



Umingmak Child & Youth Protection Centre (UCYPC)

Nunavut Child Advocacy Centre

Feasibility Study Report

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Executive Summary

In January 2015, the Arctic Children Youth Foundation contracted Roos-Remillard Consulting Services to conduct a feasibility study on the possibility of developing the Umingmak Child & Youth Protection Centre (UCYPC) Child Advocacy Centre in Nunavut.

The UCYPC Steering Committee, with representation of key mandated GN departments and the RCMP that respond to disclosures of child maltreatment, and treat victims of abuse, contracted Roos-Remillard Consulting Services to undertake a feasibility study to explore whether there was a clear and compelling need for a CAC in Nunavut, and what governance and service model would be required for Nunavut. Roos-Remillard Consulting Services and a team of researchers and technical advisors prepared this feasibility study report and recommendations to:

- Bring forward research and best practices on CACs nationally and internationally;
- Identify policy levers, demographics, statistical trends and opportunities influencing action on child maltreatment in Nunavut;
- Consult with frontline service providers and Nunavummiut on their insights into the situation of child maltreatment in Nunavut, and their recommendations regarding the establishment of the UCYPC CAC;
- Review relevant governance, financial sustainability and service delivery models;
- Recommend a model for the Umingmak Child & Youth Protection Centre (UCYPC) CAC Steering Committee and relevant decision-makers in Nunavut.

The Issue

Children and youth in Nunavut experience incidences of abuse and maltreatment at 10 times the rate of other Canadian children, though only a fraction of incidences of historic or current abuse are ever reported to the authorities. Children and youth are disclosing to trusted adults as well as their peers, but gaps in the forensic interview, follow-up health and mental health assessment after trauma, or supports to the family are weak. Even when children and youth disclose incidences of abuse, few cases proceed for prosecution and even fewer are successful convictions. Many adults surveyed stated that while they see abuse occurring they are not reporting, although they have a legal obligation to. There is a sense of futility across Nunavut to report harm against children and youth: Nunavummiut are fearful of retaliation; do not feel there are limited clinical paediatric mental health treatment services; safe spaces or support in the criminal justice system for children/youth and families after abuse.

What is a Child Advocacy Centre?

A Child Advocacy Centre (CAC) is a recognized best practice, evidence-based model and professional standard in field of child welfare, trauma-informed care and victim management for child/youth and families after an incident of maltreatment. Examples of harm include physical assault, sexual abuse and forced sexual exploitation, neglect, emotional and verbal abuse, witnessing violence, and financial exploitation. The CAC model and facility provides a dedicated child-friendly space where key mandated departments and agencies that respond to disclosures of maltreatment including the RCMP, child protection workers, medical staff, mental health workers, victim services workers and Crown Witness Coordinators, can work together for confidential case planning, case review and streamline access to necessary services required by the child/youth and family for long-term healing. As a multidisciplinary

team, the CAC helps break down a number of systemic barriers in information sharing, case review and case management required to serve this vulnerable group and families.

Methodology

For the feasibility study the project team used a combination of information gathering methods including a desktop review of existing reports and literature on CACs, child maltreatment and statistical information and trends. To further inform our work, the team conducted site visits of Canadian CACs including the Zebra Centre (Edmonton, AB), BOOST CYAC (Toronto, ON), CAC Simcoe-Muskoka (Orillia, ON), SeaStar Centre (Halifax, NS) as well as Northern international sites including Barnahús CAC (Reykjavik, Iceland) and Saaffik CAC (Nuuk, Greenland). Other centres were surveyed by phone including the Sheldon Kennedy CAC (Calgary, AB) and the Lynx Project (Whitehorse, YK). Each of the centres were eager to share their best practices and lessons learned.

The team also developed a trilingual website for the project with links to online general public and frontline surveys, an online opinion poll and conducted three community roundtables in Iqaluit, Rankin Inlet and Cambridge Bay to discuss the project and engage input from residents including Elders, youth, frontline workers and parents/guardians who had experience with the criminal justice system and supports required after a disclosure of harm. Over 94 survey respondents and 125 professionals were interviewed for this project.

Key Findings

Over 96 percent of all project informants, particularly frontline workers, support the establishment of the UCYP CAC to better support children/youth and their families after disclosures of harm. While each community would benefit from a CAC, it was recognized that establishing a sustainable CAC in each hamlet will require time and additional community-specific engagement to establish the joint approvals, protocols, tools and separate community approaches. As a first step, it is recommended to establish a CAC in Iqaluit as a key Hub - a Centre of Excellence for Nunavut – to establish the required technical procedures that support the legislative and technical requirements to respond to disclosures of child maltreatment, and building the required interdepartmental and interagency protocols and collaborative working arrangements for sustainability and success.

Recommendations

It is recommended that the UCYP CAC Steering Committee seek senior level GN and RCMP approval for the establishment of a 3-year Demonstration Project for 2015 to 2018, in order to undertake the necessary governance, service model, resourcing and joint mandates, protocols and standardized tools to establish the Umingmak CAC and test the collaborative model.

The Demonstration Project will consolidate the standards of response and victim care in the key areas of:

- Joint RCMP/Family Services forensic interviewing and investigation;
- Forensic paediatric medical assessment, evidence gathering and standardized documentation for suspected incidences of harm;
- Inclusion of mental health assessments and referrals for complex trauma;
- Disclosures of harm through family violence workers through community justice, Elders and youth, and;
- Supporting child/youth and families through case planning, case review and referrals from immediate crisis to long-term healing.

The Umingmak CAC Demonstration Project is best developed as a “Medical Model” CAC to leverage the professional capacity and organizational strategies of the Government of Nunavut (GN) Health paediatric primary care model and the GN Mental Health framework, bridging both inservice and external service delivery partners to strengthen the development of standardized protocols, forensic assessment, documentation and collaborative case planning and referrals to support children/youth and families after

incidences of complex trauma and harm. This approach will ensure a solid foundation for the Iqaluit Centre of Excellence, which will provide standardized training tools, consultation expertise and a transportable model that can be incorporated into community engagement activities and frontline training in communities across Nunavut. As a medical model focus, the existence of Health Centres in each community enables community engagement, planning and responses to child maltreatment to be framed as a healthy child/healthy family strategy, in collaboration with all mandated frontline partners of the RCMP, Family Services, Community Justice and Victim Services, to support children/youth and families along the continuum of care.

The Demonstration Project will also support the establishment of a discrete space whereby the multidisciplinary team can come to conduct forensic interviews and meet to undertake case planning, case reviews, training and child/youth and family support meetings. However, in this initial phase, the partners will not be co-located, but will take the time to use the child-friendly space as an interview and meeting site. The administrative UCYPC staff will use the space to project coordinate the Demonstration Project and support key functions over the transition and start-up phase.

Upon completion of the 3-year Demonstration Project, a formative evaluation will be undertaken to evaluate the results and determine next steps for the Umingmak CAC space and partner needs.

Background

The Umingmak Child & Youth Protection Centre (UCYPC) project is an initiative of the Arctic Children & Youth Foundation (ACYF) and a Steering Committee comprised of Government of Nunavut and RCMP officials who have mandates and a desire to improve the response for children/youth up to 19 years of age in Nunavut, and their families to receive quality supports and services after disclosures of child maltreatment. In the tradition of Child Advocacy Centres (CACs) an animal is selected as a child-friendly symbol, and is sometimes an animal that is indigenous to the region where the centre is housed.

For Nunavut the umingmak, or musk ox, was chosen. This is due in part because they can be found in most parts of Nunavut, but also because of how they protect their young as a herd. When predators approach, the adult members assume a defensive formation by facing outward and forming a semicircle or full circle around the calves. As Celina Kalluk noted in her book *Sweetest Kulu*, “Musk ox shared heritage and empowerment with you...showing you how to protect what you believe in.”¹ The image and meaning of protecting Nunavut’s most vulnerable population from harm is the basis for the selection of the name for the centre, and the use of the umingmak formation for the logo.



The watercolour logo was produced by David Samson of Montreal, QC, to promote the feasibility study promotion and for ongoing use as the CAC project progresses. The community feedback was very positive on the use of the umingmak, even though they do not exist in the Qikiqtani Region.

Purpose of the Feasibility Study

The feasibility study was undertaken between January 1 and June 30, 2015. The objective of the feasibility study was to consult with hamlets, territorial government representatives, multidisciplinary team service providers, community organizations and individuals to determine if there is a need for and the benefits of a Child Advocacy Centre (CAC) for Nunavut. The project sought to:

- Validate the UCYPC needs assessment undertaken in 2014;
- Determine whether there is a clear and compelling need for a CAC in Nunavut;
- Identify resource availability, and;
- Identify the best suited model for a single facility in Nunavut, while supporting continuity of service provision for any one child or youth in communities across Nunavut.

The study reviewed all relevant factors such as the size of the territory; the isolation of communities from a centralized facility in Iqaluit; designing and delivering programs and services that reflect the cultural values of Inuit and the demographic trends facing the territory. Finally, the study would identify and recommend practical requirements based on the systems capacity of what currently exists across mandated departments and agencies; what needs to be put in place, and; recommended next steps for action. This includes financial sustainability and funding considerations.

Methodology

For this project our firm used a multi-method approach using both qualitative and quantitative data. In light of the complexity of health, justice and social issues relating to child sexual abuse, family violence, intergenerational trauma and the polarization it can cause in communities, we used rigorous empirical research to attempt to move beyond anecdotal reports to frame the issue within data and measures, to the

¹ Celina Kalluk, *Sweetest Kulu*. Inhabit Media, Fitzhenry & Whiteside. 2014. p. 11

best extent possible. Data was collected through a scan of available literature and current evidence-based research, best practices and models; stakeholder roundtables; in-depth and in-person case study interviews; focus groups; online surveys using discourse analysis, constant comparative method and qualitative (initial and focused) coding.

Our approach to the feasibility study was guided by our belief that the best way to understand the needs of the frontline workers and community stakeholders is to listen actively and deeply to understand the core values, principles and objectives of the project. As such, our approach was highly engaging, facilitating conversations to identify the full range of issues, conditions and challenges, while drawing out relevant socio-cultural and political considerations that may impact approaches or long-term sustainable solutions. To achieve this we undertook a significant amount of research, intelligence gathering and environmental scanning to fully understand the issue of child maltreatment and the feasibility of a CAC in Nunavut. This provided a solid foundation of knowledge, scoping of practical, evidence-based and relevant approaches to test potential models for Nunavut.

Given our extensive experience in Nunavut and Inuit communities, we continuously gathered best practices from Northern circumpolar regions, research on Inuit peoples, experiential practices and innovative approaches that built on previous research and recommendations on child maltreatment and family violence. While we endeavoured to be cost efficient in all cases, we undertook sufficient in-person meetings and activities in Nunavut to build mutual understanding of what a CAC is and how it can contribute to the needs of children/youth and families. Given the sensitive subject matter we allowed flexibility to have face-to-face conversations, particularly where simultaneous translation or review of terminology and materials was required. In addition, our approach was flexible to integrate local protocols, the inclusion of Elders, youth and guardians who had direct experience in child maltreatment. We also involved local Inuit for technical and subject-matter expertise in all onsite work to understand the community context, Inuit traditional knowledge, language and that content that would need to be integrated in the proposed design and recommendations for next steps.

For the feasibility study, we undertook a series of qualitative and quantitative activities to help answer key guiding questions as posed by the Steering Committee to:

- Review the CAC concept and service delivery model, including a review of CACs in other Canadian and international communities from urban gold standard models to rural, Northern and circumpolar examples for analysis and comparison;
- Develop a backgrounder for readers and decision-makers on how child abuse is currently being dealt with in Nunavut. This section provides an overview of services and resources available in Nunavut; the development of a consultation plan, including identification of stakeholders and interested parties to be consulted; preparation of interview questions and background information, and undertaking interviews (Nunavut-based organizations or extra-territorial child and youth delivery partners) with stakeholders either in person or by phone, to get their views on the feasibility of establishing a CAC in Nunavut, and other key considerations;
- Review applicable policy levers, socio-economic data, community profiles, trends, funding resources and SWOT indicators to inform sustainability and options for models;
- Deliver regional roundtables in each of the three Regions in Nunavut with key frontline workers and invited Elders, youth and caregivers to contribute to brainstorming, issues identification, recommendations and/or validation of community-based input;
- Elicit additional input from community members through online surveys, an opinion poll and social media tools, telephone interviews or in-person meetings.

To achieve this work we prepared and provided data gathering tools to support the consultation including:

- A consultation guide for interviews (Annex Tab 1)

- A frontline worker survey;
- A general public survey;
- PowerPoint presentations for community consultations and issue backgrounders for participants to review prior to the community meetings;
- Facilitation of three regional community meetings including a 2-day roundtable (Iqaluit) and two 1-day community meetings (Rankin Inlet and Cambridge Bay);
- Telephone interviews;
- Face-to-face meetings;
- Facilitated survey input with over 20 youth and 10 Elders;
- A project website located at www.ucypc.ca and Facebook Project Page at www.facebook.com/ucypcfeasibilitystudy with online polls and links to the surveys;
- Media interviews with CBC Radio North, Nunatsiaq News and NewsNorth to raise public awareness about the project²;
- Development of the UCYPC logo for use in the project and beyond;
- Selected CAC site visits to Edmonton (Zebra Centre), Toronto (BOOST CAC), Orillia (Simcoe County CAC), Iceland (Barnahús CAC) and Nuuk (Saaffik CAC) and SeaStar Centre (Halifax), and;
- Phone interviews with Whitehorse (Project Lynx) and Calgary (Sheldon Kennedy CAC) for design models and operational questions.

The team collected over 112 research sources to review best practices and lessons learned in the creation of a sustainable CAC, relevant literature related to child maltreatment as well as an environmental scan of relevant information to help inform strategic planning.

There were 103 total respondents to the online surveys developed for this project:

54 - General Survey
49 - Frontline Worker Survey

which was made available online through Survey Monkey from May 1 to May 31, 2015. For the full summary reports see Annex Tab 2 and Annex Tab 3. The demographic profile of all respondents was:

- 62 percent adult women;
- 17 percent girls under 18 years of age;
- 15 percent adult men;
- 4 percent boys under 18 years of age
- 1 percent Elder woman
- 1 percent Elder man

Frontline survey respondents spanned the following professions:

- 25 percent educators/school counsellors
- 22 percent forensic investigators (social worker/police officer)
- 6 percent employees of GN Victim Services
- 22 percent “other” employees including nurses, physicians, community justice worker, daycare manager, shelter worker, sports coach Crown Attorney, Corrections worker

² Northern News Services. “Centre sends survey to schools”. May 4, 2015
http://www.nnsi.com/frames/newspapers/2015-05/may4_15mh.html;

Framing Child Protection in Nunavut

“I think we need the support of family and community. Many times, family members keep what they know to themselves. Perhaps they don’t trust the system or they feel pressure from family members not to talk about things. We need to break down these barriers and let people know where there is support and help...[because] all forms of abuse are wrong.”

UCYPC General Survey Respondent, May 2015

Policy Hierarchy on the Rights of the Child

Children and youth in Nunavut have explicit rights, which are set out in a variety of political conventions, agreements, national and territorial legislation and operational policies. Canada is a signatory in the international global community to the *Convention on the Rights of the Child*, which came into force on September 2, 1990.³ The Convention on the Rights of the Child recognizes all children and families are entitled to special care, assistance, freedom of cultural values and support to improve living conditions and protection for harmonious development.⁴ Children are accorded rights and freedoms regardless of their race, colour, sex, language, religion, national or social origin, property, birth or status.

Within the Canadian policy hierarchy, children’s rights are protected under the Canadian Charter of Rights and Freedoms: our national bill of rights as entrenched in the *Constitution Act*, 1982. The Charter guarantees certain political and civil rights to all Canadian citizens and provides for judicial review to enforce the expression of individual and collective rights. The Charter only applies to government laws and actions, including those of federal, provincial/territorial and municipal governments, public school boards and common law activity.

Nunavut is a unique jurisdiction that stems from the agreement and ratification of the *Nunavut Land Claims Agreement* (NLCA): a modern treaty negotiated between the Crown and Inuit beneficiaries living on their traditional lands comprising what is referred to as Nunavut. The NLCA outlines the scope of a public government (rather than an Inuit-only self governing arrangement) with powers over lands and resources and broadly defined collective rights of Inuit beneficiaries. As with other negotiated modern treaties, governments and its agencies are required to design and deliver programs, services, priority employment goals or business contracting provisions, in order to best support the socio-economic interests and wellbeing of Inuit families and children. Therefore, while the Charter protects the political and individual rights of all individual Canadians, and recognizes Sec. 35 rights of Canada’s Aboriginal Peoples, the NLCA further defines special rights for Inuit by virtue of their traditional history and modern ties to Nunavut.

The NLCA, as with all modern negotiated agreements, also defines those jurisdictions where federal legislation must be applied in the territory, including justice, transportation, fisheries, health, etc., as well as those province-like law-making authorities. For child welfare and protection, all children and families in Nunavut benefit from robust federal legislation under the *Criminal Code of Canada*, *Youth Criminal Justice Act*, *Safe Streets and Communities Act* (March 2012), *Child Protection Act*, *Protecting Canadians from Online Crime Act* (March 2015) and the *Child Predator’s Act* (April 2015). A new piece of legislation, the *Victims Bill of Rights Act* (Bill C-32), received Royal Assent in April 2015.

³ Reading, R. et al. *Promotion of children’s rights and prevention of child maltreatment*. Child Maltreatment 4. Lancet 2009.

⁴ <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx>

The Canadian *Victims Bill of Rights Act*⁵ specifies that all victims of crime, and for the purposes of this report specifically children and youth, have the following rights:

- The right to information about the criminal justice system and the programs and services that are available to victims of crime
- The complaint procedures that are available to them when their rights have been infringed or denied;
- The right to information about the status of the investigation and the criminal proceedings;
- Information about reviews while the offender is subject to the corrections process, or other hearings;
- The right to have their security and privacy considered by the appropriate authorities in the criminal justice system (threat assessment);
- The right to present a victim impact statement and have it considered, and provide the relevant forms to assist victims to convey their views at sentencing and hearings proceedings;
- The right to have the court consider making, in all cases, a restitution order against the offender;
- The right to receive a restitution order form and have it entered as a civil court judgment that is enforceable against the offender;
 - Where there are multiple victims, restitution orders may also specify the amounts owed to each victim and the priority of payment among the victims;
- Make testimonial aids more accessible to vulnerable witnesses, like children;
- Enable witnesses to testify using a pseudonym in appropriate cases;
- Make publication bans for victims under the age of 18 mandatory on application;

The *Victims Bill of Rights Act* also specifies the period during which the rights apply; the particular individuals who may exercise the rights; the requirement for federal departments to create complaint mechanism for victims, and; how the legislation is to be interpreted.

This legislation, and the amended legislation due to this Act, includes changes to the *Criminal Code of Canada*, *Canada Evidence Act*, the federal *Corrections and Conditional Release Act*. Under the *Canada Evidence Act* amendments, spouses can now be compelled to testify against their spouse if they are the accused. In addition, the questioning of witnesses over the age of 14 years in certain circumstances has also been amended. Where the offender has been convicted, victims will also be permitted to:

- Request and receive information about the offender's progress in relation to the offender's correctional plan;
- Designate a representative to receive information;
- Receive information on its victim-offender mediation services;
- Receive information regarding the offender's release date, destination and conditions of release, etc.

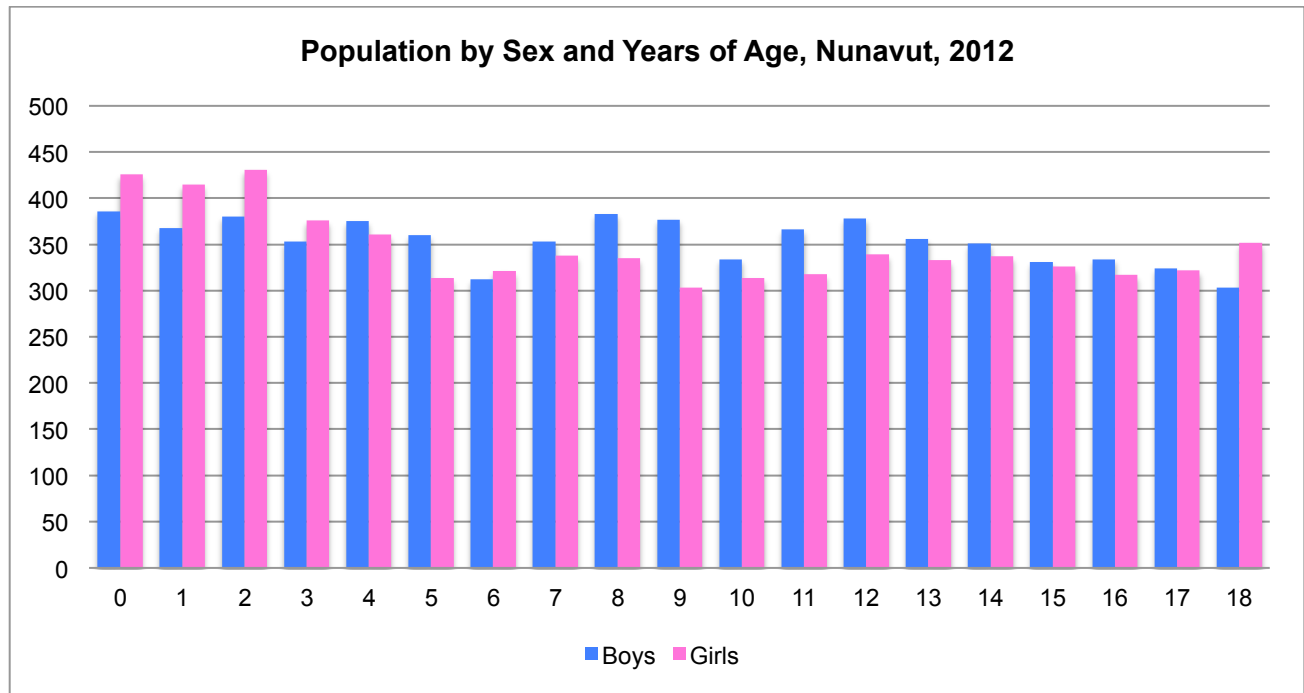
and other provisions from the Parole Board of Canada and victim rights.

The UCYPC can play an important role in providing information to child/youth victims of harm, and families, on their rights and access to supports and services. The Office of the Child and Youth Representative for Nunavut (ORCY) will also be a key resource to Nunavummiut on the full range of rights-based public education materials and information. There is a good opportunity to work collaboratively through the expertise of the multidisciplinary team members to shape a consistent understanding of the legislative amendments, and through the participation of youth, families and the community, to design and deliver relevant information on rights-based issues, and on the programs and services available in the territory.

⁵ <https://openparliament.ca/bills/41-2/C-32/>

Territorial Legislation

There were 36,700 people in Nunavut as of January 1, 2015, living in one city and 24 hamlets.⁶ Statistics Canada estimates that as of July 1, 2014, that one third of the population of Nunavut was less than 15 years of age: almost twice the Canadian population rate of 16.1% for the same age cohort. Nunavut has Canada's youngest and one of the fastest growing populations: growing by 2.1 percent annually since 2002, compared to 1 percent annually in Canada. The population places new demands on the health and education systems. Due to the young age distribution, governments must consistently monitor the youth population and incorporate their needs into strategic plans and operational considerations such as new capital facilities and budgets to build the required capacity and delivery of effective programs and services.



The June 2, 2015, Speech from the Throne delivered by The Hon. Nellie Kusugak, Deputy Commissioner of Nunavut⁷ reinforced the current long-term strategic priorities of the Government of Nunavut as articulated by *Sivumut Abluqta*⁸, the 20-year scenario plan. The Speech envisions a strong and prosperous territory with Nunavummiut who have a positive outlook on life. The key strategic pillars relating to children, youth and families recognizes that its people must be Nunavut's strength. With the youngest and fastest growing population in Canada, the demands on the territory are extreme, requiring a robust housing stock, health, education and infrastructure, and an economy that supports growth and opportunity. The strategic focus envisions and prioritizes a place where physical and mental health will improve, so all residents can be optimistic about the future.

Nunavut seeks to dramatically lower the rates of addiction, suicide and reliance on social assistance, for social, cultural and economic prosperity. It recognizes that it must work together internally, and with other partners including regional Inuit organizations and the federal government, to achieve success. It also seeks to improve health outcomes and enhance the ability to look after children from domestic violence,

⁶ Nunavut Bureau of Statistics, *Nunavut Population Estimates by Sex and Single Years of Age, 1996 to 2012.xls*. [http://www.stats.gov.nu.ca/Publications/Popest/Population/Nunavut%20Population%20Estimates%20by%20Sex%20and%20Single%20Years%20of%20Age,%201996%20to%202012%20\(3%20tables\).xls](http://www.stats.gov.nu.ca/Publications/Popest/Population/Nunavut%20Population%20Estimates%20by%20Sex%20and%20Single%20Years%20of%20Age,%201996%20to%202012%20(3%20tables).xls)

⁷ The Hon. Nellie Kusugak, Deputy Commissioner of Nunavut. *Commissioner's Address at the Opening of the Third Session of the Fourth Legislative Assembly of Nunavut*. June 2, 2015. p. 11

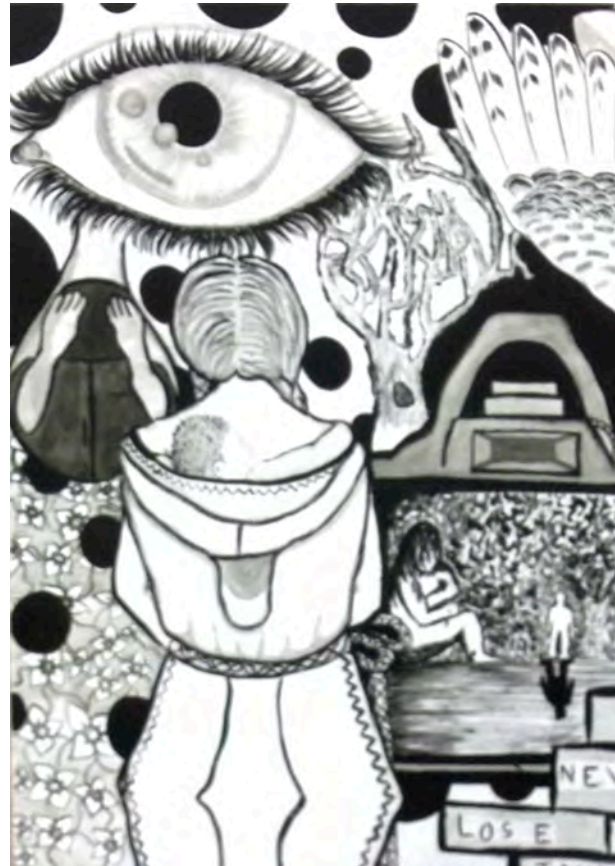
⁸ <http://gov.nu.ca/node/2047>

mental illness, addictions and suicide, in order to have strong and resilient communities and healthy families. The GN acknowledges that there is a role for both traditional community-based solutions and clinical approaches to help people regain their health and well-being, which is the goal of the UCYPC CAC and model.

The newly enacted *Nunavut Child and Youth Representative Act* is a powerful tool for children and youth to ensure their voice is heard in concerns regarding their individual case management for those in government care or youth in the communities seeking information about their rights. The role of the Child and Youth Representative in Nunavut (ORCY) is an official government advocate whose job it is to protect the interests and welfare of all children and youth in the territory. The office's powers are legislated and the investigation team can compel individuals and organizations to provide information about a particular child's case and its handling.

The ORCY specialists have experience in child protection, education, criminal justice and health and review how individual cases have been handled, and what recommendations are required for government departments and agencies to remedy gaps in care, or remove barriers in services. The team can review any type of matter relating to a child or youth under all territorial statutes, or issues which may also have criminal or human rights violations. The team will be particularly well versed in the main statutes that govern child welfare in Nunavut including the *Child and Family Services Act*, *Adoptions Act*, *Guardianship and Trusteeship Act*, *Aboriginal Custom Adoption Recognition Act*, along with other territorial legislation that may affect children and youth either directly or indirectly.

The *Child and Family Services Act* is the primary legislation providing for the protection and wellbeing of children, and the delivery of intervention services to children, youth and their families. Nunavut child protection covers children and youth up to age 19, and is also extending services through a framework of support up to 21, and in extenuating circumstances, 26 years of age.



In the case of Nunavut, children and youth also benefit from innovative tools within the *Family Abuse Intervention Act* (FAIA) such as the Emergency Protection Order and the Community Intervention Order.⁹ This Nunavut-specific legislation supports solutions to violence being experienced by children and youth who are being victimized in their homes, either those experiencing or witnessing violence. The FAIA uses a framework that integrates Inuit societal values and traditional approaches used to find consensus-based solutions within the family and with support from advisors within the broader community. This legislation is available to youth 14 years and older to seek assistance from harm but want to support their family to get the help they need to address addictions, interpersonal conflict and other triggers that cause child maltreatment. While solving the deep-rooted trauma should not be the responsibility of a child. Youth repeatedly express their desire to help their family, while trying to stay safe.

⁹ To view the FAIA Emergency Protection Order or Community Intervention Order application see <http://www.nunavutcourts.ca/faia>

Effectiveness of Child Welfare Policies and Services

The last comprehensive review of Canadian policies and practices regarding child welfare was conducted in 1976. At that time it was found that “most policies and practice decisions [by frontline workers] are still based primarily on value judgments, assumptions, driven by crisis-driven need and are largely irrespective of service effectiveness.”¹⁰ Since that initial report, the social services sector continues to call for changes to strengthen the work of child services with evidence-based approaches.

As one of the fastest growing social service delivery sectors in Canada, with the number of maltreatment investigations at over 200,000 annually, organizations must find better ways to respond.

It has been conservatively estimated that Canada spends between \$3B to \$4B annually on direct child welfare services, with broader indirect costs such as justice, corrections, education and health services as a result of abuse and trauma, estimated at over \$15B per year.¹¹ As courts continue to order mandatory interventions of assessments, programming and services, limited evidence-based research is being funded, undertaken or applied to address the critical importance to the financial cost and child and adult health implications of effective child welfare policies and services. While an economic model to quantify these costs is available, no specific analysis of Nunavut’s departmental investments against the model has been undertaken. However, suffice to say the costs are in the multimillions per year in Nunavut to resource child protection, justice, corrections, primary health and mental health costs related to child maltreatment.

The Truth and Reconciliation Commission report related to the residential school legacy of Aboriginal children in Canada released on June 2, 2015, reinforces and underlines those recommendations made by the Auditor General of Canada, for the need for systematic change and process improvements in key areas of health, justice, education and child welfare.¹² Of its five recommendations vis-à-vis child welfare for First Nations, Inuit and Metis youth, the Commission calls upon federal and territorial governments to commit to reducing the number of Aboriginal children in care by:

- Better monitoring and assessing investments of neglect;
- Resource organizations and families to staff together where it is safe to do, or regardless of where they reside, provide culturally appropriate environments be they temporary or permanent placements;
- Ensure social workers and others involved in child welfare investigations are properly educated and trained about the history and impact of residential schools;
- Require that child welfare agencies and courts consider the impact of the residential school experience on children and their caregivers in their decision-making.

The Commission further calls upon federal and territorial governments to work together to provide data and publish an annual report on the number of Aboriginal versus non-Aboriginal children in care, including the reasons for apprehension. Additional information for annual reporting should include the total spending levels on prevention and care services and the effectiveness of those interventions.

Finally, all governments are called upon to adopt Jordan’s Principle, to resolve intergovernmental or interdepartmental funding jurisdiction disputes where payment for a child’s care is in question. Jordan’s Principle is a child-first principle used in Canada to resolve jurisdictional disputes within and between governments regarding payment for government services provided to children. Jordan’s Principle was a private members bill, which passed unanimously in the House of Commons on December 12, 2007. The principle applies to all government services and states that if a dispute arises, the government of first

¹⁰ http://www.mcgill.ca/crcf/files/crcf/Knowledge_Mobilization_CW.pdf

¹¹ Audra Bowlus et al. *The Economic Costs and Consequences of Child Abuse in Canada: Report to the Law Commission of Canada*. March 2003.

¹² Truth and Reconciliation Commission of Canada. *Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada*. Ottawa: June 2015.

contact with the child must fund the service, then resolve the jurisdictional dispute later through intergovernmental or interdepartmental dispute resolution mechanisms.

As a fairly young government in developmental years, Government of Nunavut struggles to find the right approach, build and retain sufficient capacity and create horizontal solutions to address the challenge. As per the Office of the Auditor General's 2011 and 2014 reports, on child and family services in Nunavut, continued effort is required to strengthen internal case management, information gathering, risk management, staffing and training, and conducting due diligence reviews of foster home and residential placements and reporting on individual cases. The CAC model, developed in 1985, is increasingly recognized as an internationally adaptable evidence-based model and professional standard of practices that is child-focussed and brings together multidisciplinary teams to support victims of harm from the time of disclosure, investigation and through coordinated healing and family support. We believe this model will be of direct assistance to the Department of Family Services, through effective information gathering tools, seamless coordinated response and case planning and case reviews on disclosures of child maltreatment, that can address the Auditor General and management responses, and improve the lives of Nunavut's children and youth.

We are fortunate in Canada and in Nunavut to have a robust suite of legislative tools, programs and services to help protect children and youth. We must use them to the fullest extent, while working to support families in their healing and for a strong future.

The Rate of Child Maltreatment in Nunavut

The Department of Family Services is responsible for the quality and delivery of child protection and child welfare across the Qikiqtani, Kivalliq and Kitikmeot Regions. Each community in Nunavut has at least one social worker assigned to investigate child protection concerns and deliver social programs, where there are no vacancies. When a report of suspected abuse or neglect is received, the child protection worker conducts an assessment to determine whether the child is being, or is at risk of, being abused.

If the child's safety or wellbeing is in immediate danger, the social worker will take action to ensure the child's safety, including apprehension, but only as a last resort. The focus is on keeping families together using the least intrusive methods possible to ensure the child's safety. However, there are protection concerns, a plan of care agreement is required to assist children/youth and families immediately. The worker may also request a court-ordered supervision of the child in the family home, or placement in temporary home or permanent custody of the Department. The parent may also ask for support, in which case a worker will conduct an assessment and may enter into a voluntary agreement to provide:

- Counselling;
- In-home support;
- Respite care;
- Parenting programs;
- Mediation services;
- Support to youth;
- Referrals to other agencies, or;
- Services to assist the family in caring for the child.

The real rate of child maltreatment is unknown, as only a small proportion of cases are reported to the authorities, and of those, even fewer result in formal charges against the accused. Health professionals across the continuum of care from the emergency room, paediatric unit, family practice, public health centre or community health clinics indicate that they receive 1-2 sexual assault cases per month. However, for the full range of maltreatment, community social service workers can identify several children and youth in their community on any given day living in and experiencing harm. At minimum, a collaborative approach will help to quantify the rates, particularly with standardized paediatric assessment and forms for health centres to identify red flags, note and document physical indicators and refer cases faster for consultation, and link these vulnerable children and youth with the supports they require.

Many more cases are known to be occurring, across the spectrum of harm, but too many children and at-risk youth are falling through the cracks of response and care. As one community social services worker noted in a one-on-one interview after a particularly busy weekend of child protection calls:

We need to make our response to child harm bigger and stronger. A concrete plan.

It's like we have this big cut: it's bleeding, throbbing and infected. We keep just putting a Band-Aid on it, and we repeat, and we repeat, until we have a 3" stack of Band-Aids, with the blood still soaking through it. That's what the situation is right now in our communities with kids living in constant harm and pain.

We take a few antibiotics to numb the pain, and we keep adding some Band-Aids, but it's already turned gangrenous. Of course it's not healing properly.

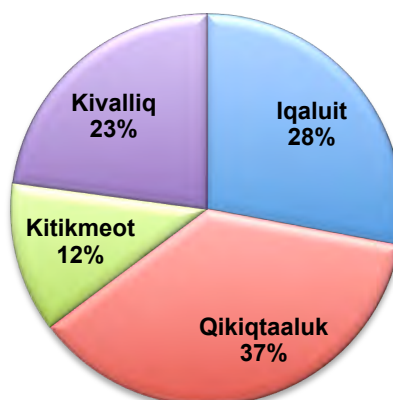
We can't keep pretending that we don't have these issues in our communities, but I don't know where to start anymore. Sixty-two extra hours over my regular 40 hour week already. This is what we're working under. We are just tired, overworked, don't have the support from management or the tools to do our job.

I have 20 kids in [the community] right now who need to get out of their homes. I can't get them out because there is no place to put them. There is too much red tape. Two weeks to get a Pre-Placement Review Committee hearing; another 5 weeks to get them to help, and my hands are tied in the community today!

I'm ashamed of the decisions I have to make. I lose sleep. These kids deserve to have better here.

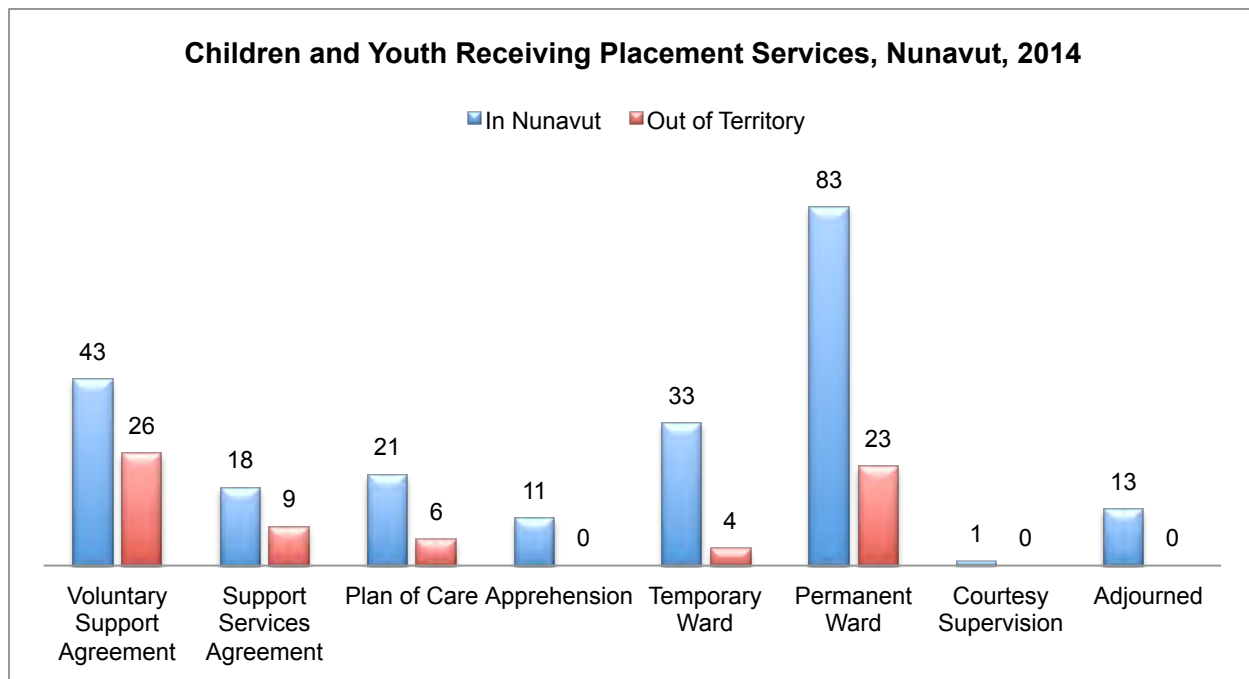
According to the Department of Family Services 2013-14 annual report, 372 children and youth are receiving services and need protection as a result of neglect, abuse or exploitation, including family support, prevention or early intervention services.¹³ As social workers note, this is simply a drop in the bucket of the number of children who experience harm and require assistance. The following indicates the breakdown by Region, with Iqaluit separated from the rest of the Qikiqtani Region.

Percentage of Children and Youth Receiving Services by Region, Nunavut, 2014

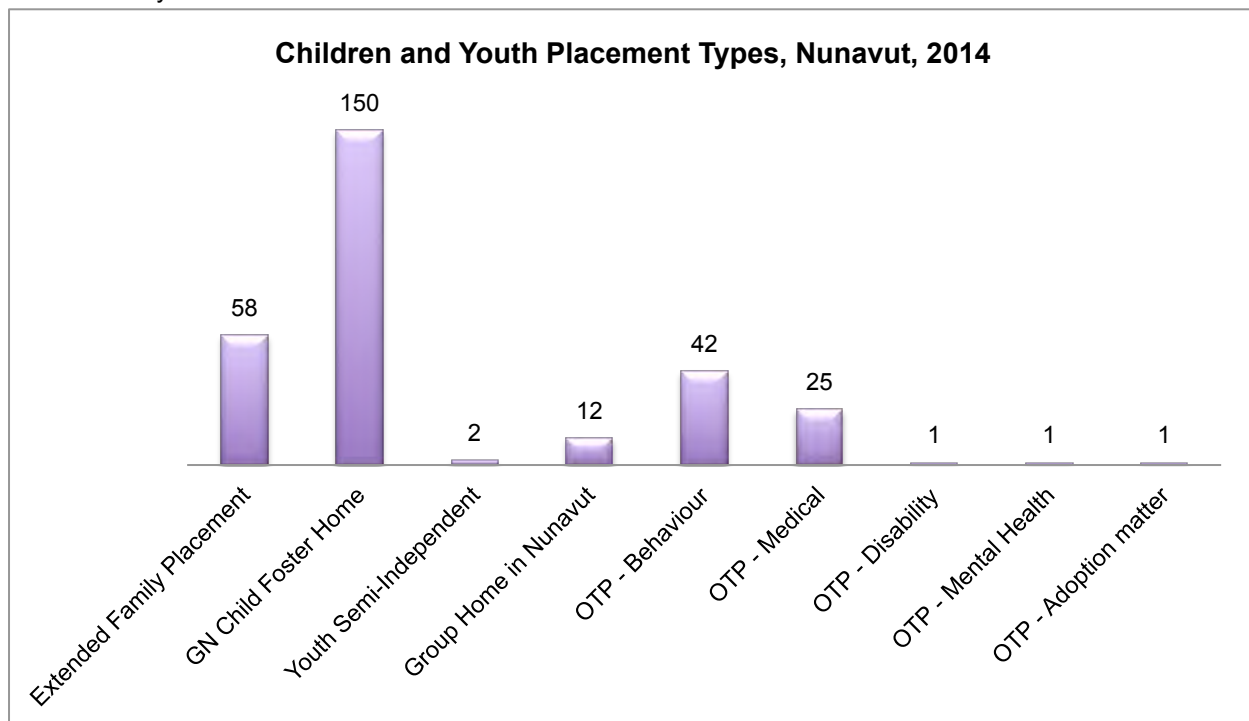


¹³ Department of Family Services, *Director of Children and Family Services Annual Report 2013-14*. p.3

Of those, 291 children and youth receive placement services depending on their particular case and needs.¹⁴



Each of the children and youth in placement also vary in the types of facilities, based on availability and need. The following reflects the distribution and types of facilities used for those placements of Nunavut children and youth.



¹⁴ *Ibid.*, p. 4

At the root of the problem is the lack of safe spaces for children and youth. This critical need of safety was confirmed by all frontline professionals. If a child/youth and/or the parent knew there was a safe place for them to go, then more disclosures would occur. Family Services may fly a woman and her children to the women's shelter for a 6-week stay, or there may be flights for medical assessment, but there is no proper respite and transitional housing system to support children/youth and families after incidences of child maltreatment in Nunavut.

In these cases, the Department of Family Services implemented a planning and decision-making process called the Placement Planning Review Committee (PPRC) where community social service workers must submit a case request for review and decision. The PPRC held more than 150 meetings in 2013-14, and is a direct response to the Auditor General of Canada requirement for the GN to improve the quality of care, have better outcomes for children and best use resources for child protection. However, social workers outside of Iqaluit noted that the PPRC is a highly centralized approach, which takes two weeks for decision-making on client files. There are no facilities in communities to safeguard children in an abusive home for that amount of time, and serves to frustrate the immediate action required on behalf of children and youth. Some measure of delegated authority is required for Regional community workers to be able to act quickly on incidences of harm and facilitate placements.

Nunavut's *Family Abuse Intervention Act* (FAIA) may be a key tool to reverse the perception that the child or youth and affected family members must be dislocated from their home, and provide the safety and stability required for action. Another key opportunity is the strategic work underway in primary care and mental health, the RCMP and community justice on victim services. There is also support and a willingness within the Nunavut Arctic College Inuktitut interpretation training program, to explore the terminology related to healing¹⁵ and mental health, maltreatment and care, which will make it easier to engage families and communities moving forward. However, it will be necessary to harness senior level support, commitment and integration of the required management responses by Family Services, Health, Justice, Education and the RCMP within the CAC collaborative approach, to ensure seamless response and care planning.

Charge Data for Nunavut

In Canada, there were 16,700 children and youth that were victims of a family-related violent crime in 2013.¹⁶ This is 243.5 children and youth under the age of 18 years old out of 100,000. Physical assault was the most common type of violence, with sexual offences being the second most common type. The rate of violent crime tends to increase with the age of the victim, with girls being more likely than boys, to experience sexual assault. Moreover, 88 percent of sexual offences are most commonly perpetrated by someone known to the child/youth victim.¹⁷

In general across Canada, girls are one and a half times more likely than boys to experience physical abuse, and 4 times higher than boys to be a victim of sexual abuse by a family member. While physical injuries were reported in about 4 in 10 cases of family violence, the vast majority are minor injuries not requiring medical treatment or first aid but are signals of problems for attention and action. In fact, only 45 percent of incidents against children and youth ever result in charges laid by law enforcement.

Many factors help explain the high crime rate in Nunavut, including lower education, overcrowded homes and poverty, but the majority of crime is committed while the offender is under the influence of illicit drugs and/or alcohol. Addiction and mental health concerns continue to have an impact on a large portion of the

¹⁵ Pauktuutit Inuit Women's Association. *Nuluaq Project: National Inuit Strategy for Abuse Prevention*. p. 113. Some terminology just as *IKAJUQTI: To help someone; INNUSILIRIJI: To take care of someone; MAMISANIQ: To cure or fix someone; MAMISAQ: To heal a physical wound; NIAQULIRIJI: Used sometimes to describe a psychologist; NALAUTAJI: Predict or see into the future about what will happen.*

¹⁶ Statistics Canada. *Juristat – Family Violence in Canada: A Statistical Profile, 2013*. Cat. 85-002-X. January 15, 2015.

¹⁷ http://cac-cae.ca/wp-content/uploads/fr_-DOJ_NSM-Research-Update_April-11+12_-S.McDonald-Eng-Version.pdf p 5.

population. Many offenders were victimized themselves, or suffer from disorders that are often undiagnosed or untreated. This underscores the need for a coordinated approach to include family services, health, community justice, education and corrections (both Young Offenders and Adult Centres) to address a holistic approach of acute care, mental health assessments, addiction treatment, family mediation and plans for the family as well as offenders, to promote healthy communities and stop the cycle of abuse in Nunavut.

