations under the HSSPA:

- *Naturopathic Profession Regulations*
- *Psychology Profession Regulations*

The Department is currently working to bring other professions under the HSSPA, with the eventual goal of bringing all professions under the Act, with the exception of nursing professionals.

BACKGROUND

Regulated health and social services professions in the NWT are currently governed by twelve separate pieces of legislation. The Department of Health and Social Services (DHSS) is responsible for the regulation of health and social services professionals in the NWT excluding nurses. Nurses are regulated the College and Association of Nurses of the Northwest Territories and Nunavut, which is created by and operates in accordance with the provisions of the NWT *Nursing Profession Act* and the Nunavut *Nursing Professions Act*.

In Canada's provinces, regulated professions are governed by self-regulating Colleges as authorized by the provincial governments. Colleges are responsible for the administration and operation of their organization and must maintain their own regulations, bylaws, standards of practice, and code of ethics. Self-regulation in smaller jurisdictions, such as Canada's territories, is not always viable due to the small number of professionals and costs required to operate an independent regulatory office.

The intent of the HSSPA is to bring all DHSS regulated health and social services professions under the umbrella statute to ensure consistent and comprehensive regulatory frameworks for all health and social services professions. Work is underway to move the regulation of the pharmacy, midwifery, and dental hygienist professions under the HSSPA from their individual and outdated statutes. The remaining health and social services professions currently regulated by DHSS under separate enactments will follow.

The HSSPA was passed in the Legislative Assembly in March 2015 and came into force March 1, 2022.

WHAT WE ARE PROPOSING

KEY ELEMENT	PROPOSAL	ADDITIONAL INFORMATION
Registration Committee Participation in Registration Process	Amendments would propose to allow the Registrar of Health and Social Services Professions (Registrar) to refer a registration decision to a Registration Committee, on an as-needed basis. This would streamline registrations, ensuring that straightforward registrations, renewals, and reinstatements may proceed without delay.	• A Registration Committee may be established for each profession to provide profession-specific expertise respecting eligibility for registrations, renewals, and reinstatements. • Currently, if a Registration Committee exists, they are responsible for all registration activities, and for directing the Registrar to register applicants, when appropriate. • This approach may result in delays and unnecessary work on behalf of a Registration Committee to assess straightforward registrations, renewals, and reinstatements. • Currently only one Registration Committee is established under the HSSPA, for Psychologists. • The Department engaged with members of active Registration Committees, including for those professions not currently regulated under HSSPA, for feedback respecting their involvement with initial registrations and renewals. Respondents were supportive of providing the Registrar with discretionary authority to engage the Registration Committee for their recommendations during the renewal process, on an as-needed basis. • Current requirements for the composition of a Registration Committee are not expected to change.
Mandatory Reporting of Unprofessional Conduct by Employers	Amendments would propose to require employers to report to the Complaints Officer if the employer believes the conduct of a registered member is unprofessional and because of the unprofessional conduct • The employer terminates or suspends employment; • The employer revokes, suspends or restricts entitlements; or • The registrant resigns or voluntarily relinquishes or restricts their entitlement to practice. This would ensure mechanisms exist to protect the public.	• There is a growing trend for professional regulatory legislation to require employers to notify regulatory bodies if an employee (who is a regulated member) has resigned, terminated, or been sanctioned for unprofessional conduct, including behavior that would constitute sexual abuse. • This would include any type of employment on a full-time or part-time basis as a paid or unpaid employee, consultant, contractor, or volunteer. • This proposed amendment aligns with recent amendments to the NWT *Nursing Profession Act*.

KEY ELEMENT	PROPOSAL	ADDITIONAL INFORMATION

Mandatory Notice to Employers of Licence Conditions, Suspensions, or Cancellations	Amendments would propose to require the Registrar to notify any known employer of the registered member if their licence is suspended or cancelled, or conditions are placed on their licence.
	
	This will ensure mechanisms exist to protect the public.
		• This will provide a mechanism for employers to be made aware of the following actions taken by the Registrar, Complaints Officer, Inquiry Panel, or Supreme Court:
		  ○ Conditions placed on a licence
		  ○ A licence is suspended or cancelled
		• This proposed amendment aligns with recent amendments to the NWT *Nursing Profession Act*.

Mandatory Notice to Regulatory Bodies of Licence Conditions, Suspensions, or Cancellations	Amendments would propose to require the Registrar to notify the bodies that regulate the profession in other Canadian jurisdictions if the licence of a registered member has been suspended or cancelled, or if conditions have been placed on their licence.
	
	This will ensure mechanisms exist to protect the public.
		• This will provide a mechanism for regulators to be made aware of the following actions taken by the Registrar, Complaints Officer, Inquiry Panel, or Supreme Court:
		  ○ Conditions placed on a licence
		  ○ A licence is suspended or cancelled
		• This approach aligns with other jurisdictions, and bylaws under the NWT *Nursing Profession Act*.

Approval of professional codes, standards, programs for professions and liability insurance amounts.	Amendments would propose to allow the Registrar to approve continuing competency programs, formats of the recording of continuing competency requirements, guidelines, standards of practice and codes of ethics. The Registrar would be able to approve these items for adoption or reference in the corresponding professional regulation.	• Currently the HSSPA requires the Minister to approve all educational facilities and courses, training programs, exams, continuing competency programs, formats for the recording of continuing competency requirements, guidelines, standards of practice, codes of ethics and liability insurance amounts. • The approach would propose the Registrar approve items related to continuing competency, guidelines, standards of practice and codes of ethics, after engaging with individuals representing the profession, including any existing professional association(s). • The approach would propose that educational facilities and courses, training programs, exams and liability insurance amounts are approved by the Minister, on recommendation of the Registrar.

KEY ELEMENT	PROPOSAL	ADDITIONAL INFORMATION
Emergency Registration	Amendments would propose to allow the Minister of Health and Social Services to direct the Registrar to register and issue licences for a designated profession if a state of emergency is declared. This would be available to a person who is entitled to practise that profession in another province or another territory.	• This would give the Minister power to direct the Registrar to register and issue licences for a designated profession if a state of emergency is declared under the *Emergency Management Act* or other GNWT statute. • A similar power currently exists in the HSSPA for if a public health emergency is declared under the *Public Health Act*. In this case, the Minister, on the recommendation of the Chief Public Health Officer, may direct the Registrar to register professionals and issue licences. • These amendments would allow the GNWT to ensure health professionals are available during all states of emergency.
Registrar Imposing Conditions on a Licence	Amendments would propose to allow the Registrar to impose conditions on an applicant's licence at initial registration without requiring those conditions to be limited or restricted in any way. This would protect the public to ensure that certain requirements are fulfilled or abided by until the conditions are removed.	• Conditions on a licence are intended to protect the public by ensuring that a person is not entitled to practice the profession or provide those services in contravention of the conditions. • The HSSPA allows the Registrar or Registration Committee to impose conditions on an applicant's licence at initial registration, but only in accordance with the regulations. This limitation does not exist for conditions placed on a licence at renewal. • The Department believes this is overly restrictive, and the Registrar should have the ability to impose any conditions at initial registration. • Currently the Complaints Officer and Inquiry Panel may impose conditions, and there is no requirement for them to be in accordance with the regulations. • Conditions may include, but are not limited to, the requirement to practice under supervision, to complete certain training/education, to undergo drug testing, or to complete an ethics exam.

KEY ELEMENT	PROPOSAL	ADDITIONAL INFORMATION

Composition of Boards of Inquiry and Panels of Inquiry	Amendments would propose to allow for out of territory professional representation on Boards and Panels of Inquiry, instead of requiring it.	• The Department feels it is unnecessary to seek representation from outside the territory for Boards of Inquiry and Panels of Inquiry, unless in the event of a conflict or other reasonable cause.
		• Currently, representation on a Board of Inquiry and Inquiry panel includes:
		  ○ At least one person who is a registered member of the profession in the NWT
		  ○ At least one person eligible to practice the profession in a province or another territory
		  ○ At least one person who is a layperson
		• Amendments would propose for representation to include:
		  ○ At least two people who are registered members of the profession in the NWT (with the option of seeking out of territory representation in the event of a conflict or other reasonable cause)
		  ○ At least one person who is a layperson
		• This approach aligns with other jurisdictions.

Repealing Existing Professional Legislation	Amendments would propose to repeal existing professional legislation, as needed.	• As professions are regulated under the *Health and Social Services Professions Act,* the existing legislation that regulates the profession must be repealed. • No changes would be proposed to the existing process for bringing professions under the HSSPA.
Consequential Amendments	Amendments would propose to allow changes to other pieces of legislation that directly relate to the profession being regulated under HSSPA.	• The Department is currently working to regulate the pharmacy, midwifery, and dental hygiene professions under HSSPA. • The proposed approach would, as an example, allow any mention of the *Pharmacy Act*, *Midwifery Profession Act* and *Dental Auxiliaries Act* in other legislation be changed to reflect the name of the new Regulation.
Modernize language	Amendments would ensure provisions that pertain to personal pronouns be gender neutral.	• References to “him or her”, “he or she” or “himself or herself” would be replaced with “they” or “their” or “themself”.