The rates vary from year to year, but on average offenders in Nunavut are charged by the RCMP with sexual violations against children and youth at over *10 times* the national rate.

Sexual Violations Against Children & Youth		2010	2011	2012	2013
Canada	Actual Incidents	3,684	3,804	3,953	4,232
	Rate per 100,000	10.83	11.08	11.37	12.04
Nunavut	Actual Incidents	37	52	35	39
	Rate per 100,000	110.93	152.06	100.86	109.58
<i>Nunavut's Higher Rate Compared to Canada</i>		<i>10.2 times higher</i>	<i>13.7 times higher</i>	<i>8.9 times higher</i>	<i>9.1 times higher</i>

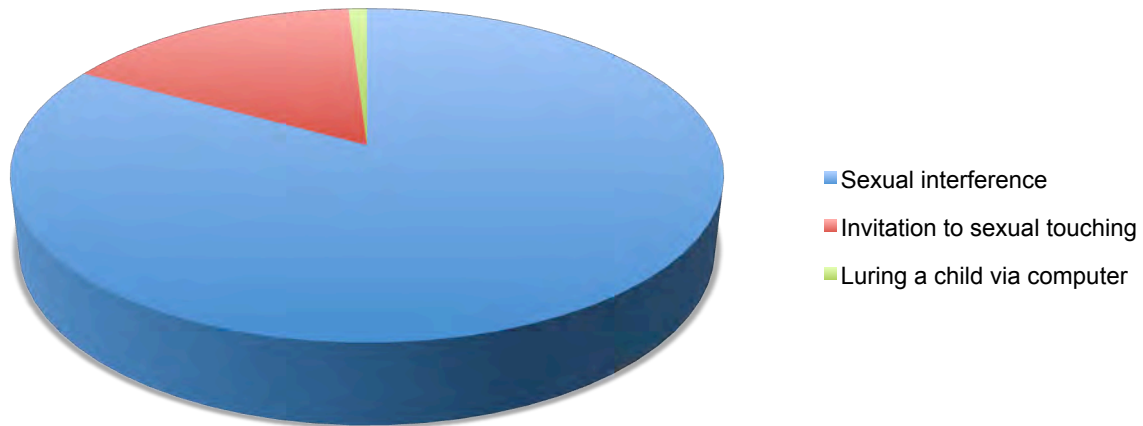
Nunavut is not a charge approval jurisdiction. If an RCMP officer has reasonable and probable grounds to lay charges, after an investigation, then an Information outlining the allegations is sworn and filed with the Nunavut Court of Justice. Once the Information is sworn and filed, the RCMP forwards the disclosure to the Crown who then review it to see if there is a reasonable prospect of conviction. If there is a reasonable prospect of conviction, then the Crown assesses if it is in the public interest to proceed. The Crown's decisions are guided by the Public Prosecution Service of Canada (PPSC) Deskbook.¹⁸ The threshold for the RCMP to lay the charge is lower than the evidentiary burden that the Crown faces when assessing the reasonable prospect of conviction, so in many cases, complaints do not proceed for prosecution.

Nunavut Tunngavik Incorporated's (NTI) *2013-14 Annual Report on the State of Inuit Culture and Society*, cited RCMP data that there were 149 total reported incidents of sexual offences against children and youth in Nunavut between 2008 and 2012.¹⁹

¹⁸ <http://www.ppsc-sppc.gc.ca/eng/pub/fpsd-sfpg/index.html>

¹⁹ Nunavut Tunngavik Incorporated, *2013-14 Annual Report On The State of Inuit Culture and Society*. Iqaluit, NU. 2014. pgs. 15-16. No data was available from 1999 to 2007, with either no sexual violations committed, no charges laid or report data is missing.

Sexual violations against children by incident type, Nunavut, 2008-2012

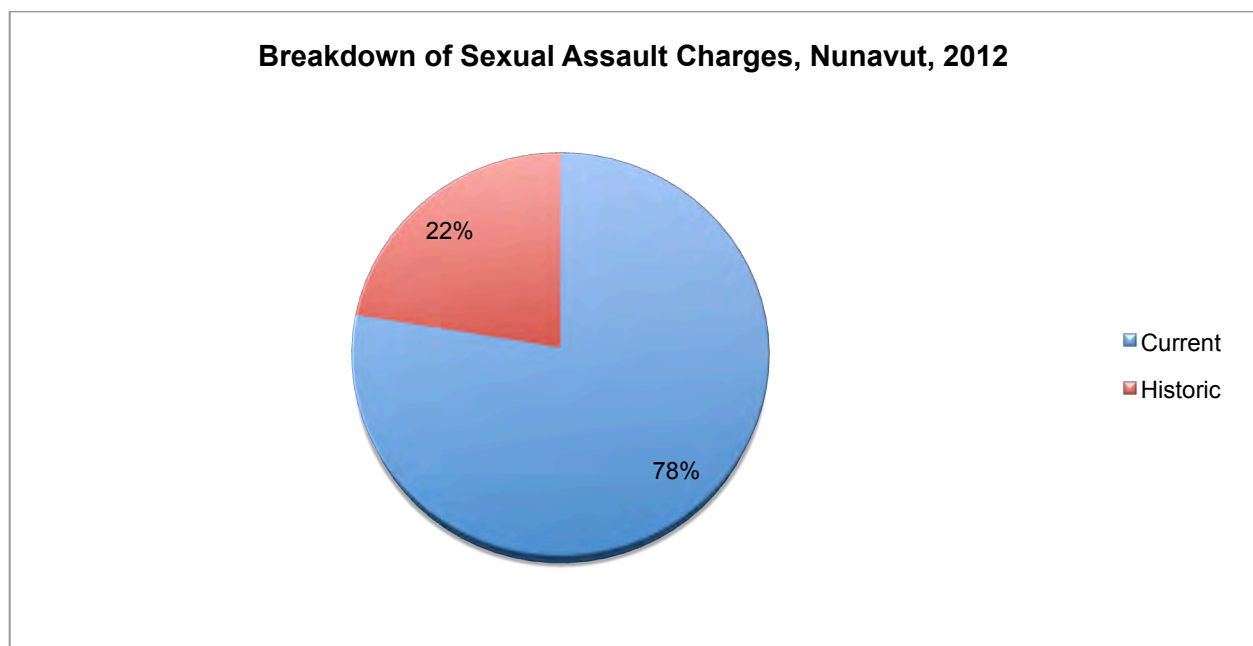
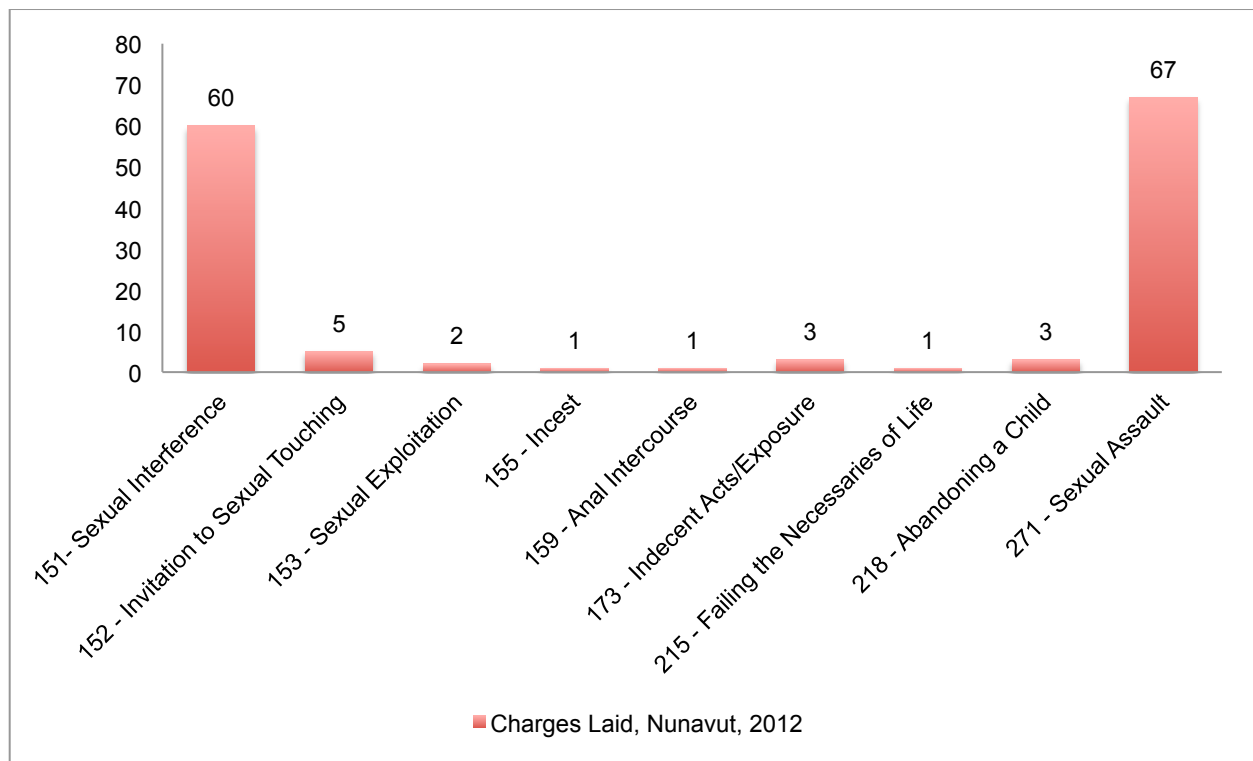


In 2012, the RCMP laid a total of 516 charges of harm to children and youth across Nunavut.²⁰ The total types of charges available under the Criminal Code of Canada are:

- Sexual Assault
- Sexual Interference
- Invitation to Sexual Touching
- Sexual Exploitation
- Sexual Exploitation of a Person with a Disability
- Incest
- Corrupting the Morals of a Child
- Luring a Child via the Internet
- Anal Intercourse
- Bestiality
- Voyeurism
- Assault Level 1 (Physical Assault)
- Assault with a Weapon Causing Bodily Harm
- Aggravated Assault
- Robbery
- Criminal Harassment
- Indecent/Harassing Telephone Calls
- Uttering Threats

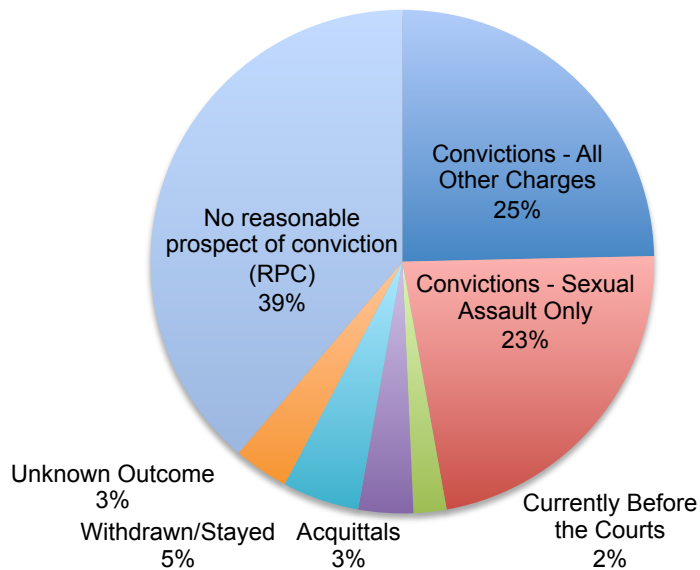
²⁰ Statistics Canada Justice Statistics *Uniform Crime Reporting Survey: Child Youth Victims 2012-2013 UCR2 (Nunavut), 2012.*

The following provides a breakdown of the types and distribution of charges laid in 2012²¹.



²¹ Statistics provided by email between Sgt. Yvonne Niego, "V" Division RCMP to Helen Roos, June 10, 2015. As a note on the data, each section was queried separately by charge. Note that Section 151 charges are often counted as Sec. 271 charges, because both charges are often laid together. This may also occur for other categories of charges as well.

Status of Charges, Nunavut, 2012



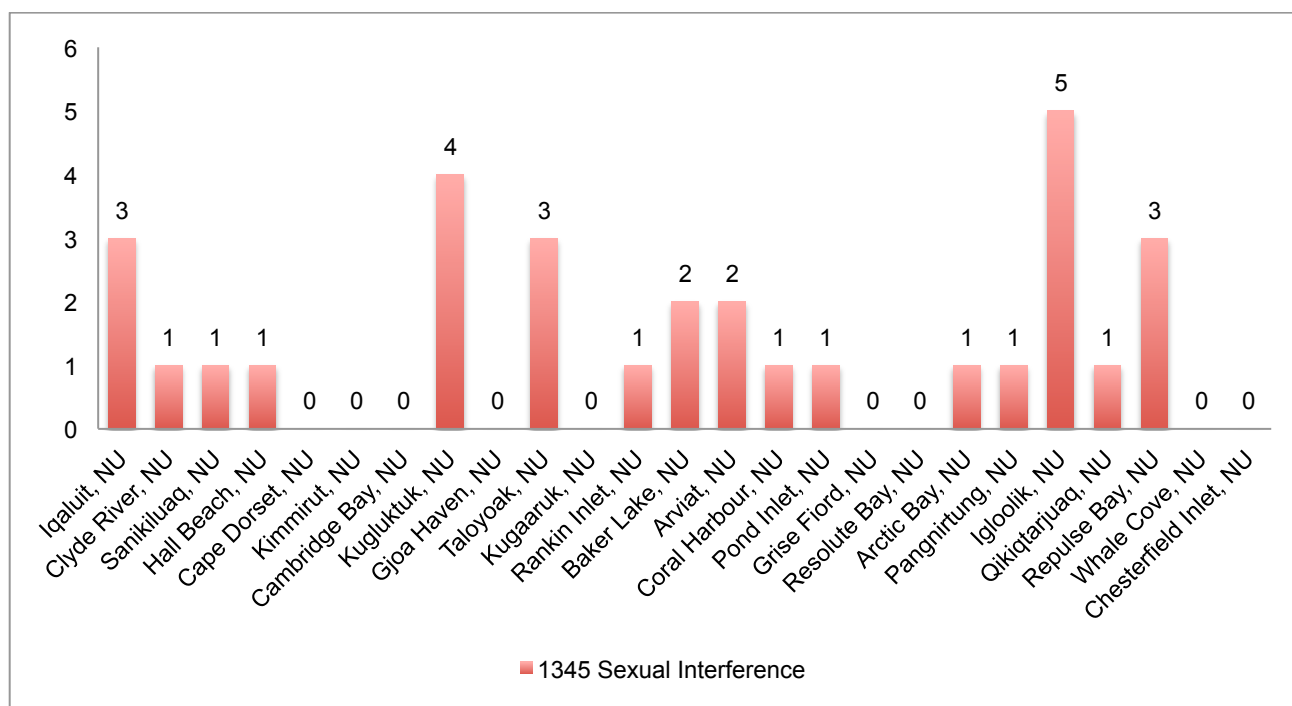
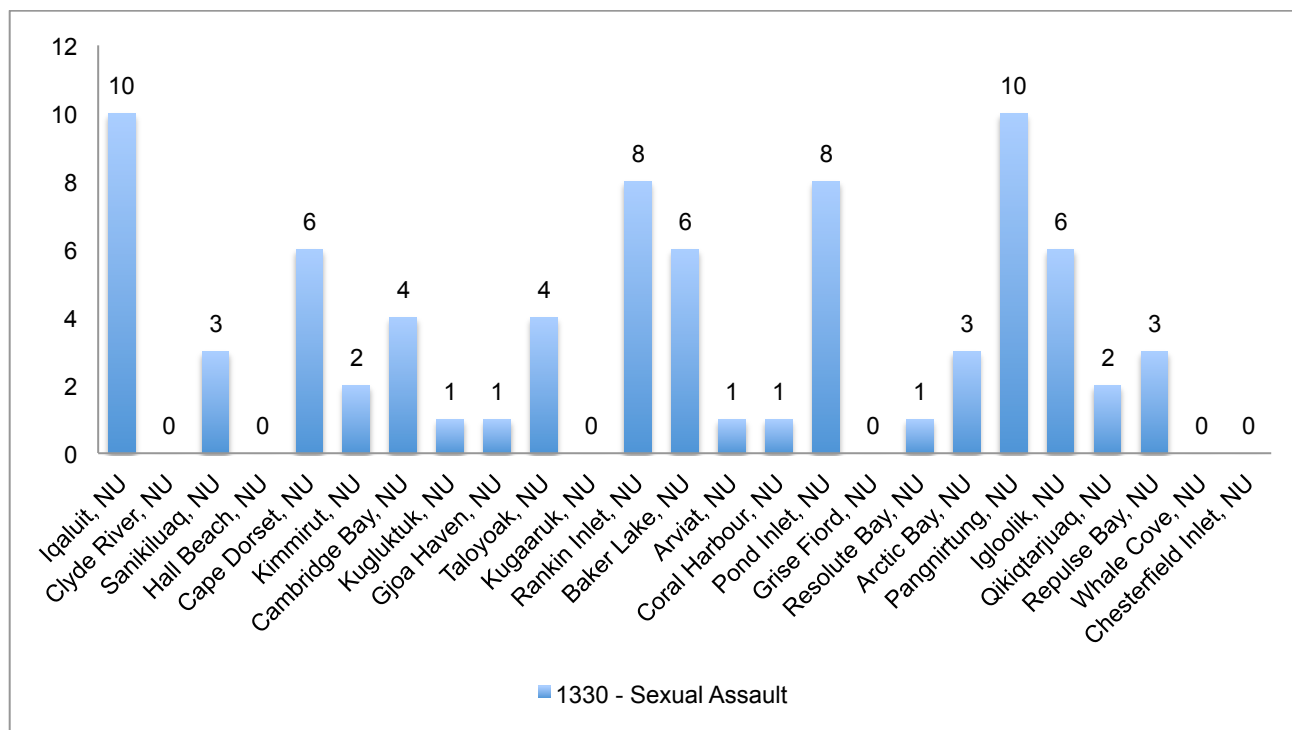
Other interesting information from the charge files was the offender profile:

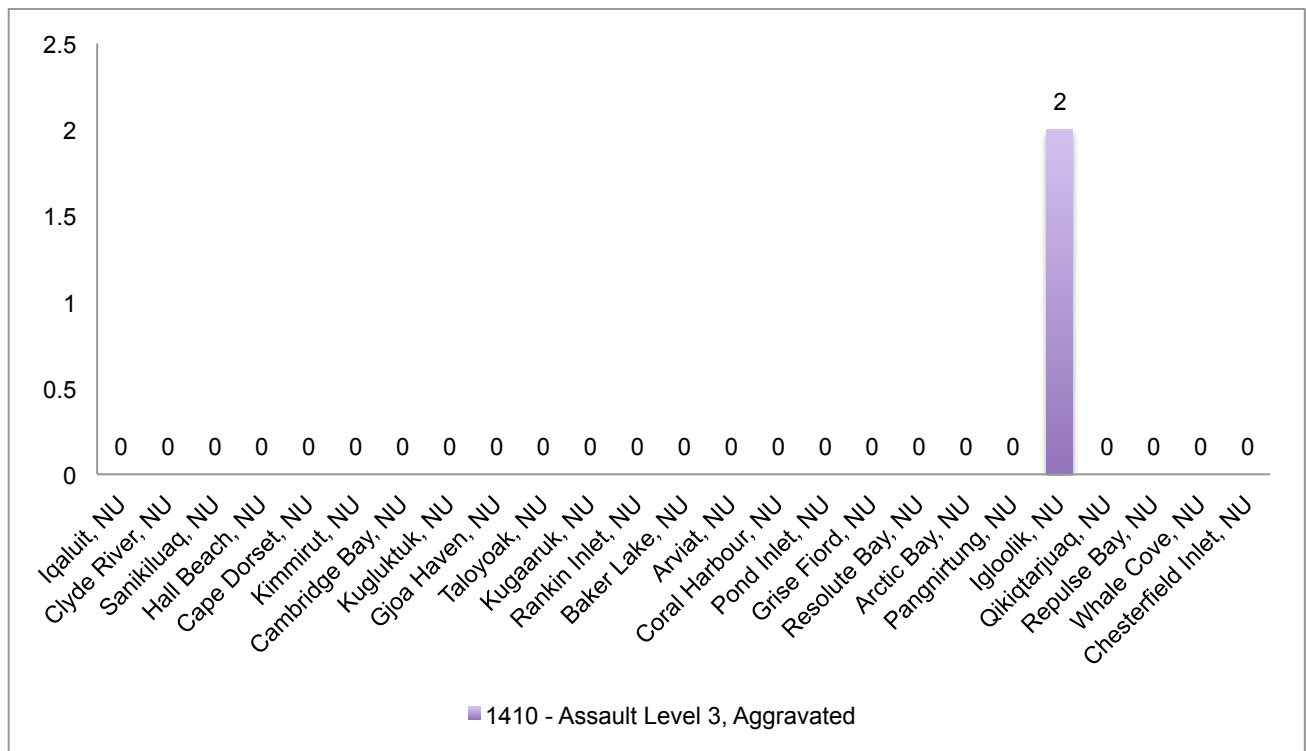
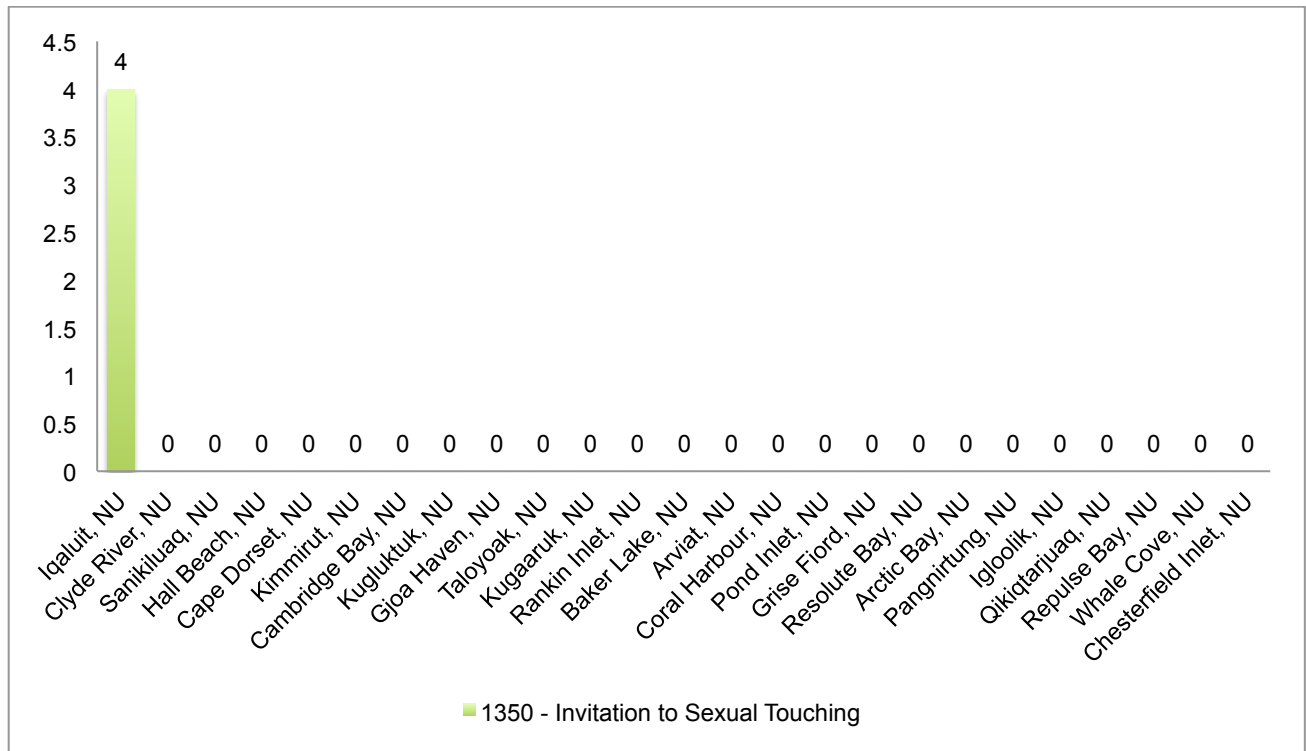
- 7 were *under* the age of 19 years;
- 10 were *over* the age of 40 years;
- None of the offenders were women.

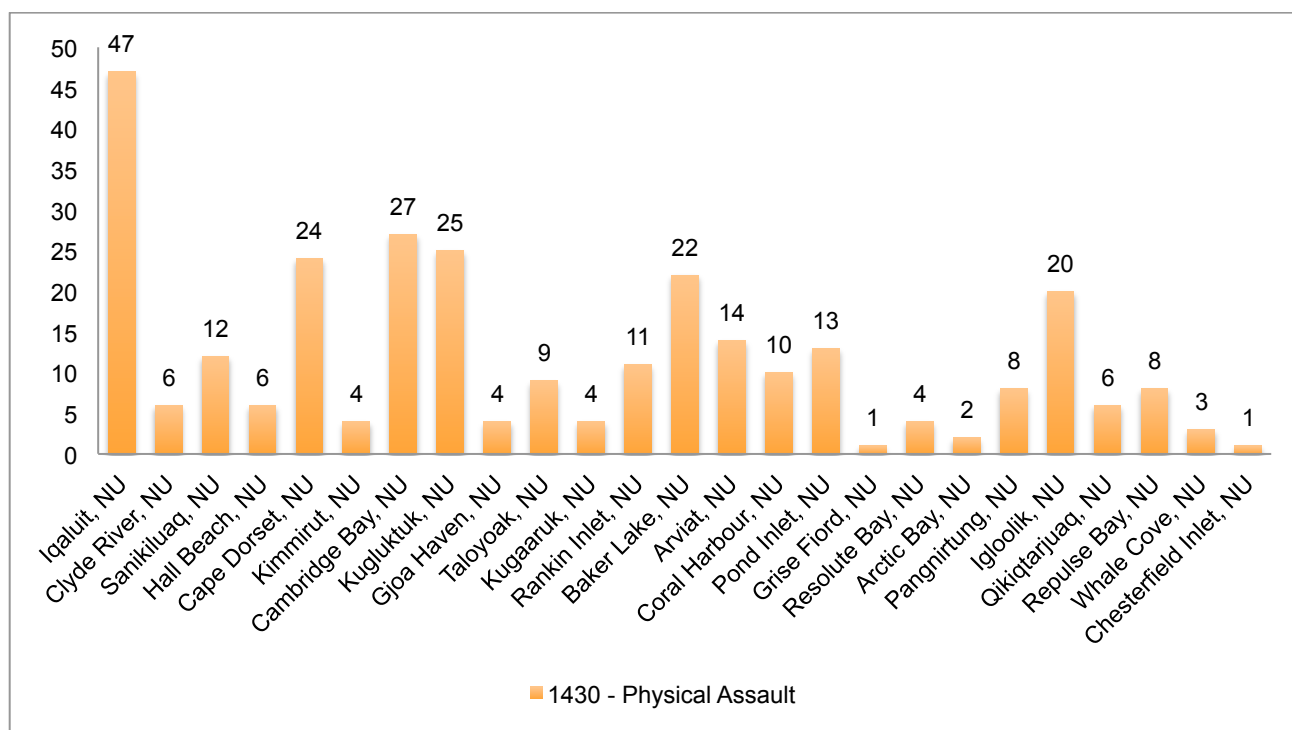
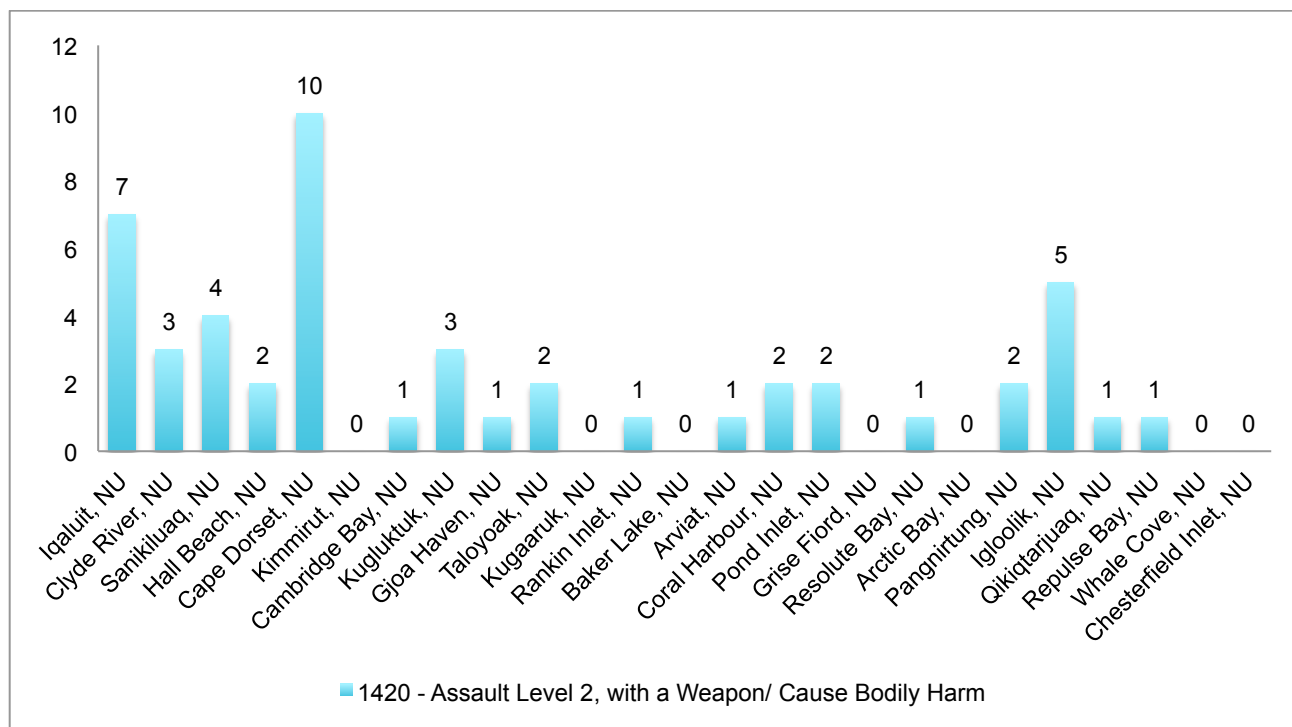
Of the victim profile from the charge data:

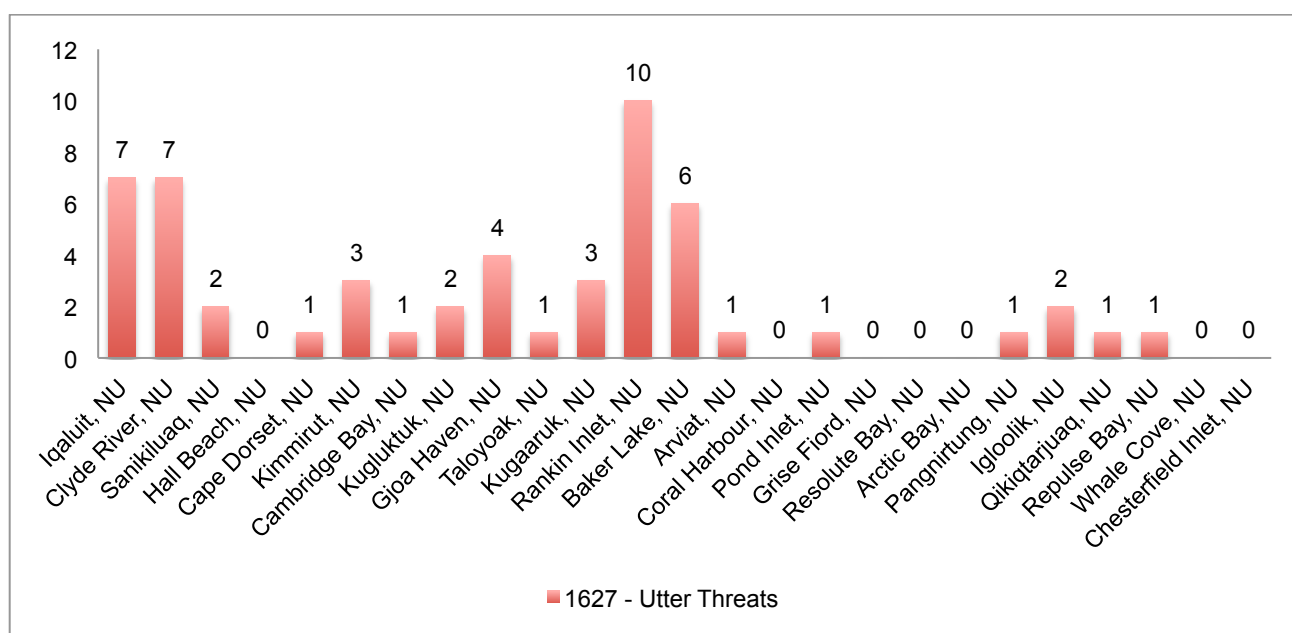
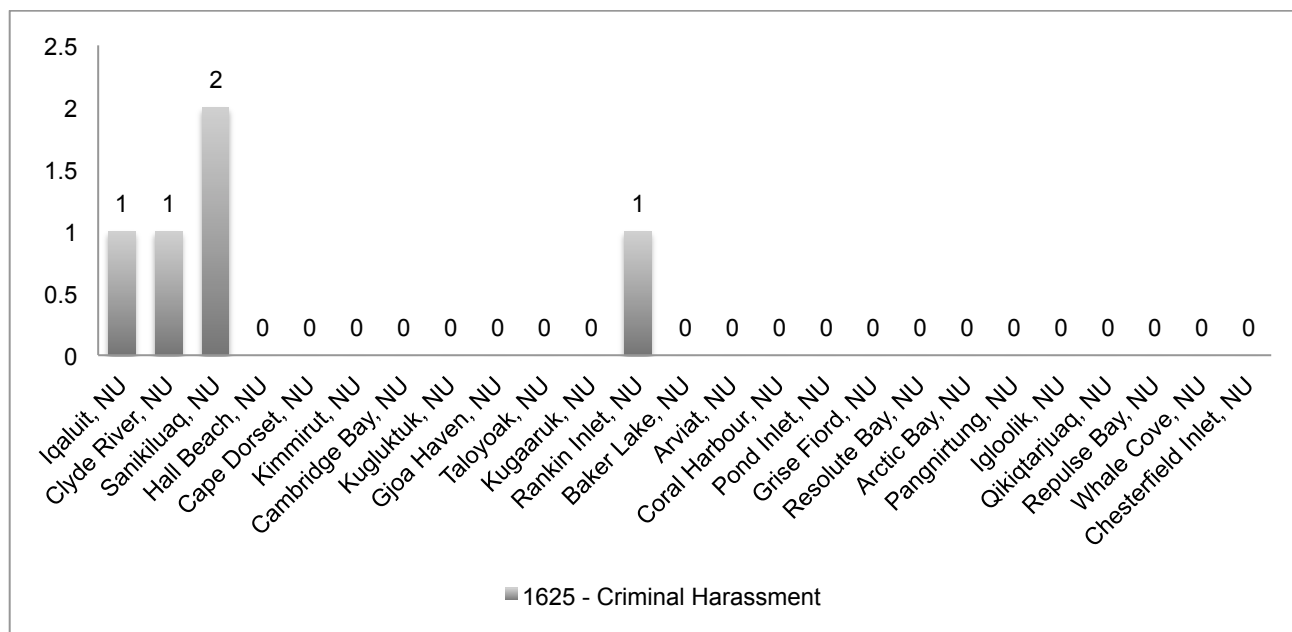
- 3 victims were 0 to 5 years of age;
- 11 victims were between 6 to 10 years of age;
- The remainder were 11 to 17 years of age.

The following charts provide a breakdown of charges against children and youth by type and by community for 2012-2013 through the Statistics Canada *Uniform Crime Reporting: Child Youth Victims* data.









This information is an important springboard to start community engagement on the types of harm occurring within communities across Nunavut. It will also be important for the engagement of and input from Elders, youth and community leaders into the development, design and delivery of targeted prevention programming for children and youth and public awareness campaigns.

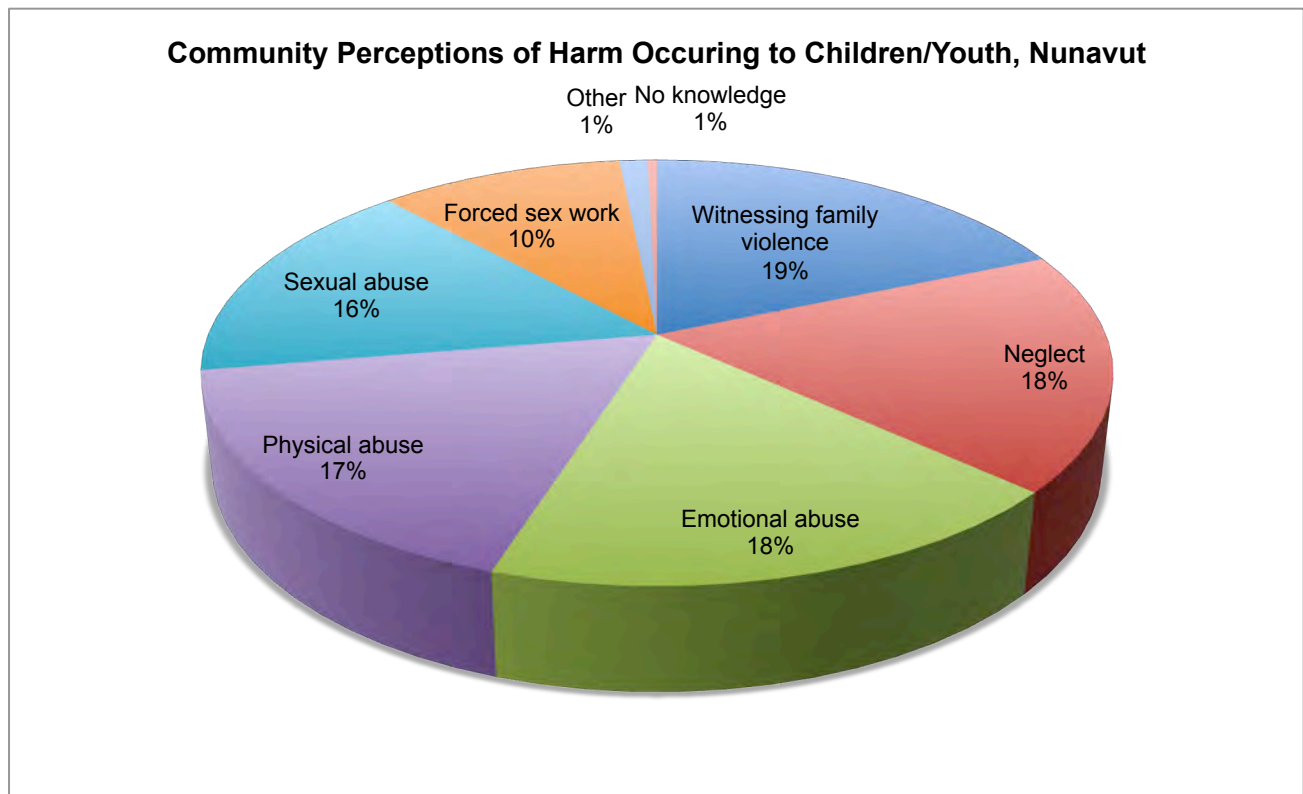
Community Perceptions of Violence Against Children and Youth

Through the General Survey developed for this study, Nunavummiut living in communities were asked confidentially about the types of abuse they personally believe has occurred in their community and to

select all types that they were aware of.²² The following types of harm were provided for their consideration:

- **Witnessing family violence** – seeing incidents of parents fighting, yelling and dangerous situations
- **Neglect** – not being fed, cleaned, properly clothed for the weather, no attention being paid, lacks basic necessities of life
- **Emotional abuse** – putting the child down, making them feel bad about themselves, low self esteem
- **Physical abuse** – hitting, kicking, slapping, punching, pinching, etc.
- **Sexual abuse** – physical touching, violation or invitation to engage in sex; watching pornography; relations with someone 2+ years older than themselves at 14 years old;
- **Forced sex work** – where someone else forces a child to have sex for money, alcohol, drugs or other goods for another person
- **Other** - please specify
- I do not have knowledge of incidences of child abuse in my community

The 51 respondents indicated that they believe children and youth from newborn to 19 years of age are experiencing harm in the following proportions:



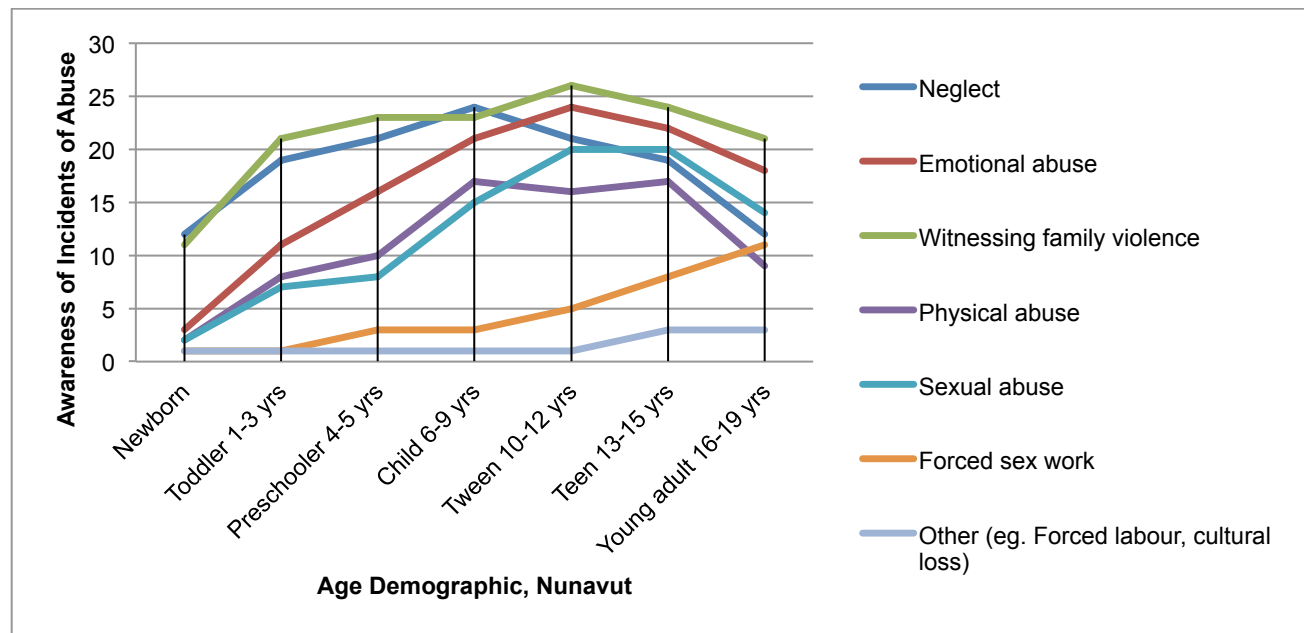
Other forms of abuse were noted such as verbal abuse, loss of culture and financial abuse/labour exploitation. One respondent explained that youth are often forced to work instead of going to school in order to support their family for food or to pay household bills. Among older youth respondents they indicated that they are aware of many youth who are forced to go on social assistance and provide the money to the family or caregiver to support their addictions. Financial abuse is a prevalent issue among

²² Roos-Remillard Consulting Services. *General Survey: Umingmak Child & Youth Protection Centre Feasibility Study*. Ottawa: May 2015. Question 3, p4.

youth who do not know their rights, and are forced to stop their own education and future goals due to family poverty and addictions.

One respondent also noted that loss of culture as an example of abuse, as many children are not being granted access to cultural activities due to their family's situation and activities.

An additional question was posed to the respondents of whether they were personally aware of incidents of abuse directly against a child/youth, and what were the ages per type of harm.²³



It is interesting to note that the rate and level of perceived harm steadily increased for all types of harm and ages until roughly 6 to 9 years old at which time physical abuse and sexual abuse are consistent for a 3 to 6 year period until 15 years of age. It is thought that harm declines at 15 years of age. This increase in perceived victimization among community members is consistent with charge data for Nunavut, as well as national research on the victimization of girls: that sexual violence increases with age.²⁴

It is also interesting to see the same trend and reports of increased forced sex work (sexual exploitation/prostitution) and forced labour (financial exploitation) is reported as occurring and increasing from 13 to 15 years of age up to 19 years old. This is also consistent with other research nationally and internationally that shows that youth, and predominantly young girls from 14 years of age, are lured or forced into exploitative situations.²⁵

Much more awareness around the nature of sexual abuse, exploitation and these types of crimes is needed among frontline workers and first responders. Specialized investigation training and targeted prevention work is required to support children, teens and young adults around safety, consent, healthy relationships and exploitation. This must also include targeted programming and outreach to boys, which based on research conducted with First Nations street-affected males in British Columbia is estimated to

²³ *Ibid.*, Question 4, p7.

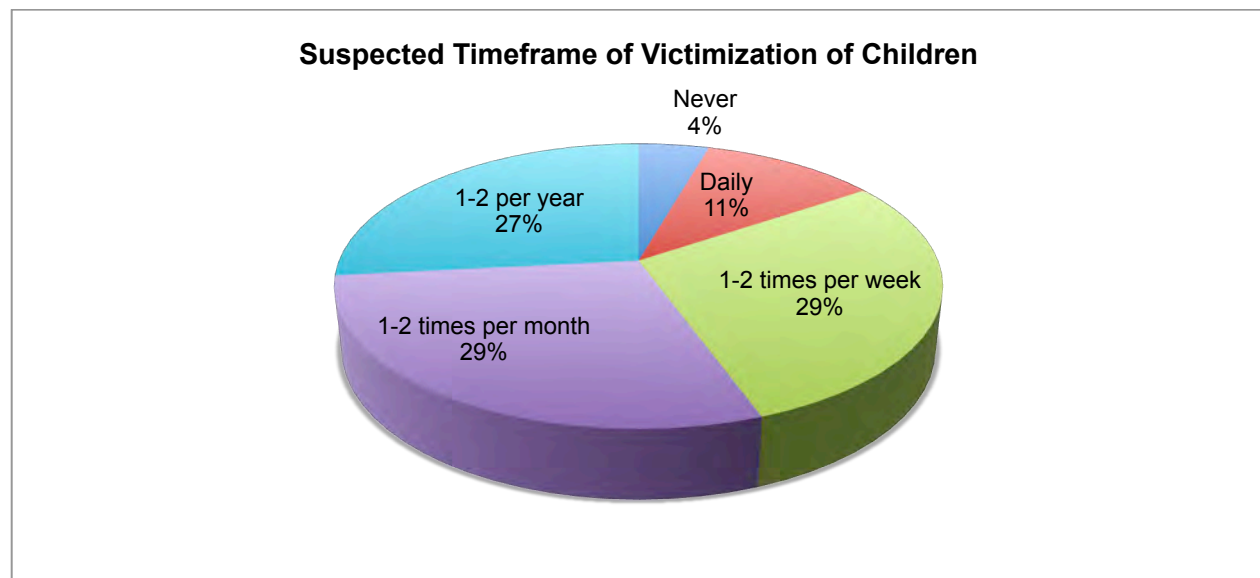
²⁴ http://cac-cae.ca/wp-content/uploads/fr_DOJ_NSM-Research-Update_April-11+12_-S.McDonald-Eng-Version.pdf
p. 3

²⁵ Royal Canadian Mounted Police. *Project SAFEKEEPING: Domestic Human Trafficking for Sexual Exploitation in Canada*. The National Human Trafficking Coordination Centre (HTNCC) Ottawa: October 2013. See also Native Women's Association of Canada. *Sexual Exploitation and Trafficking of Aboriginal Women and Girls: Literature Review and Key Informant Interviews*. Ottawa: March 2014 and Pauktuutit Inuit Women's Association. *Inuit Vulnerabilities to Human Trafficking*. Ottawa: August 2013.

be at least 20 percent of victims of child sexual abuse and further exploitation into young adulthood. However, through adult male residents and staff at Mamisarvik Healing Centre, and male youth who participated in a sexual exploitation therapeutic art project through the OICC, men intimated that for Inuit boys, the rates of sexual abuse, incest and exploitation is much higher. More research needs to be conducted on this issue, but at minimum, youth outreach, programming and interventions must be inclusive of both girls and boys across all types of harm.