KEY ELEMENT	PROPOSAL	ADDITIONAL INFORMATION
Layperson Definition	Currently, a layperson on a Registration Committee, Board of Inquiry or Panel of Inquiry must not be a member of any profession regulated under HSSPA. Amendments would propose to allow a member of another regulated profession to participate as a layperson on a Board of Inquiry, Inquiry panel or Registration Committee.	• A Registration Committee, Board of Inquiry and Inquiry panel all require representation from a layperson. • Amendments would allow a psychologist, for example, to participate as a layperson on a Board of Inquiry for a naturopathic professional, but not for another psychologist. • This approach aligns with other jurisdictions.
Language Proficiency	Amendments would allow the Regulations to require demonstration of language proficiency.	• Regulatory bodies are permitted to request demonstration of language proficiency if, for example, this has not been previously assessed by the regulatory body in the province/territory of origin. • Acceptable proof of language proficiency would be included in the profession-specific Regulation.
Continuing Competency Requirements	Amendments would give the Registrar some discretion with respect to timing for completion of continuing competency requirements.	• Continuing competency requirements for renewal must be completed in a specific time frame, specified in the Regulations. • Amendments would allow the Registrar to accept deviations from the time frame, if the Registrar is satisfied that there is a reasonable explanation for a delay in acquiring continuing competency requirements.
Virtual Care	Amendments to ensure the Department is not unintentionally prohibiting health professionals from providing care to patients who are non-residents, temporarily in the NWT, and receiving virtual services from a health professional located in another jurisdiction.	• The Department does not want to unintentionally require registration from professionals providing virtual continuing care to non-residents in the NWT. • Health professionals providing care virtually from another jurisdiction to NWT residents must be licensed in the NWT.
Fees	Amendments would allow for a consistent application fee for all professions, and a separate registration/licensing fee, depending on the profession.	• The HSSPA currently allows for only one fee to be charged at initial application, which is a fee for initial application, registration, and licensing. • This amendment will allow for a lower application fee, separate from the registration/licensing fee.

KEY ELEMENT	PROPOSAL	ADDITIONAL INFORMATION
Accepting Applications for Self-regulation	The Department is looking to propose amendments that would allow a profession to apply to self-regulate under the HSSPA.	• Amendments would allow the Department to accept applications for self-regulation from a group or body representing a health or social services profession. • Amendments would propose criteria for determining whether a health or social services profession should be self-regulated under the Act. In addition to the existing criteria for designation, this would include an assessment of the ability of the proposed college of to carry out the mandate, powers, and duties of a college under the Act. • Amendments would allow for a college to be established, along with a governing body (board of directors or council) to manage and conduct the business and affairs of the college. • The amendments would allow for the appointment of a registrar and complaints officer, establishment of a registration committee, adoption of standards and scopes of practice, codes of ethics, continuing competency programs and setting out title protection.

Thank you for your interest in this work. Your feedback is valuable.

Please submit comments and suggestions by August 30, 2024.

Your contributions will be considered in the development of the proposed amendments to the *Health and Social Services Professions Act* and included in a summary of *What We Heard*, which will be publicly available on the Government of the Northwest Territories' Have Your Say webpage.

Government of
Northwest Territories

July 31, 2024

THIS INFORMATION CAN BE MADE PUBLIC AFTER PUBLICATION OF DISCUSSION PAPER ON

JANE WEYALLON ARMSTRONG
CHAIRPERSON
STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Public Engagement on *Pharmacy Profession Regulations* under the *Health and Social Services Professions Act*

In accordance with provision 4 of the *Process Convention on Communications between Cabinet, Ministers, Standing Committees, and Regular Members*, for the information of the Standing Committee on Social Development I am writing to provide a copy of the Discussion Paper on the proposed *Pharmacy Profession Regulations* under the *Health and Social Services Professions Act.* The Discussion Paper outlines the main key elements of the proposed regulations.

I must first apologize, as the Discussion Paper was posted to the HSS website prior to the advance copy being provided to Members. In the future, procedures are in place to ensure Members are provided the advance notice required under the *Process Convention.*

The Discussion Paper was released for public and stakeholder feedback on July 29, 2024 through the Government of the Northwest Territories' (GNWT) Public Engagement website (www.gov.nt.ca/engagements). The public engagement period will run until August 30, 2024. The feedback received will be summarized and made available on the GNWT's Public Engagement website and will inform the development of the regulations.

Lesa Semmler
Minister, Health and Social Services

Attachment

c. Members of the Legislative Assembly
Principal Secretary
Deputy Secretary, Premier's Office
Secretary to Cabinet/Deputy Minister, EIA
Clerk, Standing Committee on Social Development
Advisor, Standing Committee on Social Development
Committee Members, Standing Committee on Social Development
Deputy Minister, Health and Social Services

PROPOSED *PHARMACY PROFESSION REGULATIONS* UNDER THE *HEALTH AND SOCIAL SERVICES PROFESSIONS ACT*

DISCUSSION PAPER

July 2024

Government of
Northwest Territories

OVERVIEW

Objective:

The Department of Health and Social Services (the Department) is seeking feedback on the proposed key elements for the regulation of pharmacists under the *Health and Social Services Professions Act* (HSSPA), including an expanded scope of practice for pharmacists in the Northwest Territories (NWT).

We encourage you to review the proposed key elements and welcome any comments, suggestions, and questions by August 30, 2024.

Contact:

Attention: Comments on Proposed *Pharmacy Profession Regulations*

Policy, Legislation, and Intergovernmental Relations

Department of Health and Social Services

Government of the Northwest Territories

PO Box 1320

Yellowknife, NT X1A 2L9

Email: dhssregs_feedback@gov.nt.ca

INTRODUCTION

Pharmacists and pharmacy technicians are highly skilled and trusted medication experts that undergo extensive training and education to understand the role that drugs and substances play in different medical situations. As integral members of the health care team, pharmacists and pharmacy technicians ensure that the medications prescribed for their clients are safe, appropriate, and effective and provide education, guidance, and treatment to optimize their clients' health outcomes.

The Northwest Territories' (NWT) *Pharmacy Act* (Act) came into force in 2007. It is the law in the NWT that sets out the registration and practice requirements for NWT pharmacists and the mechanism by which complaints regarding unprofessional conduct are handled. Some amendments have been made since the Act first came into force; however, few of these changes modernized the regulatory framework. As a result, the scope of practice for pharmacists in the NWT, alongside Nunavut, is the least comprehensive in Canada. NWT pharmacists are currently authorized to:

- Sell, distribute, compound, dispense, and repackage medications and other health products.
- Provide information (counsel) on the appropriate use of medications and health products, including monitoring and evaluating use.
- Issue continued care prescriptions (for existing prescriptions only) for a maximum duration of one month.
- Substitute pharmaceutically equivalent drugs (in accordance with an interchangeability formulary adopted by the Minister).

The scope of practice for pharmacists in Canada has grown significantly over the last two decades and has improved public access to, and quality of, health services. Across the provinces, not only do pharmacists dispense and sell drugs and substances, but they may also initiate prescription drug therapy, provide emergency prescription refills, renew prescriptions, adapt prescriptions (i.e., change dose, formulation, or regime), prescribe for minor ailments, order and interpret laboratory tests, conduct and interpret point of care tests, and administer certain medications and vaccinations via injection and inhalation. Further, nine (9) provinces have moved to regulate pharmacy technicians – skilled professionals that support by performing the technical aspects of prescription dispensing and drug administration, enabling pharmacists to dedicate more time to their unique and increasingly advanced clinical roles. The result is enhanced pharmacy services that improve overall public access to healthcare.

As of April 24, 2024, there were 63 pharmacists actively licensed to practice in the NWT. Pharmacy technicians are currently unregulated in the NWT.

For a snapshot of the scope of practice for pharmacists and pharmacy technicians in Canada, as developed by the National Association of Pharmacy Regulatory Authorities (NAPRA), please see *Appendix A* (Scope of Practice for Pharmacists in Canadian Jurisdictions) and *Appendix B* (Scope of Practice for Pharmacy Technicians in Canadian Jurisdictions).

For engagement purposes, there are questions included throughout the document on each specific proposed key element. All questions are included in *Appendix C*.

WHAT WE ARE PROPOSING

To ensure that NWT residents have greater access to health services, enable NWT pharmacists to practice to their full scope, improve efforts around the recruitment and retention of health professionals, and to better align with the regulation of pharmacists in the rest of Canada, it is necessary to update the existing regulatory framework for pharmacists in the NWT, primarily by expanding the scope of practice of pharmacists. Further, for pharmacists to expand their services, they need additional assistance within the pharmacy. A viable solution that the Department is proposing is the regulation of pharmacy technicians. Pharmacy technicians have the expertise to support effective pharmacy operations and play a key role in serving patients and providing quality patient care.

The practice of the profession of pharmacy will be regulated through the new proposed *Pharmacy Profession Regulations* (Regulations) under the HSSPA – the Department's "umbrella" legislation that intends to support a comprehensive and consistent framework for the regulation of all health and social services professionals in the NWT. The HSSPA sets out general requirements that apply to each profession regulated under it, such as the responsibilities of the Registrar of Health and Social Services Profession, registration and renewal procedures, appeal processes, and the handling of complaints and discipline.

The profession-specific regulations will address details associated with licensed pharmacy professionals. These regulations would update registration and renewal criteria and requirements, protect professional titles, ensure public safety by requiring that registrants meet training standards, establish a code of ethics and standards of practice, and require registrants to complete continuing competency requirements. These requirements will align with requirements set out by pharmacy regulators across Canada.

Regulating the pharmacy procession under the HSSPA will modernize the framework for pharmacists generally, introduce the regulation of pharmacy technicians in the NWT, and most significantly, expand the scope of practice for pharmacists to include:

- Initiating prescriptions;
- Issuing emergency prescription refills and continued care prescriptions;
- Adapting prescriptions (including therapeutic substitutions);
- Ordering and interpreting laboratory and point of care (POC) tests; and
- Administering certain vaccines and medications via injection and inhalation.

The Department had originally anticipated that bringing pharmacists under the HSSPA would result in a complete repeal of the *Pharmacy Act,* like has been done for professions already brought under HSSPA (i.e., psychologists); however, the *Pharmacy Act* is unique in that it regulates both the practice of the profession of pharmacy as well as the sale of pharmaceuticals, which is covered in Part 3 of the current *Pharmacy Act* and associated regulations. Provisions related to the sale of pharmaceuticals, such as those that adopt NAPRA drug schedules, set out requirements for the sale and storage of drugs, and set out requirements for prescriptions, cannot be carried over to the proposed *Pharmacy Profession Regulations* since they are intended to apply not only to pharmacists, but to other retail outlets, health and social professions, and

the public. The Department is proposing to repeal and replace the current *Pharmacy Act* with a new Act (likely renamed to clearly distinguish it from the practice of pharmacists) that only includes the necessary Part 3 provisions and associated regulations. (e.g., varying drug schedules). This aspect of the project will be addressed as part of the project to amend the HSSPA. The HSSPA amendments, new *Pharmacy Profession Regulations,* and new *Pharmacy Act* (renamed) would all come into force at the same time.

The remainder of this discussion paper focuses on expanding the scope of practice of pharmacists, as this is the area that would result in the most significant changes to the practice of pharmacy and have the greatest impact on the public.

This proposal has been developed in collaboration with the NWT Pharmaceutical Association, and the Registrar, Chief of Profession Regulation at the Professional Licensing Office, and is informed by extensive cross-jurisdictional research.

Regulating Pharmacy Technicians

Pharmacy Technicians are highly trained professionals that assist pharmacists in daily operations, helping to enhance pharmacy service delivery and improving the public's access to pharmacy services. Pharmacy technicians are not currently regulated in the NWT but are regulated in nine (9) other Canadian jurisdictions.

Pharmacy technicians have the necessary training and responsibility for certain pharmacy duties, including but not limited to, preparing medication, affixing medication labels, developing compound formulations, compounding medications, completing the final technical check on prescriptions, and instructing on the use of medical devices. Pharmacy technicians who have taken the required training may administer vaccines and medication via injection or inhalation (subject to limitations).

Questions:

1. Do you think there is value in regulating pharmacy technicians in the NWT?
    a. If yes, why?
    b. If no, why not?

Initiating Prescriptions

Currently, pharmacists in the NWT cannot initiate prescriptions (write a prescription and dispense a medication or drug, without the client first seeing a physician). Pharmacists that are trained in Canada, however, gain the knowledge and skills required to initiate prescriptions. As the health system's medication experts, allowing pharmacists to initiate prescriptions can help alleviate the number of appointments at medical clinics, reducing health system wait times and providing NWT residents with more options to access health services. Some provinces only allow pharmacists to write prescriptions for specific minor ailments and conditions.

Like in the rest of Canada, pharmacists in the NWT would not be permitted to initiate prescriptions for any controlled drugs and substances. Pharmacists would also be required to communicate the initiation of any prescription to their client's primary health care provider.

For the purpose of this Discussion Paper, the following definition applies:

"Minor Ailment" means a disease, disorder or condition, in the form indicated by the individual's signs and symptoms that:

- presents a low risk of masking an underlying disease, disorder or condition, and
- can be readily diagnosed without the need for laboratory or imaging tests; and
- the individual's signs or symptoms can be reasonably expected to resolve with only short-term or episodic treatment.

Examples of minor ailments include conditions such as eczema, acne, and lice.

Questions:

1. Do you think Pharmacists in the NWT should be authorized to initiate prescriptions (excluding the prescribing of controlled substances)?
    a. If yes, why?
    b. If no, why not?
2. Do you think pharmacists should be authorized to initiate prescriptions for minor ailments only (minor ailments are non-life threatening and include conditions such as eczema, acne, and lice)?
    a. If yes, why?
    b. If no, why not?

Adapting Prescriptions

Pharmacists in the NWT can currently substitute a pharmaceutically equivalent drug for the original drug prescribed by the practitioner, if it is listed in the formulary adopted by the Minister of Health and Social Services. NWT pharmacists may also modify or include instructions for the use of medical devices and with respect to prescription packaging.

Canadian pharmacists are trained to modify the dosage, formulation, regime (how to take), and quantity of a drug prescribed, to substitute a prescribed drug for one that has the same intended treatment effect, to complete missing information on a prescription, and to renew a prescription. Generally, this scope of practice is referred to as adapting prescriptions and is intended to ensure that clients receive the most appropriate medication at the most appropriate dosage to address their health condition(s) or achieve their health goals. Pharmacists would not be permitted to adapt any controlled drug prescriptions. A controlled drug is any type of drug that the federal government has categorized as having a higher-than-average potential for abuse or addiction. Some examples of controlled drugs are alcohol and opioids (fentanyl, oxycodone, Benzodiazepines, Amphetamines).

Questions:

1. Do you think pharmacists in the NWT should be authorized to adapt prescriptions?
    a. If yes, why?
    b. If no, why not?

Ordering and Interpreting Laboratory Tests and Conducting and Interpreting Point of Care Tests

In those provinces that allow pharmacists to order and interpret laboratory tests and conduct point of care testing, pharmacists can better determine the safety and efficacy of their client's prescription treatment regimens and prescribe appropriate treatment. Laboratory and point of care test data may be used by pharmacists to ensure a prescription is appropriate for an individual, monitor a patient's response to therapy (e.g., diabetes, cholesterol) to ensure patient safety and optimal outcomes, screen for infectious disease (e.g., COVID-19, influenza, strep throat); and to screen for possible untreated health conditions prevalent in patients existing medical conditions.

Questions

1. Do you think pharmacists in the NWT should be authorized to order and interpret laboratory tests?
    a. If yes, why?
    b. If no, why not?
2. Do you think pharmacists in the NWT should be authorized to conduct and interpret point of care tests?
    a. If yes, why?
    b. If no, why not?

Administering Vaccines and Medications via Injection and Inhalation

Authorizing pharmacists and pharmacy technicians to administer vaccines and medications via injection and inhalation has significantly improved public access to such services in those provinces and territories that have enabled this expanded scope. In each of these jurisdictions, pharmacists and pharmacy technicians must undergo additional training to be permitted to practice this scope and are only permitted to administer certain vaccines and medications.

Pharmacists in the NWT are not currently authorized to administer vaccines or any other medication, even if they have undergone the additional training to be competent in this area. Authorizing them to administer vaccines would support enhanced public outreach and offer additional options for vaccine distribution and administration.

Questions

1. Do you think pharmacists in the NWT should be authorized to administer vaccinations?
    a. If yes, why?
    b. If yes, which ones?
    c. If no, why not?

2. Do you think pharmacists in the NWT should be authorized to administer other medications by injection (e.g., Humira for autoimmune conditions) or inhalation (e.g., inhalers for asthma or COPD)?

a. If yes, why?
b. If yes, which ones?
c. If no, why not?