The general survey respondents indicated that at least 56 percent of the children/youth they suspected were victims of harm was their friend's child or a child from their neighbourhood.²⁶ Twenty percent noted it was their student or client, while 9 percent indicated that they themselves experienced abuse, or 7 percent being their sister or brother. Only 2 percent noted that it was their niece or nephew.

When probed further, respondents across Nunavut indicated that they have seen, heard of or suspect that incidences of violence toward children and youth in their respective communities occur:²⁷



Lack of Reporting of Abuse

“Abuse happens in my home to me and my siblings and in my friends homes. I never report because I don’t trust the justice system or family services. Abuse has become normalized, so why bother? I am also afraid of retaliation.”

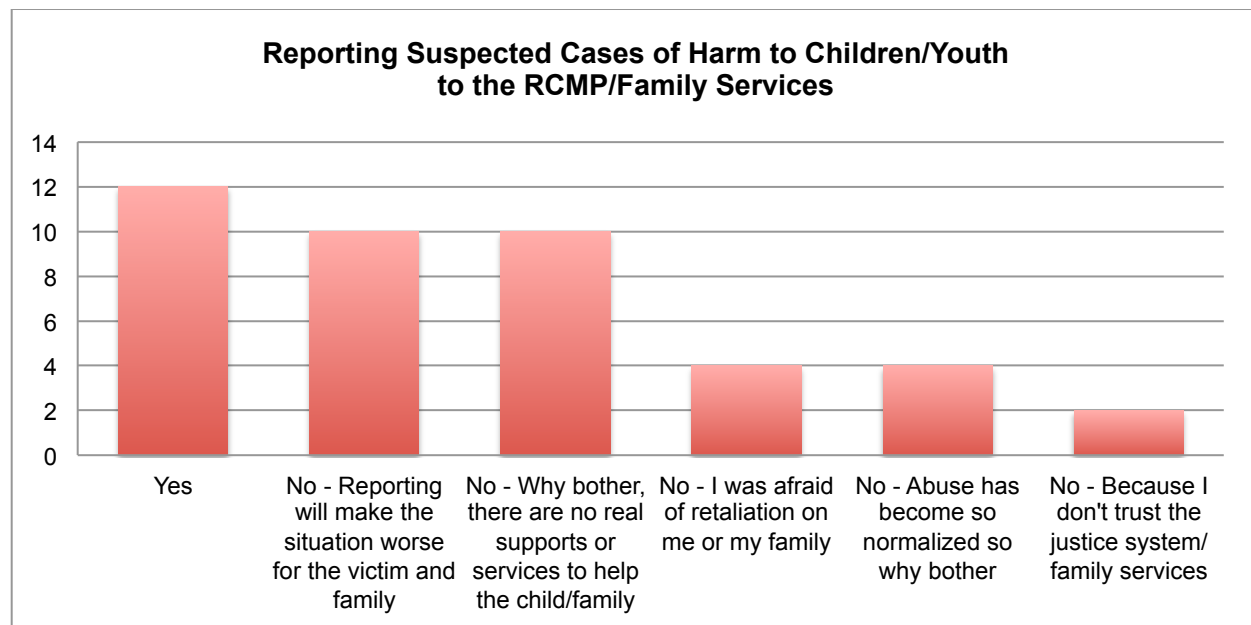
UCYPC General Survey – Youth Respondent

There were clearly articulated statements surrounding the issue of child harm and reporting suspected incidents of abuse. Input ranged from complacency, overwhelming feelings of futility as well as disturbing attitudes that the child/youth victim “did something to provoke the abuse, and therefore deserved it”. Much work needs to be done to remedy this notion and behaviour within individuals, families and communities across Nunavut.

²⁶ Roos-Remillard Consulting Services, General Survey, Question 6, p. 9

²⁷ *Ibid.*, Question 5, p. 8

A key question we wanted more information on was how many community members reported the suspected cases of harm, and if they did not, why not. Although all responses were confidential, 11 people chose not to provide an answer. Therefore, of the remaining respondents, the following was reported:



While everyone has a legal obligation²⁸ to report suspected cases of harm, it is clear that over 70 percent of respondents do not feel safe reporting cases to the RCMP or Family Services, or that reporting would be futile both in any real meaningful support for the victim, or achieve redress in the criminal justice system. This is a damning statement that children and youth do not have the support or protection of their community to act on their behalf.

When asked what would help reduce the stress on a child/youth or family after a disclosure of abuse, the following recommendations were provided and ranked in the order of highest response²⁹:

- 1. Have a child-friendly facility in communities for immediate protection, forensic interviewing and trauma services;**
 - a. Have several 24/7 safe spaces for children and youth to go to across Nunavut like a foster home facility, emergency home or open house building to access basic needs;
 - b. Ensure strong organizational delivery, strong staff training, clearly defined and safe “traditional healing” approaches, security and policies guiding the vulnerable sector is in place.
- 2. Have more mental health and trauma counselling supports for the child/youth and immediate family;**
 - a. Enable broader mental health assessments including FASD to ensure proper diagnosis and treatment for healing;

²⁸ Individuals making a report are protected from civil action as long as the report was purposely false. Failure to report suspected abuse toward a child or youth is punishable by a prison term of not more than six months, a maximum fine of \$5,000, or both.

²⁹ Roos-Remillard Consulting Services, General Survey, Question 8, pp. 11-12; Question 13, p. 20.

- b. Include mental health interventions from 2-3 years of age as toddlers and school-aged children – we are missing the critical ages of development and glossing over children, or not at all;
 - c. Referrals to specialized out-of-territory residential treatment centres for child abuse is vital;
 - d. Victims should be able to access rehabilitative programs that do not have them strictly talking to a counsellor: art, music, dance and other related therapies that allows the victim to be active and productive while healing should also be made available.
- 3. Reduce the number of people the child needs to retell his/her story to directly so they are not retraumatized over and over again;**
- a. Children/youth and families need to have a trusted, confidential and single place where they can be interviewed and the key social services, medical and mental health professionals and community justice outreach worker can view the tape and provide wraparound support after a disclosure of harm;
 - b. While a child may disclose harm to a professional, the child/youth should not be encouraged to share their story multiple times, but to wait to speak to the RCMP-Social Worker joint forensic investigator team in a comfortable location where it can be videotaped.
- 4. Have more rehabilitative programs for the abuser to heal the community;**
- a. Review the ineffectiveness of Community Justice Committees in Nunavut and standardize the delivery of restorative justice models for offenders and victim/family looking at success models such as the Hollow Water First Nation Restorative Justice project³⁰ as multi-faceted system that integrates justice, health, social services and corrections with clinical treatment and traditional programming with high success rates;
 - b. Restrict alcohol and drugs from abusers and direct removal for treatment;
 - c. Work together with GN Corrections staff on healing and therapeutic programs for adult offenders as well as young offenders (victims) to stop the cycle of abuse through admitting to the offence for accountability and clinical therapeutic and traditional healing interventions.
- 5. Have a zero tolerance approach to community retaliation and harassment of child/youth victims of abuse;**
- a. Deliver prevention training for community-based frontline workers to identify and respond to disclosures of abuse;
 - b. Enforce the laws of neglect and other types of harm;
 - c. Empower community social service workers to remove the child in unhealthy homes (where witnessing drunken behaviour, drug use, sexual and physical violence and other forms of abuse) rather than having to attend to witness the “crystallizing moment of crisis” in order to enforce removal for protection and support purposes. *The standard of protection and decision-making authority cannot be that as long as there is a sober adult in the home, where that individual is a known abuser, then the children are sufficiently safe to stay in the home;*

³⁰ <http://www.publicsafety.gc.ca/cnt/rsrscs/pblctns/cst-bnft-hllw-wtr/index-eng.aspx>

- d. Vigorously enforce the duty to report with the legislated penalties in suspected cases of child maltreatment, as required by law.
- 6. Train law and medical personnel in each community in the collection of forensic evidence to support criminal prosecutions of child abuse cases**
- a. Ensure that the person being disclosed to is properly trained to deal with such issues so that the child feels validated and heard...so that children who are abused feel trust, warmth and safety from the helper;
 - b. Get standardized documentation in place for health professions on red flags, indicators and protocols for referrals to paediatric specialists so children and youth do not fall through the cracks of acute and mental health care.
- 7. Include traditional healing and Elders in rehabilitation programs**
- a. Using “traditional healing” would need to be clearly defined, and inclusion of Elders or community members needs to prove that they have a safe approach;
 - b. Use the FAIA tools and process for Elder engagement and family intervention supports.

The Role of Alcohol in Victimization

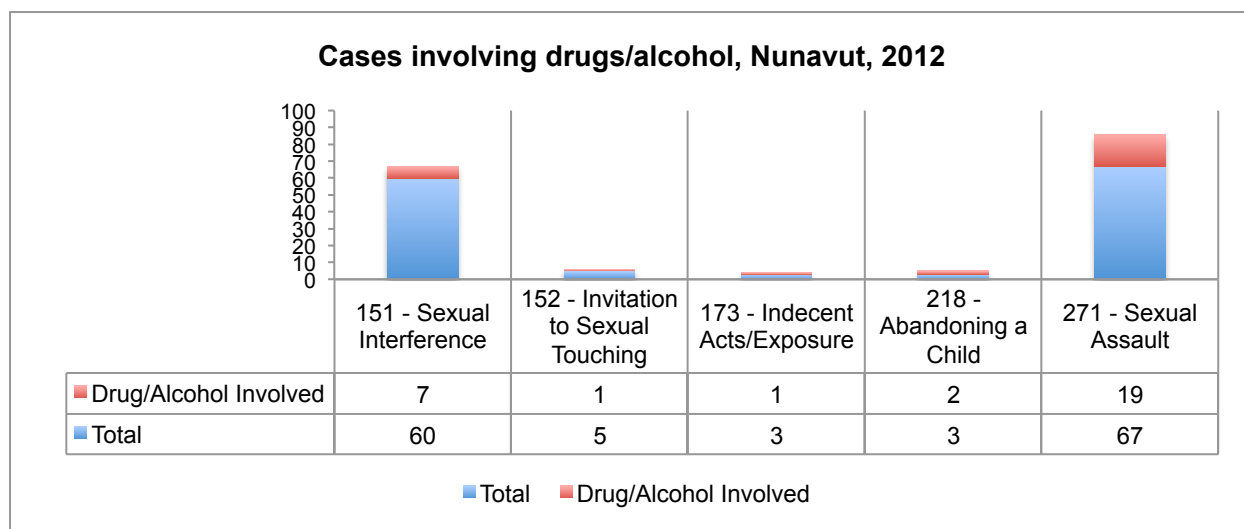
“Alcohol abuse must be addressed. It is the main contributor too [sic] all violence and abuse.”

UCYPC General Survey – Youth Respondent

According to frontline workers, the role of alcohol is the key element noted in incidences of child harm in Nunavut. Most professionals recognize that it is unrealistic to think that imposing dry communities is a solution, as there is always alcohol that finds its way into homes. There is significant travel into communities, from private passengers to cargo, contraband bootlegging or even homebrewed alcohol. Individuals will find it and pay a premium for it.

As the RCMP members in communities noted, violence and victimization is fueled by alcohol. As the 2012 charge rates indicate, 29 cases involved the offender using alcohol and/or drugs at the time of the incident.³¹ The breakdown is as follows:

³¹ Email correspondence from Sgt. Yvonne Niego, “V” Division RCMP to Helen Roos, Roos-Remillard Consulting Services, June 24, 2015.



With respect to the sexual assault cases, case notes indicated the following:

- 18 of the cases noted that the offender was intoxicated by alcohol; 1 where the offender used both alcohol and illicit drugs during the assault;
 - 6 cases involved where the child/youth was intoxicated, having been given alcohol under the legal drinking age;
 - 2 cases involved where the victim was intoxicated, but the offender was not;
 - 1 case where both the offender and victim were using alcohol; the victim also using drugs.

The RCMP analysis of the cases noted that in the drug related instances, the street drug MDMA (ecstasy) was involved in one of the cases; marijuana in all others. It must be noted also that there is a high likelihood that a higher number of cases involved alcohol, but were not indicated in the RCMP PROS case management database. These omissions are easily made where the victim was too young to know about alcohol, so it was not listed in the case notes.

In November 2012, the Nunavut Liquor Act Review Task Force final report recognized the role of alcohol in the communities and sought to adopt a harm reduction approach. Their recommendation, in part for revenue generation, sought to examine the establishment of government-owned liquor sales and look at policy development strategies aimed at changing Nunavut's drinking culture of binge drinking and bootlegging.³² The strategy seeks to expand access to less expensive beer and wine to hopefully reduce the demand for \$300 bootlegged vodka and other high alcohol content spirits.

As one community social services worker noted:

[Alcohol] becomes a seedy thing. It can be healthy but there needs to be education around that.

The study also found that public education regarding the effects of alcohol is limited. There is broad support to deliver programs for people to deal with addictions and alcohol education³³ but there are few opportunities for youth or adults to develop knowledge or skills about drinking responsibly.

³² http://www.nunatsiaqonline.ca/stories/article/65674nunavut_liquor_task_force_urges_harm_reduction_gn_monopoly/

³³ http://www.nunatsiaqonline.ca/stories/article/65674beer-wine_store_plebiscite_in_nunavuts_capital_draws_voters_with_varie/

However, even court-ordered programs for offenders are rarely delivered in many communities in Nunavut. As one Court Justice Worker noted, most community members do not want to participate in group therapy programs in their home community because of lack of confidentiality and shame. In other cases, where the impetus for the design and delivery of programs is left as a community-based responsibility, it may not be undertaken due to limited capacity to access proposal driven funding. Where the abuse of alcohol is largely a coping mechanism for stress, underlying trauma and conflict within the family, then alcohol treatment and programming must be integrated in a more holistic and family healing manner.

A multidisciplinary approach would be key, involving the Community Justice Outreach Worker to interview in suspected cases of harm toward children where alcohol is involved, for broader intervention tools and approaches.

Civil Cases

The Nunavut Legal Services Board (LSB) provides counsel for child clients who require independent representation for their own interests related to child welfare cases: when their interests are separate from those of guardians or the state.³⁴ The LSB provides legal counsel across the three Regions for clients without financial means and require legal aid counsel in the areas of criminal justice, family law and poverty law. In some cases, children also require legal representation for their own interests regarding child welfare and child protection.

All child matters are covered to a first stage order. If the child is apprehended by social services, a staff lawyer is immediately assigned to deal with the first stage apprehension order for the parent(s). Where the child is not immediately returned to the family, LSB will provide legal counsel for the duration of the Court proceedings for financially eligible clients.

Counsel will also be assigned for children where the Court orders representation, or if it deemed necessary by counsel, for the welfare of the child or on custody matters. Otherwise, the Department of Family Services may request representation for a child in matters relating to their case. This ensures that the rights and interests are upheld for the child, and not influenced by the guardian or the state's interest. This also includes applications related to contested adoptions, contested paternity and exclusive possession of the matrimonial home. However, applications under the FAIA are not covered by the LSB unless they are ancillary to approved family or criminal applications.

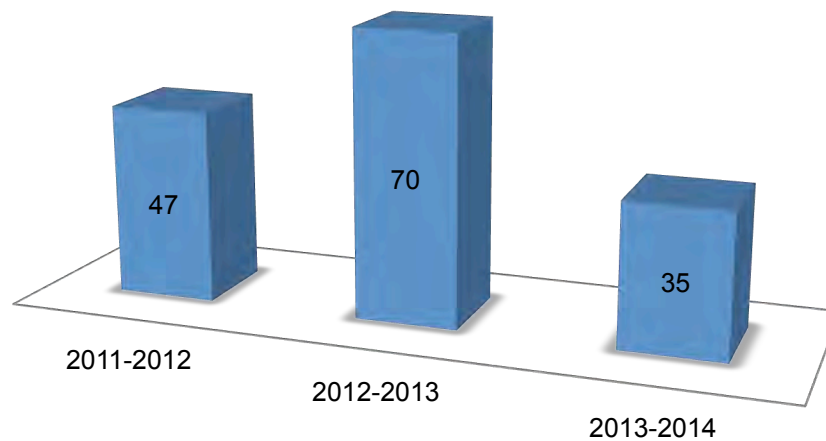
LSB reporting on child welfare cases is improving annually, where the rate of child welfare cases within the scope of family matters were identified and reported. In 2012-13, where there were 70 applications for child welfare representation: this was 32 percent of total family law cases.³⁵ This dropped 50 percent in 2013-14.³⁶ The resources required to defend child protection files is significant: those files are generally the most complicated and time-consuming for counsel.

³⁴ Legal Services Board of Nunavut, *12th Annual Report 2011-12*. Iqaluit: 2012. pp. 13-14.

³⁵ Legal Services Board of Nunavut, *13th Annual Report 2012-13*. Iqaluit: 2013. p. 4

³⁶ Legal Services Board of Nunavut, *14th Annual Report 2013-14*. Iqaluit: 2014

Legal Services Board, Child Welfare Matter Applications, Nunavut, 2011-2014



Children and youth are also receiving counsel representation for child welfare matters, particularly for youth between 10 and 16 years of age,³⁷ with requests for representation usually through the Department of Family Services. This is encouraging to ensure that children and youth receive unbiased representation for their welfare and interests.

LSB staff lawyers also assist to develop materials for distribution in communities on topics related to rights-based issues. The UCYPC could work in collaboration with the LSB to develop information for children and youth on their legal rights and remedies for redress.

Other Socio-Economic Indicators

Poverty is a challenging topic in Nunavut, and even harder to measure than in the south. In the three Northern territories, Statistics Canada does not collect the enormous amount of data required to support the calculation of measures (such as Low-Income Cut-Offs, or LICOs) used in the provinces, but there is no doubt that deep child poverty exists in Nunavut. The most recent Inuit Health Survey in 2007-08³⁸ revealed that 70.2 percent of Inuit households overall are food insecure, and 71.4 percent of households with children are food insecure. By contrast, only 9 percent of Canadian households were considered food insecure according to the 2004 Canadian Community Health Survey.

The Department of Family Services through the Income Assistance Division provides financial resources as well as other government programs and services to help people achieve independence and self-reliance from unemployment, disability, illness or retirements.³⁹ In 2013, approximately 14,578 Nunavummiut, or over 41 percent of the total population, relied on income assistance with a median income of \$24,868 annually.⁴⁰ Of those recipients, 6,236 were dependents, which we can assume includes children and youth up to 18 years of age. Forty-nine percent – almost half of all children in Nunavut – are living in poverty meaning a dependence on income (in the region with the highest cost of

³⁷ Email correspondence between Jonathan Ellsworth, Executive Director Nunavut Legal Services Board and Helen Roos, Roos-Remillard Consulting Services, June 19, 2015.

³⁸ Egeland, G.M. *2007-2008 Inuit Health Survey – Nunavut*. Centre for Indigenous Peoples' Nutrition and Environment. McGill University. Montreal: 2008.

³⁹ http://www.gov.nu.ca/sites/default/files/2015-2018_government_of_nunavut_and_territorial_corporations_business_plan.pdf p. III-6

⁴⁰ http://www.gov.nu.ca/sites/default/files/2015-2018_government_of_nunavut_and_territorial_corporations_business_plan.pdf p. III-8

living), housing support and food insecurity. It is vital that activities and interventions are made to improve the health, skills development, graduation rates and full participation of Nunavut's working aged youth in the wage economy to enable self-reliance.

Poverty in Nunavut is often coupled with poor health indicators for Inuit. Substantial work is required to improve the socio-economic conditions of Inuit in communities, which can only be done by addressing the underlying conditions that influence the health outcomes of Inuit. According to the Children's Health Policy Centre, children in disadvantaged circumstances have a much greater chance of experiencing trauma: living in poverty, or with a parent with a mental illness, can quadruple a child's risk of being exposed to trauma.⁴¹

As an Inuit Tapiriit Kanatami (ITK) report on the social determinants of Inuit health in Canada notes, 11 factors are key levers that impact the success of children, youth and families.⁴² These include:

- Quality of early childhood development
- Culture and language
- Livelihoods
- Income distribution
- Housing
- Personal safety and security
- Education
- Food security
- Availability of health services
- Mental wellness, and
- Environment

These issues are compounded by the fact that basic mental health services are under development for children and youth in Nunavut, but a wide range of types of supports for people struggling with trauma or mental health disorders is needed due to the range of stressors.

Over-crowded housing compounds the stress that many families experience. Thirty-nine percent of Inuit families in Nunavut experience overcrowded living conditions and inadequate housing.⁴³ The Nunavut Housing Needs Survey report released in October 2010, noted that 35 percent of Nunavut homes are overcrowded and 23 percent of social housing stock requires major repairs.⁴⁴ As NTI's 2013-14 *Annual Report on the State of Inuit Culture and Society*⁴⁵ noted the severe housing shortage in Nunavut puts stress on a population with many people who have experienced trauma. Women and children are the most vulnerable to violence, often because they lack economic security and access to shelter or affordable housing.

It must be noted that these factors are and must be included in any Nunavut CAC global child and family assessment, care planning and scope of referrals to support the success of the individuals it serves.

The Impact of Historic Trauma/Common Pain

There are no historical data on the sexual abuse of children in Nunavut; no way of knowing with any precision at all what the situation was on child treatment 50 or even 100 years ago. That being said, while it is generally believed that some amount of child sexual abuse occurs in all human societies, there is no

⁴¹ Children's Health Policy Centre, Simon Fraser University: Faculty of Health Sciences. 2011.

⁴² Inuit Tapiriit Kanatami, *Social Determinants of Inuit Health in Canada*. Ottawa: 2014. p.2

⁴³ *Ibid.*

⁴⁴ [http://www.gov.nu.ca/sites/default/files/2015-](http://www.gov.nu.ca/sites/default/files/2015-2018_government_of_nunavut_and_territorial_corporations_business_plan.pdf)

[2018_government_of_nunavut_and_territorial_corporations_business_plan.pdf](http://www.gov.nu.ca/sites/default/files/2015-2018_government_of_nunavut_and_territorial_corporations_business_plan.pdf) p. III-28

⁴⁵ Nunavut Tunngavik Inc. 2013-14 Annual Report on the State of Inuit Culture and Society. Iqaluit. 2014. p. 1.

reason to believe that historical Inuit society experienced the sharply elevated rates of child sexual abuse that it suffers today. There is simply no evidence to that effect.

The historical trauma framework was initially developed in regard to Jewish Holocaust survivors and their descendants, and began to be employed in the context of indigenous peoples in the mid-1990s. Nunavummiut are increasingly employing a 'historical trauma' framework to speak about the process they believe to be behind the increase in social problems in recent decades. There have been two noteworthy uses of the framework in Nunavut in recent years: the Canadian Truth and Reconciliation Commission final report which reported, "what took place in residential schools amounts to nothing short of cultural genocide."⁴⁶ The other use being the Qikiqtani Truth Commission (QTC), a commission of inquiry headed by retired Labrador judge James Iglooliorte, was created and funded by the Qikiqtani Inuit Association "to create a more accurate history of the decisions and events that affected Inuit living in the Baffin Region from 1950-1975."⁴⁷

Historical trauma has been translated into Inuktitut as:

Sivulirijat aksurunaqtukkuurnikugijangat aktuiniqaqsimaninga kinguvaanginnut
The trauma experienced by generations past having an effect in their descendants.

It is important to differentiate historical trauma from post-traumatic stress disorder (PTSD). Historical trauma is a complex *collective* phenomenon incorporating both the psychological and social sequelae of historical oppression, whereas PTSD is largely confined to the psychology (and accompanying substrates) of the *individual*. Historical trauma is *cumulative* and *intergenerational* in its impacts.

The QTC documented many different sources of trauma in Inuit society in addition to the killing of sled dogs, which was its original focus. The QTC's final report, *Achieving Saimaqatigiingniq*, noted that by the 1970s, when almost all Inuit were living in settlements and most had access to liquor and even drugs, many families were experiencing first-hand the devastating consequences of substance abuse, including alcoholism, addiction, physical and sexual abuse, neglect of children, poverty and death.⁴⁸

It was clear during our community consultations for this project that the experiences of Inuit from abuses experienced at the Sir Joseph Bernier School in Chesterfield Inlet are still palpable among senior adults in hamlets across Nunavut. *Achieving Saimaqatigiingniq* included the recommendation⁴⁹ that Canada⁵⁰ should formally acknowledge that the levels of suicide, addiction, incarceration and social dysfunction found in the Qikiqtani Region are in part symptoms of intergenerational trauma caused by historical wrongs." The understanding that historical trauma can be passed from one generation to the next does not excuse afflicted individuals who harm others; nor does the examination of the roots of historical trauma in Nunavut allow definitive blame for the current suicide rate to be placed on any single entity. Rather, understanding historical trauma and how it is transmitted from generation to generation, and mapping the appropriate clinical therapeutic and traditional cultural supports to address complex trauma is vital. The UCYPC CAC is a key model to assist children/youth and families to receive specialized response and support as an imperative first step in breaking its cycle in Nunavut.

⁴⁶

http://www.nunatsiaqonline.ca/stories/article/65674trc_aboriginal_residential_schools_amounted_to_cultural_genocide/

⁴⁷ <http://www.qtccommission.com/> See also:

http://www.nunatsiaqonline.ca/stories/article/65674qikiqtani_truth_commission_gets_the_inuit_story_down_on_paper/

⁴⁸ Qikiqtani Inuit Association. *Qikiqtani Truth Commission Final Report: Achieving Saimaqatigiingniq*. Iqaluit. 2010. p. 17.

⁴⁹ *Ibid.*, p. 48

⁵⁰ The healing and reconciliation efforts through the Health Canada funded Indian Residential Schools Resolution Support Program was a start to support dedicated counselling for Inuit survivors. Many call for continued dedicated federal funding to support mental health interventions in Nunavut. In April 2015, the federal government through Hon. Leona Aglukak, MP announced \$3.5M in mental health funding for Nunavut.

The Nunavut Suicide Prevention Strategy (NSPS), developed jointly by the GN, NTI, the RCMP and the Embrace Life Council (together referred to as 'The Partners') found that "...the rapid increase in suicidal behaviour in recent decades, especially among young people, is probably the result of a change in the intensity of social determinants – among them the intergenerational transmission of historical trauma and its results (increased rates of emotional, physical, and sexual abuse, violence, substance abuse, etc.)."⁵¹

Among the commitments made in the NSPS Action Plan were that the interagency partners would undertake research and provide information on the role that child sexual abuse plays as a risk factor for suicidal behaviour later in life, and what can be done to break the cycle of abuse.⁵² Furthermore the partners would prepare or commission a research paper which summarizes a) the evidence base on the role that child sexual abuse plays as a risk factor for suicidal behaviour; and b) best practices in documenting and healing for both the victims and their families from child sexual abuse.⁵³ These commitments were at least partially fulfilled by the Embrace Life Council commissioning a report.⁵⁴ Among the report's observations were that childhood adversities of various kinds are factors, with repeated and severe abuse and child sexual abuse are important risk factors for suicide. It should also be noted that some children who experience sexual abuse also have other protective factors that make them resilient.⁵⁵ The report also indicated that there are important disincentives for disclosures of sexual abuse, especially if the disclosure could result in a powerful or important person in the family being sent away. Children may experience pressure not to disclose under those circumstances, and may experience guilt if they have disclosed. It is felt that most sexual abuse is not reported.

The NSPS further concluded that the trauma experienced firsthand by Inuit in the settlement transitional period has had an immense impact on all following generations, as many Inuit who were negatively affected in this period did not ever heal. This is referred to as the intergenerational transmission of historical trauma.⁵⁶ This unresolved trauma compromised the ability of many to cope with stress in a healthy manner. The symptoms of this deep-rooted trauma invariably results in negative behaviours in the form of alcohol abuse, sexual, physical, and emotional abuse, child neglect, and violent crime.

It is important to note that *elevated suicide rates emerged within the first generation of Inuit youth who grew up in communities*. In the absence of an adequate healing process, a continuous cycle of trauma has been created, which has been passed from generation to generation.

It is possible to treat and resolve sexual abuse trauma, such that the experience no longer puts the person at risk and breaks the cycle of abuse. There is a sense that people in decision-making roles are not aware of the widespread nature of sexual abuse, and thus, are not putting strategies in place to respond. However, the reality is that people are well aware that it occurs, but that it is a significant taboo topic and considered "none of your business" to discuss. To open up the wound requires protective measures for those brave enough to shed light on the truth including safe housing; a proactive criminal justice response to charge and prosecute offenders, and a robust coordinated suite clinical mental health and community programming to support children, youth and families moving forward.

It can be done, and the UCYPC CAC will be a key partner in that challenge.

Inuit Strength and Resiliency

Dr. Allison Crawford, who spearheads the Northern Psychiatric Outreach Program through the Canadian Addictions and Mental Health (CAMH) and Hospital for Sick Children (Toronto) notes that we need to be

⁵¹ Government of Nunavut et al. *Nunavut Suicide Prevention Strategy*. Iqaluit. 2010. p. 9.

⁵² *Ibid.*, Sec. 3.2

⁵³ *Ibid.*, Sec. 5.2

⁵⁴ Snelling, S. et al. *Evidence Review in Support of the Nunavut Suicide Prevention Strategy*. Embrace Life Council. June 2013.

⁵⁵ *Ibid.*, pp. 7-8.

⁵⁶ *Ibid.*, p. 6.

careful not to pathologize the entire Inuit population and territory. While the gaps in social determinants of Inuit health are in many respects a symptom of poor socio-economic conditions, the achievements of Inuit since the impact of colonization into the era of modern governance are significant. Many Inuit individuals and families are working hard to build productive lives, lead and contribute to capacity building and change, and raise families both amid personal histories of tragedy and through financial struggles. Inuit tire of constantly being bombarded by the negative statistics; the bad news stories; the weight of the task at hand, and the inability to access services when they need them most, as they continue to move forward out of the historical hangover.

There is no official history of Nunavut Inuit society in the last 100 years, but the 'Inuit power curve' developed by the Inuit college Nunavut Sivivuksavut can serve as a general guide.

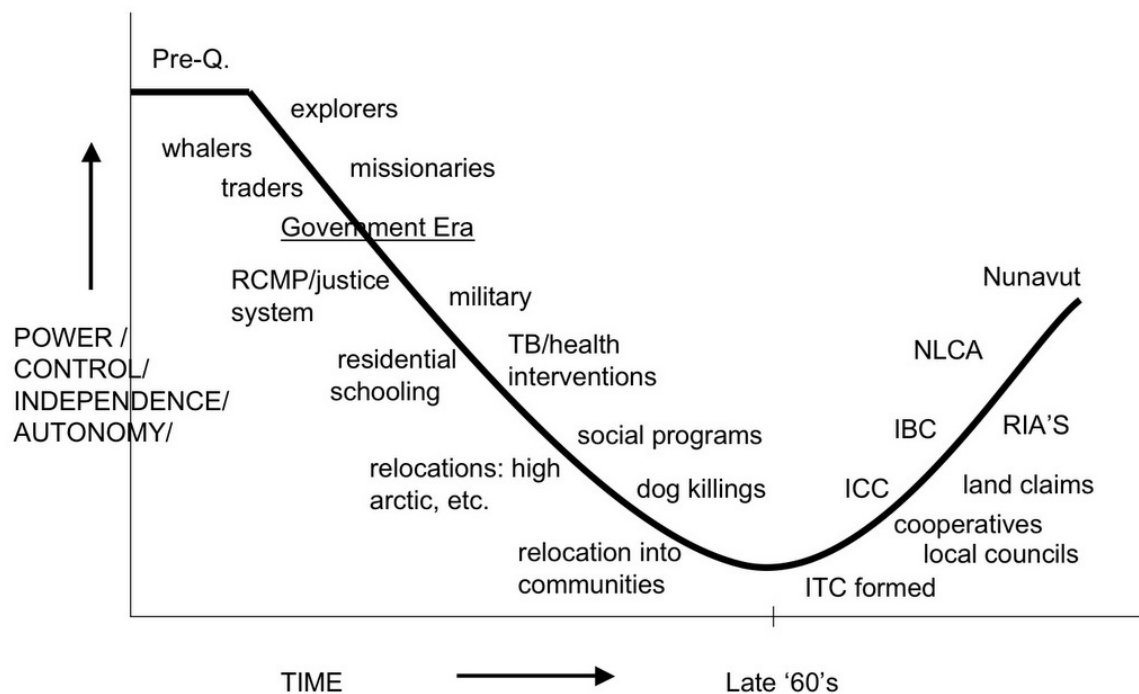


Figure 1 - Inuit Power Curve

The curve shows that Inuit “power/control/independency/autonomy” declined after contact with non-Inuit society and continued to decline until the beginning of Inuit ethno-political mobilization in the late 1960s. Inuit resiliency was gradually restored through the development of representative Inuit organizations, which negotiated with the federal Crown resulting in the 1993 Nunavut Land Claims Agreement and the creation of Nunavut on April 1, 1999. Noting that social problems such as substance abuse, suicide behaviour and the sexual abuse of children appear to have begun to increase *at the same time* as Inuit “power” was being restored does not dispute the essential point/truth of this curve.

For those working in health, justice, social services and education in Nunavut, it is important that the cultural experience not be pathologized: that is, viewing or characterizing all Inuit as psychologically or medically abnormal. As one senior official in the health sector of the Government of Nunavut noted, Inuit often take what is said about the intergenerational trauma or negative regard very literally; may see themselves as “broken”; unable to heal and therefore, internalize the negativity and are unable progress forward. However, in spite of many challenges, Inuit reach out to help their families and others within the community, and are making great strides individually and collectively, to move beyond family tragedies and broader group pain. Whatever is going on in their lives, Inuit always have a friendly word, a smile and a willingness to lend a hand. That is true resiliency and strength and social cohesion.

Inuit as a people and a cultural group are powerful, compassionate and resilient, and have survived thousands of years in one of the harshest areas on the planet. In spite of and through many socio-economic challenges, they continue to build on local Inuit supports of culture, tradition and collective identity. As one project informant noted:

We don't have most things written, but we are powerful and compassionate, we Inuit. Our resilience is/will be protected by the invisible force that binds us all over the world. Our land is that old, and so is our culture. It's just not written, and doesn't need to be, as we do things instantaneously. We don't judge things already done and passed. We forgive each other after we genuinely say sorry to each other. Living in the moment, not the past, or the future, and not "what ifs". That's the best way to explain our culture. It will never change as it's in our blood.

Youth in particular are finding their individual identity and future by walking two paths, much like First Nations and Métis peers who struggle with family and community challenges due to historic cultural trauma. On one hand they are modern Canadian youth, connected to a global world with a wide range of options available to them. On the other, many are interested in learning about, revitalizing or adopting certain elements of their cultural history, to the extent that it supports a positive sense of identity and self. In some cases, where their home or community may not be a safe haven, they still try connect to core elements of their past to help make sense of their future and provide tools and strength for a bright future.

Inuit youth are smart, caring and resilient: they are strong, and they too are choosing those aspects of their culture, family and community relationships that are healthy, and opportunities for education and success.

Inuit believe it is important to raise a child and youth to be strong so they are capable and contributing members of society – “not like an egg, which will break at the slightest tap” as was noted by an Elder. A key source of individual resiliency is to find coping strategies that affirm those healthy ties that bind as individuals, families and community. Empowering children and youth about their individual bodies and healthy respectful relationships; their individual legal and basic human rights; and debunking myths about abuse or negative activities or behaviours as being “normal” in the home, school or community is important. Information also provides children and youth with self regulation as well as points of reference across the spectrum of harm and harmful experiences, and boundaries for self determination.

As one youth noted, she just wants information – about her case, her back story, so she can understand why she feels why she does, and wants answers as to why the government didn't act more on her behalf as a ward of the state. She wants assistance to be a strong, critically thinking and an independent person, but feels like she is living in a vacuum of silence and a world of taboo topics. She wants information, plus guidance from Elders, but access to the world available to her in the south and globally.

Children naturally want to please their parent, for love and attention, and will learn to manoeuvre within harm, violence, neglect and abuse as a survival skill and coping mechanism. Many youth want to help their parents and family get the assistance they need, but are powerless to know how; have no safe place to go for respite; don't know where to turn to without shattering the family unit and potentially being placed in a more dangerous home. As one youth survey respondent reported:

DO MORE TO PROTECT KIDS! There's too much abuse. Even I was abused and my mom was the school counsellor and my dad was the social worker. Still I had no one to turn to and even when I did try to tell another social worker I had to lie to them and say my mom didn't abuse me. [My mom threatened me] cuz [sic] she said we would go to an even worsen [sic] place.

Youth explained that more and more they are turning to each other within their own peer group for help, because they know that their friend's have experienced harm and are trying to get information on what they should do: where to go to safeguard themselves. Youth are assuming responsibility for the trauma of the adults and trying to fix deeprooted pain and being subjected to highly volatile situations. This is not their responsibility to do and can have physical and significant mental health impacts on them as youth having to hear and process the harm being experienced among their peers. They remain in harm's way,

and we all must act to help and protect them. In the meantime, children and youth are not being fed, are inadequately clothed and live in fear. There must be some balance of perspective of culture, tradition and the rights of the most vulnerable and a call to joint understanding and action.

Child Advocacy Centre Models

The Child Advocacy movement refers to a range of individuals from professionals and advocacy organizations that speak out on the best interests of children. An individual or organization engaging in advocacy typically seeks to protect children's rights, which may be negatively impacted or abused in a number of areas. A child advocate typically represents or gives voice to children and youth whose concerns and interests are not being heard. Advocacy can be done at the:

- Micro level - the individual or small group of discrete types of children;
- Mezzo level – for a group of children or at the community level, or;
- Macro level – for a category of children affected by a social issue.

A child advocate will try to prevent children from being harmed and may try to obtain justice for those who have already been injured in some way. A child advocate may also work to ensure that children have access to positive influences or services which will benefit their lives such as proper parenting, access to appropriate medical assessment, treatment or other services, education or childcare.

Other forms of child advocacy occurs at the policy level and focuses on addressing policy or legislative gaps in governments or even transnational policies. These advocates do so through lobbying, policy research, file lawsuits and engage in other types of policy change techniques. Internet-based techniques would include public online petitions, social media campaigns or social justice marketing campaigns.

What is a Child Advocacy Centre (CAC)?

Child Advocacy Centres (CACs) are another type of advocacy support to children and youth, but is very operational in nature.⁵⁷ A Child Advocacy Centre (CAC) is an internationally recognized evidence-based best practice model to bring together and improve the social resources working to help children and youth who have been victimized by a crime. Under a CAC in Nunavut, the RCMP, child protection worker, medical and mental health staff specializing in paediatric care, community justice outreach worker, translator and a child and family system pathfinder would work together to put the child first and remove the bureaucratic barriers to getting convictions and providing the required care for their healing.

The child-friendly approach used by CACs helps reduce the emotional and mental harm to children and youth by reducing the need to retell their story. This improves the quality of evidence, conviction rates, and development of a joint care plan. The CAC helps link the child/youth and their family to services immediately after disclosure to long-term treatment, as required. Having these staff working closely for the sake of the child, while bringing forward their respective expertise and recommendations for the benefit of the child and family, helps break down a number of systemic barriers in information sharing, case review and case management required to serve this vulnerable group.

The notion of the CAC model began in 1985, through the organized effort of District Attorney Robert E. Cramer in the state of Alabama in the United States.⁵⁸ At that time, Congressman Cramer was frustrated as a prosecutor due to the difficulty in prosecuting child abuse cases and getting guilty verdicts or guilty pleas for offenders of crimes against children. During his career, he noted the challenge of social services and the criminal justice systems and the impact on child victims: there was little collaboration or effectiveness between the key actors in child abuse cases. The result was that children were being revictimized: children's emotional distress was high and the segmented, repetitious and often frightening experience of the criminal justice system and receiving the necessary supports for children and their families was weak.

⁵⁷ <http://www.justice.gc.ca/eng/fund-fina/cj-jp/fund-fond/cac-cae.html>

⁵⁸ <http://www.nationalcac.org/history/history.html>

As a revolutionary idea, he brought together law enforcement, criminal justice prosecutors, child protective services, medical and mental health workers into one coordinated team to service child victims of crime in a respectful way, and supported those professionals in their work.

The efforts of Mr. Cramer led to the establishment of the National Children's Advocacy Centre (NCAC), which remains a key training centre and a Centre of Expertise on CACs. The NCAC has trained over 54,000 child abuse professionals across 20 countries, building a significant community of practice of professionals proficient in collaborative multidisciplinary team building and case management through a child-focused and family supportive manner.

The CAC model is considered a leading professional best practice in how to respond to child abuse cases and has been replicated in countries worldwide as the gold standard model of evidence-based victim services for children, youth and families. To date there are more than 1,000 CACs in the United States and several others in over 12 other countries worldwide. Through the initiative of professionals and partners in communities across Canada, CACs are being established with the support of the federal Department of Justice through the Child Advocacy Centres Initiative and the Victims Fund. A brief overview of the Canadian state-of-play will be reviewed throughout this document as their experiences and best practices relate to considerations for a model that is most appropriate, feasible and sustainable for all communities across Nunavut. For a current map of CAC's in Canada, see the Justice Canada Victims of Crime Research Digest.⁵⁹

What Need Does a CAC Address?

The most common issues and gaps that exist with respect to the investigation and intervention in child abuse cases are that:

- Investigations are often not conducted in child-friendly locations;
- Children are being interviewed multiple times, and sometimes by a number of different professionals;
- There is considerable lack of coordination between professionals in the care plan or timely access to necessary health assessment or treatment services;
- Custodial parents/guardians and family members are not supported consistently, and;
- Case management and file management is inconsistent and fragmented.

The CAC model helps put in place collaborative teams, operational tools and facilities and approaches for children that produce better outcomes in child abuse investigations, prosecutions, complex medical and mental health assessments, treatment and referrals for family supports for long-term success.

CACs are well recognized and respected as an evidence-based model that provides a child-friendly, safe and neutral location in which law enforcement and child protective workers may conduct and observe forensic interviews with children who disclose an alleged instance of harm. The CAC is a space where the child and non-offending family members can receive support, crisis intervention and referrals for mental health and medical treatment.



The National Children's Advocacy Centre, Huntsville, Alabama USA

⁵⁹ <http://www.justice.gc.ca/eng/rp-pr/cj-jp/victim/rd6-rr6/fig1p2.html>

The CACs main objective is to reduce trauma to child victims by bringing all disciplines together and sharing information more efficiently to minimize duplication of interviews by the range of professionals, and streamline access to medical and mental health services and referrals. Another key benefit found that the charging decision time is shorter and resulted in a 36 percent cost savings when a CAC is involved in comparison to those communities without a CAC.⁶⁰

Variations Among CACs

“No single model for an ideal multidisciplinary program exists, because each community’s approach must reflect its unique characteristics.”

N. Chandler, 2000.

What is evident from each CAC interviewed and visited is that no two CACs are alike. In fact, the form of the CAC is significantly determined by the function of what is most needed by:

1. The culture, language and geographic environment of the child as a child-focused approach;
2. The tools, space and technology required for the multidisciplinary team to work collaboratively and effectively, and;
3. The program and service needs of the children and families within the community/territory being served.

There is also significant diversity in the scope of their respective operational structures and models based on the availability of partner funding through agreements or other fundraising measures.⁶¹

The characteristics of Nunavut’s communities, such as size, diversity and isolated locations, directly affect the nature and development of a CAC. CACs are often faced with the problem of how to provide coordinated services to isolated communities over a large geographic area. For Nunavut, with one fifth of Canada’s entire landmass, the typical model of a centrally located CAC can be impractical, and creative solutions may be required to respond to children physically in isolated hamlets, or provide services to professionals at the local level in the immediate to medium term until such a time as sufficient support, training and resources are available to set up a UCYPC CAC at the hamlet level.

Some CACs that serve Aboriginal reservations in the United States have developed creative solutions to reach out to outlying communities. Some use mobile units that travel to different locations in the geographic location being served on an as-needed basis. While this provides specialized assistance, it does not build capacity at the community level. In some cases this is the community’s approved approach based on high rates of professional turnover and lack of available space. However, for the UCYPC and Nunavut, the working objective is to establish a physical centre that can support all communities. More work will be required to engage families in each local community on the issue of child welfare and identify local strengths and work on key gaps.

A key model to review on the community engagement approach on child maltreatment is the Australian RESET program, which engaged key members of the multidisciplinary team over an 18-month period, to visit, engage and build positive working relations through immediate projects, to move communities into acknowledging child sexual abuse, and working to address it collaboratively.⁶²

⁶⁰ <http://www.justice.gc.ca/eng/rp-pr/cj-jp/victim/jf-pf/cac-cae.html>

⁶¹ Karen Kennedy. *Developing an Effective CYAC*. BOOST Child & Youth Advocacy Centre. December 2014.

⁶² Mace, G. et al. *Evaluation of Operation RESET: An initiative for addressing child sexual abuse in Aboriginal communities*. Australian & New Zealand Journal of Criminology. Vol 48(1). 2015.

Alongside demographic and geographic considerations, CACs must also take into account the capacity of the key mandated departments working in the communities; the facilities; infrastructure; workforce capacity and turnover; and the internal and external politics around the existing services related to child protection and service referrals. For instance, in some American communities, CACs have created specialized Child Protection Teams (CPT) that are medically directed multidisciplinary teams available to supplement child protection investigations that would occur in a community.⁶³ These CPTs must identify the best process for adapting to the existing service structure in the community, and avoid overlapping efforts. However, it provides a specialized team to provide ongoing coaching and support to local service providers for care planning and delivery, particularly to underserved communities that typically would not have the capacity or resources to respond quickly and with the wraparound service required for victims of trauma.

CACs also vary greatly in the way they are organized. Some CACs are independent, not-for-profit organizations, whereas others are located within hospitals, child social service agencies or Crown Attorney's offices, as examples. The organizational base has a direct effect on the pattern of agency involvement; the referral process, and; emphasis on and development of available services. For instance, where a CAC is located in a hospital or health centre, the obvious outcome is that the medical component is likely to be a major focus of the program – both acute care, assessment, care planning and prevention messaging/outreach. Some research undertaken of medical model CACs in the United States showed that because of direct referrals from the emergency department and other health care providers, data revealed that nearly half of child victims were under 6 years old, while another medical CAC location had a majority of cases of children between 10 and 15 years of age. The effect of the referrals and case management brings obvious effects of child protection and criminal justice outcomes, such as arrest and prosecution rates, but also to the ability to target and link prevention programming, services and long-term care from prenatal (domestic violence risk of developmental trauma) through to toddler, school aged, teens and young adult health risks and responses. This would provide a key opportunity in Nunavut to directly support health interventions and outcomes through CAC referrals and response.

Phases of Development

CACs require time for the necessary phases of development including:

- Phase I Key Partner Governance and Management Accountability Structuring
- Phase II Key Partner Service Model Agreements, Building Cooperation and Teambuilding
- Phase III Demonstration Project - Facility Site Selection and Transition to Operations
- Phase IV Implementation
- Phase V Reporting and Evaluation

CACs progress through key phases of development in order to determine their size, capacity, demand for services and interventions change over time. Some organizations may stay small and discrete and be very specific in the services they provide, while others expand to accommodate the range of types of harm and relevant services. As such, their organizational complexity, structure and budgets modify as required.

Therefore, a good decision-making structure and support from across partner agencies are required to support the phases of growth and change.

⁶³ <http://unh.edu/ccrc/pdf/cv80.pdf> p. 4

An Overview of Selected CACs

Some CACs only mobilize around forensic interviewing and referral supports related to cases of child sexual abuse. Others provide support to all types of harm including sexual abuse, physical assaults, neglect, emotional abuse or witnessing violence. Where the CAC may act as an individual advocate or support worker to provide appropriate trauma referrals and case management to children and families to access specialized medical assessment, counselling services, housing or other basic needs, the efficacy of CACs to support clients is dependent largely on existing services within the community and resources to support operations. Therefore, to date in Canada, there are significant differences in the scope, reach and uptake of CAC services across the country

CANADIAN

Zebra Centre, Edmonton, AB

Urban Community-based Co-located Model

***When zebras run in a group, their stripes blend together.
It may be hard for enemies to tell where one zebra ends and another starts.
When danger appears, adult zebras form a protective circle around their young.***

Melissa Stewart, Author - Zebras

The first CAC established in Canada was the *Zebra Centre* in 2002, in Edmonton, AB.⁶⁴ The project was driven by the community in partnership with law enforcement, social services and medical professionals to better respond to child abuse allegations. Over several years of development, relationship building, coordination and partnership funding, the CAC is a highly functioning and well respected organization from youth and family clients, and has garnered high praise within the justice system for their rigorous operational processes and quality standard of care to children and families. Located in downtown Edmonton, the Zebra Centre is a warm, well equipped and busy Centre, which receives over 540 cases annually for investigation and child and family support. Police investigations have increased 80 percent since 2009, with the full range of harm including witnessing violence being investigated through the facility.

As a co-located facility, specialized members of the Edmonton Police Service, Alberta Child Protection, core operational staff and over 50 highly trained volunteer advocates, undertake their respective functions. The RCMP recently joined the multidisciplinary team in May 2014. As a way to reinforce each other's roles they review mandates each morning, and discuss files including the past history.

The internal design of the CAC is intentional and specific, and places the psychological needs of the child first. The Zebra Centre is replete with the signature zebra animal throughout, but stuffed toys of every size, type and style is displayed and available for touching and play. Whatever makes the child or youth feel comfortable. As a common approach that is reflected in each CAC facility, the child is allowed to select a toy and blanket/fleece or handmade quilt to take home for comfort. This is a key aspect and intentional tool used to help survivors of abuse to self soothe and take comfort in soft, lush and tactile fabrics and tools. For a child, it helps wrap them in a feeling of protection, comfort and that the Centre is a positive space that is there for them. They are also given a small stuffed zebra as shown in the picture below, to take home as a reminder that the Zebra Centre and team is there for them.

⁶⁴ http://cac-cae.ca/wp-content/uploads/Edmonton_revised.pdf

The main spaces for the child/youth and family are welcoming and bright with a lush reception, waiting rooms replete with age-appropriate toys for young children, tweens and teens; large and bright artwork drawn by children and community members; comfortable furniture and strategically placed audio/visual equipment for monitoring and interviewing. There is also a small medical examination room, conference boardroom for the multidisciplinary team and offices with therapy dogs used within the program. The use of therapy dogs was allowed for the first time in Canadian court history in December 2014, in Calgary, Alberta.



This CAC established what some other CACs in the United States have, which are mobile Child Protection Teams. This unit of joint police and social worker teams are in uniform and exit the rear of the building, and are unseen by the children and families inside the main spaces. Separated in the rear of the Zebra Centre is the Child at Risk Response Team (CARRT), with 6 police and 6 social workers and a

vehicle. As teams of two, the unit runs the complaints. They are assigned files and investigate referrals of harm. These teams rotate in shifts to provide 24/7 response to referrals, and bring the children and their family to the Centre for interviewing and follow-up support.

There are over 50 family support and child support volunteers. The care calls come in nightly. It is overwhelming, but this was noted as a key support of the facility. After intake, the relationship is vital to show support to the child/youth and family. All parties bring together the shared behaviours, family perspective, safety planning which is all put into place immediately.

A key aspect of the Zebra Centre operations is the pristine interview and the “bracketing” of who interfaces with the child/youth and family from the time of CARRT response, from interview to case management and trial (if it proceeds). Bracketing is important, as it provides fresh resources/support workers, so that there is no tainting of the child/youth as a witness, the story and of the process.

The Zebra Centre has built a strong reputation for how it manages the CAC process, to ensure that a pristine interview is undertaken for prosecution. This means that the forensic interviewer does not meet or discuss the details of the issue prior to the forensic interview, and does not have contact with the child/youth when it is done. This ensures that there has been no coaching or tainting of the story. This is a key concern in Nunavut, when the social worker has such interaction with the child/youth through many aspects of the interview, case planning, ongoing discussions through crises and issues, up to and including the court case. This is highly problematic for the integrity of the case.

The Zebra Centre works diligently to support the integrity of its process. It has over 50 Child and Family Advocates to assist children/youth and families after incidences of harm. The Centre undertakes over 2-weeks of enhanced screening and process of police checks, training, certifications and reference validations to ensure they can work with vulnerable youth. They also undergo an additional 1-week of training on how to handle different types of techniques and scenarios.

In the event that the case proceeds to trial, a court program worker will meet with the child to prepare the child about the process, review fear exercises, will review their taped interview and may introduce the use of the therapy dogs for use in the case. Once the day arrives for trial, another volunteer child worker will be in court or in a child-friendly waiting room during recesses and breaks, so that there is no discussion of the case or muddying the facts of the case. The worker is strictly there for supervision and emotional support.

Individual offices used by forensic interviewers, counsellors, detectives or administrative offices are also welcoming to youth, where no measure of intimidation or fear such as degrees, uniforms, firearms or official status is observable for the child or family. Instead, each staff member is “required” to decorate their office with their favourite toys or characters, so as to reflect their own personalities for the children and youth, and have easy conversation starters.

However, what links all the team members to the child and family that they serve is a range of technology. For information management and case planning, the Zebra Centre adopted the powerful integrated collaborative database software for case management and case referrals called Network Ninjas’s *Collaborate* software⁶⁵. This system was developed in partnership with CAC’s in the United States and is a shelf-ready tool to quickly enable the multidisciplinary team to add their respective information, statistical data, case notes, assessment findings and recommendations for long-term case management, as required.

In addition, the specialized multidisciplinary team meets on Skype or telehealth for youth counselling and diagnoses. With the powerful technology now available, the experts often don’t need to be there physically – just connected, though relationship building over space and time is always something new. The Centre rotates psychology teams through Aboriginal populations they serve in Alberta, including Inuit, so there is significant experience. However, time is required for the teams to understand their roles,

⁶⁵ www.networkninja.com mbochneak@networkninja.com

responsibilities and working together. Technology is a key way to work, but it must be a seamless tool integrated into a solid architecture and way of working.

The operational funding for the Centre is largely a provincial government-funded venture, with justice providing core funding along with social services, health and victim services funding. The municipal government, through the Edmonton Police Service, cover the facility rental costs and communications. The RCMP reimburses back to Zebra based on expenditures relating to their cases. The remaining funds, approximately 25 percent of the total annual budget, are fundraised through donations and charitable sources.

BOOST Child & Youth Advocacy Centre (CYAC), Toronto, ON

Urban Community-based Co-located Model

The BOOST Child Abuse Prevention & Intervention agency houses the BOOST CYAC. The model is a community-based centre that co-locates the key multidisciplinary team members with a space for a coordinated response.⁶⁶ The program partners include:

- BOOST Child Abuse Prevention & Intervention
- Catholic Children's Aid Society of Toronto
- Children's Aid Society of Toronto
- The Gatehouse
- Jewish Child and Family Services
- Ministry of the Attorney General, Victims and Vulnerable Persons Division
- Native Child and Family Services
- SAFE-T Program
- Hospital for Sick Children, Suspected Child Abuse and Neglect (SCAN) unit
- Toronto Police Service

In its first year of operations in October 2013, BOOST conducted 780 investigations of child harm, with over 1,200 victims and witnesses interviewed. More than half of the total cases resulted in criminal charges laid.

The multidisciplinary team is co-located and occupies one floor of a downtown Toronto office building, with the police, social workers and mental health team members in their respective offices. The facility is a long-term space with a 5-year lease, but it is already too small for the team with a growing caseload. The Operations Director has moved with the other BOOST administrative team to another floor, which has disjointed the team, but for space reasons, it was important that the team members could have access to the designated discrete meeting rooms and interview room available on the floor.

A key function of the BOOST CYAC is the Family Advocacy Program. It is a voluntary service offered to all families involved with the CAC during a child abuse investigation. The advocates provide immediate and ongoing support, advocacy and referral services. The core functions of the advocate is to:

- Greet the family and provide a tour of the CAC;
- Introduce the family to the investigation team;
- Remain with the family throughout the interviews to provide emotional support, answer any questions or address concerns;
- Provide information on next steps and services available to them through the CAC or the community including assessment, counselling, court support or other required supports.

It was interesting to note that they receive most of their disclosures through schools, so most of their investigations occur later in the day. The police and social work may conduct the forensic interview at

⁶⁶ http://cac-cae.ca/wp-content/uploads/Toronto_revised.pdf

school or at another location off-site, in which case the family advocate will contact the family to offer support and services, where consent was provided.



The family advocacy program provided services to over 310 children/youth and 263 caregivers, which included:

- 940 meetings with the families;
- 544 meetings/contacts with the multidisciplinary team;
- 220 contacts with community agencies, and;
- 230 referrals for other support services such as housing and basic needs.

The mental health team under BOOST provided supportive counselling to over 100 individuals and participated in 200 case review consultations.

The medical team through the Hospital for Sick Children's Suspected Child Abuse and Neglect (SCAN) program conducted medical evaluations for over 40 cases of physical abuse; 60 cases of sexual abuse, and provided 40 consultations to the multidisciplinary team. The mental health team, representing 4 different agencies, are assessing the types of services required which span intergenerational trauma, self harm, suicidal ideation and supportive counselling. The BOOST CYAC treats the child/youth and family until they are properly assessed, but the assessments are largely less formal and treatment is based on best practices and evidence-based research on child sexual abuse and the need to strengthen supportive caregivers. A key challenge is making mental health services more accessible to the broader population, and treating the offender to stop the cycle of abuse.

The Toronto Police Service and child protection workers have secured a joint protocol on how they will conduct their investigations. A copy is attached as Annex Tab 11 for review.

The BOOST Family Advocacy team grew from 1 member in October 2013, to 4 full-time advocates after one year to manage the caseload. All staff and post-graduate student volunteers are well screened and must take a Child Abuse course, particularly to review issues of boundaries. After the appropriate criminal background and vulnerable sector checks, staff and volunteers are interviewed and undergo an orientation to the policies, procedures, organizational vision and mission and labour union information.

To support the forensic investigation, the Children's Aid Society of Toronto and the Catholic Children's Aid Society both increased their staff complement at the physical centre, including senior child protection workers and their supervisors, which refers their most complex cases to the BOOST team. The Toronto Police Service is also located onsite with 2 shifts and 2 members on call. The capacity infusion from across the partners has helped build the capacity at the centre, and manage the number of investigations, which continues to grow steadily due to efficiency and demand for its services.

Given BOOST's longstanding leadership role in promoting excellence in child abuse services, research, training and education, many partners were involved in the governance, service model and operational agreements for the establishment of the Toronto CYAC, though securing appropriate clinical supervision for the centre and within the 45-member management framework has been a challenge. This has revealed a gap for BOOST when they have medical crisis issues, but the project has done well to bring everyone together for a coordinated response to child maltreatment for Metro Toronto. The team is also using a peer review process to sample and examine forensic interviews to gain professional feedback and coaching for improvement. This is a key supportive approach evidenced in many larger CACs.

Sheldon Kennedy Child Advocacy Centre, Calgary, AB

Urban Medical Model – Co-Located

The Sheldon Kennedy CAC opened in March 2013, and operational partners began moving in April 2013.⁶⁷ The CAC is a not-for-profit charitable organization named after Sheldon Kennedy, a retired NHL hockey player who himself is a survivor of child sexual abuse at the hands of his former junior hockey coach. The CAC is a fully integrated co-located facility, but formally linked to the Alberta Children's Hospital through Alberta Health Services. The Community Health team are also linked to the CAC, providing immediate referrals for care and treatment in a timely, cohesive manner and in one location to assist in navigating the system, but finding hope and healing. Physicians at the Stollery Children's Hospital, located within the University of Alberta Hospital, also connect through telehealth for case conferences.

This multidisciplinary team includes over 95 professionals working at or affiliated with the CAC including law enforcement through Calgary Police Services, RCMP, social workers, medical staff including 3 part-time paediatricians, a nurse practitioner and team with specialized training in child abuse and a psychologist. For child and family supports the CAC has a full-time Child Life Specialist and family advocates through Calgary and Area Child and Family Services. The facility also houses a designated Crown Prosecutor onsite for meetings on cases proceeding for prosecution.⁶⁸ The CAC is considered a medical model because it built on the longstanding working relations between the key partners of the health professionals, police and social services, and located its designated facility across from the hospital.

The Board of Directors represents key service partners and community leaders to provide oversight and direction for the CAC. Sheldon Kennedy is a staunch advocate for the CAC model and is a very active board member and works nationally and internationally to raise awareness of the issue of child abuse and for ongoing support for the CAC model and the Calgary facility. While the CAC provides support

⁶⁷ <http://www.sheldonkennedycac.ca>

⁶⁸ http://cac-cae.ca/wp-content/uploads/Calgary_revised.pdf

throughout the Region from Red Deer south to the Saskatchewan border, the number of Treaty 7 First Nations child/youth cases has been low within the caseload. The Board of Directors will be seeking representation from Treaty 7 to bridge service gaps, enhance awareness in First Nation communities of the availability of the CAC and partner more effectively to Aboriginal serving community-based organizations for mutual support.

Youth in the region are also involved through a Youth Advisory Council within the governance structure of the CAC. Youth also participated in a 2014 World Café⁶⁹, which brought forward important youth perspectives and experience on the issue of child harm, but also helped ignite youth leadership and engagement in their future studies, community work and professional careers

The service model was developed over a 30-year period through the development of the key professional relationships and a keen analysis of the acute presentation of paediatric and adolescent primary care and the acute mental health needs of children and youth after trauma and those symptoms that present often as a result of historic trauma including addictions, suicidal ideation and self harm. The Sheldon Kennedy CAC sought to improve the timelines to access the necessary services, while providing holistic support to children/youth and their family. The CAC was designed to provide victim services for any type of harm including sexual abuse, physical assault, neglect, witnessing violence, etc., for as long as the family seeks support. This is important because you cannot force a timeline for healing, and other interventions such as mediation may be required.



The Sheldon Kennedy CAC triages cases through reports that come in from calls to Children's Aid, the police or the health partners. The CAC has been open for 2 years and has assessed over 2,700 cases,

⁶⁹ https://www.youtube.com/watch?v=3UsL79etRMc&feature=player_embedded

with an open caseload of 500 cases per year. The management team selected Apricot⁷⁰ as a secure and flexible software solution for case management, outcomes tracking, reporting and programming linkages for case management and scheduling. The platform also allows multidisciplinary team members to securely access and use the system anywhere through browser, tablet or Smartphone and provide case notes and appointment information. For ongoing victim services and family support, many are referred to community-based services for assistance.

The facility has a large child-friendly space where the children/youth wait; they feel comfortable, play and interact to have a calming space. The family room is also designed to look and feel like a porch. The design is very purposeful so they don't experience more trauma is not stressful. Play is incorporated in the space as an important way to help de-stress children and youth. Play therapy is a very open tool for all multidisciplinary team members to use with the children prior to their appointments. The Child Life Specialist is responsible to prepare the children for the appointments and activities that will occur during their visit, such as the medical assessment such as medical play with the doll, puppet and equipment based on what they communicate. There is also a therapy dog in the CAC. The play space has many different tools for play from dramatic play, crafts or quiet activities such as television or video games.

A volunteer program will be established through the Alberta Children's Hospital, and a victim support program will also be established. The CAC is developing an APP to help streamline core orientation to the centre and processes/procedures.

The CAC receives some federal government support through the Victims Fund, but the bulk of operational funding is through comprehensive provincial government agreements through Health, Education, Family Services, Justice, Law Enforcement agencies and corporate partners for capital and operational support. The ability to leverage funding is through the not-for-profit charitable status and government partnerships.

Child Advocacy Centre of Simcoe/Muskoka *Rural Community-based Model – Non-Co-Located*

The CAC of Simcoe/Muskoka, located in Orillia, Ontario, officially opened in January 2014.⁷¹ The facility provides a child-friendly and neutral place for children and youth to undergo a forensic interview, medical assessments and support by a Family Advocate. The professionals are not co-located, and a multidisciplinary team does not undertake joint case planning or case review. However, the CAC provides for a discrete location to support law enforcement from a variety of locations, including a local First Nations Reserve, to have appropriate child-friendly space to work. The Centre also links children/youth and families to Aboriginal-specific resources and services, such as the Miikanaake Community Justice Program, as required.

The CAC is a modern facility located in the rural community of Orillia, Ontario, which links communities to the north down to Barrier and Toronto by Highways 11 and 17. Over the first 15 months of operation they have served 70 families as a child-friendly space for their forensic interview, medical assessment and service referrals. The space includes a waiting room, small equipment room for the interview software and recording device/monitor, medical assessment room as well as office space and a boardroom. The boardroom is used for the social worker/police officer, medical staff and others who may come in for training or case review. The space also has a kitchenette and washroom facilities.

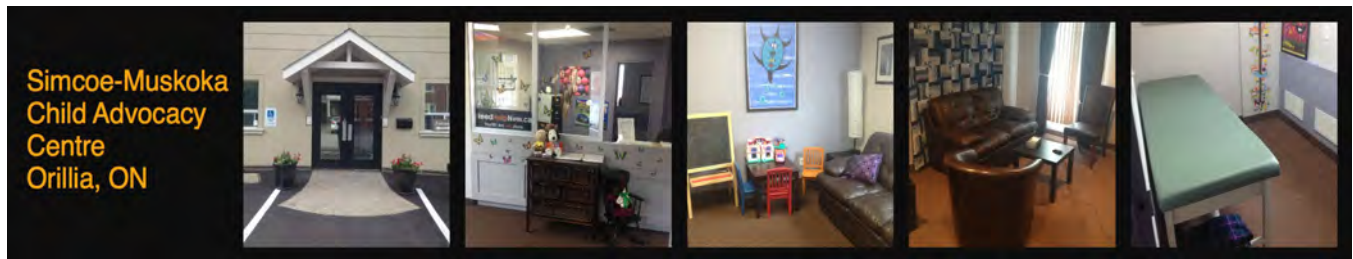
Given their rural location they are experiencing growing support from the 5 police forces that operate in their region, that are increasingly using the space for joint or independent forensic interviewing. The facility contains the approved video recording equipment for the forensic interview, and the space for the team to watch the interview. The distance though for some families and police forces has been noted as a disincentive for some to either come to use the facility, or for sending families for services, so the team does drive to promote the facility and their services.

⁷⁰ <http://www.communitytech.net/solutions/victims-support>

⁷¹ http://cac-cae.ca/wp-content/uploads/Orillia_revised.pdf

To date there are no operational service agreements with the law enforcement agencies for formal collaboration to use the centre: it has been by promotion as a best practice and equipped space for their use. The feedback to date from the law enforcement users is that they are happy that the facility is there, and they see the benefit in the quality of the child/youth comfort and follow-up case care.

There is an agreement with the local hospital to provide paediatric clinics at the CAC for children/youth as required. However, no medical files or test results are kept at the centre: those are all held with the hospital staff within their patient files. A key benefit for the medical appointments to be undertaken at the CAC is that in a small rural hospital, confidentiality can be an issue, where your neighbours see you waiting in the general waiting room and piece information together through local rumours and discussion. Having this separate space is key to allow the comfort and privacy after a traumatic event.



The core CAC staff includes an Executive Director, a Family Advocate/Social Worker, Receptionist/Fundraiser and a co-located program outreach worker from the hospital, who is also a trained social worker. The Simcoe-Muskoka CAC's key service model is the function of the Family Advocate role, and it is highlighted in the service and programming activities undertaken at the centre. As their team noted, advocacy is first: the function and role is the foundation to effective victim management and case coordination for success. They help diffuse the fear in the child/youth of the process, the team members and their respective roles, and provides the warm handover to all other partners, while maintaining a non-judgmental and objective support for the child/youth and family. The family's needs and wellbeing is at the centre of the wellness model, so the Family Advocate provides the range of supports for the individual child/youth and parent, to coordinate all appointments, referrals and family needs as they move through the process.

Having the Family Advocacy role as the key service model for the Simcoe-Muskoka CAC helps shape the culture, the primacy of the child-centered focus and the expectations for those professionals entering the space as to expectations of conduct and who the priority is the space. Due to the fact that there are no operational agreements with the local police or family services departments, the relationships are fluid, dynamic and largely positive due to relationship building and established networks in the region. However, in the event that a law enforcement officer comes who is unfamiliar with the CAC model, and takes a more aggressive/interrogation approach (which is their training when usually dealing with the offender) then the staff work to explain best approaches in forensic interviewing with a child, and work with the police force to strengthen awareness. In short, there is no tolerance of ego or organizational grandstanding in a CAC, where the focus must be the best interests of the child/youth and a clear understanding of their developmental needs and capacities.

A key challenge with the family advocacy role is the wait time for counselling referrals for youth. This is very challenging, because the youth need clinical support immediately. While Ontario's victim services allows for counselling sessions paid for under the provincial legislation, the access to urgent and short term counselling in the Region is a barrier for these children/youth and families. The team would like to have the resources and in-house capacity to deliver a dialectical behaviour therapy model of service to include 4 key areas of assistance, including:

- Individual counselling
- Telephone coaching
- Group counselling

- Exposure therapy

which would help ensure that children/youth have access to the mental health supports they need on an as-needed bases.

The CAC Family Advocate undertakes the intake process with a brief tool, because for most of the referral agencies, some intake procedures can take 45 minutes to 1 hour to complete. That is very challenging for a family to go through, so the advocate helps ease that complication. They will assist in person, by phone, and help with the completion of any other documentation, such as victim services, victim compensation or other materials. The advocate helps with court preparation, victim witness coordination and other ongoing service referrals. The Family Advocate is also trained to administer the CAFAS and PECFAS behavioural assessments to assist in assessing the 8 domains of resiliency to support case planning and referrals. While the CAC looked at using a shelf ware database such as Penelope, they are currently using a home grown database to collect base information.

Alongside the CAC functions, the team has partnered with the Canadian Centre for Child Protection (CCCP) to deliver the Commit to Kids program that teaches organizations on how to prevent child sexual abuse, as well as the Ontario Provincial Police and Georgian College to deliver public education to high school students on cyber bullying and sexting. The Commit to Kids is an important program to inform child-serving organizations on mitigating child sexual assault and abuse, and implementing safeguards for internal risk management.

The Simcoe-Muskoka CAC had its first teen youth victim case for sexual exploitation/human trafficking, which they are supporting. The CAC staff are all well trained and seasoned professionals in the law enforcement/victim services/social work fields, and have lived and worked in the Region for many years. They are familiar with who are the at-risk youth and are able to piece together the patterns of activities occurring with youth. For instance, they are seeing how the luring and baiting of children and tweens into house parties, and activities such as loan sharking, drug trafficking, family activities and forced prostitution, are occurring along the hinterland cottage country highway routes between communities to Toronto. The CAC sees where the service model opportunity can provide for both a facility to assist in investigations and family advocacy supports, but also where prevention programming is important within the communities of the region, including the First Nation communities.

SeaStar Child & Youth Advocacy Centre (CYAC) / IWK Health Centre

Medical Non-Co-Located Model

The SeaStar Centre is a demonstration project located in Halifax, Nova Scotia⁷². The small-scale demonstration program began in December 2012, hosted at the IWK Health Centre. The facility began operations in 2013, after an initial feasibility study phase, and has continued to develop its organizational capacity and case response. The facility is housed at the IWK Health Centre in Halifax, and is the only CAC in Atlantic Canada. The facility serves as a CAC, as well as a regional Centre of Excellence on child maltreatment and it has developed a toolkit to support the development of future satellite sites across lesser population regions of Nova Scotia. It is available to serve children/youth and families across the province, but travel is a challenge to reach other communities.

At the moment the SeaStar Centre case manages approximately 250 cases annually, for a total of 500 to date. While the team is not co-located, the facility serves as a meeting place in order to conduct the forensic interview (which is done jointly with the police and social services, which is a similar protocol in Nunavut) and a space for the remaining team members to view the interview from another room. The interviewing equipment including was provided by the RCMP for this project.

⁷² http://cac-cae.ca/wp-content/uploads/Halifax_revised.pdf

The space also includes the medical assessment room, where dedicated medical staff from the child protection team at the IWK Health Centre can undertake their work. The mental health support is also available in a child-friendly area. The current space is very small, but is housed within the operational area of the child protection wing of the health centre. The only dedicated staff space is 1 full-time Family Advocate, who is responsible for all case management, child/youth and family liaison and support and data entry. The SeaStar Centre developed an Excel spreadsheet as their reporting database, which is working well. They shared it with the Yukon Project Lynx CAC project, and the statistics generated are being used by all multidisciplinary partners for their reporting purposes.



The SeaStar Centre has a multi-sectoral Steering Committee with representation from the IWK Health Centre; Government of Nova Scotia departments of Community Services, Justice, Health & Wellness and Education; the Mi'kmaq Family & Children's Services, law enforcement; the Public Prosecution Service; Transition House Association of Nova Scotia, and; the Avalon Sexual Assault Centre.

By all input, the SeaStar Centre demonstration project is working very well and an excellent medical-model and non-co-located sample for the UMAC consideration to replicate. The funding for the demonstration project is provided through Memoranda of Understanding between the relevant partner agencies, and some funding has been made available through the federal Department of Justice, Victims Fund for Child Advocacy Centre initiatives.

Yukon CAC Pilot Project, Whitehorse, Yukon *Government Model, Non-Co-Located*

The Yukon government, under the leadership of the Department of Justice, Victim Services, is coordinating a 3-year pilot project to test the development of the multidisciplinary team to respond to referrals and case coordination, and identify what would be required if a CAC or facility is warranted for the territory.⁷³ It is a response model to support children/youth 19 years of age and younger, as defined by the Yukon *Child and Family Services Act*, and where consent is provided by the legal guardian or caregiver.

The challenge of development of the CAC in the Yukon is parallel to the Nunavut reality in many respects. Given the number of communities with different stakeholders in each community, the model has to take its own shape to support both the clients and the frontline workers, to do what is required. The Northern territories are a very different operating context than the urban community-based not-for-profit charitable model such as the Zebra Centre or Boost Centre, where the partners are well defined, a physical CAC is available (at comparatively reasonable cost) for co-location, and the processes, tools, training and transition planning is well developed among the key stakeholders and the organizations. Of course that took many years to develop and refine, but as a new approach for the North, we must build on what's already happening in communities to build on existing strengths and local partnerships, but reflect what you the process and child needs. That often means building onto the government infrastructure, capacity and funding sources for success and accountability.

In the Yukon, the majority of the key partners are within the territorial government, so for financial sustainability and information sharing, the CAC pilot project is grounded in the mandate, capacity and interests of child and youth victim supports of the Department of Justice, Victim Services. Project Lynx partners include:

- Victim Services Branch
- RCMP
- Family & Children's Services
- Child and Adolescent Therapeutic Services
- Public Prosecution Service of Canada
- Community Justice
- Court Services
- Yukon Hospital Corporation
- Yukon physicians

Within the Yukon, this was the best strategic option because there are already Memoranda of Understandings (MOUs) between departments and legislation to enable information sharing on client cases. However, other accountability agreements or financial sharing have not been developed as of yet. To view a sample joint MOU see Annex Tab 8.

Over the two years of the project, the focus has been on engaging the key partners who are mandated to mobilize and act on behalf of child and youth victims of harm. However, more work needs to be done to formalize the development of roles, responsibilities and final decision-making. There is certainly

⁷³ http://cac-cae.ca/wp-content/uploads/Yukon_revised.pdf

motivation among the partners to develop the strong organizational foundations of working relations, and the pilot has provided an opportunity for the partners as professionals to gain insight into the respective roles, appreciate the perspectives at the table, and value the partnerships for the benefit of the child/youth.

Over the two-year pilot period it is clear that much of the positive case successes happened due to the relationships and trust developed between the RCMP and other partners. The personal connection and opportunity to really understand the issues and how to work together is key. It should not be, because it is the official function of the professionals and the role in their day-to-day work for children, youth and families that is key, but for sustainability of the process, the team and the approach, the extra time and the communication with partners is part of the role. The information sharing is the key: that supports professional development, partnerships and client work – outside of the MOUs, the governance structure and operations. Their key external partners are the RCMP – they are the key partners – then the horizontal collaboration across the Yukon Government follows.

The working group members are not co-located at present over the 1½ years of the pilot project, but are working virtually. The partners have expressed that in order to do the case review and coordinating of files over the past year, that they do need a physical space to work. Their team is currently examining the feasibility of an existing government location for the technology drops and Yukon government network or a new community space.

At present though there is no community-based organization that could house a CAC in the Yukon. However, the intention is to move forward and take a “build it and they will come” approach to facilitate:

- The forensic interview room
- Video testimony room for court testimony
- Crown-witness meeting space
- Recording equipment and multidisciplinary team viewing centre
- Child-friendly safe space to meet with the Family Advocate to support case management discussions and client work.

It is unlikely that any future CAC in Yukon would be co-located working space for a response team: they would work out of their current office spaces. When a referral comes in, they will come to the designated CAC for the forensic interview, and the space would be available for the Family Advocate and public to access services and supports. There is public support for a facility through feedback from child/youth and family clients, to advance work on a physical space. It may be an option with the right organization and supports, but certainly not in the foreseeable future.

The same planning considerations exist in the Yukon as Nunavut in that you look to the facilities that offer the path of least resistance, and build on the infrastructure that exists. This often includes territorial government buildings, which have the IM/IT drops and connectivity; the databases and information sharing platforms; physical office and meeting spaces, and; financial sources and sustainability for both capital space and operations. Otherwise the cost is prohibitive and unsustainable.

Other considerations around the rationale and decision for the multidisciplinary team to co-locate is that the territory still has relatively low case numbers (60 cases since January 2014) to warrant co-location of a dedicated team in a facility. At the moment, while the multidisciplinary team has a Terms of Reference for the pilot project, there are no Memoranda of Understandings, contribution agreements to cost-share the project, the focus is on developing the team relationship, protocols and processes when a referral is received. There are no shared responsibility or accountability mechanisms, and there are still challenges with information sharing and data collection system are developing. The project is in the beginning stages and funded by the Department of Justice Victim Services venture with engaged partners to test the model. There is much work to be done to develop the roles and responsibilities among the partners to identify who leads the decision-making and bottom line. Everyone still functions in their own role, but there is the motivation to build the strong foundation.

In the meantime though, the model works for the Yukon in that the team undertakes the case investigation and care planning, while the project coordination team and staff in the Department of Justice Victim Services provides ongoing support to the child/youth and family outside the court process with referrals and assistance. The sustainability of the multidisciplinary team in the North, when there is turnover is high and staffing challenged, the model must formalize the participation of the key partners; the roles, responsibilities and decision-making must be clear; the protocols and procedures must be outlined for the various scenarios; and the cultural and specialized training for the work must be made available to ensure collaboration and success. There are many layers that need to be addressed for the partnership to be developed, successful and work. We constantly review the benefits to partnership; the guiding principles of roles and responsibilities, accountability and decision-making; the appreciation to support each other to manage cases; collect the data to support the need for more joint interview; the data of unequal access to mental health services; how we work together, and continuously review it and putting it to action in case coordination meetings.

INTERNATIONAL

Barnahús (Children's Home), Reykjavik, Iceland *Government Co-Located Model*

The Director General of Iceland's Government Agency for Child Protection, Bragi Gudbrandsson established the Barnahús (Children's Home) in Iceland in 1988, based on the National Children's Advocacy Center in Huntsville, Alabama.⁷⁴ He oversaw the CAC's initial years of operation before moving into senior management and continues to actively promote the best practices of child-friendly multidisciplinary facilities across the Nordic countries and the rest of Europe. Since then, Gudbrandsson has worked extensively within the framework of the Council of Europe (CoE) for over a decade as a consultant and expert drafting various recommendations, guidelines and conventions. Currently he serves as the Chair of the Lanzarote Committee to monitor the implementation of the Lanzarote Convention on Child Sexual Abuse. He is the author of the CoE publications on "Children at Risk and in Care" (2006) and co-author of "Protecting Children from Sexual Violence" (2010).⁷⁵

Gudbrandsson stressed that Iceland's Barnahús should be understood in the context of the country's very strong overall child protection system. Iceland has a population of approx. 325,000, of whom approximately 80,000 are under 18 years of age. The capital city, Reykjavik, as a population of 125,000, and a good deal of the rest of the population is located in the southwest of the country – an easy drive from Reykjavik. There are also small cities and towns located all around the country (except in the middle, which is covered by glaciers), and some sparsely populated rural areas.

Regardless of which political party or coalition of parties may be in power at any given moment, Iceland has a very strong 'Nordic welfare state' culture. People believe that the state has a responsibility to protect the most vulnerable in society, and people expect the state to deliver quality services to them. Frontline child protection work is the responsibility of the municipal governments, called *kommunes*. There are 77 *kommunes*, ranging widely in population. Many of the smaller *kommunes* have banded together to better manage their social service responsibilities, with the result being that the Government Agency for Child Protection, part of the Ministry of Social Affairs. The Agency works with 28 service areas, each of which has an interagency Child Protection Committee.

The Agency has two functional sides. One side is responsible for relationships with the service areas with regard to standard setting, monitoring, training and providing expert advice; and for national initiatives such as public relations campaigns on topics such as adults' (especially occupations such as teacher, priest, etc.) mandatory obligation to report children they feel might be at risk. Coordinating, supporting and strengthening the Child Protection Committees is a priority concern of the Agency. For example, while

⁷⁴ <http://whnt.com/2015/03/27/national-childrens-advocacy-center-in-huntsville-having-international-impact/>

⁷⁵ <http://www.nordiskabarnavardskongressen.org/en/bragi-gudbrandsson>

some Child Protection Committees do great work promoting and supporting foster parents, others have seen a lack of initiative and/or professionalism. There is therefore an ongoing need for the Agency to engage with the Child Protection Committees around foster parenting capacity and support.

The second side provides specialized services through 'national facilities' that the individual Service Areas cannot be expected to operate. These include:

- Barnahús (Children's Home);
- An expert diagnostic centre, with eight beds for children being assessed and a four-bed closed unit for acute cases;
- A facility to provide therapy to 7 to 12 year-olds using the "Oregon Model" of parent management treatment;⁷⁶
- A facility to provide therapy to 13 to 18 year-olds using a four-month 'massive intervention' model of working with the parents, the school and the community, and;
- Eight contracted-out long-term treatment facilities, offering 57 beds.

The Agency acts as a 'gatekeeper' for these facilities, screening and 'vetting' candidates recommended by the Child Protection Committees.

Gudbrandsson noted that while 'culture change' in Iceland may not have been as rapid and intense as it has been in Greenland or Nunavut, Iceland has gone through its own revolution in parenting. Not very long ago Iceland was a poor and rural country, and many Icelanders were quite taciturn. "They wrote more than they spoke," and parenting occurred "almost without words." Neglect and abuse of children occurred, of course, but it was largely left to the church to deal with. The rapid urbanization of the 1950s and 1960s created new social realities – and considerable debate about the challenges posed by the "new type of youth," the need for correspondingly new approaches to parenting, and the responsibilities of the state.

Fast forward to 2015, and we see a society with an unremarkable rate of child neglect and abuse (by European standards) but a very strong child protection system which actively looks out for the individual and collective wellbeing of children. One aspect of this pro-child approach is the estimate that 7.3% of Icelandic children alive today will be referred to a Child Protection Committee at some point before their 18th birthday – if only for a basic interview to follow up on a concern that someone has expressed. This is not because of elevated rates of 'adverse childhood experiences' in Iceland, but rather as a result of an elevated sense of social responsibility towards children.

The Barnahús, or Children's House, is located in large house in suburban Reykjavik. The tour was conducted by forensic interviewer and psychological therapist Thorbjörg Sveinsdóttir. Her personal story is an interesting one in that after researching and writing an undergraduate university paper on the institution, she changed her career plans and ended up working at it. The tour included the full facility including the offices, the boardroom (which is also the room where the judge and lawyers watch the closed-circuit TV), the interview room where the camera is located, the interview rooms (fitted out for different ages of children), the play/waiting areas, the counselling rooms and the medical examination room.

This Northern facility reflects the same model and components as the Canadian CACs, except that the judge and lawyers sometimes use the space as well, which is a difference in their legal system. In addition, the Barnahús differs in that it is not a community-based organization, but instead, a core component of the national Government Agency for Child Protection. The Barnahús functions as part of an integrated child protection system.

Another difference is in the financial sustainability for the facility as it is stable and assured. The centre is not reliant on charitable donations or fundraising for its core operations or capital costs. The staff are also

⁷⁶ <http://www.cebc4cw.org/program/the-oregon-model-parent-management-training-pmto/detailed>

all government employees with salaries, benefits and training allowances to maintain their professional development in the field of child welfare, investigations and family support. Morale is high and staff turnover is very low.

Approximately 250 children per year receive preliminary interviews at the Barnahús, and a total of 4,300 have been interviewed there since the CAC opened in November 1998. Children are almost always referred to the Barnahús by the child protection system, as a result of phone calls from members of professions, family members or from the general public, and/or investigation by staff of a Child Protection Committee. There have been a few cases of older children contacting the Barnahús directly. Children are brought to the Barnahús for preliminary interviews. Depending on the nature of the case there may be a forensic interview, medical examination or court hearing. If multiple interviews are required, the same interviewer handles them all.



Barnahús staff are almost always sent competent case notes before seeing the child, and therefore do not have to make many telephone calls or do other background research. This is based on the system put in place and documentation. Most children interviewed either live in the Reykjavik area or close enough that they can be driven to the Barnahús by a family member or by staff of a Child Protection Committee. In cases where a child and his/her escort have to be flown to Reykjavik, all arrangements are made by a different branch of the national Agency as part of the government system and processes. The Barnahús staff do not coordinate individual travel, so they can focus on providing professional services. No child over-nights at the Barnahús.

A specialized team of a doctor and two nurses come to the Barnahús every second Wednesday to examine children: medical evidence exists in less than 10% of cases, and is only conclusive in less than 5% of all cases. As well, judges come to the Barnahús as prosecutions require under the Icelandic legal system. As for clinical programming, mental health counselling is provided wherever the individual lives: either at the Barnahús, elsewhere in the drive-able range, or in the child's home community. As the staff noted, "We travel a lot." The travel budgets are also provided within the operational budget for the facility.

As was confirmed with other CACs in Canada, and as noted here by Iceland, some children experience family pressure to withdraw allegations. In one case, a child flatly denied that abuse had taken place, but returned to the Barnahús several years later and gave detailed testimony against the offender who was a family member. There have been very few women perpetrators, but a 27-year old woman was recently convicted of human trafficking by forcing a 15-year old girl for sex work. The staff reported that there are far more female victims than male victims, but the number of cases involving male victims are increasing.

From the inception of the CAC the focus was only on referrals of child sexual abuse. However, as childhood trauma specialists, the Barnahús staff were asked increasingly to assist on other matters (e.g. a boy who accidentally shot and killed a friend). As of 2014, the CAC expanded its mandate to provide services pertaining to all types of childhood trauma, but the primary focus remains on child sexual abuse. In October 2014 the staff complement of interviewers/therapists and therapists-only was increased from four to six to support the increased caseload.

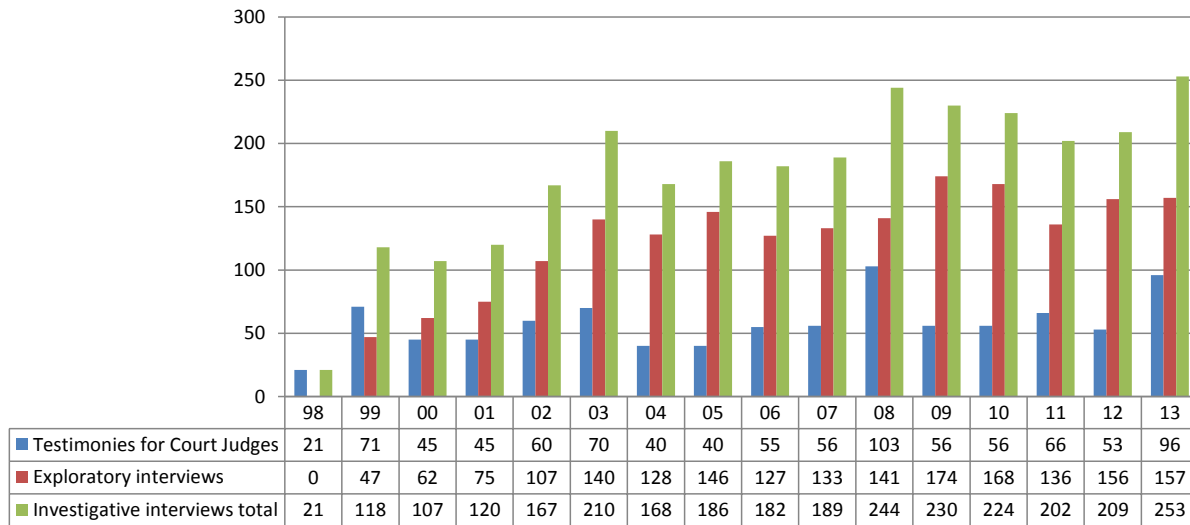
The CAC also provides a conduit to building the body of knowledge through case research. Since her early academic work, Sveinsdóttir retains her interest in research on child sexual abuse and the role of the Barnahús, an contribution she feels has been appreciated and supported by both her managers and by the national Agency. The abstract of her presentation to the forthcoming 2015 Nordic Congress on Child Welfare is a summative research piece on the nature of allegations and potential age related differences in the judicial outcomes of cases between the period 1998 and 2012.⁷⁷ The main hypotheses were that:

1. Cases are more likely to lead to a successful prosecution outcome and sentence when the children were older, and;
2. When cases involve multiple victims.

Of the total 564 cases that were analyzed, 473 (84 percent) involved girls and 91 (16 percent) involved boys. Charges were laid in only 126 of those cases, but of those, 102 resulted in convictions. The presentation will be an overview of the research and its findings including the particular factors that affected indictments being filed and convictions.

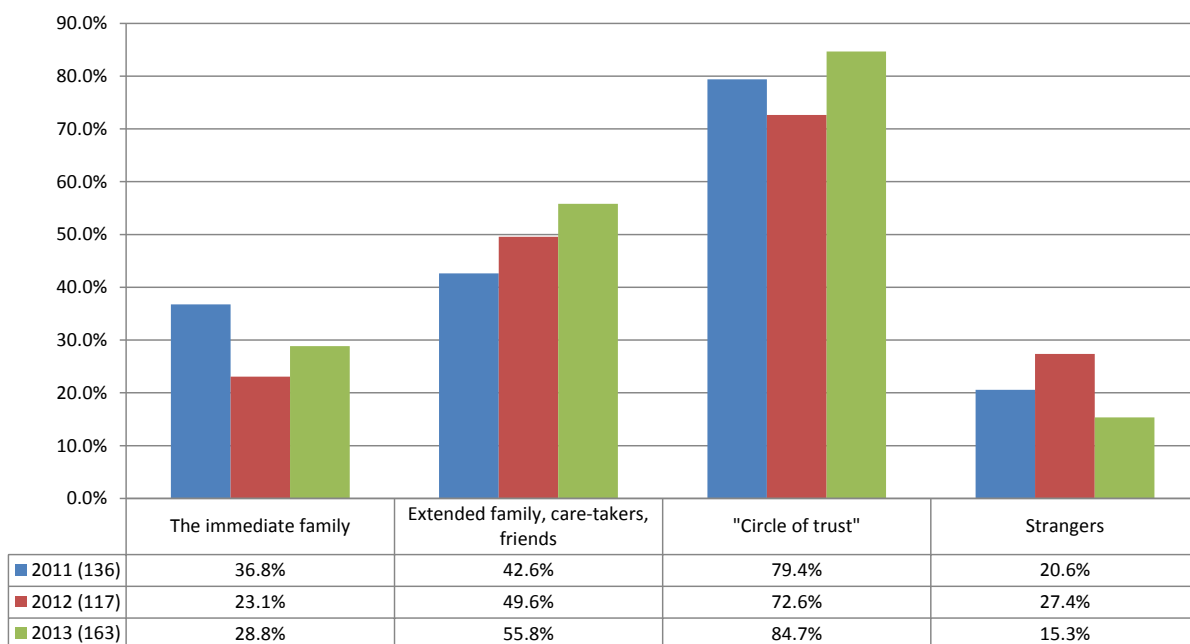
Both Gudbrandsson and Sveinsdóttir stressed the attention the Agency places on the administrative data collected by the Barnahús. In addition to the obvious count of how many children receive which level of services:

⁷⁷ The research methodology was a review of 564 cases referred to the Public Prosecution Office and review of court files for information such as sentence type, indictment phrased according to child's testimony, number of victims in indictment and defendant's testimony was carefully recorded and added to a database consisting of basic information such as the children's age and gender, relationship with the accused.