APPENDIX A [1]

Scope of Practice for Pharmacists in Canadian Jurisdictions

Table One: Pan-Canadian Overview, Effective August 2023

NAPRA ANORP
National Association of Pharmacy Regulatory Authorities
Association nationale des organismes de réglementation de la pharmacie

	Prescribing in the absence of an existing prescription				Prescribing when there is an existing prescription			Administer: includes parenteral and non-parenteral	Tests		
	Initiate a prescription	Initiate a Rx under delegation/ collective Rx	Initiate a Rx for specified conditions/ circumstances	Prescribe in emergency circumstances	Adapt: change dose, formulation, regimen, duration, route	Therapeutic substitution	Renew/ continue a Rx for continuing care		Order lab tests	Perform tests	Interpret tests
AB	✓ 1	✓ 1	✓ 1	✓	✓	✓	✓	✓ 1, 3	✓	✓	✓
BC			✓ 1		✓ 3	✓ 3	✓ 3	✓ 1, 3		✓ 3	✓
CF		✓	✓	✓	✓	✓	✓		✓ 5		✓ 5
MB	✓ 1, 3, 4		✓ 1	✓ 3	✓	✓ 6	✓ 3	✓ 2, 3	✓ 1, 3, 7	✓ 3	✓ 3
NB	✓ 4		✓ 1	✓	✓	✓	✓	✓ 2, 3	P	✓ 3	✓
NL			✓ 1		✓ 1	✓ 1	✓ 1	✓ 1, 3		✓ 3	✓ 3
NS	✓ 4		✓	✓	✓ 3	✓	✓ 3	✓ 2, 3	✓	✓ 3	✓
NT							✓ 3				
NU											
ON		✓	✓		✓		✓	✓ 1, 3	✓ 3	✓ 3	✓ 3
PE			✓ 2	✓	✓	✓	✓ 2	✓ 2, 3	✓ 6	✓ 3	✓
QC	✓ 4	✓	✓ 2	✓ 3	✓	✓	✓	✓ 1, 3	✓	✓ 3	✓
SK	✓ 2, 3		✓ 2, 3	✓	✓ 3	✓ 2, 3	✓	✓ 1, 3	✓ 6	✓ 3	✓ 3
YT			✓ 1		✓	✓	✓	✓ 2, 3			✓

KEY

- ✓ Established in legislation and regulation or Canadian Armed Forces policy
- P Pending – Legal authorization received, but infrastructure/framework required to fully implement this activity not yet in place

1 Additional formal training/ authorization from regulator required

2 Additional formal training/ authorization from regulator required in certain circumstances only

3 Further limitations on types/ classes of medication, patient groups or circumstances exist

4 Activity can only be conducted within the terms of a formal collaborative practice agreement or approved collaborative setting/ environment

5 Under delegation for the Canadian Armed Forces (CF) Health Services

6 Hospital practice only

7 Currently being phased-in

Rx Prescription

Note: This chart is a summary only for the purpose of comparing jurisdictions and is not meant to replace provincial/territorial-specific information. Pharmacy professionals are expected to consult all relevant jurisdictional laws, regulations, standards and other rules and requirements related to scope of practice in their particular jurisdiction.

Note: This chart outlines the scope of practice for pharmacists when providing care for human patients. Readers are referred to provincial/territorial legislation for more information on the scope of practice when providing care for animal patients.

[1] The National Association of Pharmacy Regulatory Authorities (NAPRA) - charts summarizing the current scope of practice for pharmacists in each province and territory - https://www.napra.ca/wp-content/uploads/2021/12/NAPRA-Scope-of-Practice-Pharmacists-EN-2023-08.pdf

APPENDIX A [2]

Scope of Practice for Pharmacists in Canadian Jurisdictions

Table Two: Definitions used to describe the pharmacist scope of practice

*Note: Authorized prescriber includes any regulated health professional who is authorized to prescribe and is practising within their professional scope of practice.

NAPRA ANORP
National Association of Pharmacy Regulatory Authorities
Association nationale des organismes de réglementation de la pharmacie

Group	Category	Term and Definition
Prescribing in the absence of an existing prescription		Prescribing that is based on assessment of the patient's condition and judgment by the pharmacist. The pharmacist is not in possession of an original prescription from an authorized prescriber. The pharmacist is responsible for decisions about the clinical management including prescribing a drug, but ensures collaboration with the patient's other healthcare providers. The pharmacist has met and practises in accordance with the requirements set by the pharmacy regulatory authority (PRA). Requirements may include but are not limited to registration with the PRA for additional prescribing authorization or prescribing in a collaborative practice or prescribing for specified conditions/circumstances, etc.
	Initiate a prescription	Generating a new prescription for a prescription drug where the pharmacist is responsible for the assessment of patients and the decisions made about the drug and the clinical management required. Prescribing authority may be restricted by the pharmacist's specialty and competency, but not to specific medical conditions/circumstances outlined in legislation or PRA standards/directives/guidelines. While it is always expected that pharmacists will only prescribe within a collaborative practice relationship/environment, a formal written agreement or approval of the practice environment/setting by the PRA is only required when indicated with a footnote.
	Initiate a prescription under delegation/collective Rx	The pharmacist is authorized to generate a new prescription for a prescription drug only through delegation or in accordance with a collective prescription. The delegation/ collective prescription provides the pharmacist with authorization to prescribe according to the conditions of the delegation/collective prescription, but this activity is not considered part of the independent scope of practice of the pharmacist.
	Initiate a prescription for specified conditions/ circumstances	Generating a new prescription for a prescription drug for medical conditions or circumstances which have been approved by the PRA and are outlined in legislation or PRA standards/directives/guidelines. These may include but are not limited to emergency contraception, smoking cessation, minor/common ailments, self-diagnosed conditions, previously diagnosed conditions, conditions that do not require a diagnosis, prevention of diseases.
	Prescribe in emergency circumstances	Prescribing a prescription drug, in the absence of an existing prescription, when there is an immediate need for drug therapy and in the professional judgment of the pharmacist, it is not reasonable for the patient to seek emergency health care elsewhere and there is a risk to the patient's health if immediate treatment is not provided (e.g., asthma attack).
Prescribing where there is an existing prescription		Prescribing for the purpose of optimizing care or continuing care based on assessment of the patient and judgment by the pharmacist. The pharmacist is responsible for the prescribing, but ensures collaboration with the patient's primary and other healthcare providers. The pharmacist has met and practices in accordance with the requirements set by the PRA.
	Adapt a prescription	Modifying or altering an existing prescription with respect to the dose, formulation/dosage form, dosage regimen, route of administration, or duration to optimize therapy.
	Therapeutic substitution	Substituting a prescribed drug with a different chemical entity that has or is expected to have an equivalent therapeutic effect.
	Renew/continue a prescription for continuing care	Prescribing a prescription drug that has been previously prescribed for the purpose of continuing therapy based on assessment of the patient and judgment by the pharmacist.
Administer		Administering a drug (substance) by parenteral or non-parenteral routes of administration.
Tests	Order lab tests	Ordering a laboratory analysis within the practice of pharmacy.
	Perform tests	Performing a laboratory test or point of care test (POCT) within the practice of pharmacy.
	Interpret tests	Interpreting test results within the practice of pharmacy.
1 Additional formal training/ authorization from regulator required		The pharmacist is required by the PRA to undergo and demonstrate completion of a training program approved by the PRA and/or must receive additional authorization from the PRA prior to undertaking these activities. This could include additional requirements for approved injection training program, additional prescribing authority, extended or advanced practice designations, or an indication on the licence that additional training has been completed. This only includes training over and above that required for licensure. In other words, if training is mandatory for licensure, it is not noted in the chart.
3 Further limitations on types/classes of medication, patient groups or circumstances exist		The pharmacist's ability to perform the activity is restricted to certain patient groups, certain types/classes of medications, certain medical conditions or certain situations (e.g., restrictions on age for administration of vaccines in most provinces, etc.). Note: This footnote is only used for further restrictions beyond those indicated by the title of the column as defined above.
4 Activity can only be conducted within the terms of a formal collaborative practice agreement or approved collaborative setting or environment		The activity can only be conducted within a collaborative practice setting or environment that has been approved by the PRA and/or within the terms of a written formal collaborative agreement. The pharmacist is responsible for the assessment of patients and the decisions made about the drug and the clinical management required in collaboration with an authorized prescriber. The prescribing may be restricted by the parameters of the collaborative agreement or the protocols of the collaborative setting/ environment, but not to specific medical conditions/circumstances outlined in legislation or PRA standards, directives or guidelines.