The data also tells us a great deal about the nature of the problem itself.

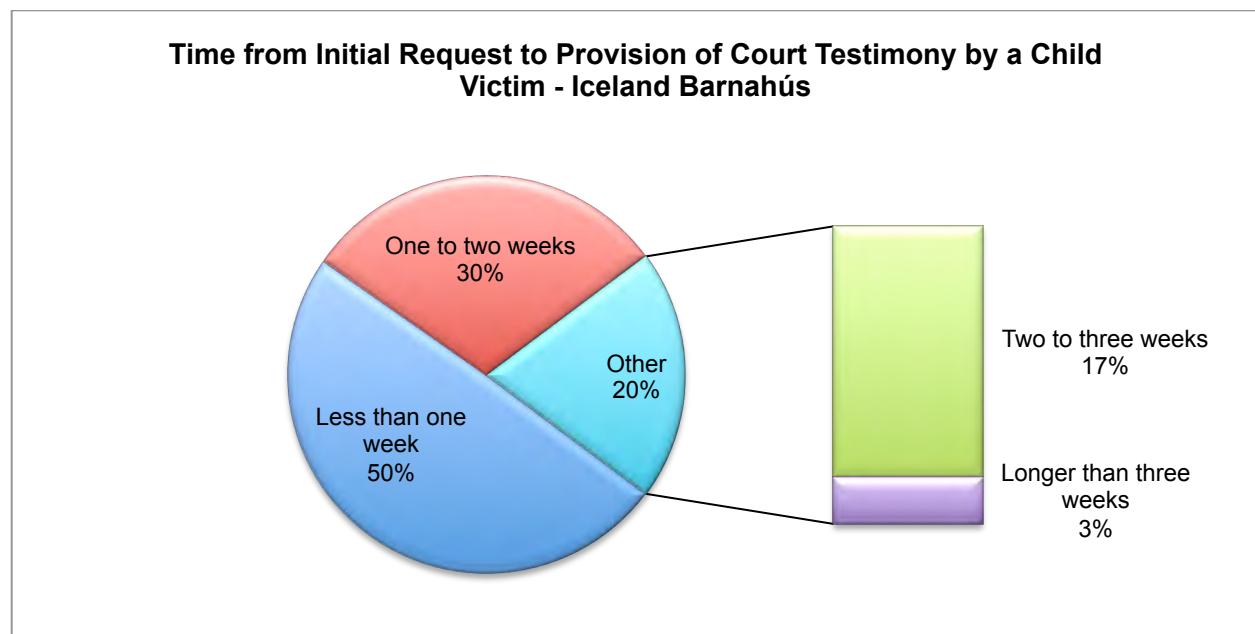
The following chart shows that the victim's relationship to the offender is 'immediate family' in less than 30% of the cases, but that members of the child's 'circle of trust' are the offenders in approximately 80% of the cases. The offenders are strangers to the child in approximately 20% of the cases. In general discussions with the RCMP in Nunavut, this is not the case for children/youth in Nunavut, where the offender is predominantly within the immediate or extended family.



The data also reveals that conviction rates higher in cases where a) there is more than one victim of the same accused perpetrator and b) the victims are older children rather than younger children. A number of factors may impact the second finding. Younger victims are more likely to have a personal connection to the offender, and therefore are more likely to have difficulty testifying against him/her, whereas a higher percentage of older children are abused by persons that have met at parties, elsewhere in the community, or on the internet.

The legal system also has expectations regarding coherence of testimony that young children may not be able to meet. Young children sometimes have problems sustaining concentration during the interview and to provide detailed disclosure on the suspected abuse. Young children are also more likely to 'jump back and forth' when recounting abuse, while teenagers are more able to offer essay-like testimony with an introduction, a middle and a conclusion. A unique aspect of what differs about Iceland's model versus the North American CAC model is the questioning. Sveinsdóttir noted that American-style open-ended questions do not always work with Icelandic children. They are used to a more traditional/conservative communication style. As such, forensic interviewing in Iceland uses more "closed" question techniques with younger children, and open-ended with older children.⁷⁸

It is noteworthy that the number of preliminary interviews and forensic interviews has increased at a faster rate than the number of prosecutions and convictions. The explanation for this is that there were always 'easy-to-solve cases,' sometimes with a confession by the perpetrator. The child-friendly approach of the Barnahús allows for attention to be paid to cases, which might not otherwise have been 'solved,' as the child in question needed the right environment, and a team of experienced professionals, in order to reveal what had happened to them, and to receive the necessary supports for healing and any court proceedings. Since the CAC's inception in 1988 to 2013, the efficiency and efficacy of supporting a child/youth to provide testimony for the court process is:



Even for a relatively compact country, that is quite an accomplishment. The sense is that most children and families who have engaged with the Barnahús are satisfied with the service provided. While since its operation in 1988, there have only been a few complaints from parents about various individual case matters, and occasionally some youth exercise their right to discontinue therapy.

Saaffik CAC, Nuuk, Greenland *Government Co-Located Model*

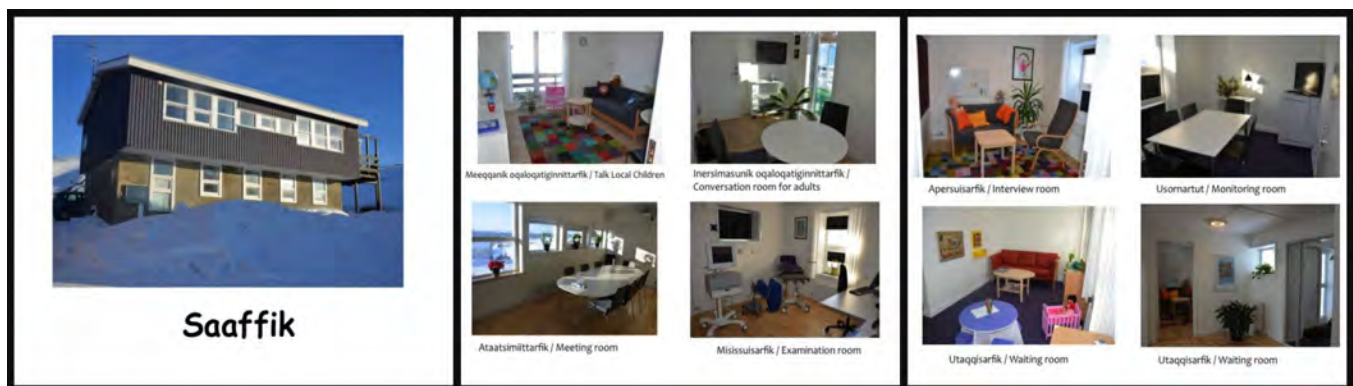
After several years of research and planning, the Saaffik CAC in Nuuk, Greenland was opened in August 2011, on a two-year pilot project basis, but continued to operate well until its closure in April 2015. To

⁷⁸ Gudjonsson, G. et al. *The ability of suspected victims of childhood sexual abuse (CSA) to give evidence. Findings from the Children's House in Iceland.* The Journal of Forensic Psychiatry and Psychology. Vol 21:4. August 2010. p. 584.

date it has been the first CAC to operate in Inuit society, and thus, provides a significant comparative facility and operation for review and analysis. This is particularly so because Nunavut often looks to Greenland Home Rule examples across the range of socio-cultural issues from education, justice, language and culture and health, to identify best practices and lessons learned.

The site tour on April 28, 2015, was led by Ane Marie Hendriksen, Saaffik Project Manager, and Ivalu Nørreslet, Head of the Family Division of the Greenland Government's Department of Family, Equality and Social Welfare. Both were very generous with their time, and genuinely wanted to share what they felt could be learned from the experience. The operational experience of the Saaffik project was summarized as 'some things worked, other things didn't.'

In Nuuk, the capital city and the location of the Saaffik facility, the CAC model could be said to have worked well. Children in the community received the same kind of supportive 'one stop' professional services that children worldwide do, which was felt to be an improvement over the services they would previously have received from the police and the hospital. Interagency collaboration with the police, the hospital and social workers was enhanced, networks were strengthened, and the society became better informed about the magnitude of the issue and the need for a society-wide effort to address it. The public perception was positive from the local municipality (kommune), the police, social services and among the children's families, though there was some resistance in the hospital: one physician simply refused to come to the CAC to attend medical assessments and case planning.



Upon internal reflection and review, the main challenges with the CAC model were:

1. Insufficient work was done in the planning phase to engage the kommunes, their child protection officials and establish protocols, procedures and travel budgets to support referrals;
2. The merits of interagency collaboration, training on child sexual abuse and education on the duty to report had not been done prior to implementation, and;
3. The centre supported predominantly children and youth from Nuuk, but travel funding was only accorded to the most egregious cases through health professionals from the kommunes.

While the Saaffik CAC was certainly not a failure on the part of the CAC model, the actual facility or the efficacy of the multidisciplinary in its work, having delivered its services effectively to children and youth in Nuuk after experiencing harm, the project failed to meet the government's goal to support children, youth and their families from across the country. No referrals were being received from the child protection workers in the kommunes across Greenland.

A key oversight was within the pre-planning phase of the original Saaffik strategy. If the goal was that the CAC would serve all children and youth who had experienced child sexual abuse, then this had not been determined or negotiated with the municipal governments or frontline workers. In Greenland, the kommunes (municipal governments) are responsible for front-line child protection in Greenland.

Therefore, without engagement, and without additional resources for travel and related supports, they elected not to pay for the children and escort travel to Saaffik. They believed that the same work could be done in the child's home community, albeit not with the same multidisciplinary collaborative manner or in a child-friendly facility.

Secondly, there was an overall lack of awareness about the project, the need for the project, and about the issue (child sexual abuse) in general among the front-line workers in the communities. Consistent information and messaging over the years improved the understanding of and need to address child sexual abuse through interagency collaboration. The CAC undertook education and support to front-line workers, which was appreciated by staff and effective for their local work. A tool called the 'worry barometer' was distributed to workers to help reporting:

- Green = normal
- Yellow = may need attention/ intervention
- Red = requires immediate attention/intervention

There is now increased recognition of who to contact, and how to proceed. As well, while child sexual abuse was the priority of the original Saaffik project, staff were well aware that the children they saw had experienced other forms of trauma, most notably neglect. CAC staff had to address other forms of trauma as part of therapy, which also expands the need to train and educate all frontline workers on complex trauma.

Finally, because the kommunes and interdisciplinary teams were not engaged on the issue prior to the facility being developed, the only children who came to Saaffik from outside Nuuk were some complex primary care cases identified by physicians and paediatricians within the health system, not the municipal social workers. Therefore, when the health system made the required referrals, the national health system arranged and paid for their travel and accommodations. This stands to reason that where travel resources are available through the path of least bureaucratic resistance, and based on medical and mental health priority, funding is a key lever needed to enable children/youth and family members to access the necessary assessment and treatment services that are not always available in smaller isolated communities.

Upon analysis, the Saaffik project was undone by the operational division of responsibility for child protection, which results in disparate approaches to reporting and response. The lack of prior engagement between the national government and the communities through their municipal governing authorities (the kommunes) was also not undertaken prior to operating the CAC, to address budget needs for travel and protocols for referrals. Saaffik was not 'plugged in' to either the health system or the level of government responsible for front-line child protection, which resulted in a lack of interagency awareness and collaboration.

A political decision was made this year to terminate the Saaffik operation as it was originally conceived at the end of its pilot project period in order to take the lessons learned and develop a new strategic approach. Their new model is expected to take a year to develop and two years to implement, and will focus on:

- Strengthening the capacity of the kommune Family Centres, which exist in 16 of Greenland's 17 towns, in order to model and deliver services to children;
- The Saaffik staff will continue to provide education and expert advice to front-line workers in the communities to build the multidisciplinary collaborative teams;
- The Department of Family Services has established a new division to focus on assisting the kommunes to better meet their responsibilities for child protection generally – e.g. the legal requirement to develop a plan of care for each child placed with extended family, foster parents, or state institutions.⁷⁹

⁷⁹ Many kommunes lack trained staff capable of doing so.

- As of September 2013, four pairs of psychologists and psychotherapists have been travelling to communities to work with adult survivors of child sexual abuse in order to help break the cycle of abuse.⁸⁰

Overall, the Saaffik project was regarded as highly effective and an overall success by both municipal and national politicians, as it effectively coordinated the seamless, coordinated multidisciplinary response to disclosures of abuse. It is unclear, though, why children and youth referrals in Nuuk are no longer using the Saaffik facility for forensic investigation or advocacy services. Instead, the team has reverted back to their original process. The facility instead is now used for the strategic planning team to expand the model within the kommunes and to build multidisciplinary team nationally.

⁸⁰ Two staff members are Greenlanders and two are Danes who speak Greenlandic. The others require translators. The teams visit selected communities once a month, for one week at a time. They deliver both group and individual therapy, educate front-line workers, and try and build networks.

Standard Core Elements of a CAC

We need a single-window entry to counselling and treatment programs for children, youth and adults from abuse, but there must be multiple entry points into the counselling and treatment programs, and not all of them should require referrals. Every door must be the right door.

Community consultation participant, Rankin Inlet

What are the Standard and Core Elements of a CAC?

As per the National Children's Alliance and the Canadian National CAC/CYAC Network, the standard and core elements for a recognized CAC program includes the following components:

- A Governance Model
- Selection of a Service Model
- Identification of the Multidisciplinary Team
- A Coordinated Approach
- A Facility / The Child-Focussed Setting
- Forensic Interviewing
- Child and Family Advocacy or Support
- Specialized Medical Assessment and Treatment
- Specialized Trauma-focused Mental Health Assessment and Treatment
- Cultural Competency and Respect for Diversity
- Case Review and Integrated Information Management
- Organizational Capacity
- Training and Education for Professionals
- Community Education and Outreach
- Financial Considerations
- Staffing Requirements

While there is significant variation in how the core elements are designed and implemented, depending on the needs of children/youth and families in a particular community, region or territory, a CAC must have the core elements to be considered a CAC for effective child-focussed response and care. The following is a review and analysis of these core components against what is occurring in Nunavut, and recommendations from frontline workers, survey respondents and interviewees on key issues for consideration when designing and delivering the UCYP CAC.



The Governance Model

CACs must have a designated legal entity that is established and responsible for the governance of program and fiscal operations and implements basic sound administrative policies and procedures. The role the CAC entity is to oversee the ongoing business practices including setting and implementing administrative policies, hiring of staff, managing financial and human resources, obtaining funding, supervising programs and services, and long-term planning.

During Winter 2014-15, the federal Department of Justice hosted 3 national Webex sessions for the CAC national community of practice to explore best practices and lessons learned in how to design and implement a CAC. The findings were important to ensure that any physical facility and partnership develops a clear understanding of the model and governance structure that will best reflect the needs, capacity, decision-making and accountability framework to support the UCYPC with a vision of long-term success.

National Lessons Learned on CAC Governance

A key early decision required by the CAC partners is to identify the governance model that the community supports, and that works best operationally for the multidisciplinary team partners and leadership. Types of models include:

- The expansion of an existing agency, adding the CAC as a program to an organization (such as the Toronto BOOST CYAC);
- As a not-for-profit charitable organization that will require a Board of Directors (the majority of Canadian models)
- As a government agency fully funded and integrated within the territorial government (Yukon demonstration project/Greenland/Iceland)

Once a governance model is determined, work is then required to negotiate the management accountability framework including:

- Decision-making authorities
- Operational agreements
- Administrative procedures and joint practices, particularly relating to information sharing;
- Legal aspects, and;
- A conflict resolution process (because conflict is inevitable).

A key aspect of any organization, unless it is fully funded by government partners, is that it will require not-for-profit incorporation registration and an application to be granted charitable status by the Canada Revenue Agency in order to solicit donations and additional funding to support project and program initiatives.

Phase I – The Governance Model

Board of Directors / Senior Advisory Committee

Whether a new agency of government, an expansion of an existing agency, or a new entity altogether, the governance of a CAC is driven by, and sustainable through, the establishment of senior official Boards of Directors or Senior Advisory Committee. This ensures that communication is horizontal across all mandated and participating departments and agencies, and that senior-level authority is secured for long-term planning and operations. The development and approval of the core Joint Memoranda of Understanding to set out clear expectations and obligations of all parties; operational agreements; joint

protocols, etc., are negotiated at this level and approved as standing mandates and direction to the seconded or designated staff to participate on the Multidisciplinary team.

Rather than develop a variety of disparate documents, using legal advisory services, the development of one comprehensive Cooperation Agreement to include the issues that apply to all parties, was preferred. The overarching Cooperation Agreement is a legally binding agreement that addresses the governance of the CAC, including the role and responsibility of the Board of the Directors, the Advisory Committee and Joint Management Committee. This is an effective document that clearly defines the roles and responsibilities of all the partner agencies, including the CAC non-government activities. The Cooperation Agreement also covers the funding levels, the terms of commitment, conditions of termination, confidentiality, information sharing and dispute resolution. The intent of a Cooperation Agreement also demonstrates the collaborative nature and commitment of the CAC partners. The Cooperation Agreement is signed for a term of 5-years.

When there were separate individual departmental or agency requirements, joint Partner Service Agreements for the operational aspects were established for each partner. This is critical to determine what decisions can be made by whom to avoid conflict down the road. These Service Agreements provide detailed descriptions of the services that will be provided, including the number of staff that will be directly seconded to the multidisciplinary team. Additional partners can be added at any time through a Service Agreement, as required for operational purposes. For an example of a joint Partner Service Agreement see Annex Tab 10.

While the Cooperation Agreement outlines how all parties will work collaboratively to provide seamless, coordinated and collaborative response and services, there may be times when conflict arises. The Cooperation Agreement outlines the progressive steps and procedures to follow to mediate, negotiate or arbitrate disputes between partner agencies.

Community Partners Advisory Committee

Most CACs have a variety of Committees that can assist in the design and delivery of discrete programs and services, as well as long-term planning. One type of entity includes a Community Partners Advisory Committee, which may include senior representatives from community stakeholders, key funders, designated youth representatives, Elders and Inuit representative organizations, to participate and provide input.

Steering Committee / Joint Management Team

Once the core governance model is approved, the establishment of a Steering Committee or Joint Management Team, which includes the CAC Manager and the designated organizational team leads of the Multidisciplinary team, transitions to develop the service model including the approved UCYPC policies, administrative procedures and response protocols, and determine the information management system/database that will be used, and any other essential processes. This team will also establish the training strategy and undertake the training for those working in the UCYPC. Once operational, the Joint Management Team meets bi-weekly to oversee the day-to-day operations of the centre.

Phase II - The UCYPC Service Model

The service model is that which you want to use in the UCYPC – but first it must be clear what strategic priority the partners want to accomplish regarding child maltreatment in Nunavut. Key questions that the partners will need to have clarity on includes:

- What do Nunavut partners want to accomplish through the UCYPC CAC?
- What services will the UCYPC CAC provide?
- How will the UCYPC CAC provide its services?
- How will cases come into the CAC?

- How will they monitored and tracked?
- How will interview debriefing and case planning, case reviews and peer reviews occur?
- How will the CAC measure success?

Depending on the objectives, the service model will flow from the objectives.

Through this feasibility study, it was clear that respondents want to improve access to and the coordination of mental health services throughout the continuum of care for children/youth and families after incidences of harm. Nunavut must look to other variables to help inform the service model such as human resources capacity, facilities/capital planning, financial sustainability and the continuum of care, to help define the recommended service model. In fact, for Nunavut, the recommended model to leverage the health/primary care/mental health capacity and strategic direction may provide a solid foundation – linking other key departments, legislation and tools – to effect a strong model. However, it will be important through the governance stage of discussions to verify among the key partners that the medical service model is a shared goal, and that there is a clear understanding that the community with support the proposed approach.

For Nunavut, this will require some additional community-specific work with families/communities/community leaders and frontline workers in the hamlets, particularly on:

1. The community awareness on the duty to report and the supports available for children/youth and families once a disclosure is made, and;
2. That the service model, including mandates, processes, tools, training and coaching, is provided to support the service model.

It will also be key to identify the range of community-based service providers, victim services and other individuals to facilitate the advocacy and support connections, outside of clinical treatment or formal assessment services. This will include healthy cultural activities such as Elder connections, on-the-land wellness activities and positive parenting support activities.

Nunavut Consultation Direction

It was interesting to note from both the general and frontline surveys directed that the UCYPC CAC should operate as a community-based not-for-profit charitable organization with a Board of Directors, but supported through operational funding support through the mandated departments of the GN.⁸¹ This would include key start-up capital for facility rental, database and base IM/IT equipment, operational and salary funding support for designated staff working through the UCYPC CAC. However, respondents were clear to note though that the core UCYPC CAC staff should not be GN staff, nor should the GN be involved in staffing. In addition, as with other CAC models, having an organization be rooted in partnerships between territorial government and agencies is a support role to assist collaboration, but does not allow for political intervention or involvement in individual cases: though this does not refer to the ORCY office in its advocacy and case follow-up role.

Key partner departments and agencies include Family Services (child and family services/child protection), Justice (community justice for family advocacy/victim services), Health (Primary care and mental health) and the RCMP, as key multidisciplinary team partners. Additional special project resources to support team training, a UCYPC manager and volunteer development can be sourced through other program partners and donor streams over time. With respect to a Community Partners Advisory Committee, youth participants were adamant that the UCYPC CAC must include significant youth involvement in an advisory and outreach capacity, as the CAC responds to their demographic and needs. This is a very positive and important consideration for the UCYPC governance planning.

⁸¹ Roos-Remillard Consulting Services, *UCYPC General Survey*, Question 18, p. 29; Frontline Survey, Question 23, p. 46

The Multidisciplinary Team

A key attribute of a CAC is the multidisciplinary team approach that brings together those mandated departments and organizations that a child/youth or family would need to interface with along the continuum of investigation and care. The multidisciplinary team includes:

- *Law enforcement officers, specialized in youth and maltreatment*
- *Child protective workers*
- *Mental health therapists*
- *Medical personnel*
- *Child and Family worker, for case management and referrals*

and depending on local needs, other members may be added to the multidisciplinary team such as Education, Community Justice/Victim Services, a Crown Attorney and language interpretation services.

The multidisciplinary team brings together those mandated frontline workers that respond immediately when a referral is made from a disclosure, through the following steps:

1. Interviewing the child/youth about the allegation (RCMP-Social Worker);
2. The other forensic evidence gathering through medical assessment (Paediatrician, Emergency Room physician, sexual assault nurse or Nurse Practitioner), and finally;
3. The joint case planning and collaborative review of individual cases as a multidisciplinary team based on the information and context of protection, living environment, level of trauma and child/youth and family needs moving forward.

From the general survey, it was felt that there were several key organizations that bring specialized capacity, programming and services in their respective communities, but that few worked collaboratively.

Between 79 and 88 percent of respondents felt that the local RCMP detachment, mental health counsellor, medical staff, community social services worker, school counsellor and Inuit language translators should be core members of a Nunavut-based CAC.⁸² However, due to specialized legislation that exists in Nunavut to provide youth and families with emergency protections and culturally-directed interventions, the key members required for a UCYPC Multidisciplinary Team is unique.

It was interesting to note though that only one respondent identified that the Inter-Agency Committee (IAC) might already serve as a Multidisciplinary Team in their community, which could function quickly. However, most other communities stated that their community IAC lacked consistency in regular participation, mandated participation or protocols and procedures to advance on initiatives. The transiency of frontline workers and high workloads also impeded regular participation or sustainability of those tables. Hence, if the IACs are used as a local entity, the leadership/Chair and participation would need to be mandated GN and RCMP senior management to their Regional and community operations in Health, Family Services, RCMP, Community Justice/Victim Services and Education, and mandated as an operational way working collaboratively through the IAC table.

⁸² *Ibid.*, Question 9, pp 13-14. Other local supports could include child/youth program workers, the local safe house/shelter counselor, Elders, ASIS/Mental Health First Aid responder, Community Justice Committee, victim services worker, psychologist/traumatologist and the family violence worker, where available.



What was heard clearly through the frontline and general community survey and community consultations was that the selection of the multidisciplinary team needs to be carefully chosen for community members to have trust and confidence in what they are mandated to do, to be effective. It is also important to ensure the team brings forward those departments and agencies that have the tools to support children and youth to come forward and access the services they are entitled to and need. As well, the team must work together to provide meaningful opportunities for families to receive the support and services they need in a timely manner.

Based on best practices and lessons learned across other Canadian CACs through the Justice Canada clearinghouse, many centres experience challenges in developing fully functioning multidisciplinary teams.⁸³ Challenges may include:

- Reluctance to share some information across partnering agencies due to different legislations that apply;
- Organizations are reluctant to commit to a collaborative project and the time develop the team with no predictable, committed or sustainable funding, and;
- It can take from 5 to 15 years from first meetings to being fully operational and serving children and their families.

While there can be an array of challenges, some key solutions to set establish solid support, commitment

⁸³ http://cac-cae.ca/wp-content/uploads/newsletter_english_april_2014v3.pdf

and action requires:

- Seeking and obtaining top management level support and commitment from those organizations and agencies that are mandated for child welfare, criminal justice and victim services, including resources and time allocation for participation, is crucial for the development phase of work;
- Early engagement of experienced professionals from their organization already working in a CAC elsewhere helps people pay attention, ask the right questions on operational and procedures, and training;
- Hire a project manager to facilitate, negotiate, ensure information sharing and development of critical partnerships to set the governance and operational foundations for success;
- Drafting a Memorandum of Understanding (MOU) is key to success for operations, staffing continuity, funding commitments and indicating to private funding partners that there is solid commitment to the initiative.

Inclusion of Community Justice Outreach Workers

What is unique about the Nunavut UCYPC Multidisciplinary Team composition, which does not exist in any other CAC across Canada, is the proposed inclusion of the Community Justice Outreach Worker.

The FAIA legislation provides a powerful tool for youth 14 years and older. The FAIA tool enables youth to request assistance for their safety from harm, and triggers a variety of emergency protections, resources for families and the involvement of Community Justice to support the care planning and range of interventions, rather than strictly relying on social workers and/or mental health workers to case manage family violence issues. The Community Justice Outreach Worker helps the family members through planning sessions, to find the root causes of harm that is occurring in the home, and discuss jointly who they can meet with to deal with their issues. It is a critical piece in the child maltreatment issue in Nunavut, because once abuse starts, it rarely stops: it has a trajectory of violence that builds and escalates.⁸⁴ However, it will require the cooperation and collaboration of all multidisciplinary team partners, and other local partners such as hamlet housing corps to make available to supports and services to enable immediate action.

As a parallel tool of intervention alongside medical and mental health supports, this is a powerful piece in the child welfare puzzle. Both the Emergency Protection Order and Community Intervention Order are immediate remedies in that the application is acted on quickly – within 24 hours – and addresses issues of residence in the family home, civil orders around protection, stalking and damages. Civil remedies may include temporary custody for the child/youth; orders so that victimizers do not follow them; threaten them; not attend the house or school; and allows for the child/youth and non-offending parent to live in the home and not be required to move because of someone else's abusive behaviour.

More importantly, the tools allow anyone the youth applicant identifies as who may be helpful by their own choice, to assist in supporting the family to open up discussion about what is happening in the home; what is hurting the child/youth; and identify practical and necessary actions that are required to help the parents and keep the child safe.

Through the community-based consultation meetings and within the survey responses for this project, all Inuit underlined the need to involve Elders where disclosures have been made, to assist in supporting individuals before disciplinary measures are taken. This is a very real and practical challenge for those who are officers of the court and/or professionals charged to act within the legal and employment

⁸⁴ Kropp P.R. et al. *Brief Spousal Assault Form for the Evaluation of Risk (B-Safer): User Manual*. 2nd Ed. Vancouver: 2010. p. 22.

obligations to protect the welfare of the most vulnerable in our society. Disclosures of harm raised by children and youth simply cannot, and should not, be left to the purview of Elders or anyone else, for internal family resolution.

As such, this *may* include an Elder if the individual so chooses, or other helpers such as a trusted family member, mental health specialist, clergy, professional mediator, etc., to participate in finding solutions to help the child/youth and family. However, the inclusion of Elders in cases involving children and youth must be their choice – as there was also much input that while some Elders are healthy, others are not, and can lead to serious revictimization and further violence toward the child. The Community Justice unit is working to build a roster of trained traditional counsellors through the Ilisaqsivik Society. The inclusion of Elders must be supported within the existing legislation and processes that ensure the safety of children, youth and families first. Community Justice is in the process of developing a list of Elders and mediators to assist in these family matters.

It was clear from those frontline workers who help teens, particularly in the middle school and high school, that more training and awareness of the FAIA as a harm prevention and family assistance tool, is required immediately. In the event that the offender is a youth, the community social service worker is involved as well in the case planning and provides supports. Most youth offender cases are coming through Community Justice Committees for diversion for vandalism, some assaults and property crime. When the FAIA is triggered, a lot of information is disclosed by mothers of what type of abuse is happening, to whom and why. A wide range of abuse is being disclosed through the Community Justice Outreach Workers such as financial abuse, damage to property, forced confinement, physical and sexual assaults.

It also helps to ensure the Community Justice Outreach Worker, social worker and RCMP are mutually aware of the steps being taken to support the family and protect the child, while working through a culturally-responsive approach.

Inclusion of Education

Children who are dealing with the trauma of abuse need time to process and heal. Allowing the child a period of healing will improve their mental state and increase their abilities to perform better at school. In other collaborative care planning groups, such as the Ottawa Collaborative Project for youth and families, mental health representatives of the local Boards of Education often participate in the individual care planning and case review, involving children in their schools. This is important because the child or youth's particular needs, and any safety concerns, are necessary for educators and the school to be aware of and operationalize. Children and youth are in the school the bulk of their waking day, so the teachers, counselling staff and administration have a duty to report any suspected harm, and protect the others in their care from harm each day. They are a vital partner in the case planning and case review, and should be included in the UCYPC CAC team after the main assessments have been determined and care planning is required. The Education representative is also bound by the confidentiality as well as information-sharing protocol and agreements that govern the UCYPC CAC and activities.

Inclusion of Victim Services

The GN Community Justice, Victim Services program is also a key partner to the UCYPC CAC suite of child/youth and family support services after the first appearance in court. While the program provides some community-based funding to deliver programs and services, the victim services workers in Iqaluit, Cape Dorset, Rankin Inlet and Cambridge Bay provide direct follow-up with child/youth victims of harm and their families, to link them to mental health supports, and other supports.

Some communities provide victim-oriented outreach, restorative justice or diversion programming for young offenders through the Community Justice Committees (CJsCs) for less serious offences, like property damage. Not every community delivers programming. It is largely based on the capacity, interest or efficacy of CJsCs at the community level. However, in cases of child maltreatment when a child

is apprehended, an order is issued to the offender, which in the case of a family member, can be a signal to engage the UCYPC CAC and multidisciplinary team for action. The Community Justice Outreach Worker is the link to the FAIA tools for immediate protection and support, and must be a key member of the UCYPC CAC multidisciplinary team to provide wraparound family violence intervention to restore a safe and supportive living environment for the child/youth. They are a key partner to help fill out the application for support, particularly if the youth or parent does not have access to a computer, phone or printer. Individuals need to know who their local Court Justice Outreach Worker is, to link them to support. For any UCYPC CAC co-located model, it would be recommended that this professional work within the Centre to provide onsite support to youth and family members seeking assistance.

In complex cases of indictable offences, particularly in homicide cases where a child witnessed the incident, the jurisdiction to hear the case is Iqaluit rather than circuit court trials in the community. The child/youth victim and their escort then travel to Iqaluit to attend hearings, the trial and sentencing, where the Iqaluit victim service workers provide direct assistance to the child/youth and family members in attendance. However, it was noted that support to the child/youth and family must extend beyond the criminal justice process. Information on what happens now, particularly after a not guilty verdict, to address the range of emotions but also put in place healing and safety supports.

Since the establishment of the Victim Services program, there have been 3 high profile cases involving children that have been managed in Iqaluit. Through their direct experience with these cases, there is an opportunity to strengthen the capacity of the program through training and linking to the UCYPC CAC to better support increasing caseloads. The victim service workers are not usually notified by the RCMP or GN Justice when there are cases involving children, so the staff actively scan the CIS and COMMS databases for the key codes used for child maltreatment or sexual assaults, assault or homicide, and where those cases will be held in Iqaluit.

It was noted that in one particular case, a 10-year old child was a key witness to the violent crime that caused the death of their mother. During the 3-year period that the case was winding through the justice system awaiting trial, the child had not received any formal mental health intervention or supports, except some time with a local Elder. Upon arrival in Iqaluit, the child had 3 sessions with a Court Witness Worker to explain what would happen in the courtroom over the lengthy block of time for the proceedings. The victim services worker provided emotional and logistical support to the father and two other minor children for the full period while in Iqaluit, and continues to follow-up and link the family to services upon request.

When a case is flagged, victim services workers will reach out to the family to introduce themselves as available to provide referrals and then link them to supports within their home community, and in preparation for circuit court, or link within their team to provide the necessary supports when they are in Iqaluit. The UCYPC CAC (and the ACYF in the interim) will be a key partner to link the child immediately for mental health supports where they are living (which sometimes is OOT) through to their travel to Iqaluit for court appearances.

The UCYPC CAC will be a key partner to assist in providing best practice supports and advisory services to those providing victim services. The UCYPC CAC team, through the expertise of national CAC/CYAC partners such as the Zebra Centre in Edmonton, can engage those experts to help inform the required processes and training for Nunavut. The Zebra Centre has developed expertise in managing the integrity of the evidence, investigation, overall case management and victim support, and have earned the respect of all partners within the criminal justice continuum and the judiciary for their model. As such, through these types of professional partnerships, the UCYPC CAC will be well positioned to assist GN Community Justice, Victim Services in the development of child-friendly spaces at the Iqaluit Courthouse, Public Prosecution Services office, and within the UCYPC CAC space for meetings with the child/youth and caregiver.

The UCYPC CAC service model may also assist victim services to coordinate childcare for any other attending siblings, and coordination of other in-court child/youth and family advocate support as well and post-court therapeutic tools for use at home and for the family. These will be important elements to discuss in the proposed service model and programming scope within a Demonstration Project.

A Coordinated Approach

The key value of a CAC is that the improved coordination of response, assessment and services for a child/youth and their family reduces the trauma and re-victimization experienced by the victim by having to retell their story multiple times to multiple agencies. For the mandated professionals, the CAC also saves time, program resources and eliminates the problem of communication gaps between law enforcement, child welfare agencies, health providers and the justice system. The CAC streamlines and reduces the duplication of services, or the ill-fit of services due to cultural or linguistic needs or poor assessment and referrals, and bridges the wait time for much-needed supports to help with healing. By improving coordination, children/youth and families gain trust in the government agencies because they experience positive treatment and assistance to reduce the fear in the process, and hopefully improve the rate of convictions of offenders.

The coordination of efforts in Nunavut among all mandated professionals is sporadic in each community. While there are good efforts being made between the GN Family Services and the RCMP to work together to undertake training and joint investigations after disclosures of child maltreatment, too many gaps remain along the full continuum of care for children/youth and their families. There is much discontent expressed by youth and families who need access to better care planning, case management and long-term mental health services and positive programming available outside of crisis supports.

In order to develop a strong coordinated approach in Nunavut, it is important to fully understand the needs of Nunavummiut to determine how the UCYPC CAC will add value, and what model is required to bridge the key gaps in the seamless and coordinated response to disclosures of child maltreatment. It is also important to establish a CAC program that is sustainable but will be able to provide service for all communities in Nunavut.

GN and RCMP Core Partners

One of the most important requirements to ensure that the UCYPC CAC will have a successful, strong and effective coordinated approach is that it requires strong leadership and support from the key partner agencies. As the review of the Canadian and International CAC models showed, the establishment of a CAC is based on the realization by those responding to and supporting child/youth victims after incidences of harm, that there are gaps in service, discontented “clients” and they need to work better together. This support must come from the top – the most senior representative of the Department or operational unit, and must be able to bind the organization and mandate their staff to work collaboratively. This includes in governance documents, operational agreements, financial plans, information sharing, integrated database use and reporting.

At minimum, the key core partners for the UCYPC CAC on child maltreatment will include:

- RCMP “V” Division
- GN Family Services - Child & Family Services
- GN Health – Primary Care and Mental Health
- GN Community Justice
- ACYF (community-based partner)

All of these key partners are currently represented on the UCYPC Steering Committee, and will be required to engage senior leadership engagement and support to develop a strong foundation for the project and future CAC. Other partners should include Education and Corrections for holistic case planning and review, as required.

Regardless of whether the future facility is a co-located model, or a child-friendly interview site and meeting space for the multidisciplinary team to conduct case planning and reviews, or family advocacy work, all core partners are required to participate in all aspects of project development. From establishing

the set of core values to the governance model, service model, protocols and procedures development to implementation to work through the many issues that will require negotiation, agreement and approval. The key foundation that supports developing the collaborative approach is developing the common philosophy, principles and focus that the work is child-centered: the organizational roles, responsibilities and interventions cannot be viewed as barriers to supporting the child, but are all essential functions along the continuum of care.

There were disclosures of deep mistrust among professionals across all frontline departments based on individual case experiences. There is a deep lack of understanding of each other's respective roles, responsibilities and the policy and operational gaps that inhibit the efficacy and efficiency of both departments respecting the response for children and youth in Nunavut. There is a lot of passing the buck among the agencies as to who was responsible for case blunders or missteps. Trust and positive relations among the team members is critical to work together for the benefit of the child/youth and/or family, and given the serious nature of cases of harm in Nunavut, clarity on who is ultimately the decision-maker for the safety of these children must be determined.

Non-Inuit RCMP members, social services and health professionals coming to Nunavut from the south face negative stereotypes and attitudes that they are only in the territory for the money; that they are just another transient worker who will not stay longer than a few years; will not want to understand Inuit culture or values; or have no real interest or commitment to families or community issues.

Other CACs have also had to address longstanding departmental and organizational silos, and found that the key partners had to build trust through a solid foundation of relationship building. There will always be people moving in and out of the CAC, but through a series of facilitated sessions people gain patience and respect through:

- Shared knowledge of the legislative authorities on child welfare and intervention tools for mutual through a joint review to strengthen understanding across all team members;
- Effective team communication skills, effective dialogue principles and terms of reference development;
- The response and care process map to:
 - Identify the respective operational roles by organization along the continuum of protection response/health response/follow-up child and family advocacy;
 - Identify the individual tasks, procedures followed and policies to identify the locus of control of decision-making for team members and accountability;
 - Identify the team tasks for seamless and coordinated action.
- The types of protocols, information-sharing agreements, accountability accords required for case planning and case management already developed by Canadian CACs and those required for Nunavut;
- The operational procedures required among the team depending on the types of scenarios of child harm in Nunavut;
- Training on the integrated database and case management software used by CACs, and;
- Specialized training for forensic interviewing skills (selected team members).

There is a lot of resistance in smaller communities to the issue of child protection. As an Inuk social services worker noted, "As a family, you're engaging in a system that does not have the best interests of the family as a whole." Other social workers noted that it is vital that anyone working with children/youth and families, particularly the UCYPC CAC multidisciplinary team members, find opportunities to get involved and be present at community events and engaging with families. Community members will warm

up to those working in these challenging areas, but frontline workers need to be out there and put a lot of effort to promote themselves as approachable and the UCYPC CAC as a positive entity for the family. Participating in fun events helps to put a face to a name in a positive way and show that you are there to help, regardless of the department or agency you represent.

Another key activity will require that the multidisciplinary teams engage families and the community to build a common understanding of child maltreatment. What is the terminology required for the engagement of unilingual Inuktitut speaking Elders; what are the key issues in communities to be addressed; what gaps need to be supported, and how can the multidisciplinary team be seen as trust supports of real help and assistance, and not reinforcing fear around apprehension and punitive measures. While it is not an easy topic to discuss, the teams will need to develop effective methods of community engagement and dialogue.

Community-Based Partners

It is well known in cases of child and youth abuse or exploitation that youth particularly with cognitive or learning disabilities are often targeted as easy prey for a range of abuses, particularly when they are older. While many children and youth do not receive professional diagnoses of disabilities unless they receive coordinated supports within a medical complex care plan, this is an issue for consideration for statistical tracking and programme development for the UCYPC CAC.

In discussion with the community-based Nunavut Disabilities advocacy organization, their mandate has expanded beyond strictly supporting the traditional physically disability model. Their mandate has been modified based on the United Nations and World Health Organization definition that disabilities (both diagnosed or self-identified) include mental health, mental illness, FASD and environmentally caused impacts. While the Nunavut Disabilities organization is a fairly young group, they are excited to partner with the ACYF and the proposed UCYPC CAC to assist in engaging children/youth and families in advocacy efforts to strengthen access to services, and participate in the design of community-based outreach, prevention programming and inclusion initiatives.

In our community consultations in Iqaluit, Rankin Inlet and Cambridge Bay, a variety of community-based groups and Committees expressed their support and interest in participating in linking their traditional healing programs and services to the needs of children/youth and families after incidences of harm. Community-based partners that represent and deliver locally-directed programs, are a key layer to strengthen the collaborative approach. These partnerships will be easier in some communities, where programs such as a Friendship Centre, Wellness Centres and established programs exist. In other communities, the UCYPC CAC and health centre will be key facilities to fill in gaps of programming, where requested and supported.

The Facility – A Child-Focused Setting

Whether there is a dedicated UCYPC facility, or partners retrofit existing spaces for professional use as a multidisciplinary team to conduct their work, a key element of working in a child-focused manner is to establish child-friendly spaces. This may include retrofitting a room at the Courthouse where child/youth victims can wait before they are called to testify, away from the general public, and wait in during recess breaks. This may also include child-friendly spaces in the paediatric ward; police station; social services, school or health centres, where disclosures or interviews may occur. In general though, the purpose of establishing stand-alone CACs is to have a dedicated space where all key functions of the forensic interview, medical assessment, family referral appointments and team case management conferences and reviews can be undertaken.

Having it all under one roof, so we didn't have to keep repeating the information, or search out services was very helpful and made dealing with everything much easier and less emotionally draining.

Parent comment on CYAC at BOOST, Toronto.

Traditionally, CACs vary in their operational scope, which invariably defines the form. What resonated clearly from all respondents was that beyond the mechanics and standards of what a CAC is; how it works, and; the type of model would best facilitate seamless service, was whether the facility would be an immediate safe house and provide beds for respite, protection and access to services. Whether for teens seeking a 24/7 safe place to escape harm at home, or as the emergency boarding space for complex cases of harm from the communities. This must be acknowledged as a key component of any UCYPC and strategy, both to support children/youth and the parent to facilitate and expedite disclosures, and as an immediate protection support (particularly where foster placements are exhausted) for children and youth experiencing harm.

The issue for a CAC in Nunavut is complicated by the need for multiple types of facilities to encourage disclosures and address the immediate safety and security of children/youth, as well as identifying child-friendly spaces for the multidisciplinary team to conduct the necessary tasks through the continuum of care. We will explore the types of facilities raised, because invariably the efficacy of the UCYPC will be plagued without addressing both logistical needs at some point in its development, particularly when engaging communities and identifying the requirements to support children/youth and families.

Respite Facility / Safe Space Beds

Every community visited shared their priority needs to have 24/7 safe spaces for youth, particularly during the summer months, where they stay out all night long to escape harm. There are no examples of CAC's that we reviewed that have onsite respite beds for overnight stays, or a residential treatment model unless they are attached to hospitals for inpatient treatment. While including a residential dormitory style facility would be a unique model for Nunavut, and certainly provide safe spaces for child protection workers to have immediate safe spaces for children/youth in harm and their parent, this is not an aspect that we will recommend on for this first phase of the UCYPC CAC.

Having the ability through a Phase I Demonstration Project to establish the required senior level support, governance, service model, database tools, training and a test facility for the multidisciplinary team, will require some initial effort. After an evaluation of the caseload and broader child/youth and family needs, the subsequent design for a facility may include some overnight respite or residential treatment space, but that should be explored through the multidisciplinary team and capital and program planning process. In the interim, this does not negate the fact that action should be taken to support the development of safe, supervised and structured 1st Stage safe spaces for children/youth and women, as well as 2nd Stage transition housing such as half-way houses for youth exiting detention, and affordable transitional housing for young adults. These projects can be undertaken through the ACYF, community frontline workers,

community members and GN partners as support projects outside of the current feasibility study and model of the UCYPC CAC.

It should also be noted that OOT external partners such as the Be Brave Ranch offers long-term residential respite and treatment care for children 8 to 12 years of age, to address trauma and healing for both the child and family.

UCYC CAC Facility / A Nunavut Centre of Excellence

As the adage goes, if you want to get something done quickly, do it on your own, but if you want it to last, then involve many others in the design and project.

All of the CACs reviewed required a significant amount time for the key mandated stakeholders in child welfare and operational/funding partners to work through the process of how children/youth and families would best be served. The process also helps determine what type of facility is needed; the service model; the level of capacity and tools required to provide mutual support, and foment long-term sustainability.

The establishment of a CAC is indeed a negotiation between government departments, partner agencies and the community. It is not sufficient to simply raise money, set up a community-based storefront, implement a model and expect clarity of understanding or financial support for the facility. The professional partners and organizations must be engaged, committed and achieve consensus on all aspects of the CAC model and its operational requirements for Nunavut, in order for it to be a facility for children/youth and families for the long-term.

The UCYPC CAC will be a Centre of Excellence in Nunavut for all professionals responding to reports of child maltreatment, and will be supported through the made-for-Nunavut protocols, processes and tools required to support frontline workers in all communities. The UCYPC CAC team members and Centre will be able to provide specialized services, training and public information, and collect valuable data on the nature of child maltreatment in Nunavut and the required medical and mental health interventions based on results.

In more advanced CAC models the multidisciplinary team either works jointly in a co-located manner in a single facility, or virtually by combining case notes and case reviews within a single database. At minimum though, the space must be able to accommodate regular team meetings either through technological connectivity (videoconferencing/teleconferencing) to communicate about, collaborate on and review jointly for plans of care and follow-up on child/youth and family cases. This horizontal and collaborative approach ensures that the team reduces duplication or mistakes and keeps victims from falling through the cracks of vital care.

For any venture in Nunavut, finding space is a key logistical challenge; location for a child-friendly facility is important; as is finding a space that is suitable for privacy, confidentiality and size to accommodate the types of work to be undertaken. Building on local facilities, future capital planning and organizational strengths are also key considerations, both to leverage existing primary health/mental health services and/or victim services programming.