[2] The National Association of Pharmacy Regulatory Authorities (NAPRA) - charts summarizing the current scope of practice for pharmacists in each province and territory - https://www.napra.ca/wp-content/uploads/2021/12/NAPRA-Scope-of-Practice-Pharmacists-EN-2023-08.pdf

APPENDIX B [3]

Scope of Practice for Pharmacy Technicians in Canadian Jurisdictions

Table One: Pan-Canadian Overview, Effective August 2023

NAPRA ANORP
National Association of Pharmacy Regulatory Authorities
Association nationale des organismes de réglementation de la pharmacie

	Compounding			Dispensing and Receiving Prescriptions							
	Develop a Master Formula or Compounding Protocol	Compound drugs according to a Master Formula or Compounding Protocol	Determine a beyond use date	Receive a verbal order (except for controlled substances)	Perform a technical check (new, refill or controlled substance Rx)	Transfer prescriptions	Provide instructions on how to operate medical devices	Provide medication information to patients that does not require application of therapeutic knowledge	Conduct tests	Supervise a remote dispensing location under the supervision of a pharmacist who is not physically present	Administer: includes parenteral and non-parenteral
AB	✔	✔	✔ 2	✔	✔	✔	✔	✔	✔ 2		
BC	✔ 2	✔	✔ 2	✔	✔	✔	✔	✔	✔ 2	✔	
MB	✔ 2	✔	✔ 2	✔ 2	✔ 2		✔			✔	
NB	✔	✔	✔ 2	✔	✔	✔	✔	✔	✔	n/a	✔ 1, 2
NL	✔	✔	✔ 2	✔	✔	✔	✔	✔		✔ 2	
NS		✔		✔	✔ 2	✔	✔	✔	✔ 2	n/a	✔ 1, 2
ON		✔		✔	✔	✔	✔	✔	✔ 2	✔	✔ 1, 2
PE	✔	✔	✔	✔	✔	✔	✔				✔ 1, 2
SK	✔	✔	✔	✔	✔	✔	✔	✔			
CF											
NT											
NU											
QC											
YT											

KEY

- ✔ Established in legislation and regulation or DND policy
- The jurisdiction does not currently regulate pharmacy technicians
- n/a Not applicable
- 1 Additional formal training/ authorization from regulator required
- 2 Further limitations on types/ classes of medication, patient groups or circumstances exist
- Rx Prescription

Note: This chart is a summary only for the purpose of comparing jurisdictions and is not meant to replace provincial/territorial-specific information. Pharmacy professionals are expected to consult all relevant jurisdictional laws, regulations, standards and other rules and requirements related to scope of practice in their particular jurisdiction.

[3] The National Association of Pharmacy Regulatory Authorities (NAPRA) - updated charts summarizing the current scope of practice for pharmacy technicians in each province and territory. https://www.napra.ca/wp-content/uploads/2023/12/NAPRA-Scope-of-Practice-Pharmacy-Technicians-EN-2023-08.pdf

APPENDIX B [4]

Scope of Practice for Pharmacy Technicians in Canadian Jurisdictions

Table Two: Definitions used to describe the pharmacy technician scope of practice

Note: Pharmacy technicians are generally only allowed to carry out the activities listed below when a pharmacist is present.

NAPRA ANORP
National Association of Pharmacy Regulatory Authorities ®
Association nationale des organismes de réglementation de la pharmacie

Group	Category	Term and Definition
Compounding		The combining or mixing together of two or more ingredients (of which at least one is a drug or pharmacologically active component) to create a final compounded preparation in an appropriate form for dosing, within the context of a prescriber-patient-pharmacy professional relationship. Compounding does not include mixing, reconstituting, or any other manipulation that is performed in accordance with the directions for use on the label of a drug approved by Health Canada. Compounding-like activities performed outside of a prescriber-patient-pharmacy professional relationship generally fall under the realm of manufacturing under the federal legislative framework and would not be considered pharmacy compounding. *(HC Policy 0051 and NAPRA compounding standards – non-sterile and sterile)*
	Develop a Master Formula or Compounding Protocol	Generating a new Master Formula or Compounding Protocol (as defined in the NAPRA compounding standards and guidance document) that describes the formula to be used and all of the steps to be followed in the compounding of a specific preparation, with which the compounder must comply. The formula or protocol must include all of the information required to prepare a particular compound. The development of a new Master Formula or Compounding Protocol is based on scientific data and includes appropriate references. *(NAPRA compounding standards and guidance document)*
	Compound drugs according to a Master Formula or Compounding Protocol	Combining or mixing ingredients in accordance with a previously established Master Formula or Compounding Protocol to create a final compounded preparation.
	Determine a beyond use date	Establishing the date and time after which a compounded preparation cannot be used (beyond-use date) based on stability data and, where applicable, sterility data sourced from the available, recognized scientific literature, when one has not already been established. *(NAPRA compounding standards and guidance document)*
Dispensing and receiving prescriptions	Receive a verbal order (except for controlled substances) from a prescriber for a drug	Receiving and transcribing a verbal order for a drug or product from an authorized prescriber through verbal communication. Note: Federal legislation and regulations do not currently allow pharmacy technicians to receive verbal orders for controlled substance prescriptions.
	Perform a technical check (new, refill or controlled substance prescription)	Determining the validity, clarity, completeness and authenticity of a new or refill prescription (including new or refill prescriptions for controlled substances), and verifying the product and its prescription label against the original prescription using a systematic approach, including a verification of the patient, drug, dosage form, strength, route of administration, directions for use, prescriber, quantity, refill authorizations and auxiliary labels. A technical check DOES NOT include an assessment of the patient, verification of the clinical and therapeutic appropriateness of the prescription and/or suitability of the drug for the particular patient for its intended use, which can only be undertaken by the pharmacist.
	Transfer prescriptions	Transfer of prescriptions that are legally allowed to be transferred from the pharmacy currently dispensing that medication to another licenced pharmacy. The pharmacy technician must ensure that the prescription can legally be transferred, is still current, is the most recent prescription available for the drug and that the prescription is inactivated following transfer to the other pharmacy.
Provide instructions on how to operate medical devices		Providing instructions on how to use, operate, and maintain drug administration devices, monitoring devices, health aids and other medical devices, but not an explanation involving the interpretation of the results or value of the device or other information that requires patient assessment, clinical analysis or application of therapeutic knowledge.
Provide medication information to patients that does not require application of therapeutic knowledge		Providing information on medications that does not require patient assessment, clinical analysis or application of therapeutic knowledge, as defined in the *NAPRA Model Standards of Practice for Pharmacists and Pharmacy Technicians in Canada.*
Conduct tests		Conducting tests within the scope of practice in the pharmacy technician's jurisdiction in accordance with all applicable laws, regulations, standards of practice and other rules. Depending on the jurisdiction, this can include: • With the consent of the patient or his or her authorized agent, piercing a patient's dermis to demonstrate the proper use of lancet-type devices for the patient's self-care and education or for the patient's self-monitoring of his or her chronic disease. • Conducting tests needed to properly manage drug therapy if delegated by a pharmacist who is authorized to order, receive, conduct and interpret tests to manage drug therapy. • Conducting tests does NOT include determining the appropriateness of conducting a test for a particular patient, which can only be undertaken by a pharmacist or another authorized health professional.
Supervise a remote dispensing location under the supervision of a pharmacist who is not physically present		"Remote dispensing location" means a place where drugs are dispensed or sold by retail to the public under the supervision of a pharmacist who is not physically present, and may be staffed with a pharmacy technician.
Administer: includes parenteral and non-parenteral		Administering a drug (substance) by parenteral or non-parenteral routes of administration. Administering does NOT include determining the appropriateness of administering a drug to a particular patient, which can only be undertaken by a pharmacist or another authorized health professional.
1 Additional formal training/authorization from regulator required		The pharmacy technician is required by the PRA to undergo and demonstrate completion of a training program approved by the PRA and/or must receive additional authorization from the PRA prior to undertaking these activities. This could include additional requirements for completing an approved injection training program, an additional permit or an indication on the licence that additional training has been completed. This only includes training over and above that required for licensure. In other words, if training is mandatory for licensure, it is not noted in the chart.
2 Further limitations on types/classes of medication, patient groups or circumstances exist		The pharmacy technician's ability to perform the activity is restricted to certain circumstances set out by the pharmacy regulatory authority, such as patient groups, certain types/classes of medications, certain medical conditions or certain situations (e.g., accepting verbal prescriptions only if there has been no change in the prescription).

[4] The National Association of Pharmacy Regulatory Authorities (NAPRA) - updated charts summarizing the current scope of practice for pharmacy technicians in each province and territory. https://www.napra.ca/wp-content/uploads/2023/12/NAPRA-Scope-of-Practice-Pharmacy-Technicians-EN-2023-08.pdf

APPENDIX C

Regulating Pharmacy Technicians

1. Do you think there is value in regulating pharmacy technicians in the NWT?
    a. If yes, why?
    b. If no, why not?

Initiating Prescription Drug Therapy

1. Do you think Pharmacists in the NWT should be authorized to initiate prescriptions (excluding the prescribing of controlled substances)?
    a. If yes, why?
    b. If no, why not?
2. Do you think pharmacists should be authorized to initiate prescriptions for minor ailments only (minor ailments are non-life threatening and include conditions such as eczema, acne, and lice)?
    a. If yes, why?
    b. If no, why not?

Adapting Prescriptions

1. Do you think pharmacists in the NWT should be authorized to adapt prescriptions?
    a. If yes, why?
    b. If no, why not?

Ordering and Interpreting Laboratory Tests and Conducting and Interpreting Point of Care Tests

1. Do you think pharmacists in the NWT should be authorized to order and interpret laboratory tests?
    a. If yes, why?
    b. If no, why not?
2. Do you think pharmacists in the NWT should be authorized to conduct and interpret point of care tests?
    a. If yes, why?
    b. If no, why not?

Administering Vaccines and Medications via Injection and Inhalation

1. Do you think pharmacists in the NWT should be authorized to administer vaccinations?

    d. If yes, why?

    e. If yes, which ones?

    f. If no, why not?

2. Do you think pharmacists in the NWT should be authorized to administer other medications by injection (e.g., Humira for autoimmune conditions) or inhalation (e.g., inhalers for asthma or COPD)?

    d. If yes, why?
    e. If yes, which ones?
    f. If no, why not?

Thank you for your interest in this work. Your feedback is valuable.

Please submit comments and suggestions to dhssregs_feedback@gov.nt.ca by August 30, 2024.

Your contributions will be considered in the development of the proposed NWT's *Pharmacy Profession Regulations* and included in a summary of *What We Heard*, which will be publicly available on the Government of the Northwest Territories' Have Your Say webpage.

Committee Project - Housing as a Human Right

Status Legend	
↑	Proceeding as planned
–	Delays
↓	Significant challenges
*	Modifications

Goals	Strategies	2024		2025		
		July - Sept	Oct - Dec	January	February	March
Goal #1 Complete a literature and legislative review of multiple jurisdictions *where housing is considered a human right and is treated as such in law* . The principles and learnings will be *applied to the territorial context.*	1.1 Literature and legislative review	Staff to start creating a literature and legislative review to present key findings to Committee before the end of the year	Present first draft of findings to Committee and Committee to provide Staff direction	Present final literature and legislative review to Committee		
	1.2 Apply learning to the territorial context			Present how principles and learnings from the review can be applied to the territorial context and help frame recommendations to the GNWT.		
Goal #2 Examine how the right to housing (as recognized in international law) *can be transferred to the local level* , and examine how to *draw from human rights law principles to inform law reform.*	2.1 Receive briefing from experts in international law, specifically on the right to housing	June - Staff to present list of experts/briefings to Committee. July - Staff to reach out to briefings list experts to book briefings	Committee to receive briefing from international law experts on the right to housing	Committee to continue to receive briefings	Staff to present to Committee how international law and human rights principles can be transferred to the local level and present draft recommendations to inform law reform to include in the report	
Goal #3 Examine *existing transitional housing* examples across Northern Canada that *recognize housing as a human right.*	3.1 Create a list of Northern Canada transitional housing examples	Staff to start to create a list of Northern Canada transitional housing examples (territorial and northern provincial examples)		Present examples to Committee	Include examples as part of the report	
	3.2 Create a list of Indigenous-led transitional housing examples	Start to start to create a list of Indigenous-led transitional housing examples				
Goal #4 Examine existing housing programs in the NWT, and how they are addressing homelessness, increasing housing affordability, accessibility and suitability and opportunities to improve these programs.	4.1 Create a list of housing programs in the NWT		Staff to start creating a list of housing programs in the NWT		Staff to present to Committee final findings of housing programs in the NWT to include in report	
	4.2 Invite housing programs to present to committee	Staff to present to Committee a list of potential NWT housing program witnesses	Staff to start booking briefings and Committee to receive briefings	Committee to continue to receive briefings		
Goal #5 Examine and highlight the scope of work of the Indigenous-Territorial-Federal Housing table	5.1 Provide Committee a summary of the Indigenous-Territorial-Federal Housing table		Provide Committee a summary of the Indigenous-Territorial-Federal Housing table		Include summary in report	
Goal #6 Compile *policies* that recognize housing as a human right	6.1 Create a list of policies across Canada and showcase them to Committee	Staff to start a policy review to present to Committee by the end of the year	Present draft policy review for Committee to comment	Committee to draft recommendations	Include recommendations in report	
	6.2 Understand local and current policies and parameters for tenants and eviction notices in the NWT	Staff to create a local NWT-specific policy review to present to Committee by the end of the year				
	6.3 Understand current legal parameters for tenants and homelessness in the NWT (i.e. policies on encampments)	Staff to present to Committee a list of potential witnesses to present on policy and legal parameters related to homeless and encampments	Staff to start booking briefings and Committee to receive briefings	Committee to continue to receive briefings		
Goal #7: Propose recommendations to the GNWT on ways to recognize and acknowledge housing as a human right as consistent with international rights principles and obligations, including those outlined in the universal declaration of human rights, the international convenant on economic, social and cultural rights and the UNDRIP	7.1 Draft and propose recommendations			Staff to present draft report and recommendations to Committee after briefings and research	Include final recommendations in final report	

Report back to the House

Committee Project - Housing as a Human Right

List of Presenters for Briefings

Who	Where	Invitation	Briefing Date	Why	Link	Related to which Goal	Notes for Committee	Highlights from Briefings
Kristel Derkowski	Independent Researcher (Masters thesis)	Letter sent, invitation accepted	Monday August 12th - 10:30am - 12:00pm	Kristel has recently finished her Masters thesis, titled: *"Retracing Pathways Home in Radeyili Ko: Towards a Resilient Homeownership Model for Northern Indigenous Communities"*. This research explores the housing system in Fort Good Hope. This research gives a historical review of housing policy and how the crisis has evolved and key contributing factors to current housing conditions. The research also outlines a potential intervention and recommendations for a transitional model of homeownership.	Here is a link to her research	Goal #3, #4 and #6	Kristel has already reached out to some members to present her research.	
Major Tony Brushett	Executive Director for the Salvation Army - Yellowknife	Letter sent, invitation accepted	Friday August 16th - 10:30am - 12:00pm	The salvation army in Yellowknife provides a men's emergency shelter and the Salvation Army Bailey House that exists to provide transitional housing for men who have experienced homelessness or are in a critical state that without the services of Bailey House they would become homeless.	Here is a link to their website	Goal #4		
Michele Biss	National Director of the National Right to Housing Network	Letter sent, invitation accepted	Thursday September 5th - 1:30pm - 3:00pm	The National Right to Housing Network (NRHN) is a broad-based, grassroots civil society network established to fully realize the right to adequate housing in Canada. The NRHN has two goals: 1. To advise and strengthen Canada's infrastructure for the implementation and growth of Canada's commitment to housing as a fundamental human right, and; **2. To build a community-based movement and culture that support the meaningful implementation of the right to housing**	Here is a link to their website	Goal #2	Michele advised SCOSD that on her Steering Committee there is an expert named Janine Harvey who is doing incredible right to housing work in Uluhaktok. She and her colleague, Lisa Alikamik, recently travelled across the NWT and NU to conduct culturally appropriate interviews with Indigenous community members, gathering their stories and first-hand experiences of what it's like trying to find affordable, safe, and secure housing in the North. They work a report outlining their recommendations (see below).	
Marie-Josee Houle	Canadian Human Rights Commissioner - Federal Housing Advocate	Letter sent, invitation sent to the Advocate's engagement team, invitation accepted	Wednesday September 25th 9:30am - 12:00pm (during Committee Week)	The Federal Housing Advocate is an independen, nonpartisan watchdog, empowered to drive meaningful action to address housing need and homelessness in Canada. The Office of the Federal Housing Advocate, housed at the Canadian Human Rights Commission, helps to promote and protect the right to housing in Canada, including the progressive realization of the right to adewuate housing. **The goal of the Advocate's work is to drive change on key systemic housing issues and advance the right to housing for all in Canada.**	Here is a link to their website	Goal #2		
Dr. Sarah Buhler	Associate Professor, University of Saskatchewan College of Law	Letter sent, invitation accepted	Wednesday October 9th - 10:30am - 12:00pm	Sarah is an Associate Professor at the University of Saskatchewan Department of Law and has published research in: Housing, Housing Law Advocacy in Canada, claiming justice for tenant experiences	Here is a link to her bio and research	Goal #6, Goal #2	Dr. Buhler may also be able to speak to how international law, specifically the right to housing, can be transferred to local law	
Hawa Dumbuya-Sesay (Executive Director), Kate Wilson (Director of Housing)	YWCA NWT	Letter sent, invitation accepted	Thursday October 10th - 10:30am - 12:00pm	Housing is a key component of the YWCA mandate, along with shelter from family violence, afterschool care for children and empowerment programs. YWCA NWT offers supportive transitional and emergency housing options to women and families.	Here is a link to their website	Goal #4		
Kate Jarvis (Director, Housing & Infrastructure), Jamie Koe (Chief Executive Officer)	Gwitch'in Tribal Council (GTC)	Letter sent, invitation forwarded to CEO, invitation accepted	Wednesday October 23rd - 10:30am - 12:00pm	The GTC will be providing transitional housing opportunities to their members and may have feedback for Committee on the right to housing.	Here is a link to their website	Goal #4	Presentation will be from Kelly McLeod ,Vice-Chair of the GTC Board of Directors; Jamie Koe, Chief Executive Officer; and Kate Jarvis, Director of Housing and Infrastructure	
Alayna Ward	Executive Director for the Habitat for Humanity Northwest Territories	Letter sent, invitation accepted	Looking at what dates work for them	For more than a decade, Habitat for Humanity NWT has been providing a hand up to northern families and the opportunity to own an affordable home.	Here is a link to their website	Goal #4		
Annie Hodgins & Sara Beyer	Executive Director; Manager of Policy of the Canadian Centre for Housing Rights	Letter sent, invitation accepted		The Canadian Centre for Housing Rights works to advance the right to housing across Canada and beyond so that everyone has an adequate, accessible and affordable place to call home. They do this by: Engagement communities and proposing solutions, **Creating knowledge and informing solutions**, **Sharing knowledge and tools to transform lives**, Empowering renters to claim their rights and stay housed, Seeking justice for impacted communities	Here is a link to their website	Goal #2	Sara Beyer, Manager of Policy responded to Committee	
Renee Sanderson	Executive Director for the Yellowknife Women's Society	Letter sent		The Yellowknife Women's Society provides supportive housing options across multiple programs: Spruce Bough, Women's Centre, Housing First and Rapid Rehousing.	Here is a link to their website	Goal #4		