Community respondents indicated that the most appropriate facilities that could be used or retrofitted as a child-friendly interview, advocacy and trauma counselling space includes⁸⁵:

1. Women's shelter (where they exist)
2. Healing centre / hospital
3. Youth programming centre
4. School
5. A house

⁸⁵ Roos-Remillard Consulting Services, *UCYPC General Survey*, Question 11, p 16-17

6. RCMP detachment
7. Friendship Centre (where they exist)
8. Victim services program (where they exist)
9. Hotel space
10. Spiritual sanctuary
11. Dormitory with office space
12. Elder's Centre
13. Renovation of an old hamlet building

As we engaged youth, it was clear that school is viewed as a safe place and many youth see educators and school counsellors as trustworthy adults who can help them, so many disclose harm there. However, as we spoke with teachers, principals, school counsellors and DEA representatives, bringing the full business of the CAC into a school would be challenging. As well, women's shelters do not exist in every community, and space is at a premium.

Community health centres are represented in each community, and the QGH and other regional health centres, are key common infrastructure to leverage in each community. As well, grounding the CAC model for Nunavut on improving the continuum of care for children/youth and families after harm directly supports the GN's long term strategic objectives for healthy families. To report child maltreatment requires action to address the deep rooted manifestations of trauma occurring in families through family violence, addictions, mental health and abuse toward the most vulnerable. Therefore, the child maltreatment response supports the continuum of care around the impact of trauma on the development of a child from prenatal check-ups through to adulthood, and wraparound services for children/youth and families.

As per the previous section we examined a variety of urban, rural and Northern models, and assessed them against core space requirements as:

- 1) **Non-co-located** space for forensic interviewing, case planning and review space, child/family meeting rooms and CAC admin and child/family advocate office spaces
 - a. Multidisciplinary team uses a space only as an interview site or a hub for joint work, training and external referrals
- 2) **Co-located** space for all multidisciplinary team members (RCMP, social worker, Nurse Practitioner, mental health counsellor, justice outreach worker) and CAC admin/family advocacy staff to work out off
 - a. Full CAC staff and Multidisciplinary team members work from a single space across the continuum of care

Having a storefront space is a challenge in Nunavut, where space availability is low and the cost is high to find suitable rental space or new build projects. It is not an easy task to consider a new build project, given land lease, construction planning and implementation is at minimum a 2-year timeframe, and ongoing operational costs. While renting corporate space or an existing house may be feasible, the market-based inventory for houses to provide a space that could accommodate the number of rooms would be a challenge. A facility would require at minimum a waiting room, child assessment space, an interview room, boardroom meeting room and office space.

In all cases, the space in the local community must provide a sense of safety, anonymity and enable some retrofitting to undertake the work of the multidisciplinary team and follow-up advocacy work. What was clear both from local site tours of the regions and input from respondents is that the UCYPC must work within the system, the existing services and build on the infrastructure strengths and capital planning already underway.

Nunavut-Specific Child-Friendly Design Input

Each of the community meetings held in Iqaluit, Rankin Inlet and Cambridge Bay provided input on what key design elements would reflect items of comfort for children and youth of Nunavut in a CAC brought smiles and enthusiastic input. For children's waiting rooms, the interview room and any counselling space, design elements were proposed such as:

- Cultural images
- Materials such as soft furs like rabbit, sealskin mats and umingmak (musk ox)
- Artwork that depicts the Arctic landscape and land-based activities, such as Pangnirtung's Andrew Qappik stencil drawings of children playing;
- Rich use of colour (though soft and soothing colours are better for children or youth who may have FASD) and textures
- Bean bag chairs
- Stuffed animals like ravens, oopiks and Sila dolls
- Amoutiq paintings
- Toy qamotiks, skidoos, ATVs
- The community participants even envisioned that the waiting room or counselling space could be decorated like the interior of a qammaq (traditional tent) – a fun and confidential safe space to talk
- Fun furniture designs like a qamotik with cushions and furs
- For older kids who are waiting, online apps and games, like the Cape Dorset matching game
- Toy qulliq in a play area for children
- Bones of seals to make a house – Inugait and other traditional bone games for keeping children busy

As is tradition with CACs to name the centre after an animal, usually children and youth who have visited the centre receive a take-away small toy to remind them that they can always come back, and for comfort. Having small stuffed umingmak/muskoxen made for the child/youth clients would be a similar item for the UCYP. As well, another tradition is to provide quilts made by community grandmothers or sewing groups, for the child to take to wrap themselves in comfort as part of their healing. This could be another key aspect of the design and programming for the UCYP.



For the adult meeting space with the family advocate or support worker, community members recommended that the space be designed with the following elements:

- Lots of window to let natural light in
- A place to wind down with plush furniture and soft things, not sterile
- Plants
- Have tea and coffee available
- Ensure the spaces are sound proof
- Have pictures of Arctic scenery, flowers, the land
- Have Arctic cotton in vases – elements of the land
- Candles, tea lights and fresh smelling scents
- Have sewing supplies available to busy the hands
- Have a fireplace shaped like a qulliq
- Lots of Kleenex

Forensic Interviewing

The key core functions of a CAC are two-pronged. First, the CAC provides a safe and supportive environment where the child is given the opportunity to make a statement about what happened to them. Second, the child has a forensic interview – the legally sound and developmentally appropriate questioning by a trained professional. The key aim of the forensic interview protocols for children is to obtain an account of the alleged offence in the child's own words, with as little specific prompting as possible. The non-interviewing members of the multidisciplinary team will observe the interview by video link in real-time from another room. The interviews are recorded, thus reducing the number of times the child is interviewed, therefore reducing trauma to the child. The information gathered in the forensic interview is then used to make decisions about what evidence to gather, the scope of the investigation, protection needs and safety risk, prosecution, physical assessment, mental health treatment and supports for the custodial parent/guardian and other family members, as required. Conducting forensic interviews with child victims in a designated CAC is well recognized as a best practice.⁸⁶

The selection of who or what agency will conduct the interview may vary depending on the CAC. The Zebra Centre in Edmonton uses specially trained forensic interviewers. In other CACs, the multidisciplinary team may decide who will conduct the interview. At the SeaStar CAC, the RCMP and social worker do the forensic interview jointly.

In Nunavut, depending on the type of disclosure, the RCMP and/or social worker have been conducting the interview based on the joint training and protocol established in 2011, between the GN Child & Family Services and the RCMP. However, several social workers and RCMP members interviewed said they would benefit from this training, which is specific to children and youth. Law enforcement officers often particularly benefit because their interviewing skills are often geared toward the offender, so interviewing child and youth victims requires a different approach. In addition, in Nunavut it would be highly beneficial to train both a male and a female Inuktitut-speaking forensic investigator, to better identify socio-cultural and linguistic aspects affecting the child/youth and recognize strategies for a successful interview.



While some interviews may be conducted in the social services offices, which are more child-friendly and less intimidating, most video and audio recorded sworn statement interviews are conducted at the RCMP detachment. However, some RCMP detachments are simply not equipped with video recording equipment, or members do not always take video statements when interviewing children.

Where interviews are held in local detachments, these are not very welcoming, friendly or comfortable spaces for children or youth, particularly if they come with a fear of authority or negative opinion of the police and social workers. As one social worker noted, it is a very painful process to watch a child/youth go through. If the case is an historical abuse, the child is trying to remember all the relevant details and put it into the proper terms and words that are required. Where a child may have cognitive impairments,

⁸⁶ Jones, Lisa et al. *Criminal Investigations of Child Abuse: The Research Behind Best Practices*. Trauma, Violence & Abuse. Vol 6 (3), pgs 254-268.

dates and details are blurry and cannot be confirmed for charges. Immature children cannot express the body parts, the acts and details well.



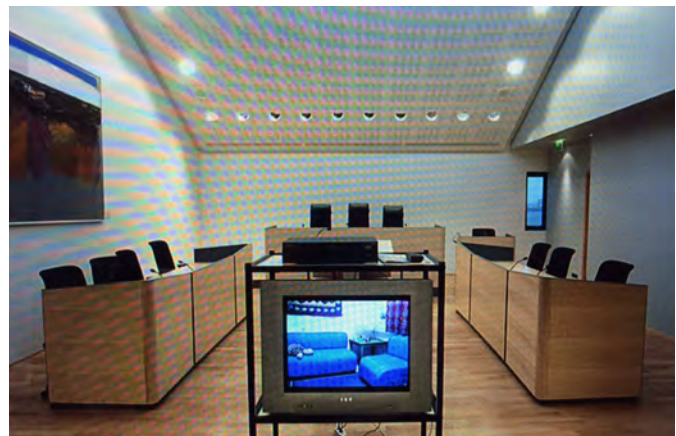
There was some discussion at each consultation meeting, and specific mention of the issue of interviewing Inuit children, for this report. On one hand frontline professionals noted that given the lack of trust of people in positions of authority, whether Inuit or not, it will likely be difficult to get the full story in one interview. Some recommended that the child be interviewed a few weeks after the event, so they are not so traumatized. However, there are particular problems with that from an investigative and prosecutorial perspective in that interviews, medical assessments and interview gathering must be undertaken immediately. In the

case of historic disclosures of harm where the evidence likely no longer exists, it is less pressing. However, it was stressed that time is not a luxury if the offender is to be successfully prosecuted.

If the interview gives a sufficient amount of particulars about the act, the Crown can play the video in court and get the child or youth to adopt the content of the video. This saves them from having to recount their entire story in direct examination. If there is no video or audio statement, the Crown is precluded from making an application under Section 715.1 of the Criminal Code, which facilitates the testimony of victims under the age of 18. However, the child or youth is still subject to cross-examination by the defence counsel, which is always emotionally hard for any victim of abuse to go through. In small hamlets where court is held in the local community centre of school auditorium, it can be further traumatizing because you are facing the entire community of attendees. In addition, not all detachments have video equipment to record the interview. This would be a key investment required for the RCMP to assist children/youth in all communities.

The issue of who would be best to conduct forensic interviews in Nunavut was also discussed. It was felt that given the majority of children and youth being harmed are Inuit, and there are particular cultural, linguistic and gender considerations and perceptions of trust and authority, it would be best to have specially trained forensic investigators who are both men and women, Inuit and bilingual English/Inuktitut. It is also necessary to have French language capacity as well to support all official languages in Nunavut.

There cannot be a reliance on using interpreters due to efficacy, efficiency and possible questions in skill levels. At minimum, the RCMP should not be in uniform and more female interviewers are needed.



Child and Family Advocacy and Support

In most circumstances, it is the mother, father, family and teachers who advocate for children. However, at times when the family unit has been disrupted, children may require support from other individuals.

The term “Advocate” is often used interchangeably across organizations, which can be confusing. Child advocates can be found in a variety of different organizations. In Canada, provincial and territorial governments have established Ombudsperson offices as independent public bodies to promote and protect the rights of children and youth and follows up to investigate allegations of mishandling of a child’s case and plan of care. The newly established Office of the Child and Youth Representative in Nunavut, which reports directly to the Legislative Assembly, is one such level of child advocate that takes instruction from the child or youth and elevates their voice within the system.⁸⁷ These offices are separate and distinct from CACs, as the CAC is a one-stop sensitive service provider for children and youth after an incident of harm for operational professionals to undertake their work.

Within the criminal justice system, child advocates also have powers and obligations that flow from legislation and roles. These advocates are concerned with the developmental needs of children and young people, and can play an important role in ensuring due process rights for young people in conflict with the law. Other child advocates exist in schools, communities and even home environments, to work on individual, group or government-wide levels to protect and nurture children and youth. These individuals are also guided by broader legislation, policies and procedures, but must refer any issues to mandated child welfare authorities for action.

The term “Advocate” is also used by some CACs as those working directly with children, youth or their families to assist with a variety of social and health referrals over a long-term period. Some CACs structure their operations (and accordingly, their budgets) by including Family Advocates as paid employees, while others are volunteers. Either way, the training, recruitment, selection and security threshold is high to ensure the safety of the children and youth at all times.

Some CACs, such as the Sheldon Kennedy CAC in Calgary, AB, prefers to term their workers as “Family Liaison Workers” or “Child Life Workers” to help clarify for families and the public.⁸⁸ The Ottawa Inuit Children Centre in Ottawa, ON, through the multidisciplinary coordinated approach of the Ottawa Service Collaborative *Integrated Plan of Care Process*⁸⁹, provides case management, case conferencing and referral services for Inuit youth and families. In order to reduce confusion, their staff are referred to as “Family Systems Navigators, which they say resonates better with clients on what support they offer.

The second key function of CAC child and family advocates is to coordinate any referrals for specialized assessments, treatment appointments, counselling or other needs for the child and family members, to assist them in their day-to-day healing after the event. This is vital because the effects of trauma resulting from abuse for a child is significant and will continue to impact the emotional, behavioural and social life of the child and family over the coming days, months and years. This is particularly true if the case is brought forward through the criminal justice system for prosecution. Therefore, the role of a CAC is vital to ensure the necessary psycho-social and healing supports are in place through coordinated and dedicated case management by non-political advocates.

Court Supports

It was noted in the consultation survey that better support is needed for the child/youth after they testify in court. The whole of issue of ensuring the child/youth has a sense of security to say what actually happened is important. The child/youth often faces retaliation in the home community during the period of

⁸⁷ <http://www.cbc.ca/news/canada/north/sherry-mcneil-mulak-nunavut-s-first-child-and-youth-rep-1.2669309>

⁸⁸ Telephone conversation between Linda Anderson, Executive Director, Sheldon Kennedy Child Advocacy Centre and Helen Roos, Roos-Remillard Consulting Services. April 24, 2015.

⁸⁹ <http://servicecollaboratives.ca/servicecollaborative/ottawa/>

time that the charges were laid until court, which can be months or even a few years.

CACs provide Family Advocates from the Centre to assist the child and family on the court process to prepare the child emotionally. In Nunavut, the Crown Witness Coordinator will meet the child/youth just prior to the court date, to explain how the physical process will work. The new Public Prosecution Services office has a child-friendly room. The Court Witness Coordinator will help explain the process and a screen or closed circuit video may be used for the child/youth testimony. The transcript will be reviewed from the interview, as the child has to be able to match up their interview with their testimony.

For post-court supports, the child's social worker will often attend court with the child and parent, and provide emotional support after the trial. This is problematic in Nunavut, where the social worker has often conducted the forensic interview; provided ongoing support, which a defence counsel may consider as having coached or informed the testimony, and then participates as well with the child/youth at court. This is a particular risk and issue that is mitigated by a CAC because there are clear roles and distinctions placed on who hears the story, versus providing the ongoing support for the case and court proceedings. The Zebra Centre has a clearly defined process and bracketing of staff from interview through to court proceedings, to safeguard the integrity of the case, while providing wraparound support to the child/youth and family.

Community Justice also has a Victim Services worker in Iqaluit, and provides funding to other communities like Cambridge Bay as well as Rankin Inlet through the Friendship Centre, to support children/youth and their families. This position and role has strengthened over the last 2 years, to reach out to victims of crime to link with resources and onsite supports, where possible. In an interview with the victim services worker, more training and resources on the needs of child/youth victims and their families along the continuum of care would be beneficial through the UCYPC CAC and partners. A key tool could include legislative and resource tools commensurate with other provincial and territorial *Victim Services Acts*, where access to counselling services both for the child and the parent of a minor, is entrenched in legislation. In most Canadian jurisdictions, child victims of harm and their parent can access 10 counselling sessions through an approved list of accredited counsellors immediately after the trauma, as well as additional blocks of counselling prior to and after a court process.

Other Recommended Programs and Services for Children/Youth and Families

Once stakeholders and the public were provided an opportunity to identify the gaps and opportunities to strengthen programs and services for children/youth and their families, a wider list was identified.

Across all consultation input for the UCYPC study youth, families, Elders and frontline workers indicated their belief that having dedicated youth outreach and family support workers is critical for the territory. The Iqaluit consultation group was asked ***"What help does a child/youth need to support their feelings, who have experienced harm in Nunavut?"***

1. *Families need to believe their children, protect them, support them and not punish them*
2. *Address root causes of abuse to stop/prevent abuse from reoccurring*
 - a. Community education and awareness about the effect of neglect
 - b. Connect youth and families with supports to help address issues before they escalate (e.g. FAIA and Community Justice Outreach Workers)
3. *Provide immediate and consistent long term counselling for child, family/guardians*
 - a. A safe place/environment/proper protection
 - b. Therapists to help them express/tell their story using art therapy, play therapy
 - c. Provide a teddy bear / soft things
 - d. Options of outlets based on the interests of the child
 - e. Providing anonymous online counselling for youth
4. *Distraction from the situation*

- a. Consider the time duration of child being away from parents – not too long for period of respite
5. *Activities that support love, acceptance, belonging, reassurance and guidance*
- a. Put in place a well informed and trained support network for parents, counsellors
 - b. Time to process without constant pressure
 - c. Need to be comforted, let them know its not their fault

More information on what to expect, how best to support the child/youth, and what support is available for all families in a timely and consistent manner is needed.



In addition, it was noted that parents/guardians are often not provided support, information or training on how to support the needs of a child / youth who has experienced harm, or how to manage their own feelings. The Iqaluit consultation participants offered this input⁹⁰:

1. *Parents/guardians need education on the long-term consequences of children witnessing violence/experiencing abuse*
 - a. Duty to report and why it is important to report
 - b. How can non-offending parents feel safer and more supported when reporting/protecting complainants from retaliation
2. *Training for parents/guardians on dealing with children that have gone through trauma*
 - a. Understanding the cycle of abuse from the perspective of child/youth victims / the implication of FASD and PTSD on emotions, physical responses and behaviour
 - b. Violence and abuse information and prevention programs (this is not a one-time mistake or incident)
 - i. Education on online abuse/exploitation/victim-blaming
 - c. Parent and Foster Parent home training
3. *Parent/Guardian support group*
 - a. Mentoring programs on parenting and communication skills with trained staff
 - b. Access to services without being scared their kids will be taken away (counselling, support resources and education – FAIA / CIO)
 - c. Trauma counselling
4. *Proper information on system processes and the available services and programs*
 - a. The judicial system
 - b. Public legal education
 - c. Mental health and treatment options
 - d. FAIA – Community Intervention Orders and EPO tools
5. *Government systems improvement*
 - a. Education centre – a “one stop shop” for resources and help available to the community
 - b. Good screening process of foster homes, group homes and parents
 - c. More transparency with government

All participants were asked what prevention programs or investments are needed immediately in their community to protect children from harm. The following were ranked from the Iqaluit, Rankin Inlet and Cambridge Bay community consultations.

1. *24/7 safe spaces for youth of all ages*
 - a. Support staff to assist in semi-independent transition homes
 - i. Group
 - ii. Family
 - iii. Independent living
 - iv. Half-way houses
 - b. Life skills programs
2. *Youth programming*
 - a. Boys Club, Girl's Club
 - b. Hang out café / safe with staff
 - c. Children who witness abuse programs (counselling, mental health)
 - i. Teaching children/youth in understanding addictions/trauma

⁹⁰ Roos-Remillard Consulting Services. *UCYPC Feasibility Study Iqaluit 2-Day Roundtable Consultation*. Conducted for Arctic Children Youth Foundation. May 19-20, 2015.

- ii. Grief and loss
 - d. Organized youth or on-the-land trips – build on what exists
 - e. Family centre
 - f. Mentoring program
 - g. Anger management
- 3. *Parenting programs/services*
 - a. Triple P parenting
 - b. Target young parents
- 4. *Victim assistance program*
 - a. Online suicide support
 - b. Online crisis helpline
 - c. Confidential disclosure tips line
- 5. *Violence prevention training program*
 - a. Drug and alcohol education and the physical effects
 - b. The Fourth R – Healthy Relationships

Specialized Medical Evaluation and Treatment

Trauma-informed services are not specifically designed to treat symptoms or syndromes related to sexual or physical abuse or other trauma, but rather are informed about, and sensitive to, trauma-related issues present in child and youth survivors of violence. Research undertaken by the U.S. National Children's Advocacy Centre indicates that children who are experience multiple traumas (or polyvictims) make up 75% of children in traumatic stress treatment programs.⁹¹ This insight leads us to assume that a more comprehensive assessment of the incidences of trauma, physical and mental health will require more indepth assessments and individual case planning.

The strategic mental health programs and treatment services for Nunavut youth will require a menu of programs and services available in the home, the community, territory-wide and in urban centres where Inuit travel to for education, medical treatment or work. Nunavut Tunngavik Incorporated's 2011-13 *Annual Report on the State of Inuit Culture and Society* summarized data from the 2007-08 Inuit Health Survey (IHS).⁹² Participants were asked if they had experienced any form of physical violence or sexual assault when they were growing up or as an adult, with responses showing that a painful number of Nunavut Inuit have experienced violence and sexual assault in their lifetime. Key findings included that:

- 41 percent of participants indicated that they had experienced severe sexual abuse during childhood, which includes someone threatening to have sex with them, touching the sex parts of their body, trying to have sex with them, or sexually attacking them;
- Women were over 52 percent more likely than men (22 percent) to be survivors of severe sexual abuse during childhood;
- Of half of the IHS participants, 52 percent of women were slightly more likely than men at 46 percent to have experienced physical abuse as an adult
- In 18 percent of the IHS participants, 27 percent of women, while 5 percent of men, said they experienced forced or attempted forced sexual activity.

The UCPC can also assist to address key specialized assessment gaps in the territory. This includes consultation services to children, families and officials where any aspect of child maltreatment (sexual abuse, neglect, physical or emotional abuse) is at issue. In particular, the assessment program can engage trained specialists to assess child maltreatment, the impact of maltreatment, court-ordered assessments on parenting capacity or home environment, sexual assault follow-up and counselling, a medical follow-up clinic and foster care consultation service.

Survey participants noted that where some community members may not want to access local medical resources because they fear of a lack of confidentiality, or where services may be lacking, or families cannot afford private medical support, the following options were offered (in priority order)⁹³:

1. Employ counsellors in each region who are trained to work with abused children and their family;
2. Bring abused children and their family into a centre that has counsellors with the skills and knowledge to work with abused children and families;
3. Train existing community mental health, family violence, addictions counsellors and Elders that work with abused children and their family to increase the use of existing community resources;
4. Employ a mobile team of counsellors who travel to communities on a regular schedule
5. Use telehealth (or Skype videoconferencing) to access confidential counselling services;

⁹¹ van der Kolk, B.A. *Developmental trauma disorder: Towards a rational diagnosis for children with complex trauma histories*. *Psychiatric Annals*, 35(5). 2005.

⁹² Nunavut Tunngavik Incorporated. *Annual Report on the State of Inuit Culture, 2011-2013*. Iqaluit. 2013. p.15.

⁹³ Roos-Remillard Consulting Services, *UCPC General Survey*, Question 14, p 21.

6. Provide a set amount of money to be used for immediate and/or short term counselling services for children/youth and families.

The specialized assessment team would include paediatricians, psychiatrists, social workers, nurses and child life specialists

Existing Services Within the Territory

Each community across Nunavut has a local health centre that provides a variety of services. These include clinics such as:

- Emergency services
- Well children clinic
- Pre and post-natal clinic
- Visiting (or resident) paediatrician

and specialist clinics. However, each community has evolved their individual model of health delivery. The primary care system in all communities across Nunavut is the community health centre or regional hospital. Each community has at minimum a nurse practitioner, with regional centres having more robust teams, which may include southern physician supports and telehealth capacity.

Iqaluit

In Iqaluit, disclosures of abuse are called to social services or the RCMP, and either of those will bring them to the Emergency Room at the QGH, which has specialized paediatric expertise. While there is the joint RCMP/Social Worker training, this is not consistently followed. They do not always meet the child/youth together, particularly in overnight shifts. For the collection of any forensic medical evidence, it can be done if it's collected within the first 72 hours after the alleged assault. If it is a pre-pubertal victim, paediatrics undertakes the examination, which is very sensitive and requires anaesthetic. If the victim is post-pubertal, a rape kit provided by the RCMP is provided, the samples taken, and the RCMP seals it for evidence and testing.

While some locums in the Emergency Room are new and rotate through the territory, it has been difficult to have a consistent response to disclosures and medical assessments for children and youth. It is also challenging when parents are allowed into emergency, as we need the time to privately examine the patients. It was noted that for children and youth, the CAC approach would be good, where the interview and assessment could be a regular clinic and a calm, friendly and welcoming environment, and parents can be interviewed by a family advocate, to identify the context and domestic issues and needs.

The current process is very disjointed. The partners will work with each other within their own respective link in the chain of practice, but there is little to no communication regarding the ongoing care plan or referrals. This is not healthy for the child/youth or family, and causes confusion among the professionals working on children's health and safety. There is also no regional or territory-wide health database for patient records, so silos continue to disjoint and disrupt the care and response for families. While a centralized health system is in underway, it was believed that the specialized databases used by CACs, which are also used across broad geographic regions, would be very advantageous for effective case management.

At the family practice clinic in Iqaluit, staff note that they do see cases of child and youth trauma, but primarily historic cases. Where acute cases are seen, predominately with teenaged girls, the nurse practitioners work closely with the sexual health clinic, QGH and engages social services and mental health for immediate support. While the family clinic staff indicate that they feel that all child and youth cases should be referred immediately to the QGH paediatric team for the immediate medical assessment and individual plan of care coordination with the multidisciplinary team, with the family clinic being

available to provide follow-up referral services and supports. The family practice clinic tries to keep track of individual cases and follow-up, but it needs to be better coordinated across the lifespan of the patient.

All health staff working with teenagers are aware of particularly at-risk youth you are either engaged in survival sex and or in suspected exploitative relationships, and living in fear of disclosing names and details of their abuser. However, there is no automatic screening for violence (which is standard in Ontario in sexual assault clinics)⁹⁴ and the sexual assault clinic are seeing the same youth patients. It was noted that the territory have high sexually transmitted disease rates such as syphilis, and medical staff recognize that youth are experiencing abuse. Unfortunately, individuals are bringing children and youth with an STD to the public health nurse, though it is not where children or youth should be going: they need to be brought to the QGH for testing and treatment. Luckily the public health nurse is referring those youth to the paediatric unit for assistance.

Hamlets

In other communities across Nunavut, the local health centre is the triage point for cases involving children and youth. Some cases may easily be decided on how to treat, while others require consultation. Survey respondents agreed with this statement and were particularly candid that having an on-call health team to assist with disclosures and assessments is important, as they are often the first call or have early involvement in the case. One physician noted that many cases of harm are occurring, but very little is being documented by nurses from the time of presentation at the health centre. This was a shocking statement to hear. Where there is no screening, documentation in the chart or consultation requests, a large amount of time passes when the visiting physicians return and learns of the suspected case, with little ability to follow-up. Of the direct sexual abuse cases that that particular paediatrician was aware of, which were 8 out of 800 children, they were all under the age of 9 years old. That does not even address older children or teens experiencing harm.

Current Process

Through the leadership of Dr. Amber Miners, Chief of Paediatrics at the Qikiqtani General Hospital, there is significant movement to better coordinate the acute and mental health response to complex paediatric cases in Iqaluit. The Paediatric Complex and Chronic Care Committee (PCCC)⁹⁵ recognizes that child maltreatment, particularly sexual assault and physical assaults, would be included in the definition of a complex case for case planning and review by this team. However, the paediatric unit is not called for all cases of disclosure occurring in the communities, which is leaving gaps in recognizing suspected cases of harm and action. It is felt that a territory-wide policy or procedure is required to ensure all suspected cases are reported to the RCMP/Social Services, and that the appropriate health response is provided.

A key tool developed to support the PCCC collaborative initiative is a home grown complex and chronic care paediatric database. This captures the types of cases, which are usually complex medical issues, but is now expanding to include children and youth who have experienced trauma; are positive for STDs, require homecare, public health, psychology, rehabilitation or mental health referrals and needs.

Other capacity gaps noted is that a full-time Nurse Practitioner is required for each community, to ensure they have the training, expertise and authority to respond. It was felt that nursing staff vary greatly in their training and skill level, and at times, are working above their accreditation. It was further explained by paediatricians providing fly-in service to communities that there is no pre-printed physician order (PPO) used for paediatric sexual assault or physical assault cases in the health centres they worked in. These forms are key tools to assist the local nurse and medical staff in choosing the most appropriate care for the medical management of the patient. It also accompanies a clinical practice guideline to streamline the flow of communications and response. Screening forms such as those contained in the Ontario Sexual

⁹⁴ Ontario Network of Sexual Assault/Domestic Violence Centres. *SA/DVTC Standards of Care*. January 2013.

⁹⁵ The Paediatric Complex and Chronic Care (PCCC) team received the Connected Care Award by CTV and CHEO under the Healthy Kids' Award for the team's work to optimize health services for children with complex needs. The PCCC was established in 2009, to improve the coordination of care, facilitate information sharing and optimize the resources at the local level.

Assault/Domestic Abuse Standards (See Annex Tab 14), paediatric diagrams to indicate lesions or other signs of abuse, or any forensic medical assessment, would be useful tools. An initial counselling form is also included as a sample (see Annex Tab 15) that is used under the sexual assault/domestic abuse standards, though it would need to be tailored for children/youth, but could be used with caregivers for information gathering.

There is strong interest and an offer of assistance expressed by CHEO paediatricians, coordinated care, the Sexual Assault forensic nursing unit and mental health, to assist in supporting medical education, training and development of standardized tools based on paediatric expertise and experience operating in Nunavut. As the physicians noted, to improve the immediate capacity and response to child maltreatment requires training and tools for health professionals territory-wide on how to identify the red flags; how to document will be instrumental to identifying cases (which will immediately help to quantify the nature and the rates of types of harm, and; mobilizing a multidisciplinary response. These are key basic steps for action, and there is strong capacity in the territory, and through external partners, to assist in this work. Even with high turnovers, as long as there is consistency in the protocols, processes and standardized documentation to be used across Nunavut in each community with nurses, this will be a key starting point to enable concerted action.

External Partners

A key partner providing physical medical fieldwork in communities across Nunavut, as well as external service supports, is the Children's Hospital of Eastern Ontario (CHEO). Where children or youth are sent to the Child and Youth Protection Team at CHEO, these cases are for inpatient care for youth under 18 years of age. Children and youth will be sent for skeletal surveys, or for suspected physical abuse, such as "shaken baby", for ophthalmology exams, head imaging with MRI or other significant injuries. The CHEO team, as well as the Winnipeg Children's Hospital, provide child wellness clinics twice annually into communities across Nunavut, and are available by phone or email for consultations.

Given that Ottawa is also examining the feasibility of establishing a CAC, CHEO may also be a virtual advocacy centre model partner, to leverage the use of technology and connectivity to coordinate multidisciplinary partners and case planning, rather than rely on a physical co-located model. However, at minimum the virtual model will require a joint venture with a CAS social worker and a project manager/coordinator for case planning and case management. This will be a first, and will require a coordination of procedures, protocols and working relations, but the hospital has the resources and tools: it is a safe place, but lacks space. The issue of space is always an issue, so the group is looking to use creative solutions and the use of technology to bridge professionals beyond usual paper and traditional approaches.

The issue of "consent" is always an issue when working collaboratively. As CHEO noted, the key issues are actually easy to facilitate. Firstly, it's the temporal scope: how long/what is the extent of consent, and to what partners. All of the CAC organizations in the US, Canada and internationally have all managed to address this issue. As CHEO noted, there is no age of consent when you have gained the maturity of making decisions. While this may be contentious to some, it can only actually be addressed through a psychologist assessment of capability of consequences of making the decision. In Quebec, the age of consent is 14 years of age. However, in most cases, consent forms only bracket the scope of consent from 6 months to 1 year at the time of signing, so there really is little risk in the issue of consent.

In other instances, the legal capacity of a parent is where hospitals have larger concerns, particular with respect to custom adoptions, and the mother wants to give the newborn to another person. This brings into issue the legal position of the newborn child, who has no other representative, on the legal positions of cultural competency and risk management. We must be clear on the law, and the rights and safety of the child, which is certainly an issue for hospitals.

On the issue of cultural competency, CHEO has established a working group, with a workplan underway. The team has developed 4-5 modules, which are web-based, for visiting physicians and local practitioners. The information includes the history of Inuit peoples; population, family systems; ensure that

services are helpful and not doing harm. CHEO is certainly supportive of working with all partners to further inform the development of these training resources for local Ottawa and visiting paediatricians and other staff.

Ottawa Health Services Network Inc. (OHSNI) is a not-for-profit organization that was established in 1997, that supports patients coming from the Qikiqtani Region of Nunavut into Ottawa, and coordinates specialists and tertiary health care in Ottawa. They provide translation support for children and families coming into Ottawa, and support the increase of access to specialty clinics at the QGH through Tele-health connection between medical providers and families.⁹⁶ The organization is a key liaison between the Government of Nunavut, incoming patients and CHEO's Coordinated Care program and other medical service providers. OHSNI provides support with non-medical issues such as accommodations and transportation, appointment bookings, will coordinate with children's needs and book travel appointments. Other OHSNI interventions includes coordinating key clinics that support children and youth including services with specialists, cardiologists, orthopedics and paediatrician visits.

CHEO's medical health partnership provides for bi-annual visits by paediatricians to hamlets, as does the Winnipeg Children's Hospital to the Kivalliq, and Yellowknife into the Kitikmeot Region. As the UCYPC CAC service model develops, it is recommended to leverage the professional expertise, interest and support of key physicians such as Dr. Louise Murray (Pond Inlet); Dr. Toby Audcent (Clyde River); Dr. Leigh Fraser Roberts (Baker Lake); Dr. Rahda Jetty (CHEO/Tungasuvvingat Inuit Clinic), and Dr. Amber Miner (Chief Paediatrician, QGH Iqaluit) in the development of standardized protocols, documentation and consultation processes for suspected incidences of child maltreatment in communities. Other partners for engagement should include Dr. Sue Bennett (former Chief, CHEO Child Protection Unit) and Brigitte Richard, RN, Manager, Paediatric Sexual Assault Unit to deliver medical education and training to the nurses and medical staff to support the UCYPC CAC project.

⁹⁶ <http://www.ohsni.com>

“A lot that I have learned, from past neglect and abuse, came from reasoning and understanding from others. It’s a big help to have people reassure you, and show you that you’re not alone.”

UCYPC General Survey – Youth Respondent

Specialized Trauma-focused Mental Health Services

The Nunavut Suicide Prevention Strategy report identified that sexual and physical abuse is a widespread problem with serious consequences in Nunavut communities.⁹⁷ It is also an issue that appears not to be openly acknowledged, and that creates a challenge in terms of being able to address it effectively.

Key informants commented that what is needed is safety for victims, support for natural helpers in communities who provide assistance for victims and families, treatment programs, family healing, healing for offenders, and healing with recognition that the causes of abuse are, in many cases, rooted in trauma including intergenerational and historical trauma. Since 2010, no specific programs are readily identifiable in Nunavut with respect to intergenerational trauma, and no specific child/youth mental health programs are being delivered within Nunavut specifically aimed at children or youth across their developmental age categories.⁹⁸ Mental health interventions have been focussed on adult residential school survivors or offenders, and children and youth are either passed between Family Services and Mental Health, and in absence of in-service treatment, are sent to OOT residential treatment centres or inpatient programs when the needs are critical.

An additional barrier to addressing intergenerational issues is that many people are both perpetrators and victims, so it is difficult to find a forum or outlet in which people with multiple connections to the issue can speak about their experiences. There is always a risk in individuals discussing their trauma and believing what has happened to them, their family and the past, as making them “damaged” and irreparable. There is a risk that a victim may be blamed for disturbing the family and as a result will experience more shame and trauma. Systems must be in place to support victims who come forward.

However, information about what supports are available; knowledge about how trauma manifests itself emotionally, physically and behaviourally and gives permission for the ability to talk and express their fears, gain control over their experience, their story and their future, is deeply empowering. When people understand that their feelings, their somatic responses and fears are natural – that they are part of the human condition for those who have also experienced traumatic incidences – they can begin heal and move forward in their lives. However, being safe and having supports is critical for healing to be possible.

Children and youth can learn that adults must be accountable for their decisions: that as children they cannot and should not assume the burden of responsibility for the problems of the parent(s) or family members. They can be taught how to set healthy boundaries for their own health and wellbeing. Their sense of being “broken” is lessened, and hope is instilled that tomorrow is another day. As one physician noted, a key part of the overall mental health approach must be to address cultural transformation and breakdown the normalization of violence in the home and community that is pervasive. This must include breaking the socio-cultural taboo of acknowledging that child sexual abuse and child maltreatment has occurred in families, and continues to occur in high numbers in Nunavut. To move forward requires public acknowledgment, individual accountability, apology, acceptance to enable healing.

⁹⁷ Snelling, Susan, et al. *Evidence Review in Support of the Nunavut Suicide Prevention Strategy*. Prepared for the Embrace Life Council. 2013

⁹⁸ Lindsay, T. and G.K. Healey. *Needs Assessment for Child and Youth Mental Health Services in Nunavut*. Qaujigiartit Health Research Centre. Iqaluit: July 2010. pp. 25-26.

What We Know About Child/Youth Trauma

Psychological trauma can occur either in the face of overwhelming traumatic stress causing “intense fear, helplessness, or horror or through cumulative, negative stressors that negatively affects someone’s ability to cope.”⁹⁹ Traumatic stress can be placed into four general categories including:

1. Simple trauma;
2. Complex trauma;
3. Attachment trauma; and
4. Vicarious trauma.

Simple or Type I trauma involves a single incident stressor (e.g. car accident) and is most closely associated with the classic symptoms of post traumatic stress disorder (PTSD), including intrusion, avoidance, hyperarousal, and cognitive distortions. Complex or Type II trauma involves repeated exposure to traumatic stress (eg. sexual or intimate partner violence). It typically results in the classic PTSD symptoms as well as affect dysregulation, cognitive distortion, dissociation, and interpersonal problems.¹⁰⁰

Attachment trauma occurs when the child’s caregiver is the source of the abuse. The attachment system is the foundation of all human relationships, and secure attachment to one’s primary caregiver results in the development of healthy identity and relationships. Insecure attachment, on the other hand, has been linked to a range of negative psychosocial outcomes that may be transmitted across generations.¹⁰¹ These include, but are not limited to, mental illness, poor parenting, lack of trust, pervasive feelings of unsafeness, and spiritual distress.¹⁰²

Finally, vicarious trauma occurs through empathetic engagement with another person’s trauma¹⁰³ resulting in cognitive distortions related to safety, trust, esteem, intimacy, and control (Adams & Riggs, 2008). Some research suggests that vicarious trauma may have a neurological etiology caused by mirror neurons, which are the foundation of observational learning in human beings.¹⁰⁴

Psychological Impact of Trauma

Exposure to ongoing mental, physical, emotional, and sexual abuse is associated with a range of psychological problems including posttraumatic stress disorder, emotional dysregulation, difficulty concentrating, low self-esteem, relationship problems, physical illness, alterations in systems of meaning,¹⁰⁵ fragmentation of the survivor’s identity, inability to trust, an altered sense of autonomy,¹⁰⁶

⁹⁹ Brière, J & Scott, C. *Principles of trauma therapy: A guide to symptoms, evaluation and treatment*. Thousand Oaks, CA: Sage. 2006.

¹⁰⁰ Courtois, C. *Complex trauma, complex reactions: Assessment and treatment*. Psychological Trauma: Theory, Research, Practice, and Policy, 1. 2008.

¹⁰¹ Benoit, M., Bouthillier, D., Moss, E., Rousseau, C., & Brunet, A. *Emotion regulation strategies as mediators of the association between level of attachment security and PTSD symptoms following trauma in adulthood*. Anxiety, Stress & Coping, 23(1). 2010; de Zulueta, C.F. *Mass violence and mental health: Attachment and trauma*. International Review of Psychiatry, 19(3). 2007; Elwood, L. S., & Williams, N. L. *PTSD-related cognitions and romantic attachment style as moderators of psychological symptoms in victims of interpersonal trauma*. Journal of Social & Clinical Psychology, 26(10). 2007; Lauterbach, D., Koch, E., & Porter, K. *The relationship between childhood support and later emergence of PTSD*. Journal of Traumatic Stress, 20(5). 2007.

¹⁰² Cohen, E., Zerach, G., & Solomon, Z. (2011). *The implication of combat-induced stress reaction, PTSD, and attachment in parenting among war veterans*. Journal of Family Psychology, 25(5). 2011; Elwood & Williams, PTSD-related, 2007; Gingrich, H. *Complex traumatic stress disorders in adults*. Journal of Psychology and Christianity, 28(3). 2009.

¹⁰³ Pearlman, L. A., & Mac Ian, P. S. *Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists*. Professional Psychology: Research and Practice, 26(6). 1995.

¹⁰⁴ Rizzolatti, G., & Craighero, L. *The mirror-neuron system*. Annual Review of Neuroscience, 27. 2004.

¹⁰⁵ Courtois, Complex trauma, 2008; Moran, P., Coffey, C., Chanen, A., Mann, A., Carlin, J. B., & Patton, G.C *Childhood sexual abuse and abnormal personality: A population-based study*. Psychological Medicine, 41, 1311-1318. 2011.

major depression, suicidal ideation,¹⁰⁷ self-harm,¹⁰⁸ addiction, poor coping strategies, and increased risk of revictimization.¹⁰⁹ Indeed, current research suggests that drug and alcohol abuse may well be attempts by trauma survivors to reduce their emotional distress by self-medicating.¹¹⁰

Developmental Trauma

Developmental trauma is defined as the experience of multiple and/or chronic and prolonged, developmentally adverse traumatic events by a child or youth, most often of an interpersonal nature (eg. sexual or physical abuse, family violence) and early-life onset.¹¹¹ We are now seeing a new population of individuals who suffer from traumatic stress disorders. These are victims of community — war zones, in which children exist under combat conditions. James Garbarino has studied community violence in the United States and abroad. His findings indicate that the symptoms exhibited by children who live in some of the most violent cities in the world — Mozambique, Belfast, etc. — are no different than those seen in children who live in inner cities across the United States.

When a child or youth experiences an act, or multiple acts of violence, their developing brain is impacted by trauma through:

- Attachment
- Neurobiological and neuroendocrine responses
- Affect regulation
- Behavioural control
- Dissociation
- Cognition
- Self-concept/self-care

The high stress hormones in the brain can do damage to the brain while it is developing. Research studies have demonstrated hippocampal/limbic abnormalities as well as catecholamine and neuroendocrine alterations in samples of abused and sexually abused children.¹¹² Where chronic stress due trauma activates ongoing responses of the hypothalamic-pituitary-adrenal (HPA) axis, the chronic activation has negative consequences by “wearing out” parts of the body responsible for memory, cognition and arousal.

Another set of neural systems that also becomes sensitized by repetitive stressful experiences are the dopaminergic and noradrenergic systems. These neurochemical systems become altered following

¹⁰⁶ Williams, W. *Complex trauma: Approaches to theory and treatment*. Journal of Loss & Trauma Vol.11(4). 2006.

¹⁰⁷ Cankaya, B., Talbot, N. L., Ward, E. A., & Duberstein, P. R. *Parental sexual abuse and suicidal behavior among women with major depressive disorder*. Canadian Journal of Psychiatry, 57(1). 2012; Fu-Gong L. et al. Quarrelsome family environment as an enhanced factor on child suicidal ideation. Research in Developmental Disabilities Vol 35. 2014.

¹⁰⁸ Maniglio, R. *The role of child sexual abuse in the etiology of suicide and non-suicidal self-injury*. Acta Psychiatrica Scandinavica, 124(1). 2011.

¹⁰⁹ Bellmore, A. & Cillessen, A. *Reciprocal influences of victimization, perceived social preference, and self-concept in adolescence*. Self and Identity, 5. 2006; Cannon, R., Lubar, J., Gartner, L., & Baldwin, D. *Perceptual distortions and negative self-concept in the addicted brain: EEG alpha and beta frequency domain activation patterns during processing of images in the recovering addict using (sLORETA)*. Paper presented at the 2008 convention of the American Psychological Association, Boston, MA. August 2008; Henderson, C., Dakof, G., Schwartz, S., & Liddle, H. *Family functioning, self-concept, and severity of adolescent externalizing problems*. Journal of Child and Family Studies, 15. 2006; Lee, S., Puterman, E., & Delongis, A. *Self-concept clarity and self-esteem in the stress and coping process*. Paper presented at the 2007 convention of the Western Psychological Association, Vancouver, BC. May 2007.

¹¹⁰ Ford, J. D., & Smith, S. F. *Complex posttraumatic stress disorder in trauma-exposed adults receiving public sector outpatient substance abuse disorder treatment*. Addiction Research & Theory, 16(2). 2008.

¹¹¹ B. van der Kolk (2005)

¹¹² B.D. Perry, *Traumatized children: How childhood trauma influences brain development*. The Journal of California Alliance of the Mentally Ill. 11:1, 48-51, 2000. Studies include Dr. Michael DeBellis and Dr. Martin Teicher on neurobiological abnormalities due to chronic stress and trauma.

traumatic stress resulting in a cascade of impacts in motor hyperactivity, anxiety, behavioural impulsivity, sleep problems, tachycardia and hypertension and an increased resting heart rate. This suggests altered autonomic regulation of the individual at the level of the brainstem.

Children suffering from PTSD are irritable, volatile and often have lower I.Q.'s. They re-enact trauma in play; what they do not have in language to describe is acted out in their behaviours. They have problems concentrating. They have a foreshortened sense of the future; they are devoid of aspirations and dreams. They have difficulty getting along with other children. They are misdiagnosed with ADD/ADHD, conduct disorder, learning disabilities and affective disorders. Because they are difficult, these children are vulnerable to further abuse in their homes and institutional settings. They are at great risk of being failed by the care taking system that is designed and mandated to protect them.

Child Maltreatment

Children who are repeatedly exposed to abuse, neglect, and violence are at extreme risk for psychological and behavioural problems in childhood, adolescence, and adulthood¹¹³. In Nunavut, transgenerational trauma from residential schools and foster homes has impaired caregivers' ability to effectively parent, thus increasing the risk of child maltreatment¹¹⁴. The earlier that maltreatment occurs, the greater the negative impact on the child's development. For example, abused infants in general exhibit serious deficits in their social behaviour¹¹⁵ while maltreatment in later childhood can result in PTSD, depression, poor self-esteem, cognitive distortion, negative rumination¹¹⁶ and substance abuse¹¹⁷.

Domestic Violence

Less attention has been given to the effects of chronic domestic violence, despite studies that show that these victims suffer from the same symptoms described by combat veterans. However, since the 1970's there has been an increasing awareness that most post traumatic stress victims are civilians who have survived enduring abuse and have existed in conditions of relative captivity. One of the most well known studies was conducted by Ann Burgess and Lynda Holmstrom in 1972. They found a characteristic pattern of symptoms that they called *rape trauma syndrome*. This led to studies of child sexual abuse. It was not until 1980, when posttraumatic stress disorder was validated by the efforts of combat veterans and included in the DSM-III, that the symptoms seen in domestic abuse and rape survivors were recognized and given credence by the medical and psychological communities.