Dr. Shelagh McCartney	Together Design Lab (Housing program in Northern Manitoba)	Letter sent	Together Design Lab at Metropolitain University takes a collaborative approach to investigating and creating innovative solutions to housing issues with marginalized communities in Canada. Let by Dr. Shelagh McCartney, together design lab relies on an immersive model of partnership bringing an interdisciplinary teams of students and collaborators together with communities to understand the meaning of housing in shaping lived experience. Recognizing the cultural, gendered and classes implications of dominant housing systems, this model of partnership looks to reimagine home environments through the values, goals, and aspirations of our partners. Housing issues and solutions are not limited to discussions of basic shelter provision but are understood as central unit of analysis of personal and community well-being.	Here is a link to their website	Goal #2, Goal #3	
Mr. Jody Linklater	Pewapun Construction Ltd. (Housing program and training in Northern Manitoba and Rankin Inlet)	Letter sent	Pewapun is a social enterprise that creates sustainable livelihoods for Not Employed, Educated or Trained (NEET) Indigenous peoples through education and embedding them into employment opportunities. One of the services they provide is building energy efficient homes. There has been a recent partnership between Nunavut Housing Corporation, Nunavut Arctic College and Pewapun Contruction Ltd for Nunavut students to build new student housing in Rankin Inlet. The Manitoba-based construction company (Pewapun Construction Ltd is supplying $3M in materials and support for apprentices and instructions at the college to build six three-bedroom units for students in Rankin Inlet.	Here is a link to their website	Goal #4	Here is a link to a CBC story on student housing built in Rankin Inlet, Nunavut by Petawun Construction Ltd
Khulud Baig; Lisa Thurber (NWT Tenants Association)	Women's National Housing and Homeless Network, on behalf of the NWT Tenant Association	Propose to Committee		Here is a Cabin Radio article about the NWT Tenants Association launching in March 2023	Goal #4	They have approached Committee to provide oral feedback.
Janine Harvey and Lisa Alikamik	A research project through the National Right to Housing Network (Stark Truths)	Propose to Committee	This project - proposed, envisioned, and led by Inuit right to housing advocates in the NWT - disrupts these gaps and highlights the state of housing-related human rights violations taking place in remote and northern Indigenous communities. In partnership with local Indigenous leaders and community members, and with the aim of documenting and amplifying their housing conditions, concerns, and solutions, the National Right to Housing Network received funding from the Catherine Donnelly Foundation to facilitate and enalbe this important research. It will also serve as a submission to the Federal Housing Advocate.	Here is a link to their report	Goal #1, Goal #2, Goal #6	Recommended by Michele Biss, Executive Director of the National Right to Housing Network

Committee Project - Healthcare Accountability and Sustainability

Status Legend	
↑	Proceeding as planned
–	Delays
↓	Significant challenges
*	Modifications

Goals	Strategies	2024		2025			
		Sept - Oct	Nov - Dec	Jan - Mar	Apr - June	July	August
SUSTAINABILITY - Goal #1 Evaluating case study examples of successful and complementary staffing models that create a sustainable system for healthcare	1.1 Studying case studies on improving staff recruitment, retention and job satisfaction in the healthcare system	Staff to present list of experts/briefings to Committee on staff recruitment	Staff to reach out to briefings list to book meeting Briefings occur	Staff to start compiling case studies to present to Committee	Briefings continue	Committee to draft recommendations	
	1.2 Studying case studies of successful and complementary staffing models that create a sustainable system for healthcare	Staff to present list of experts/briefings to Committee on staff recruitment rent		Staff to start compiling case studies to present to Committee			
SUSTAINABILITY - Goal #2 Evaluating how to empower healthcare professionals so that they feel valued and continue to feel valued - in small communities and larger centers	2.1 Gather feedback on how to empower healthcare professionals so that they feel valued and continue to feel valued	Staff to present list of experts/briefings to Committee on empowering healthcare professionals	Staff to reach out to briefings list to book meeting Briefings occur	Briefings continue		Committee to review findings and present in report	
SUSTAINABILITY - Goal #3 Evaluating reasons for the use of temporary healthcare workers, and providing recommendations to mitigate the use of those workers	3.1 Conducting a policy and literature review of the use of temporary healthcare working		Staff to start creating a policy and literature review of the use of temporary healthcare workers		Staff to present final policy and literature review to Committee	Committee to draft recommendations	
	3.2 Provide recommendations to mitigate the use of temporary healthcare workers	Staff to present list of experts/briefings to Committee	Staff to reach out to briefings list to book meeting Briefings occur	Briefings continue	Committee to review recommendations	Include recommendations in report	
SUSTAINABILITY - Goal #4 Evaluating the current mechanisms in place for the NWT's healthcare system to adapt and remain resilient in the face of threats or emergencies	4.1 Policy and program review of current mechanisms in place for the NWT's healthcare system to adapt and remain resilient		Staff to begin program and policy review		Staff to provide review to Committee	Committee to draft recommendations	
SUSTAINABILITY - Goal #5 Identify what factors affect the systems sustainability of NWT healthcare	5.1 Meet with stakeholders and conduct a literature review to receive advice on factors that affect systems sustainability of NWT healthcare	Staff to present list of experts/briefings to Committee	Staff to reach out to briefings list to book meeting Briefings occur	Staff to conduct literature review		Committee to draft recommendations	
ACCOUNTABILITY - Evaluating the three elements of an accountability regime	Element #1 - That are the goals and objectives of our NWT healthcare system and are they in line with current needs?						
	Element #2 - How are our healthcare goals currently being measured and monitored and should this change?		Scheduling in briefings with the GNWT		Committee to evaluate and draft recommendations	Include recommendations in report	
	Element #3 - What are the mechanisms in place for remaining accountable and achieving our goals?						
SUSTAINABILITY & ACCOUNTABILITY - Goal #6 & Goal #4 Propose evidence-based recommendations to the GNWT	6.1 Propose evidence-based recommendations to the GNWT that are within the GNWT's scope of authority and purview and are related to the sustainability of the NWT's healthcare system					Include recommendations in report	
	6.2 Propose recommendations to the GNWT on how accountability within NWT's healthcare system can be strengthened by looking at case studies and best practices from other jurisdictions				Staff to present to Committee case studies and best practices from other jurisdictions on strengthening accountability		

Report back to the House

Committee Project - Healthcare Accountability and Sustainability

List of Presenters for Briefings

Who	Email	Where	Why	Link	Related to which Goal	Notes	Invitation Complete?	Briefing Date
Dr. Gavin Parker, President; Jennifer Barr, Chief Operating Officer	jenniferm@srpc.ca	Society of Rural Physicians of Canada	The Society of Rural Physicians of Canada (SRPC) is the national voice of Canadian rural physicials. Founded in 1992, the SRPC's mission is championin rural generalist medical care through education, collaboration, advocacy and research. On behalf of its members and the Canadian public, SRPC performs a wide variety of functions, such as developing and advocating health delivery mechanisms, supporting rural doctors and communities in crisis, promoting and delivering continuing rural medical education, encouraging and facilitating research into rural health issues, and fostering communication among rural physicians and other groups with an interest in rural health care.	Here is a link to their website	#2, #3			
Lesa Semmler, Minister of Health and Social Services; Terrence Courtoreille, ADM of Healthcare System Sustainability, HSS; Kim Riles, CEO Stanton Territorial Hospital, NTHSSA		Government of the Northwest Territories			#4, #5, Element #1, Element #2, Element #3			
Megan Wood, Executive Director	megan.wood@cannn.ca	The College and Association of Nurses of the Northwest Territories and Nunavut	The College and Association of Nurses of the Northwest Territories and Nunavut was created by and operated in accordance with provisions of the Nursing Profession Act of the NWT and the Nursing Professions Act of Nunavut. Their dual mandate is to protect the public and promote a sustainable future for nurses in the North.	Here is a link to their website	#2, #3, #5			
Dr. Katherine Breen, President/CEO	nwtmda@gmail.com	Northwest Territories Medical Association	Google says this is permanently closed?		#2, #3, #5			
Jason MacLean, Chairperson;	hello@healthcoalition.ca	Canadian Health Coalition	The Canadian Health Coalition advocates for the preservation and improvement of universal public health care across Canada. "We are a coalition of frontline health care workers, community groups and experts".	Here is a link to their website	#1, #3,	Here is a link to a story by the Coalition on "the use of agency nursing is exploding"		
	naoobservatory@utoronto.ca	North American Observatory on Health Systems and Policies, Institute of Health Policy, Management and Evaluation (University of Toronto)	The North American Observatory on Health Systems and Policies (NAO) is a collaborative partnership of interested researchers, research organizations, governments, and health organizations promoting evidence-informed health system policy decision-making. Due to the high degree of health system decentralization in the United States and Canada, the NAO is committed to focusing considerable attention to state and provincial health system and to creating a foundation for more systematic health system and policy comparisons amount substates.	Here is a link to their website	Element #3	Interesting research presented by NAO includes "supporting the development of the public health system performance indicators", "sustainability and resilience in the canadian health system", and case studies: "public health system financing in British Columbia", "Newfoundland and Labrador: A Health System Profile"		
Gwen K. Healey Akearok, Executive and Scientific Director	titiqqaq@qhrc.ca	Qaujigiartiit Health Research Centre	The Qaujigiartiit Health Research Centre is an independent, non-profit community research institute that was founded in 2006 by Nunavummiut, for Nunavummiut, to answer the health questions of our communities. The vision of Qaujigiartiit is to use research as a tool for action to address health inequities in our communities.	Here is a link to their website	#3, #1	Involved in research on: Addressing provider turnover to improve health outcomes in Nunavut		
	help@cihi.ca	Canadian Institute for Health Information (CIHI)	The Canadian Institute for Health Information (CIHI) provides comparable and actionable data and information that are used to accelerate improvements in health care, health system performance and population health across Canada, Our stakeholders use our broad range of health system databases, measurements and standards, together with our evidence-based reports and analyses, in their decision-making processes.	Here is a link to their website	#5	Not sure if CIHI can provide a presentation to Committee, because they are mainly a data and research hub. But you can "register for a CIHI education session" on their website		
Jennifer Zelmer, President & CEO	info@hec-esc.ca	Healthcare Excellence Canada (amalgamation of the Canadian Foundation for Healthcare Improvement and the Canadian Patient Safety Institute in 2020)	Healthcare Excellence Canada works with partners to spread innovations, build capability and catalyze policy changes so that everyone in Canada has safe and high-quality healthcare. "Our programs help turn proven innovations into lasting improvements in healthcare quality and safety"	Here is a link to their website	#3, #2, #1			

Lisa Little	lisa@lisalittleconsulting.ca	Lisa Little Consulting (they conducted a project for Healthcare Excellence Canada)	With over 25 years experience in health care, my consulting practice focuses on health research and policy, planning, analysis, stratey development, facilitation and project management. I established my consulting practice in 2010 and was previously 10 years at the Canadian Nurses Association, where I served as director of public policy. While there, I led national research projects, committees, advisory groups and policy initiatives in the quest to share health public policy.	Here is a link to a Report she helped produce: Promising practices to support retention of the healthcare workforce in northern, rural and remote communities in Canada	#3, #2, #1	
Dr. Kelly Penz	kelly.penz@usask.ca	Associate Professor, College of Nursing, University of Saskatchewan	Dr. Kelly Penz is an Associate Professor with the University of Saskatchewan (Usask) College of Nursing. Her Professional Quality of Life program of research aims to explore the psychosocial wellbeing and nature of practice of nurses in rural and remote practice and nurses who provide palliative and end of life care provincially and nationally. Main research themes within the above populations include jon-demands/job-resources, distressing/traumatic events, workplace violence, recruitment/retention, and various outcomes related to their psychosocial and occupational health. She also has been involved in the development and psychometric evaluation of new instruments/scales measuring the job-demands and job-resources inherent in various areas of nursing practice and primary health care engagement of nurses in rural and remote practice.	Here is a link to her bio	#3, #2, #1	Related research includes: factors influencing nursing recruitment and retention in rural and remote Western Canada from the Early Twentieth Century to 2023, exploring the distressing event and perceptions of support experienced by rural and remote nurses, the mosaic of primary nurses in rural and remote Canada, rural and remote licensed practical nurses' perceptions of working below their legislated scope of practice

Agenda Page

SD-160

NORTHWEST TERRITORIES
LEGISLATIVE ASSEMBLY
TERRITOIRES DU NORD-OUEST
ASSEMBLÉE LÉGISLATIVE

Motion
Mouvement
No./Nu. XX-20(1)

Appointment of Person to Investigate the Critical Incident of James Kochon

WHEREAS the ongoing effects of colonialism and anti-Indigenous racism continue to impact the healthcare system in the Northwest Territories;

AND WHEREAS an unnecessarily delayed treatment for an infection resulted in significant harm to Mr. James Kochon;

AND WHEREAS his family states that the treatment of Mr. James Kochon is an example of substandard health care for Indigenous people;

AND WHEREAS clear, immediate and measured actions from the Minister of Health and Social Services are required to prevent such incidents from happening again;

AND WHEREAS Section 23.5 (3.1) of the *Hospital Insurance and Health and Social Services Administration Act* (the Act) states that the Minister of Health and Social Services shall, when directed by motion of the Legislative Assembly, appoint a person to investigate, in accordance with the Act and the regulations, a critical incident or an alleged critical incident;

NOW THEREFORE I MOVE, seconded by the Member for [insert seconder], that the Minister of Health and Social Services appoints a person to investigate the incident of the treatment of Mr. James Kochon;

AND FURTHER, that the Minister of Health and Social Services table before the Assembly at the earliest opportunity any recommendations that the investigator includes in their investigation report alongside a plan to advance such recommendations;

AND FURTHERMORE, that the Government of the Northwest Territories provide a response to this motion within 120 days.

Note to SCOSD:
Glen advises that Committee seek written consent from Mr. Kochon to be named in this motion.

Date of Notice: October XX, 2024
Date de l'avis : XX octobre 2024

Date of Introduction:
Date de présentation :

Disposition:
Disposition :

Carried:
Adoptée :

Moved by:
Proposée par :

Seconded by:
Appuyée par :

Ruled Out of Order:
Déclarée irrecevable :

August 13, 2024

Standing Committee on Social Development

Committee Planning

Highlight = Discussion or decision at today's meeting

	Subject	Committee tasks	Target	Output for October sitting
Legislation	Stat Review: Mental Health Act	Review public comments and provide direction to Staff Write report	October sitting	Written Report
	Bill 8: An Act to Amend the Student Financial Assistance Act (PMB)	Engage stakeholders Public hearing – Aug 20th Clause-by-clause review	October sitting	Report back to the House
	Stat Review: Legal Aid Act	Internal briefing Engage Stakeholders Review Feedback Write report	February sitting	N/A
Projects / Studies	Housing as a Human Right (SY Motion)	Project Tracker update Scheduled briefings update Proposed briefings	Report by Spring 2025 sitting	N/A
	Healthcare Sustainability and Accountability	Presentation of Project Tracker Presentation of proposed briefings	Report by Fall 2025 sitting	N/A
Draft Reports	Mental Health Act Statutory Review	Review public comments Write report Review report Approve report	August	Report
Correspondence	2024-07-11 Inuvialuit Coordination Agreement and Information Sharing Agreement	Take as information or respond	August 13 meeting	
	2024-07-12 Response to Letter Requesting Minimum Wage Data	Take as information	August 13 meeting	
	2024-06-12 HIV Legal Network and Harm Reduction Nurses Association	Take as information or respond	August 13 meeting	
	2024-07-02 Adult Psychiatric Admission SOP	Take as information	August 13 meeting	

	Subject	Committee tasks	Target	Output for October sitting
	from Health and Social Services			
	2024-07-22 Notification of 2024-2025 Capital Appropriation Transfer	Take as information or respond	August 13 meeting	
	2024-07-22 Notification of 2024-2025 Capital Appropriation Transfer	Take as information or respond	August 13 meeting	
	2024-07-25 Senior Home Heating Subsidy – Subsidy Enhancement	Take as information or respond	August 13 meeting	
	2024-07-26 MLS to SCOSD Response on Systemic Racism in NWT Health System	Take as information or respond	August 13 meeting	
	2024-07-31 Public Engagement on Pharmacy Profession Regulations	Take as information or respond	August 13 meeting	
	2024-07-31 Public Engagement on Proposed Amendments to the Health and Social Services Professions Act	Take as information or respond	August 13 meeting	
Miscellaneous Initiatives	Systemic Racism in the Healthcare System	Review draft motion Review return correspondence	August 13 meeting	
	Medical Travel	Waiting on return correspondence	TBD	