The DSM IV (1994) only listed PTSD and various traumatic stress disorders, while the DSM V (2013) includes a new developmental subtype of PTSD for preschool children 6 years of age and under, which is more behaviourally anchored and developmentally sensitive. Domestic violence, which is experienced by 15% to 71%¹¹⁸ of women around the world has been extensively documented in Nunavut. Studies of domestic violence have found that 24 percent of women victims met criteria for PTSD¹¹⁹, while almost 100 percent met criteria for major depression¹²⁰. Children who witness domestic violence are particularly at

¹¹³ Faust, J., & Katchen, L. *Treatment of children with complicated posttraumatic stress reactions*. Psychotherapy: Theory, Research, Practice, Training, 41(4). 2004; Terr, L. C. Childhood traumas: An outline and overview. The American Journal of Psychiatry, 148(1).1991.

¹¹⁴ Schwartz-Kenney, B., McCauley, M., & Epstein, M. *Child abuse: A global view*. Westport, CT: Greenwood Press. 2001.

¹¹⁵ Valentino, K., Cicchetti, D., Toth, S., & Rogosch, F. *Mother-child play and maltreatment: A longitudinal analysis of emerging social behavior from infancy to toddlerhood*. Developmental Psychology, 47(5). 2011.

¹¹⁶ Leeson, F., & Nixon, R. *The role of children's appraisals on adjustment following psychological maltreatment: A pilot study*. Journal of Abnormal Child Psychology, 39(5). 2011.

¹¹⁷ Oshri, A., Rogosch, F., Burnette, M., & Cicchetti, D. *Developmental pathways to adolescent cannabis abuse and dependence: Child maltreatment, emerging personality, and internalizing versus externalizing psychopathology*. Psychology of Addictive Behaviors, 25(4), 2011.

¹¹⁸ <http://www.who.int/mediacentre/factsheets/fs239/en/>

¹¹⁹ Coker, A. L., Weston, R., Creson, D., Justice, B., & Blakeney, P. *PTSD symptoms among men and women survivors of intimate partner violence: The role of risk and protective factors*. Violence and Victims, 20(6). 2005.

¹²⁰ Chandra, P. S., Satyanarayana, V. A., & Carey, M. P. *Women reporting intimate partner violence in India: Associations with PTSD and depressive symptoms*. Archives of Women's Mental Health, 12(4), 203-209. (2009)

risk, exhibiting significant cognitive deficits as a direct result of their exposure to vicarious trauma¹²¹. Beyond the DSM V though, there is no diagnosis that accurately captures the impact on the development of complex trauma in childhood. Many forms of trauma do not qualify as a “traumatic event”. This could lead to the wrong treatment, leaving children feeling unsafe.

Sexual Abuse

A particularly egregious form of child maltreatment is sexual abuse or incest. This form of interpersonal trauma involves multiple forms of violation including betrayal, powerlessness, traumatic sexualization, stigmatization¹²², and forced isolation¹²³. There are at least 45 known pathological outcomes of child sexual abuse ranging from severe mood disorders to permanent neurological alternations¹²⁴.

Father-daughter incest appears to be the most common form of incest, with almost half of cases occurring before age seven¹²⁵. In a 2014 study, Martin and Silverstone found that more than 95 percent of sexual abuse survivors do not report the crime. Termination of the abuse typically occurs when the victim is more mature and feels less isolated and powerless¹²⁶.

Shame is a common outcome of sexual abuse, often becoming a central feature of the child’s personality. Shame is strongly correlated with anxiety, stress¹²⁷, anger¹²⁸, depression¹²⁹, self-harm¹³⁰, eating disorders¹³¹, physical violence¹³², and dissociation¹³³. Dissociative disorders, in turn, strongly predict multiple suicide attempts¹³⁴ and repeated self-injury¹³⁵.

The connection between CSA and suicide behaviour is well established that having been sexual abused as a child is a significant risk factor for a range of negative health outcomes later in life, including suicide behaviour. While sample sizes for Inuit population or local studies are small, both the Canadian Centre

¹²¹ Graham-Bermann, S., Howell, K., Miller, L., Kwek, J., & Lilly, M. *Traumatic events and maternal education as predictors of verbal ability for preschool children exposed to intimate partner violence (IPV)*. Journal of Family Violence, 25(4). 2010.

¹²² Finkelhor, D., & Browne, A. *The traumatic impact of child sexual abuse: A conceptualization*. American Journal of Orthopsychiatry, 55(4). 1985.

¹²³ Anderson, K. Surviving incest: The art of resistance. Families in Society, 87(3), 409-416. (2006).

¹²⁴ Moran et al., *Childhood sexual abuse*, 2011; Neuman et al., 1996; Sanchez-Meca et al., 2011; Trickett, Knowel, & Putnam 2011; Williams, 2006

¹²⁵ Atwood, J. D. *When love hurts: Preadolescent girls’ reports of incest*. American Journal of Family Therapy, 35(4), 287-313. 2007.

¹²⁶ Lorentzen, E., Nilsen, H., & Traeen, B. *Will it never end? The narratives of incest victims on the termination of sexual abuse*. Journal of Sex Research, 45(2), 164-174. 2008.

¹²⁷ Matos, M., & Pinto-Gouveia, J. *Shame as a traumatic memory*. Clinical Psychology & Psychotherapy, 17(4), 299-312. 2010.

¹²⁸ Harper, F., & Arias, I. *The role of shame in predicting adult anger and depressive symptoms among victims of child psychological maltreatment*. Journal of Family Violence, 19(6). 2004.

¹²⁹ Vikan, A., Hassel, A. M., Rugset, A., Johansen, H. E., & Moen, T. *A test of shame in outpatients with emotional disorder*. Nordic Journal of Psychiatry, 64(3). 2010.

¹³⁰ Milligan, R.-J., & Andrews, B. *Suicidal and other self-harming behavior in offender women: The role of shame, anger and childhood abuse*. Legal & Criminological Psychology, 10(1). 2005.

¹³¹ Grabhorn, R. et al. *Social anxiety in anorexia and bulimia nervosa: The mediating role of shame*. Clinical Psychology & Psychotherapy, 13(1). 2006; Murray, C., & Waller, G. *Reported sexual abuse and bulimic psychopathology among nonclinical women: The meditating role of shame*. International Journal of Eating Disorders, 32(2). 2002.

¹³² Kivisto, A. J., Kivisto, K. L., Moore, T. M., & Rhatigan, D. L. *Antisociality and intimate partner violence: The facilitating role of shame*. Violence & Victims, 26(6). 2011.

¹³³ Talbot, J. A., Talbot, N. L., & Tu, X. *Shame-proneness as a diathesis for dissociation in women with histories of childhood sexual abuse*. Journal of Traumatic Stress, 17(5). 2004.

¹³⁴ Foote, B., Smolin, Y., Kaplan, M., Legatt, M., & Lipschitz, D. *Prevalence of dissociative disorders in psychiatric outpatients*. American Journal of Psychiatry, 163(4). 2006.

¹³⁵ Saxe, G. N., Chawla, N., & van der Kolk, B. *Self-destructive behavior in patients with dissociative disorders*. Suicide & Life - Threatening Behavior, 32(3). 2002.

for Justice Statistics and the Inuit Health Study have documented the elevated rate of CSA in Nunavut. In addition, the Learning From Lives That Have Been Lived suicide follow-back study has documented the elevated rate of Nunavut Inuit who died by suicide who suffered CSA (and other forms of childhood abuse) as compared to the control group. There can be no question that CSA is one of the key risk factors underlying Nunavut's elevated rate of suicide behaviour.

The 2005-10 *Learning From Lives That Have Been Lived: Nunavut Suicide Follow-Back Study* reported that:¹³⁶

Childhood abuse was ... divided into three groups in our study. We asked whether individuals had been sexually, physically, and/or psychologically abused in childhood. Several individuals had experienced more than one form of abuse, and therefore individuals may be represented in more than one group. 21.6% of the suicide group had experienced physical abuse in childhood, compared to 13.3% of the comparison group. 15.8% of the suicide group and 6.7% of the comparison group had experienced sexual abuse in childhood. 20% of the suicide group and 10.8% of the comparison group had experienced psychological (emotional) abuse in childhood. Significantly more individuals in the suicide group had been physically and/or sexually abused in childhood compared to the comparison group.

However, there may be more to the relationship between CSA and suicide behaviour in Nunavut.

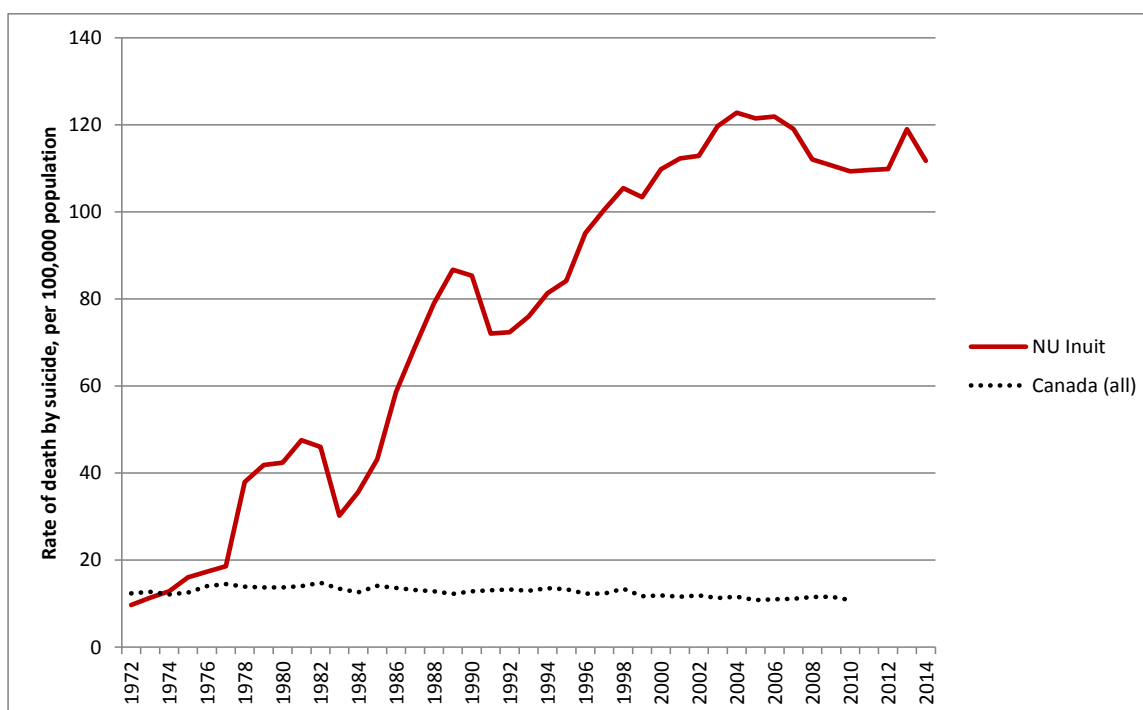
Our research obtained record-level data on deaths ruled to have been suicides in the pre-division NWT, since records began being kept in 1967, through an Access to Information request to the GNWT Department of Justice.¹³⁷ Combined with data from the Office of the Chief Coroner of Nunavut and Inuit populations from the Census of Canada, we have calculated the rate of death by suicide by Nunavut Inuit as a five-year rolling average to smooth out the jumps that occur when doing such calculations on small populations.



¹³⁶ Chachamovich, E., and Monica Tomlinson. *Learning From Lives That Have Been Lived: Nunavut Suicide Follow-Back Study*. Montreal QC: Douglas Mental Health University Institute. 2013, p. 33.

¹³⁷ Jack Hicks, *Suicide Rates for Nunavut: 1972-2014*. Ottawa, ON. May 2015. There are no comparable historical data for the number of adults charged with sexual offences against children.

Suicide rates for Nunavut Inuit (five-year rolling averages) and all Canadians, 1972-2014



It is clear that the rate of suicide by Nunavut Inuit began to increase in the late 1970s, rose drastically during the 1980s and 1990s, peaked in the early 2000s, and has since been at an average rate of approximately 110 per 100,000 population. Nunavut's suicide is ten times the national rate – the same as the difference between the rate at which adults are charged with sexual violations against children in Nunavut and across Canada as a whole.

There is one weakness in the suicide data obtained from the GNWT Department of Justice in that they withheld the age of the deceased, to prevent the identification of individuals. Therefore, we are unable to replicate a comparison chart about between Nunavut and Greenland that would have offered unique and important insights into social change in Inuit societies since World War II.

Regardless, Nunavut often looks to Greenland for examples of approaches and Inuit-specific models to gain insight on lessons learned within an Inuit delivery context. This chart, prepared by prominent Danish public health researcher Dr. Peter Bjerregaard, shows that the rate of suicide began to increase significantly among men born after 1953.¹³⁸ The year is important, as 1950 saw the release of the recommendations of the Danish government's Greenland Commission of 1948, which released its report in 1950 and why it is referred to as the G-50 report. G-50 resulted in massive Danish state investment in Greenland, and an intensive process of 'modernisation' the country and of Greenlanders. G-50 sought to concentrate the population in fewer places, so a number of small settlements were closed and their populations relocated to towns and cities. There was also a large increase in the number of Danes, especially men, moving to Greenland.

Much has been written about the impact of the rapid social change, under very unequal power dynamics, that G-50 brought about. It was a time of considerable stress for many families, not only those who were relocated but also those who felt powerless in the face of change driven by outsiders. One possible

¹³⁸ Bjerregaard, P. & Inge L. *Suicide – A challenge in modern Greenland. Archives of Suicide Research* 10: 2006. p. 213

explanation of the above chart is that there was an increase in the amount of 'family problems' (parental stress, alcohol abuse, etc.) during 'the G-50 years,' and that an increased rate of 'adverse childhood experiences' resulted in an increased rate of suicide behaviour as these children became young adults. Men seem to have been particularly impacted. Increased rates of CSA may have been both a factor in the later increase in the rate of suicide behaviour and the result of more people (especially men) growing up with unresolved historical trauma. It is our hypothesis that if we had similar data for Inuit in Nunavut, it would support a similar conclusion.

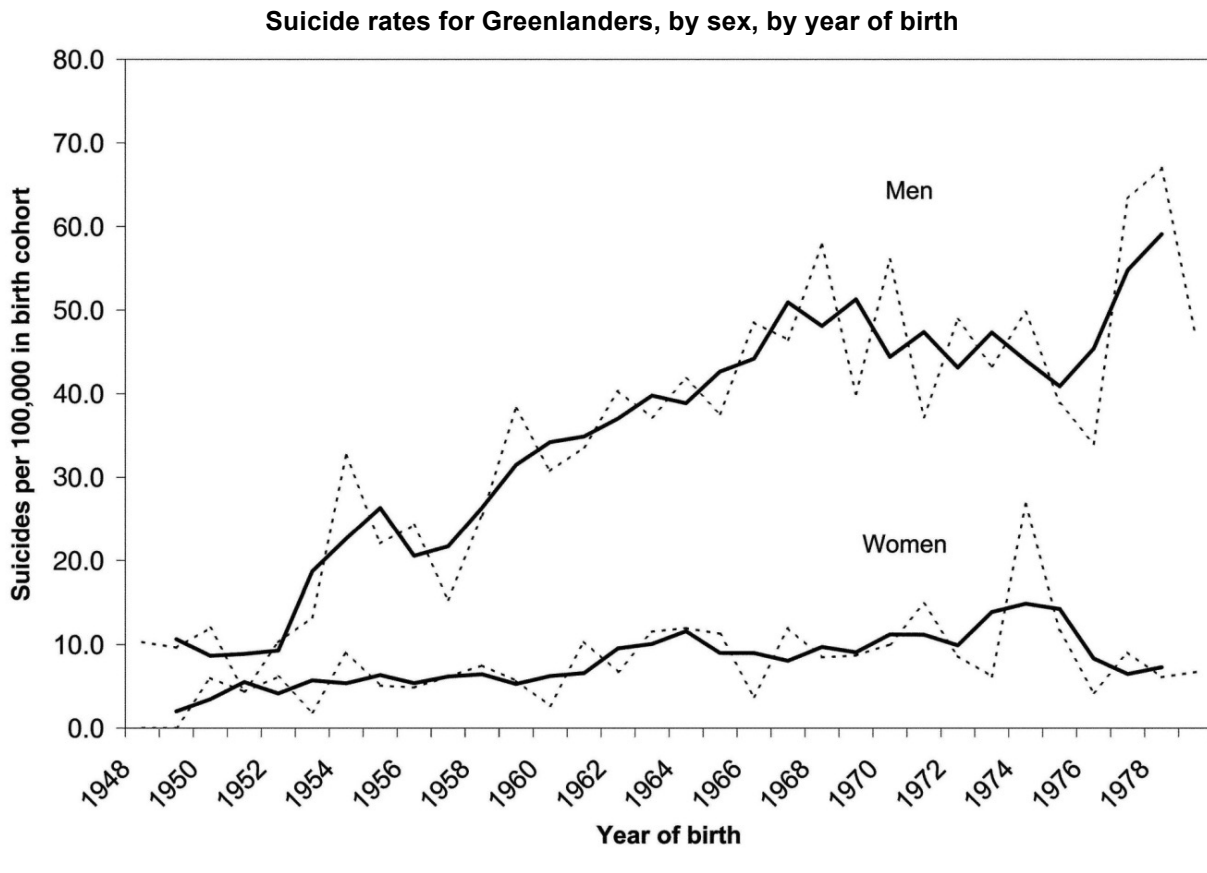


FIGURE 3. Youth suicides (age 15–29) by birth cohort among Inuit of Greenland, observations by birth cohort (dotted line) and 3-year moving averages (solid line).

Rapid social change under conditions of colonial powerlessness resulted in increased rates of anger and tension in families, resulting in substance abuse and violence. Children in those families grew up at greater risk of experiencing adverse childhood experiences, the most extreme and damaging of which was child sexual abuse. This higher rate of adverse childhood experiences resulted in higher rates of mental distress as teenagers and young adults, which in turn resulted in high rates of both suicide behaviour and the perpetration of abuse against children. There is now an intergenerational transmission of historical trauma taking place, with sexual abuse being one of the ways in which the transmission occurs.

A cycle of transmission has been established: a cycle that was not a characteristic of historical Inuit society. It is a cycle that can and must be broken, but must support individual perspectives to identify a consensus approach to peeling back the fundamental taboo of harm, while building in accountability and mechanisms of support for individual and community change. The CAC, its programs and services cannot be imposed, otherwise the foundation for the child and youth will not exist and will serve to further victimize the child.

Existing Mental Health Services Within the Territory

Each community across Nunavut has a local health centre that provides a variety of mental health services. These include:

- Counselling services
- Mental health services
- School health and health promotion programming
- Help lines such as the Kamatsiaqtut Help Line and the national Kids Help Phone
- Organizational links to Embrace Life Council, Inuit Mental Wellness, Mental Health Commission, Canadian Mental Health Association, GN Foster Care and CAMH

and specialist clinics. However, each community has evolved their individual model of mental health service delivery, with some communities coordinating externally sourced group counselling and non-clinical healing initiatives.

Iqaluit residents benefit from core facilities including a public health centre, the Qikiqtani General Hospital, the Tammattaavik Boarding Home and a Mental Health Central Intake Coordinator as well as alternative medical homes such as the Elders home and most recently, the Akausisarvik residential inpatient and outpatient mental health facility. There are only a few private accredited counsellors in communities across Nunavut, but few can afford private fees and it has not been easy for others to receive referrals for service by Family Services or Mental Health. Some private counsellors in Iqaluit are supporting residential school survivors, family members and youth referred within their plan of care with Family Services. Otherwise, some will seek out assistance through Elders or spiritual leaders within their family or community. Many noted that mental health services in Iqaluit are quite segregated, and more work is required to streamline and support children and youth across the continuum of care. The Government of Nunavut currently has in place a community psychiatric nurse or mental health nurse in each community across Nunavut.

Through the frontline worker and community member surveys undertaken for this project, the highest ranked need in Nunavut is improved access to mental health services for children and youth after incidences of harm.¹³⁹ However, others did indicate that there are supports available at every level, but the lack of interdepartmental communication between GN Health and GN Family Services to use existing community resources was a top priority for action. Without training and linking community mental health workers, RCMP, social workers, family violence, addiction counsellors and Elders who work with those after incidences of harm, poor collaboration among frontline workers and weak case follow-up resulted in children/youth and families falling through the safety net. Comments included:

- In several communities both the mental health consultant position and community social service worker positions are often not staffed. Therefore, if there is a referral for protection placement and trauma support, the cases fall to the community health nurse to coordinate an inservice and aftercare programs;
- Social workers noted that some community mental health staff only provided services to adults and openly stating that mental health counselling to children and youth was the responsibility of the community social service worker by virtue that they were mandated to support children in crisis;
- Alternatively, mental health workers raised their frustration that community social services workers were not referring the child to mental health in a timely fashion to receive services;
- Employ counsellors in each region who are trained to work with abused children and their family;

¹³⁹ Roos-Remillard Consulting Services, *UCYPC Frontline Worker Survey*, Question 11.

- Services to families to prevent abuse are few;
- Children and youth are languishing on long waiting lists;
- We need to identify therapeutic tools that can be used in the home for the child/youth and family;
- More abuse and suicide prevention programs are needed in communities.

It was very strongly noted in frontline worker feedback that staffing existing vacancies in community mental health teams, including addictions, is a priority. Having pragmatic on-the-ground clinicians rather than travelling fly-in therapists is important. A key recommendation was having Family Support Workers trained to deliver trauma-focused care to provide support at the time of investigation through to case management and support referrals. This is for all intents and purposes the same function as the CAC Child/Youth and Family Advocate.

Registered psychiatric nurses (RPN) are a specialty of nursing that supports individuals of all ages in mental distress or living with diagnosed mental illnesses such as schizophrenia, bipolar disorder, psychosis, depression or dementia. Nurses who specialize in this field receive more training in psychological therapies and engaged in the therapeutic network for individual care plans, to support challenging behaviours and are able to administer psychiatric medication. Also within some communities are mental health counsellors who hold M.A. level accreditation. Both levels of staff at the community level provide outreach to children, youth and their families, and the department is looking to further hire a child and youth outreach worker who will work with mental health staff for referrals.

Typically anyone can be referred to mental health supports in the community, including primary care professionals, social workers, teachers and RCMP. Once a referral is made, the availability is dependent on the wait list and caseload. Anecdotal responses from frontline workers, youth and families are that the wait time is months, with no interim supports.

The key therapeutic supports currently available to Community Social Service workers and Mental Health workers are mechanisms and delivery partners that can try to put the child back into a condition of safety, which may include:

- Establishing contact with a safe relationship; a disruption and need not to go to through school/regain a sense of safety;
- A sensory detective – what sensations are reminders of the event (sounds, taste, visual, a particular touch) or that triggers and be clear that we give the right dose that the child can handle; recover from the sensation; get back into safety;
- Increase the child's sensory comfort that they can feel safe: provide a toy, blanket, music or space
- Tell the story of the experience – a narrative – and making sense of the experience and make meaning (before, at the time, what was the most frightening, what body felt like (inside, emotions), pictures. What's shareable is bearable, then it becomes more bearable.

While there is discussion internally within the GN regarding a residential care facility and a long-term care facility (and public desires for an addictions treatment centre within the territory) they are only bookmarked in long-term capital planning goals.

The provision of mental health support to children and youth, particularly up until a few years, was reported to be very weak. Where mental health services did exist in communities, it was found that those supports are primarily reserved for adults only. Children and youth who were victims of harm, and most certainly their parent or guardian, were not easily able to access timely mental health supports, or were on lengthy wait lists for referrals, or, had to pay for private counselling services. A wide variety of

respondents, including several youth and their parents/guardians who had experienced cases of maltreatment, said that community social service workers were relied upon to provide counselling assistance. However, that is well outside the scope of their training or accreditation to provide specialized trauma counselling, and cannot be managed against high case management and administrative reporting obligations.

For children in care, community social service workers identify, manage and coordinate a wide variety of referrals across the continuum of care for a child outside of simply foster home or other residential placements. These include referrals and transfers to a wide variety of external services providers (for protection, addictions, mental health treatment and assessments). Mental health workers are also now responding to individual cases, some with external placements, but in isolation of Family Services. While mental health can respond quicker than the centralized supervision and decision-making on child and youth cases in Family Services, better coordination is required overall.

Psychiatric nurses will soon be available in each community in Nunavut, which will assist. However, children as young as 2 years of age require access to mental health programming and services well into the school years, so it is unclear whether the new psychiatric nurse will support the full range of children and youth as well as adults. The school counsellor cannot be relied upon for mental health services. The Learning Collaborative – an initiative through Johns Hopkins University, noted that better connection to services for children under 6 years old who witness violence and experience abuse, need assistance. This age range will certainly need to inform the experience and therapeutic techniques used by incoming mental health staff in Nunavut.

The group home service agreements through southern firms are coordinated through the department of Family Services, but not in consultation or collaboration with Mental Health. This clear disconnect speaks to the need for better interdepartmental relationship building, coordination and capacity building for operational supports and referrals, which can be achieved through the UCYPC multidisciplinary team approach and CAC model. The care plan and services must address both safety, respite and specialized treatment needs, with all relevant departments and agencies mandated to support children/youth and families apprised of case management and appropriate follow-up.

This history has created variations, which the department of Health is working to standardize the level of capacity and standards of practice across the Territory. For example, there is no routine screening of cases of care, or population-wide programming given the prevalence of trauma in communities, including “attachment” or other disorders often present from neglect, placement in foster homes, southern residential treatment, etc. Intervention is on a case-by-case basis, and wait times are lengthy for specialized supports. The department is building up the capacity for referrals, but at present, there are no specialized protocols for dealing with specific profiles. This will be a timely and important opportunity for the development of protocols for screening, assessment, referrals, standards of care and procedures through a multidisciplinary lens, and with community engagement, to shape a model that is seamless, collaborative and reflects the needs and desires of Inuit.

Community-based Traditional / Cultural Mental Wellness Activities

Pauktuutit Inuit Women’s Association has worked tirelessly since the 1980s to research and produce tools for use in communities rooted in Inuit traditional wisdom, while blending evidence-based research and frameworks to support children and families. Pauktuutit’s work on the Nuluaq Project documented interviews with many Inuit Elders who were recognized as community healers for their assistance with others.¹⁴⁰ They observed that childhood sexual, physical and emotional abuse created the cycle of pain, and that those who had been hurt ended up hurting others. The mistreatment caused them to commit the same acts to other children, and from childhood to youth, into adulthood, and influenced their behaviour throughout their life. They lived with anger but could not understand why, through too many “family secrets” and unresolved issues passed from generation to generation. The healers all noted that in the

¹⁴⁰ Pauktuutit Inuit Women’s Association. *Analysis Report: Inuit Healing in Contemporary Inuit Society*. Nuluaq Project: National Inuit Strategy for Abuse Prevention. Ottawa: March 31, 2004. p. 18.

end, people just want to be needed – want to belong – so they put up with the abuse just so that they can belong.

Some communities have dedicated Wellness Centres that are natural community hubs for the delivery of a variety of mental health and prevention programming. Community wellness centres such as Cambridge Bay delivers Heal & Hunt activities for on-the-land skills training and counselling supports. Other groups such as Kivalliq Inuit Association deliver community-based language projects, such as language nests, to revitalize Inuktitut language in the home, community and workplace. Inuit Broadcasting Corporation produces and broadcasts numerous programs on a range of issues, topics and genres in Inuktitut. The award winning Ilisaqsivik Society¹⁴¹ in Clyde River is a single-window not-for-profit organization that manages delivers a variety of wellness programming to support individuals and families. In this community, paraprofessional counselling services are delivered through a Yellowknife firm to deliver group therapeutic sessions around trauma, loss and the Inuit experience. The program also blends facilitation by individuals with lived experience in order to provide support and guidance.

There are many ways that Nunavut communities, through funding provided through government grants and contributions and private partners, are helping children and youth build on essential lessons of resiliency and coping. Many are rooted in Inuit social values and Inuit Qajimantikanjit (IQ) to build a strong sense of individual purpose and healing after trauma through values of *connection*, *work* and *survival*.¹⁴² Project informants also noted that there are many community-based groups delivering excellent non-clinical programs that support mental health and wellness. A key group noted was the Qaujigiartiit Health Research Centre in Iqaluit. Their delivery of the Makimautiksat Youth Camp program and advancing initiatives seeking to measure Inuit youth health and wellness, are important partners for program referrals and joint project initiatives.¹⁴³

CONNECTION	WORK	SURVIVAL
Respect	Practice	Perseverance – Don't quit
Acceptance	Mastery	Conserve energy – patience
Equality	Focus	Adaptation
Love	Teamwork	Creativity
Trust	Help Others	Cooperation
Honesty	Flexibility	Sivummut – moving forward
Sharing	Effort	Value Life

Supporting a population of youth with positive cultural experiences, culturally safe coping strategies that provide connection, and sense of personal identity is key for a Nunavut CAC. They seek to blend the teaching of fundamental survival skills for land-based activities, and learning about familial experiences (to the extent that the past is open to share) through storytelling, building community connections across helping families and institutions, and supporting spirituality, whether traditional shamanism or Christianity, for individual protection and strength.

There are many initiatives in communities that are pockets of healing, strength, vision and wisdom outside of formal clinical “western” mental health approaches. However, more information and peer support programming is needed for youth on how to help each other, while safeguarding themselves from harm.

¹⁴¹ <http://ilisaqsivik.ca>

¹⁴² Helen Roos, *Phase I – Service and Capacity Review for Victims of Sexual Exploitation and Human Trafficking in Nunavut Final Report*. Ottawa: November 2013. p. 93

¹⁴³ Mearns, C. and Healey, G.K. *Makimautiksat Youth Camp: Program Evaluation 2010-2015*. Qaujigiartiit Health Research Centre. Iqaluit: 2015.

External Residential and/or Treatment Partners

At present, the Government of Nunavut relies on southern residential or specialized treatment centres, both for child/youth placements as well as medical or mental health specialized treatment and care. As per a recent report, the \$10M annual budget under the Department of Family Services for child protection was distributed as \$9.3M for Out of Territory placements, with only \$165K spent in Nunavut in 2013-14.¹⁴⁴ The department used the following residential care service providers for out-of-territory residential placements as per the individual child/youth's care plan:

Facility	Province/Territory
Annie's Haven Ltd.	Ontario
Broken Arrow Residential Treatment	Ontario
Calder Centre	Saskatchewan
CHEO	Ontario
Gloria Penner 5788847 MB Inc.	Manitoba
Hawk Residential Care and Treatment Homes	Ontario
Homewood Health Centre	Ontario
Judy Borne	Manitoba
Macdonald Youth Services	Manitoba
Mary Homes	Ontario
Massey Home 663997 MB Ltd.	Manitoba
Ontario Shores Centre for Mental Health Science	Ontario
Options Youth & Associates	Ontario
Parkland Community Living and Support Society	Alberta
Partners in Parenting	Ontario
Protegra Inc.	Alberta
Ranch Ehrlo Society	Saskatchewan
Roger's House	Ontario
Royal Ottawa Hospital	Ontario
Selkirk Mental Health Centre	Manitoba
Sinclair Residence Inc.	Ontario
St. Vincent's Hospital	Ontario
Stepping Stones	Ontario
Terrace Youth Residential Services	Ontario
Tungasuvvingat Inuit	Ontario
Winnipeg Inuit Centre	Manitoba
Winnipeg Regional Health Authority	Manitoba
Wood's Homes	Alberta
Youthdale	Ontario

Some of the facilities are known through urban Inuit serving organizations to be better than others with respect to the provision of programs, services and supportive linkages to Inuit socio-cultural connections for Nunavut's children and youth in care. Between April 1, 2011 and March 31, 2015, there were 80 annual facility reviews conducted in out-of-territory facilities that Nunavut's children and youth in care are being housed and treated.¹⁴⁵ Some facilities make more effort to provide language, country food and participation in Inuit-specific programming, but few provide the trauma counselling, connection with family or community necessary to healing. The placements of Inuit youth are unique and must include social needs and specialized supports for success.

The OICC works with local residential treatment centres and foster placements in Ottawa like Mary Homes, Stepping Stones, Bairn Croft Residential Services, Children's Aid Society and CHEO. The liaison function of the OICC serves to effectively link children and youth with relevant socio-cultural and health supports, and ensures that the children/youth and families know where to come for culturally-specific services as required. However, when GN Mental Health initiates the placement of children/youth into Out-

¹⁴⁴ http://www.nunatsiaqonline.ca/stories/article/65674nunavut_family_services_minister_were_working_on_it/

¹⁴⁵ Government of Nunavut. *Response to the Standing Committee on Oversight of Government Operations and Public Accounts on the Review of the Report of the Auditor General of Canada to the Legislative Assembly of Nunavut on the 2014 Follow-up Report on Child and Family Services in Nunavut*. April 2015. pp. 3-4.

of-Territory facilities for support, the child is not always connected through the GN Family Services, OICC or other systems, so there have been reports of children and youth living in isolation from their socio-cultural community and Inuit-serving organizations.

A collaborative process and approach like the UCYPC CAC for Nunavut would ensure that all relevant mandated partners are aware of plans of care; appropriate case information is shared and transferred on the child's care plan; and that Inuit-serving organizations in the urban centres can provide meaningful assistance for the benefit of the child.

Ottawa is a test site for the Coordinated Access Collaboration Project: a 3-year initiative by the Province of Ontario that links over 22 child/youth and family specialized organizations to Individual Plan of Care (IPC) planning, case review and coordinated care, depending on the child/youth and family's needs.¹⁴⁶ This initiative reduces the duplication of services, while streamlining the referral process and supports to children/youth and their families for a wide range of needs. For Aboriginal children/youth and family services, there are two streams. Wabano Health Centre coordinates First Nations IPCs, while the Ottawa Inuit Children's Centre (OICC) is the mandated child/youth case management organization for Inuit children, to coordinate seamless wraparound support for families requiring assistance.

As at May 2015, they were coordinating 5 Inuit child/youth IPC processes. The OICC recognizes that Inuit children from Nunavut fit within 4 categories:

1. Children born in Nunavut, but not raised in the South
2. Children born in Nunavut, but raised in the South
3. Adopted out (custom or private)
4. Children in temporary care or permanent care

Each category of child/youth requires different needs in care planning, a range of specialized clinical and community-based pro-social supports, which results in a diversity of case management. One case had 17 organizational representatives linked to support one child's care plan: the most representatives to date under the entire Coordinated Access project for a single IPC.

This speaks to the complex care needs of some Inuit children coming from Nunavut. The staff indicated that they would benefit connecting with any UCYPC CAC database when children are referred to southern centres for care, to add case notes and coordinate care. Details are getting lost when children are transferred, often with little or no documentation. This can be critical and significantly revictimizes a child when service partners are unaware of the context of apprehension, removal or referral for treatment. Any proposed database would also benefit from linking with 1) Family Finder: a geonomic family mapping tool to link families to the required supports; 2) psychiatric assessments on FASD, ADHD, PTSD as symptoms are often the same, but are required for proper treatment planning, and 3) strengthening occupational therapy treatments for FASD, etc.

The Youth Services Bureau leads the IPC process of non-Aboriginal child/youth and families. Unlike the Youth Services Bureau IPCs, the OICC case planning does not require the parent(s) to be part of the discussions. Hence, the OICC is in fact working as the Family Advocate/Case Management role that a CAC would have, and as a multidisciplinary team for case planning, case conferencing and seamless access to services based on the assessed needs of the child/youth. However, the OICC title is Family Systems Navigator. As a Family Systems Navigator, the OICC staff are key partners that provide a "soft hand off" and relieves the stress for parents to make the appointments and figure out the system. They also assist to connect specialized care through referrals to private occupational therapists, schools, medical staff, psychologists, family therapists and other resources, and even taxi or bus tickets to remove barriers of transportation, so that appointments can be kept as required for the IPCs.

As the OICC noted, many children and youth from Nunavut have not dealt with the complex trauma they have experienced, and continue to be negatively impacted when they are living in residential centres or

¹⁴⁶ <http://coordinatedaccess.ca/en/>

foster placements, with no access to their language, culture, food and community. It places another layer of stress and confusion on the child. As such, the OICC fills the gap in culturally-specific programming from early childhood programming as an Aboriginal Head Start daycare with deep cultural content and activities; quality mental health programming for families of school aged children, mothers, teens and older youth programs such as healthy role models/life coaching, sports and recreation, counselling and therapeutic interventions for attachment.

The OICC works in direct partnership as well in child welfare placement planning with the Children's Aid Society of Ottawa, and CHEO when child/youth patients are brought in on an inpatient basis. They also provide Inuit cultural training to CHEO for coordinated care/ fly-in paediatricians and child protection unit staff. Staff noted that much more work is needed to focus interventions on what they are seeing with youth such as attachment disorder, FASD, and the trauma that is being caused by custom adoption, favouritism of certain children in families over others, and other maladaptive cultural practices. They do not see the high rates of trauma in children from other Inuit Nunangat communities, but have certainly seen trends in complex trauma in their child/youth and family cases.

Northern Psychiatric Outreach Program (NPOP-C)

The key external mental health service provider to Nunavut communities in the Qikiqtani and Kivalliq Regions is the Northern Psychiatric Outreach Program (NPOP-C) through the Centre for Addiction and Mental Health (CAMH).¹⁴⁷ Led by Dr. Allison Crawford, Program Director, the NPOP-C program provides culturally-specific and equitable access to psychiatric services to underserved rural and remote communities through the Department of Psychiatry, University of Toronto. Through her involvement with the National Inuit Suicide Prevention Strategy and the Arctic Council Mental Health Summit, the program foundation uses storytelling and the arts as a CBT psychological intervention to explore the impact of trauma. The team and student residents provide weekly client consultations and are also available to individuals by email for any urgent concerns. Psychiatrists also visit communities twice annually for individual face-to-face sessions.

Key areas that were discussed was the impact of early child neglect, parenting capacity and educating frontline workers on trauma-focussed care and trauma therapy using cultural adaptation and interventions for Nunavut. Having the southern clinical service partnerships is what provides the department of Health with the ability to respond quickly and efficiently for emergency cases for immediate transfer; access telehealth capacity to nurses at the community level, and; provide appropriate referrals. A key element of the NPOP-C program expansion for Nunavut in the coming years will be the engagement of the Hospital for Sick Children (Toronto) to coordinate referrals and treatment and introduce the use of telepsychiatry for children and youth with clinicians. The use of technology to connect with clinical specialists will support additional education, child services and mental health supports. It will be important for the community to see what resources are available.

It was also noted that any mental health assessments, care planning and interventions requires training for the multidisciplinary team and community practitioners on trauma-focussed care and of the specialized evidence-based treatments that work across the spectrum of paediatric and adolescent complex trauma. This would include the community-based psychiatric nurse, health centre workers, social worker, addictions counsellors and other wellness and youth workers for knowledge building, skills development and more trauma-informed care.

It is evident that the NPOP-C program can provide significant assessment, clinical treatment and referral support to the multidisciplinary team of the UCYPC CAC, to expedite:

- General psychiatric assessments for children/youth and families after incidences of harm;
- Specialized psychiatric assessments and diagnoses to open doors for services;
- Specialized court-ordered parenting capacity assessments;

¹⁴⁷ Northern Psychiatric Outreach Program <http://www.psychiatry.utoronto.ca/education/postgraduate-program/outreach-program/>

- Care planning and treatment through telehealth, telepsychiatry, in-person or online connectivity to make improvements with the child/youth and family along the continuum of care;
- Clinical supervision for UCYPC CAC clinical staff, as required, and;
- Research and analysis on key issues to inform early adversity protection; gender analysis of maltreatment, and; need for programming in Nunavut.

The NPOP-C will be a key partner to provide trauma-informed and culturally-specific clinical treatment capacity to the mental health toolkit for the UCYPC CAC supports for children/youth and families.

Children’s Hospital of Eastern Ontario (CHEO)

During the period of this feasibility study, the Government of Nunavut also signed a service agreement for mental health services with the Ottawa-based Children’s Hospital of Eastern Ontario for primary care, and Ottawa Royal Mental Hospital to provide services for adult patients. The provision of child/youth mental health services will primarily be provided by Sick Kids Hospital and CAMH in Toronto. CHEO will continue to provide paediatric acute care specialized support for urgent primary care cases, while Toronto will focus child and youth mental health assistance in the meantime. However, CHEO did indicate an interest in assisting with child and youth mental health supports, but it is in the early stages presently, and will take 3 years planning to strengthen to adequately support Nunavut’s needs.

Kackaamin Family Development Centre – Child & Family 6-Week Traditional Healing Centre / Addictions

One best practice residential treatment centre noted by social service staff is the 6-week family-centered addictions and healthy families program at Kackaamin Family Development Centre located in Port Alberni, British Columbia.¹⁴⁸ The Government of Nunavut has used them sporadically since 2013. It was felt by social workers that if such traditional healing centres could be identified as a preferred facility, it would ease the strenuous process of getting approval to send families for treatment.

Be Brave Ranch – Child & Family 28-Day Residential Treatment Centre / Child Sexual Abuse

Another new specialized clinical treatment facility is the Be Brave Ranch, located in Sherwood Park, AB. The project team had the opportunity to tour the facility while in Edmonton meeting with the Zebra Centre CAC. Dr. Jacqui Linder, project advisor on clinical treatment on child sexual abuse and trauma is the Clinical Director of this newly established facility.

The medical literature around child sexual abuse shows that unfortunately many children who have been sexually abused receive little to no treatment. Even for those who do receive some treatment, it equates to only 15-20 hours of actual therapy, but no follow-up. The Be Brave Ranch specializes in clinical mental health treatment for child survivors of child sexual abuse for children between 8 – 12 years of age, and their families.¹⁴⁹ This full-year long program includes an initial 28-day clinical residential treatment program; 3 additional 14-day stays, and; follow-up outpatient supports through 60-90 minute parent group teleconferences and 30-minute calls with the children to discuss any issues while at home.

¹⁴⁸ Kackaamin.org

¹⁴⁹ <http://bebraveranch.littlewarriors.ca>



Throughout the year-long program, the child and their families receive over 200 hours of multimodal therapy run by clinical professionals including:

- Trauma-focused cognitive behavioural therapy (TF-CBT)
- Art therapy
- Music therapy
- Recreational activities
- Aboriginal spiritual perspectives and activities
- Peer group (cohort) support

Therapy is provided in an enriched “camp-like” environment where the children also have a lot of fun: to reconnect to being a child through play, laughter and moving forward through connection and hope for the future. Being in a cohort helps the child recognize that they are not alone, and connects them with others who have experienced similar traumas. The long-term relationships and deep bonds helps facilitate their

healing.

The approach is an evidence-based program based on two separate gold standard trauma intervention models – the Tri-phasic model and Trauma Focussed Cognitive Behavioural Therapy (TF-CBT). Treatment is divided into multiple stages over a 12-month period. The initial 28-day treatment program combines multiple proven therapies for children ages 8-12 years of age and allows for the child to connect with their cohort of 8 other children. The children receive a lot of resources and get through the body's defence system after trauma to build up their individual confidence, address key issues and develop a safety plan. Subsequent to this initial stay, the children return for three additional 2-week blocks to continue their face-to-face therapy and reconnect in person with their cohort.



The residential spaces for the children, and the parent's lodge, are superbly outfitted for youth. The child's lodge has 24/7 adult resident and safety support.

Child abuse affects the whole family, so the program uses a family-centered approach providing clinical support to parents and guardians as well. The non-offending parent can also attend to assist the child in transitioning to the centre, as well as receive individual counselling on a range of issues such as

emotional trauma, grief, guilt, anger and co-dependency and participate in therapeutic activities such as yoga, art therapy and safety planning. The adults have their own residence, and while the children receive therapy and programming, the adult can participate in services as well. The parent connects with their child on a daily basis, but does not participate in the child cohort activities. The approach supports research that the child cannot heal unless the home environment and primary caregiver is educated about the long lasting effects and symptoms of post-sexual abuse trauma and prevention.

For the 2014-15 operational year, the Be Brave Ranch has free clinical spaces for children between 8 and 12 years of age, who pass the assessment screening for participation in the program, during the clinical trial, which is being undertaken in partnership with the University of Alberta for evaluation and peer review. Once the clinical trial period is over, the cost of participation is approximately \$25,000 per child for the residential and outpatient support, but exclusive of travel costs for the child and/or parents. However, the staff will discuss any financial barriers on a case-by-case basis.

The referrals to the Be Brave Ranch program are accepted from individuals, parents, guardians, caregivers and family members for cases that have already been reported to the authorities. Professionals may also refer including physicians, psychologists, social workers and youth serving agencies, sexual assault programs and other community-based organizations. For children in government care, return travel costs are often covered through mental health or social services care plans.

Children's Hospital of Eastern Ontario (CHEO)

While CHEO through the Coordinated Care program coordinates treatment for children and youth through the various treatment streams, they remain open to strengthening their support to children and youth from Nunavut. CHEO is linked by way of operational partnership with the Royal Ottawa Mental Hospital for youth mental health services. The Royal has provided service in the past, but recently has limited inpatient mental health supports to Inuit children and youth of Nunavut. Bed stays are limited to a maximum of 13 days observation, but engaging in their home, school and education life is necessary for rehabilitation and reintegration. The secure confines of the hospital is challenging for an appropriate diagnosis and treatment.

A key tool that was developed by CHEO is the Youth Net/RéseauAdo program, which is by youth, for youth.¹⁵⁰ It is a program specific to youth mental health, which promotes alternatives services for youth aged 13 to 20 years old. For youth from Nunavut, the age was extended to 25 to 26 years old, and provides clinical back-up resources for additional supports. The program provides an opportunity for youth focus groups to talk about mental health and illness in a confidential and supportive environment; has presentations for youth on mental health, mental illness, stress and depression; provides an 8-week Girls talk on self esteem to prevent depression, and; Guys Talk for health promotion and risk-prevention for males.

This program is quite innovative, integrating therapeutic art activities such as Pens and Paints, with a 10-week initiative that focuses on coping with stress through visual arts and creative writing. Other coordinated physical activities, which are important to reconnect the physical body after trauma, include snowboarding, hiking, canoeing and yoga. The program also includes a Youth Advisory Committee that works to develop promotional materials to de-stigmatize mental illness and crisis intervention information. The program uses the principles and framework of peer mentorship and the street credibility of youth who face mental health challenges.

For practical considerations in order to assist children immediately and in the short term, any UCYPC approach will need to leverage the availability of dedicated space in existence in communities, and integrate a CAC in Iqaluit, and community-based capacity, within the medical paediatric primary care

¹⁵⁰ <http://www.cheo.on.ca/en/youth-helping-youth>

model, integrate space needs and design within ongoing capital planning exercises (and funding) and strengthen the emerging capacity of care already underway.

Participants also identified existing infrastructure (health centre, wellness centre, youth centre or vacant buildings) and the leadership of mental health or primary care health staff as the most appropriate community leads for CAC activities in the community. With the proper training, tools, operational support and local delegated authority to mobilize for children, much can be accomplished in the short term.

Cultural Competency and Diversity

The importance of frontline workers across the multidisciplinary team to have the competency (the knowledge, skills and ability) to deliver programs and services effectively to all Nunavummiut across the diversity of multicultural population, languages and worldview, is critical. All CACs identify that in order to service children, youth and their families appropriately, one must have training and the ability to practice how to provide culturally competent care for all individuals, but in particular of the Inuit culture, in Nunavut. This requires Inuit cultural sensitivity training and cultural safety, and provision for southerners who have made Nunavut their home.

Cultural safety was first introduced by Irihapeti Ramsden, a Maori nurse in Aotearoa (New Zealand) in 1990.¹⁵¹ Her description of the term explained that cultural safety moves beyond simply cultural sensitivity and cultural competence (which is having knowledge about the culture – “the other” – and recognizing the fundamental power imbalances in our systems, society and practices. This includes the political ideals of self-determination and de-colonization. This deeper learning incorporates aspects about the population being served on issues including:

- Cultural awareness – the acknowledgment of difference
- Cultural sensitivity – the recognition of the importance of respecting difference
- Cultural competence – focusing on the skills, knowledge and attitudes of the practitioner
- Cultural safety – involving self reflection and a deeper understanding that cultural values and norms of the child, youth or family may be different due to unique socio-political histories

This deeper learning and awareness leads to empathy and the capability to share another person's emotions and feelings. This in turn improves the therapeutic care planning, engagement of other team members to address other key needs of the client, which leads to better health outcomes. Empathy also leads to better advocacy and case management of the client for the benefit of the broader community.¹⁵²

Dr. Allison Crawford, head of the *Northern Psychiatric Outreach Program*, has provided practical leadership to support the competency development of southern health professionals working in Nunavut in the area cultural safety. Her learning online tool entitled *Inuit Story Bones: A storied approach to Inuit mental health and wellness*¹⁵³ is a valuable tool and testament to the importance of translating cultural values, principles, norms and historic context of Nunavut, to those working in clinical and human helping professions.

Inuit Societal Values in Program Design and Delivery

Any CAC initiative in Nunavut must respect and be rooted in the fundamental principle that programs and services available to Inuit shall be based on Inuit Societal Values (ISV), the principles and concepts of Inuit Qaujimaatunqangit (IQ) and respect for Inuit cultural identity.¹⁵⁴

From both the general and frontline surveys, each of the Inuit societal values applied to all core activities of a CAC, with *Inuuqatgiitsarniq: Respecting others, relationships and caring for people* as the highest ranked option.¹⁵⁵ An additional value, *Inunnguiniq: Raising a capable/able person* was also identified as a priority.¹⁵⁶ This means raising a person who is loved cherished and supported to develop tot heir fullest

¹⁵¹ Koptie, S. *Irihapeti Ramsden: The Public Narrative on Cultural Safety*. First Peoples Child & Family Review. Vol 4:2. 2009.

¹⁵² For information on cultural safety training in Canada among health practitioners see the Anishnawbe Health Toronto Aboriginal Cultural Safety: An Overview at <https://www.youtube.com/watch?v=Bs42CHW5L0g&feature=youtu.be>

¹⁵³ <http://www.inuitstorybones.ca/node/1>

¹⁵⁴ Government of Nunavut. *Incorporating Inuit Societal Values*. Iqaluit: 2013.

¹⁵⁵ UCYPG General Survey, Question 15, p. 25; UCYPG Frontline Survey, Question 16, p. 35

¹⁵⁶ National Collaborating Centre for Aboriginal Health. *Inunnguiniq: Caring for Children the Inuit Way*. Prince George, BC: 2009. p.3

potential. This includes raising a child in an environment that is not only free from abuse or neglect, but also supports the child to thrive and develop to the best of their ability.

Another key element of successfully implementing Inuit societal values in the design and delivery of the UCYPC CAC includes family and community engagement and developing the Inuit terminology to support child and youth protection and healing. While some terminology has been developed for sectors including justice, there are key gaps in language and understanding to fully engage Inuit participation, buy-in, and ultimately, individual and community accountability for action. As several Elders noted, unless Inuit are well engaged, the CAC and its programs and services will result in the same southern imported programs and self-serving values. As one respondent noted:

The word mamisarniq, or “healing” comes from healing circles. The work stuck, although it literally means “healing an open wound” like skin. Healing the soul is totally different, and a different concept than tangible skin. The skin is something you can see: not the soul. Inuit use the holistic – whole – approach. All these well-intentioned incentives are coming from outside of our culture, based on legislations and policies from science and common or criminal law. They have no soul; are not ours; they are not our values. We are not a “self” oriented society and we work as a whole through consensus and will never change. If a Centre is to work, it cannot be a top-down approach. It will not succeed: like the Greenland Centre [Saaffik] closure. It has to be based on communities first, the objectives of the NLCA and not the regional centres.¹⁵⁷ We have to remove the barriers.

Local programs and any support for community-based CACs must be developed in accordance with Inuit, and through the development of the relevant terminology to reflect the concepts of child harm, trauma and healing. While some of this terminology has likely been developed in Greenlandic for the Saaffik CAC and programming, work will need to be done in this area.



¹⁵⁷ Email correspondence between Leetia Janes, Iqaluit, NU and Helen Roos, Roos-Remillard Consulting Services. May 30, 2015.

The key response from Elders and community members was that the need for the Umingmak Child & Youth Centre is undisputed. However, Inuit recognize and articulated strongly that services and programs to support the children, youth and families affected by harm, will not work as outlined from migrant “academic” mental health, social workers and justice specialists. Several community respondents noted that Elders and key stakeholders must be included on how to develop this approach as they have tremendous influence of the process and the “when to seek outside help” and when they will address issues within the family.

This is of course a key area of contention between frontline workers who have witnessed firsthand how children and youth have been re-victimized through statements such as “what did you do to provoke the abuse?” or when some Elders outright say that they will not report incidences to the police or community social service workers. Alternatively, the key language and meaning is more often the youth’s terms used to denote what is happening to them. Often times youth say “someone’s bothering me” or “someone’s picking at me”, which actually means touching, pinching, scratching or hurting them. It is much more relevant to decode what youth mean through their terminology and socio-linguistic meaning, than that of traditional Inuktitut. For some youth, that decoding is less relevant than understanding the everyday language that children and youth use about what is happening to them, and creating, development and relaying language that reflects their current reality, and not what families or Elders want others to hear.

Perhaps the key to balancing an Inuit approach to justice, and meeting the legislative obligations to respond and protection children in need is through FAIA. It is a key area where youth and families may seek assistance and specialized supports through community justice/restorative approaches. While the *Family Abuse Intervention Act* and its tools are not without its detractors, citing legislative gaps, lack of prior community consultation prior to design and drafting, and the potential for a Charter challenge, the Community Intervention Order (CIO) and Emergency Protection Order (EPO) are tools available to youth 14+ years old to signal familial strife and safety concerns, and seek immediate support.

The intervention tools can engage trained and specialized resources, such as mediators and/or trained and vetted Elders, for the family to identify the source of conflict, abusive behaviour and joint agreements on how to improve the family home. Participation must be voluntarily, and where mediated agreements and conditions are negotiated, the plan of care can be formalized through a Court Order, thus prioritizing the need and access to therapies and supports. More outreach to youth and families that this tool exists could be a powerful prevention tool to support and empower youth, while balancing family wellness through Inuit cultural values and approaches.

It must be noted though that there child harm is disclosed, the Community Justice Outreach Worker works in conjunction with community social workers and the RCMP for information sharing and case tracking, and where emergency placements are required for youth, those are undertaken to ensure the primary of the welfare of the child.

What becomes a challenge is in translating and operationalizing ISV. As one social worker noted:

“We’ve lost touch of what it means for Inuit social values – that moment – that perspective of cultural values and the respect that it deserves. How can you measure it? What does it mean? We can promote it, but it often seems like a blanket term, because it is what we do, but isn’t recognized as being good enough or right. It’s frustrating.”

When government and organizations design results-based programs and services, they link their longterm 20-year vision (to eradicate child and youth harm in Nunavut) to intermediate pillars that are strategic priorities (3-4 statements) for action and investment. Of course that is horribly bureaucratic, but at some point ISV must be clarified. When we asked 79 frontline and general survey respondents, the top 4 pillars to form a UCYPC strategic results-based strategy, as identified by ISV priorities, were ranked in order of priority as:¹⁵⁸

¹⁵⁸ Roos-Remillard Consulting Services. *UCYPC Frontline Survey*, Question 17, p. 36; UCYPC General Survey, Question 16., p. 26.

1. More Inuit children/youth will receive protection from violence
2. More frontline staff will receive specialized skills training in child/youth abuse and prevention
3. It will achieve an increased rate of direct support to child/youth victims and their families
4. It will incorporate traditional Inuit teachings on resiliency and coping within trauma counselling services

Identifying 2-3 key quantitative (statistics) and qualitative (participant surveys and other input) to evaluate how effectively Inuit societal values and the UCYPC is addressing child harm will be an important aspect of the future strategic planning work.

The OICC in Ottawa is currently developing a strategic outcomes framework of principles based on the 8 ISVs to link their core programming and activities. This will ensure that their programming, services and interventions reflect that the child is at the centre of their purpose; attachment to the parent/family; support a continuum of wellness; that children and families are living a good life, and reflect the theory of change within the Inuit community. The UCYPC CAC would benefit greatly when undertaking their governance and service model discussions, to leverage this strategic work done to date on incorporating ISV within a child/youth and family serving interventions.

Case Review and Data Tracking

The CAC provides a safe environment for the multidisciplinary team to review cases where there are criminal charges to be laid; the file is highly visible with media; protection and support matters are complicating the case; there are issues with the caregiver; there are multiple perpetrators; custody issues; a high risk of recanting, and; always when there is a child protection issue. The case review process for the team allows them to share differing opinions and approaches. The topic is heavy and each are specialists in their field, so it is important that each feel respected for the expertise they bring and the role and responsibility they have to the file and the process. The Chair of the case reviews need to be skilled in facilitating respectful team discussions, supportive collaboration and positive case outcomes for the benefit of the child/youth and family.

The use of a collaborative data collection software or tools is key for effective case review, to review all relevant steps and facts within the child/youth's case. Consent must be given by the child/youth/family for the collection and sharing of information between the team for case management.

Case reviews are a collaborative, formal process where information, experience and expertise are shared by the multidisciplinary team members to make child-centred informed decisions that reflect the best interests of the child/youth and families being served by the UCYP CAC. Regular case reviews should be conducted with all multidisciplinary team members involved in a respective child/youth case to share concerns and discuss ongoing planning. CACs hold mandatory bi-weekly review team meetings, either in-person or virtually by teleconference, to:

- Track and monitor cases, particularly where there are immediate safety concerns including:
 - Apprehension of the child/youth and any siblings
 - In cases where criminal charges have been laid
 - Where a family cannot be located
 - In cases that have resulted in serious physical injury
 - Where there are concerns about emotional/mental stability
 - High profile/media exposure cases
 - High-risk of recantation
 - Involving multiple victims or offenders
 - Include custody or visitation disputes
 - Child protection cases that are being transferred to another community or OOT services
 - Reunification of victim and offender is being considered, or
 - Cases where progress has not occurred as planned
- Provide mutual support and promote shared responsibility as a team for the child/youth and family
- Review all aspects of the case and share appropriate information from each participant as a report back and provide feedback on case decision-making
- Update all documentation and record keeping for individual cases within the integrated database
- Maintain effective team dialogue to discuss problems, issues, concerns for effective case management
- Address the needs of children/youth and families at a common table and in an appropriate, timely, efficient and coordinated manner, which reduced trauma and confusion for families
- Determine an agreed-to course of action to facilitate progress over the next two-week period for that family

The caseload for Nunavut-based social workers and child protection workers is high. While the 2014 Follow-up Report of the Auditor General of Canada on the Department of Family Services noted that some progress continues to be made to fill staffing vacancies and do a workload assessment, minimum standards are still not being met on case plan reviews, meetings with children and their families, and supervisor reviews of case planning.¹⁵⁹ The timely and consistent collection and sharing of basic information about the children in government care still requires corrective follow-up and action. Attention is often directed to immediate crisis management issues and protection requirements.

In order to effectively coordinate information sharing on supports, the need for strong supervision and regularly scheduled case conferences, is critical. As a highly transient and young workforce, it is necessary to provide strong supervision, coaching, and training for effective case reviews and case management.

Data Collection Tools

CACs have developed variations of consent forms that are signed upon intake at the facility, to ensure that the multidisciplinary team has the approval to collect, document and share within the team for the purposes of case review and case management, the child/youth and family's key information. A sample of the consent form can be found in Annex Tab 12.

Family Services established the Residential Services Client Tracking Tool for all children and youth placed in residential care. This database provides detailed information to support care planning, and work has commenced to develop a client information system that will be required in the medium term.¹⁶⁰ In most CACs, the child protection officers/social workers still maintain their departmental case information on their internal records management system, but still enter case notes into the integrated CAC database, for a holistic case planning, case review and case management scope.

The key benefit of instituting a common file form is that it supports the coordinated and collaborative multi-disciplinary model of a CAC. The only key common band of data that the team would see is the:

- Child identification number
- Gender
- Date of birth
- Date of referral to the CAC;
- Type of abuse
- Relationship of the offender
- Whether the interview was CFS, RCMP or joint;
- Who the investigators were
- If there were other witnesses
- When they were interviewed
- Were charges laid
- Case review dates
- Case review consent form approval received
- Case outcome
- Any follow-through in the justice system for notification.

However, in the integrated database partners have fields for their entry that can expand on particulars within their assessments as required, which are not shared broadly. This provides for integrated data management systems that capture key information related to protection, investigation, types of harm,

¹⁵⁹ http://www.oag-bvg.gc.ca/internet/English/nun_201403_e_39111.html Exhibit 6

¹⁶⁰ Auditor General of Canada. *Follow-up Report on Child and Family Services in Nunavut – Department of Family Services*. Ottawa: March 2014. p. 26; Government of Nunavut. *Department of Family Services, Director's Report 2013-14*. Iqaluit. 2014. p. 9.

support referrals and statistical reporting. To view a sample of a common file form see Annex Tab 12, or the statistical report form Annex Tab 13.

For Nunavut, given the dearth of information on the real level of child maltreatment in Nunavut, it is important to use an integrated data collection system to collect the full range of statistics, including health centre reports, child protection, RCMP charge data, and others as documented.

Various IM/IT platforms are available shelf-ready through the ongoing development such as Network Ninja¹⁶¹, developed by the National Children's Alliance used by the Zebra Centre in Edmonton, Alberta.¹⁶² This powerful software is able to link the entire territory with a searchable database for clients, caregivers and offenders, which for collaborative multi-disciplinary case management, provides a powerful case management and analytical tool for frontline workers.

The multidisciplinary team members, from the assigned health professionals, law enforcement officers, social workers, Crown Attorneys and CFS case workers, would enter their key data within a case-tracking system that has been specially designed for CACs, to connect the child/youth information. Other CAC team members, from the case coordinator to administrative staff are prompted through the best practices electronic to-do list to ensure the process of caring for the child runs smoothly. All key team members from frontline workers to administrative staff are able to review the electronic file, and updates are enabled through CAC officials authorized to make changes.

The software effectively replaces a case supervisor, because the software leads each member through each phase and task of their respective role from initial intake, the forensic interviews, forensic medical exams and assessment results, calendars and appointments, team group meetings, map reporting, mental health assessments, addictions treatments and counselling notes, case history, job to volunteer/candidate matching, billing management for fee-for-service/payments and other private customizable options. The software was designed over a three-year period and is now used by over 500+ CACs. The software license is \$150,00 US for use by a CAC. While this system is designed specifically for CACs, it is an American company and product, so the storage of information on a cloud-based platform may have data security issues.

Other shelf-ready customizable case management software also exists for Canadian CACs includes Apricot, as used by the Sheldon Kennedy CAC and Athena's "Penelope",¹⁶³ recently purchased by the Office of the Child & Youth Representative in Nunavut. Some review and discussion will need to be done as a separate project to review the technical specifications, data storage, key information needs, territory-wide application by community-based Health, Law Enforcement, Social Services and Community Justice professionals for case management, and cost for the UCYPC CAC is determined. The service model, information sharing protocols and reporting requirements will also be key determinants.

However, most CACs in the pilot stage or in their first few years of operation rely on home grown databases using Excel or other platforms for basic data and case management. For instance, the Yukon Department of Justice Victim Services pilot program is using a system developed by the SeaStar CAC in Halifax for reporting purposes. These smaller systems are for the smaller urban area, whereas a robust CAC platform can be used territory-wide and link all multidisciplinary inter-agency partners, particularly where children/youth may be flown to Iqaluit from hamlets, or out for clinical treatment. In addition, the software is powerful to assist Family Advocates/Pathfinders with individual case "bring forward" reminders to follow-up on referrals and case notes to assist families for ongoing care.

For the federal Department of Justice, the statistical reporting from any CACs is the national interest on the number of charges laid, the number of cases proceeding and court outcomes. These global numbers are all easily provided through the software for policy development and results-based outcome purposes.

¹⁶¹ <http://collaboratesoftware.com/features/>

¹⁶² Interview with Lori Farquharson, Zebra Centre on March 10, 2015. Edmonton, AB.

¹⁶³ www.athenasoftware.net Penelope Case Management software for health and social services

The investment in this robust software would immediately address a key recommendation to the Government of Nunavut to the department of Family Services for information management, case management, plans of care, ensuring all checklists and procedures are followed and reporting: at least for complex cases of child harm, and would assist the PCCC medical collaboration team with a robust tool to link all partners across all communities where there is medical travel, referrals to CHEO, Sick Kids mental health, and all other referrals for services, in a single case management database and reporting tool.

Appropriate access and safeguards are included so that only authorized personnel can access their respective health sector or justice portion, as required, so access and confidentiality is strictly controlled. Only key administrators have the authority to review the full file, and case analysts are able to generate appropriate reports and analyze the information.

Organizational Capacity

The key consideration for the organizational capacity of the UCYPC CAC in Nunavut is that there must be clarity on which “model of care” best addresses children and youth after disclosures of harm. The UCYPC will benefit greatly from the collaborative and open CAC Community of Practice that has been fostered across Canada among the various Executive Directors and staff working in CACs, once the model of care is approved through senior officials and the Steering Committee, because approval of the model and core hub of capacity upon which to leverage the processes and facility provides the core foundation of leadership, support and resourcing moving forward.

The federal Department of Justice hosted and delivered a series of Webex virtual meetings from between December 2014 and March 2015, presented by Karen Kennedy, Executive Director of BOOST CYAC. The presentations were attended by members of each CAC nationally, and provided practical information on best practices, lessons learned and organizational issues for consideration when establishing a new CAC, or moving into the next phase of growth and service delivery.

Leveraging Existing Capacity

Capacity is a key issue in Nunavut across all departments and agencies due to the transient nature of professional staff in Nunavut. RCMP members are either rotated to new communities every 2 to 4 years based on operations, career progression or burnout, or if they are it is easy to train people to assume positions, but difficult to maintain the operational capacity, consistently high level of service and efficiency of programs and services.

There are currently competing developments within the GN Department of Health with the primary care model for paediatric care, whether to build that out and to leverage the capacity and investments being made within the primary care teams have strong relationships with teams and trauma needs (medical model) or could be separate.

A key challenge moving forward in Nunavut is that each community has developed their own functioning as an inter-agency committee or multidisciplinary team. There is no handbook on how to run them, and they falter when someone leaves the community. They are not rooted in any management accountability framework or performance agreement.

There is also a fear of information sharing. While one has been developed on suicide or those at risk of harm to themselves or others (Legal Duty to Report), information sharing does not expand beyond an individual providing voluntary consent for case management purposes. As frontline workers, those practical tools are lacking but are needed in order to move forward. It is unfortunately an exercise in bureaucracy and policy development when the daily needs of children are critical and palpable. Yet it must be undertaken and quickly to leverage the desire to work together, and foment inter-agency collaboration across the departments mandated to respond to children in crisis and requiring care.

Trauma-informed Service Delivery

Key guidelines established for trauma-informed care and collaboration for organizations include the development of an operational philosophy and vision, and mapping of practices at both the system and service levels.¹⁶⁴

Philosophy and Vision Commitments

¹⁶⁴ Dr. Anna Baranowsky, *Field Traumatology (9th Ed.)*, Traumatology Institute (Canada). Toronto. 2010, p. 13

- Establish service-charters with multidisciplinary team member organizations to commit to trauma-informed care;
- Emphasize a recovery orientation and establish five foundations principles of safety, trustworthiness, choice, collaboration and empowerment;
- Promote understanding of the impacts of trauma and the importance of coordinated care;
- Commit to survivor-driven systems and needs;
- Commit to all forms of diversity;
- Incorporate Inuit Societal Values in the work and the approach;
- Incorporate a message of optimism and hope into all interactions between service-providers and clients;
- Implement Jordan's Principle as an Aboriginal child-first principle to access government services without delay over departmental or governmental funding jurisdiction disputes

System-Level Commitments

- Promote co-ordination between and among systems of justice, child services and health to incorporate trauma-informed principles;
- Revise all policies and procedures to incorporate trauma-informed principles;
- Involve consumers in all systems and articulate and uphold trauma-informed rights;
- Review education and training to incorporate trauma-informed principles;
- Identify funding requirements and identify a Jordan's Principle mechanism for inter-governmental or inter-departmental funding disputes for services to children;
- Promote education in trauma;
- Promote and respect for diversity.

Service Level Commitments

- Identify key formal and informal activities and settings
- Ask key questions about each of the activities and settings including:
 - **Safety:** ensure physical and emotional safety;
 - **Trustworthiness:** maximize trustworthiness through task clarity, consistency and interpersonal boundaries;
 - **Choice:** Maximize child/family choice and control
 - **Collaboration:** Maximize collaboration and sharing of power
 - **Empowerment:** Prioritize empowerment and skill-building
- Prioritize goals for change
- Identify specific objectives and responsible persons
- Service policies
- Screening for trauma – ensure a mechanism for screening of underlying trauma.
- Establish the referral pipeline to the modalities of interventions¹⁶⁵ appropriate for child and youth survivors of harm, as well as families, including:
 - Crisis intervention in the immediate aftermath of disclosure and investigation
 - Brief time-limited individual interventions
 - Group interventions
 - Long-term interventions and specialist referrals

¹⁶⁵ Tavkar, P and Hansen D. *Interventions for families victimized by child sexual abuse: clinical issues and approaches for child advocacy centre-based services*. Aggression and Violent Behaviour Vol 16. 2011.

Training and Education for Professionals

As a core foundation to an effective CAC, multidisciplinary team members need to receive ongoing skills-based training that is relevant to the specialized field of child abuse, collaborative case planning and case review and peer review for ongoing learning. Team members and staff also benefit training that helps to create a collaborative work culture that fosters trust, respect, open communication and teamwork. Team members must be able to share their ideas and raise concerns that are aimed at supporting the child/youth and family, and not viewed as challenging the efficacy of any one department or agency.

The joint GN-RCMP training on child abuse is already being viewed as an effective training program, and almost cathartic relationship-building opportunity, for frontline workers to better understand the respective roles, responsibilities and requirements as team members, working together for the benefit of the child/youth. It has served to be an opportunity to air grievances from previous negative experiences on child harm cases, and bridged understanding toward collaboration and relationship building.

The issue of training and education came up through the consultation project several times. It was clear that even among frontline workers working with children and youth, many people do not know that they have a legal requirement to report suspected cases of child abuse to the authorities. Several teachers who completed the survey noted that when they started teaching in Nunavut, they did not receive any training on the policy or procedures on what to do: who to call and how to handle the child or youth disclosing harm. Nurses noted that it is confusing and difficult to understand the various systems, but they need to understand their legal obligations for reporting. Furthermore, it was noted that if they do see it in the Health Centres, then they are in denial about what they see and are failing to document and report the high number of cases that are seen routinely in public health, family practices, health centres and the hospital.

The following are specialized skills training to support the UCYPC CAC multidisciplinary team members.

Specialized Forensic Investigator Training

The US National Children's Advocacy Centre has trained thousands of professionals from 12 countries to date in this advanced skill. The course is a 5-day highly participatory course on:

- Forensic Questioning
- Child Development
- Memory and Suggestibility
- Pre-Interview Planning
- Strategies for Reluctantly Disclosing Children
- Strategies for Actively Disclosing Children
- Use of Media in the Forensic Interview
- Corroboration in Child Abuse Cases
- Interview Practicum and Peer Review
- Potential Challenges in the Forensic Interview
- Direct and Incremental Transitions to Area of Concern
- Effective Courtroom Testimony
- Mock Court

The NCAC course is \$1,250 US and is often delivered monthly for new trainees and an additional training is available on interviewing child victims with disabilities.¹⁶⁶ The course is primarily for members of the

¹⁶⁶ <http://www.nationalcac.org/events/bfi-training.html> and <http://www.nationalcac.org/ncac-training/interviewing-child-victims-with-disabilities.html>

multidisciplinary team (particularly the RCMP, social worker and Crown Attorney) to enhance their interviewing skills.

Family Advocates/Pathfinders

Family advocates supporting the child/youth and family are uniquely positioned to provide information and support to children and families who often have a variety of questions, concerns and needs during the investigation, healing and court process, if a case proceeds to prosecution. Family advocates/pathfinders provide crisis intervention, education about the processes, ongoing support and helps connect the families to resources and follow-up on referrals within the care plan. While many family advocates/pathfinders are individuals with a social services worker background, training is available through the National Children's Advocacy Centre (NCAC) on how family advocates/pathfinders work within a CAC model, and in particular as a support to, but separate from, the multidisciplinary team.

The NCAC training program has trained thousands of family advocates working in CACs and is a good intermediate session for individuals who have some basic training and work experience in social services work or human helping professions. The course leads trainees through the following topics:¹⁶⁷

1. Foundational sessions:

- a. Introduction to victim advocacy
- b. Dynamics of child abuse
- c. Crisis development, intervention, and resolution
- d. Trauma, grief, and secondary trauma
- e. Effective collaboration with the multidisciplinary team
- f. Support and advocacy for caretakers
- g. Cultural considerations

2. Skill-based sessions:

- a. Crisis intervention
- b. Court preparation

This NCAC course is \$850US and is delivered to social service workers with at least 2 years experience working in a CAC or in a multidisciplinary team.

Some of the Canadian CACs participate in the annual NCAC Conference that is held annually in Huntsville, AB. The conference is an opportunity to participate in a variety of presentations from child abuse specialists on a range of topics of interest, emerging research and best practices from CAC leaders. It is also an opportunity to network with others in the CAC professional community globally.

As Canadian CACs gain several years of operational experience, they are also developing training curricula and offering cost-recovery training. The Zebra Centre coordinates annual training and refresher courses for their CART team and new staff, and also engage Canadian specialists in forensic interviewing for peer review of interviews, videos and case plans, for quality assurance and auditing. It is also beneficial for new multidisciplinary teams to hear from others regarding the growing pains, lessons learned and reviewing tools to assist in their organizational development. The Zebra Team has offered to assist in any training needs of the UCYC team moving forward.

¹⁶⁷ <http://www.nationalcac.org/ncac-training/va-training.html>

Proposed Nunavut-Specific Multidisciplinary Team Training Modules

There is a strong need to increase the number of Inuit working in human helping professions across the full continuum of care. What works really well is where there is a mixed team of Inuit and non-Inuit, for cross training, shared perspectives and self care supports. As one Inuk counsellor candidly stated during a community meeting:

I have to be healthy before I can help anyone. It hurts me to see my peers stuck and I want to help. They ask 'how do you do it to maintain your balance?' The way I work on myself, it may not help you. It hurts me to say because you want to help. The system is the problem. I hate the system. The rules and regulations: some are just negative. I really love the Elders, but they don't realize they are hurting too. They had their children taken from them. I am thankful for the generations [youth] here today. I don't mind them sharing my story with their peers because they don't understand why they're being neglected. They are stuck too.

This sentiment was echoed across the frontline worker survey responses and in one-on-one interviews. When one moves beyond discussion of the technical skills training and administrative knowledge of legislation and work processes of the job, then the real competencies and behavioural readiness to do this work sustainably is vital when planning to operationalize a multidisciplinary team and CAC.

On the technical training side, the Nunavut Arctic College Social Service Worker program is a small program and is currently only available in Cambridge Bay. It is a basic level program, though individuals can select an area of interest in Year 2 within addictions or social work support. A key criticism of the program is that to fill the need for Inuit social service workers, the program needs to be more accessible in communities across Nunavut. In 2014, there were only 2 successful applicants for that program. The Department of Family Services is currently working with the College to make the curriculum more clinical in nature, and support for graduates leading to further accreditation as a Bachelor or Master of Social Work, to assume management positions within the territorial government. The program graduates would be well suited as a child outreach worker, case support worker or family advocate/pathfinder.

Given the importance of building on the medical model in Nunavut, it will be important to engage and collaborate with the Nunavut Arctic College Nursing Program to integrate on trauma-informed practice particularly regarding child maltreatment; protocols and documentation required for suspected harm; techniques for collecting forensic evidence, and networking/relationship building with the UCYPC CAC through the Nunavut Nurses Association. The Emergency Room locums also require training and information, as they often rotate through the GHB and turnover has a big impact on ensuring that children/youth seen in the ER are referred to paediatrics and appropriate case planning. It will also be important to engage Dr. Allison Crawford and her team through the specialized mental health delivery, and engage all mental health partners supporting communities across all three Regions for a broader collaboration, training and link to the UCYPC CAC processes and Centre of Excellence for child maltreatment.

It was key to see that in all CACs reviewed and interviewed, the team-based approach allows for significant specialized training, case consultation and interdisciplinary discussion and peer review and feedback of sample cases, to strengthen the capacity of individuals and the overall team. For example, at the Iqaluit consultation session¹⁶⁸ participants prioritized the following training as needed to better identify and report a disclosure of harm including:

- 1) *Legal rights and obligations to report education for all frontline workers including supervisors*
 - a. Government of Nunavut-RCMP Joint Training on Child Sexual/Physical Abuse Protocol
 - b. Duty to report
 - c. Confidentiality
 - d. Types and signs of abuse – and what constitutes abuse
 - e. Protocol, process, procedures, debriefing and follow-up

¹⁶⁸ Roos-Remillard Consulting Services. *UCYPC Feasibility Study Iqaluit 2-day Roundtable*. Iqaluit. May 19-20, 2015.

- f. Training on the *Family Abuse Intervention Act (FAIA)*
- 2) *Access to resources that already exist to strengthen individual competencies*
 - a. Frontline workers need proper onboarding/orientation training of the GN system, including those working in their own community, the system and processes – staff are on their own trying to make sense of the system
 - b. Nunavut Arctic College Social Service Worker program to support Family Advocate or Child and Youth Outreach Worker functions for the UCYPC CAC at the community level
 - c. Nunavut Arctic College Nursing Program to strengthen trauma-informed care and approved standardized protocols, documentation and referrals to the UCYPC CAC medical team for consultation and assessment
 - d. Specialized Forensic Investigator and Family Advocate training
 - e. From Darkness to Light, ASIST suicide alertness and intervention training
 - f. High Five youth peer leader training
 - g. Intake child/youth assessment tool for immediate supports (e.g. University of Laurentian Aboriginal Children's Health and Wellness Measure¹⁶⁹; PECFAS/CAFAS¹⁷⁰; CANS¹⁷¹)
 - h. Accredited counselling training
 - i. Referral database of programs, services and community wellness initiatives to support family and community inclusion in healing and protection
 - 3) *Good team and horizontal communication*
 - a. There must be an information-sharing agreement about child/youth cases across those who need to know, including teachers, in the individual care plan for safety planning and assistance
 - b. Trauma-informed service guidelines
 - c. Provide general information about trauma and vicarious trauma
 - d. Debriefing and emotional support
 - e. Support for self care
 - 4) *Inuit cultural safety*
 - a. Inuit societal values
 - b. Roots of historical trauma and resiliency - Qikiqtani Inuit Association, Kivalliq Inuit Association
 - c. Inuit language training
 - d. Cultural Safety - Inuit Story Bones: A storied approach to Inuit mental health and wellness
 - 5) *Administrative Skills Training*
 - a. CAC Integrated Database training
 - b. Core CAC Orientation session on governance agreements and service agreements, case file standards

While this is primarily done to develop trust, build effective strong working relations and foment the collaborative model, the ability to invest and support all individuals in their professional competencies is clear. This would be of significant benefit in Nunavut, so social workers and child protection investigators are not isolated and without the necessary supervision.

¹⁶⁹ <https://zone.biblio.laurentian.ca/dspace/handle/10219/2304>

¹⁷⁰ <http://www2.fasoutcomes.com/content.aspx?contentid=1084>

¹⁷¹ <http://socialsciences.uottawa.ca/smea-cymh/eng/>

Community Education and Outreach

Where the capacity or funding exists, CACs may also deliver prevention programs or public awareness campaigns to address gaps in information related to child welfare, reporting obligations, processes related to the criminal justice system, First Nations, Inuit or Metis specific community-based justice programs, or the confidential referral services available to children and families after a disclosure of abuse.

The community consultation meetings, survey responses and participation by Nunavut youth indicated that they can play a valuable role explaining and helping families navigate the justice system and deliver a variety of information sharing activities. In fact, youth in Iqaluit were excited by the idea of developing a drop in space where onsite counselling support could be available; access to a wide range of information; workshops, seminars and individual online learning; an informal café for positive discussions, and where families could receive non-judgmental support and referrals for assistance. Parents or individuals can also partake in individual or group activities for self exploration and-. This was echoed in Rankin Inlet and also Cambridge Bay, which further expanded the idea to include a 24/7 safe space for youth seeking shelter from violence and alcohol.

From the general survey, respondents recommended the UCYPC deliver the following supports in order of highest response¹⁷²:

1. Coordinate community public awareness campaigns about child abuse and reporting obligations;
2. Train community-based professionals and caregivers to understand and navigate the existing systems;
3. Promote public awareness campaigns involving Elders on traditional Inuit societal values on parenting, resiliency from harm and strong families;
4. Help find ways to explain and describe the child protection/social services system, criminal justice and investigation needs;
5. Use community radio and TV for public education that explains these systems;
6. Promote multiple entry points to access counselling and treatment programs for children and adults from abuse, and they should not all require referrals;
7. Create a cell phone or computer APP for youth using technology that they can use and understand;
8. Use social media like Facebook, Twitter and other platforms for reporting disclosures and getting help.

With the establishment of the Child & Youth Representative for Nunavut, that office will also be a key resource for community members and professionals on the obligation to report suspected cases of harm and children's rights. The Law Society of Nunavut is another partner that promotes the awareness of vulnerable sectors and group rights. Schools through onsite counsellors are also individuals to share and promote information through.

Youth Role Models

A consistent need articulated through public consultation and with Nunavut-based social workers is the need to provide Nunavut youth with positive role models, a safe adult connection and effective foster placements. While we discussed the need to ensure protection, nurturing and healthy development in a child's early years, the need to support middle-school aged youth up to 19 years old is critical, to discuss healthy relationships, respect and sexuality, as well as intervention for mental health and medical issues where required.

National Prevention Programs and Materials

¹⁷² Roos-Remillard Consulting Services, *UCYPC General Survey*, Question 12, p18.

The Canadian Centre for Child Protection is a charitable not-for-profit national organization that specializes in producing and delivering evidence-based training, public awareness and prevention activities to reduce the risk of the victimization of children in Canada. Their key national programs include reporting tools to law enforcement including *cybertip.ca* and *missingkids.ca*. Other national initiatives includes *kids in the know*, which is a series of age-appropriate tools for children and youth on online safety and general personal safety, and the *Commit to Kids* program for youth-serving organizational training on child sexual abuse prevention. A Sport Edition is also available for the training of sport and recreation organizations and coaching staff.

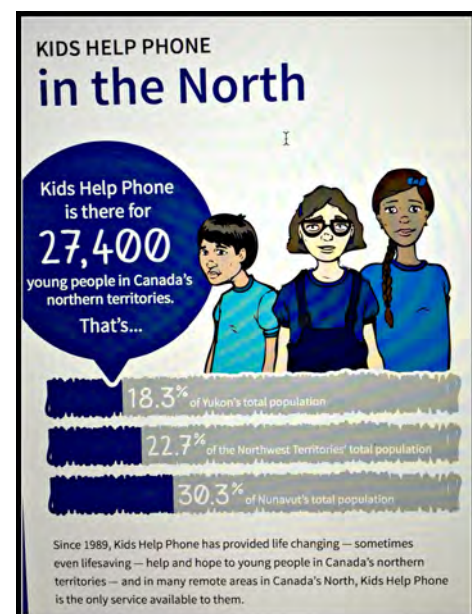
The CCCP has also produced a variety of other brochures and toolkits targeting children, teens and adults including:

- Teatree Tells: A Child Sexual Abuse Prevention Kit - Pre-school to Grade 1
- Billy Brings his Buddies – Grades 1-2
- Zoe & Molly Online – Grades 3-4
- Be Smart, Strong & Safe – Grades 5-6
- Your Online Source for Everything Textual: textED.ca – Grade 7
- NeedHelpNow.ca: You(th) Are Not Alone – Grades 7 and up
- MediaSmarts – Grades 7 and up
- Self/Peer Exploitation: It's Not OK – Grades 7 and up
- Cyber bullying Resources – Grades 7 and up
- The Door that's not Locked.ca – Educators and Parents
- Commit2Kids – Organizations on child sexual abuse prevention
- Parenting Tweens and Teens in the Digital World
- Smartphone Safety: A guide to parents/guardians (mobility.protectchildren.ca)
- Child Sexual Abuse: It Is Your Business

For schools, the CCCP has education modules from Grades 7-10 on personal boundaries, healthy/unhealthy relationships, unsafe situations, online luring, mean and cruel online behaviour and empowering youth against sexual assault and the attitudes that contribute to sexual assault.

Alongside supporting youth around these topics, parents and frontline workers also need information on how to appropriately handle a disclosure of sexual abuse. This is important, because the reaction and response will affect the severity of the child's overall trauma.¹⁷³

The *Kids Help Line* is also a national charitable not-for-profit organization that provides a vital service for youth in crisis. Through their toll-free number at 1-800-668-6868, youth across the North can access professional counsellors to discuss a range of issues and obtain online therapeutic support to over 700 on-the-ground local resources. Such supports include shelters, health clinics, LGBTQ services or counselling centres. In 2013, their Northern youth reach supported approximately 4 youth per day across the North by telephone, online at kidshelpphone.ca through the Live Chat function, or can search for local resources in their community. Youth can also access the Kids help Line resources through the *Always There* APP.¹⁷⁴ However, a cursory review of the search tool for local resources did not provide much information by way of local supports in Nunavut communities. Additional work could be undertaken there as a future UCYPC partnership with the *Kids Help Line* to further develop this confidential tool for youth.



¹⁷³ Finkelhor, D., & Browne, A. *The traumatic impact of child sexual abuse: A conceptualization*. 1984

¹⁷⁴ <http://dev.kidshelpphone.ca/main-data/uploads/2014/11/Northern-Territories-Highlights-Report.pdf>

In Nunavut, the Embrace Life Council has also delivered the Red Cross RESPECT ED as well as the VoiceFound/Stewards of the Children D2L/Darkness to Light Suicide Prevention training program. These programs directed at schools and adults teach individuals to talk about child sexual abuse and issues affecting them. Ongoing work in this area is vital, and the UCYPC CAC can be a key partner to deliver public awareness and outreach programming with local and national partners.

Inuit-specific Prevention Tools

Pauktuutit Inuit Women's Association has undertaken the development of tools and resources such as *Good Touch, Bad Touch* and *I'm Happy Because I Am Safe*, parenting resources and a significant amount of research related to family violence and health indicators of women and children.¹⁷⁵ They are also currently partnering with Dr. Marika Morris on a survey related to urban Inuit teen use of the Internet and online safety.



CAC Available Resources

The CYAC Boost Centre in Toronto produces a range of easily accessible information sheets for families and the general public, and delivers training modules on a cost recovery basis for groups, frontline workers and train-the-trainer sessions. See Annex Tab 5 for the information sheets and Annex Tab 6 for the training brochure.

PRIDE training for Foster Parents

Frontline workers or foster parents who know that a child has been involved in a traumatic event need to know that not all events lead to disastrous mental health outcomes, but they should be provided with some key information on how best to support the child moving forward. The vast majority of youth do pretty well, but they do need kind support, awareness and attention of warning signs to take the next step and get professional help.

Foster parents in Nunavut are not receiving any formal training to prepare them in their role. Input provided by project respondents, and supported through research undertaken by the Qaujigiartiit Health Research Centre, families want and would benefit from training.¹⁷⁶ A key program that is delivered nationally and available upon request is the Parenting Resources for Information, Development and Education (PRIDE) program designed to strengthen the quality of the foster home and care. The Foster PRIDE program builds the competence of foster parents on how to:

- Protect and nurture children;
- Meet children's development needs and address developmental delays;
- Support relationships between children and their families;
- Connect children to safe, nurturing relationships intended to last a lifetime, and;
- Work as a member of a professional team.

Additional training noted for delivery, particularly as it relates to child maltreatment and healing, includes:

- Signs and symptoms of abuse;
- Fetal Alcohol Spectrum Disorder and the effects of drug/alcohol on child development;
- Learning disabilities;

¹⁷⁵ Pauktuutit Inuit Women's Association, *"I'm Happy Because I'm Safe" Communication Strategy*. Ottawa: April 2013. p.3

¹⁷⁶ Lindsay, T. and Healey, G.K. *Perspectives of Families Working With Nunavut's Foster Care System*. Qaujigiartiit Health Research Centre. Iqaluit: 2012.

- Attachment and separation;
- Sexualized children, and;
- Loss and grief.

Financial Considerations

CACs in North America have focused on community-based models and P3 partnership funding approaches, due to the dearth of federal funding for capital costs and stable operations of CACs. Instead, most CACs through the multidisciplinary team, have arranged for largely a 75/25 split in funding, with 75 percent of annual budgets funded through operational cost-sharing agreements with the provincial departments responsible for the core operational activities of child protection (law enforcement and social services), primary health, mental health and victim services activities undertaken by seconded staff in the facilities. The remaining 25 percent for the CAC Executive Director, IM/IT data analyst and family advocates (if paid positions) are funded through charitable donations and fundraising.

It must be noted though that in all CACs examined, the multidisciplinary partners (UMAYC Steering Committee) often establishes a 2-3 year pilot period to establish the multidisciplinary team, develop the required working protocols and agreements, and examine the function and form of a physical CAC required at the community level, which also determines the sustainable financial arrangements. This will certainly be the next phase of work for the Steering Committee to build internal capacity, senior level mandates and support for a collaborative approach, and securing sustainable funding for a CAC.

Identifying the Funding Levers

As the UCYPC Steering Committee examines next steps vis-à-vis the feasibility of establishing a CAC in Nunavut and community approaches, it is important to examine the question of financial sustainability for a CAC.

The overwhelming challenge facing all CACs in Canada is the sustainability of core and operational funding. Since 2010, the federal government has invested \$10.3M through the Victims Fund for feasibility studies, the creation of demonstration projects or enhancements of existing CACs.¹⁷⁷ Additional funding intended for CACs was announced in the 2015 Economic Action Plan, but there is no indication of what new resources are being made available, or what eligible costs can be sought for projects outside of current project types.

Most CACs receive the bulk of their operational funding for equipment, space rental, communications and related O&M expenditures through partner funding agreements with provincial/territorial government departments responsible for child welfare, health, victim services and law enforcement partners, usually when teams are co-located. For family advocacy functions and core CAC staff, funding is often secured through government grants and contributions or charitable funding.

In stark contrast, in Nordic and circumpolar countries where the protection of children has been squarely positioned as a government responsibility based on legislative obligations and social values, CACs are 100 percent funded by the government. In fact, it was noted that the notion that CACs must leverage funds from corporations, foundations and private donors for the protection and support of children is unthinkable. In the Nordic mindset, the welfare and care of children and youth are not a charitable activity, but the duty of the state and its citizens. We tend to agree with this social welfare position, particularly given the population-wide level of risk for children and youth in Nunavut.

For Canadian CACs the practical implication of Jordan's Principle is an important financial consideration. This legislation requires that a child-first principle is applied to ensure that Aboriginal children in particular, receive immediate access to government services and that no child is left waiting for critical government services due to bureaucratic decision-making or frontline level disputes. Through this principle, whatever department the child/family went to first receive services, is the government department as first point of contact that is responsible to pay for the required services. The reconciliation of funding between

¹⁷⁷ <http://pm.gc.ca/eng/news/2015/04/24/pm-announces-intention-provide-new-funding-child-advocacy-centres>

departments or levels of government (federal or territorial) is determined later, and must not be an issue to delay access to services. The recent Truth and Reconciliation Commission reinforced the call for governments to adhere to Jordan's Principle.

Community Consultation Feedback

Before outlining the financial considerations of different funding sources, it must be noted that all frontline and general survey respondents provided their input on the question of financial sustainability. While the federal government through the Department of Justice Victims Fund may be a source to provide some funding for an initial 3-year Demonstration Project for the creation of the UCYPC CAC, no federal funding source can be recommended as a core or sustainable funding option.

In all CACs, the bulk of long-term operational funding is negotiated through the key mandated government departments responsible for child protection, forensic investigation, medical and mental health assessment, and the coordination of case plans and long term victim services. As such, consultation respondents ranked in priority, the funding partners required for the long-term sustainability of the UCYPC CAC:

1. Government of Nunavut – The operational departments that are mandated to provide child protection investigations, victim services and healing services to children/youth and families should provide 100% support by way of operational agreements, to support salary and core operational costs for the UCYPC CAC;¹⁷⁸
2. Inuit representative organizations, both territorial and regional, as key partner contributors;
3. Charitable donors (foundations and private donors) for capital and project funding;
4. Extractive industry partnerships;
5. Community-based project funding for victim services, youth and crisis supports;
6. Crowdfunding campaign.

Territorial Funding Streams

The Government of Nunavut receives most of its revenues from the Federal government through the 5-year block Territorial Formula Financing (TFF) agreement, the Canada Health Transfer, and the Canada Social Transfer, with the balance of territorial resources through taxes and own-source revenue streams. As was announced in March, Nunavut will receive \$32M for a 3-year investment to support mental wellness, chronic disease, children's oral health and medical travel.¹⁷⁹

As per *Sivumut Abluqta: Stepping Forward Together*, the 2015-2018 Government of Nunavut business plan, the UCYPC CAC fits within the second priority pillar – *Healthy families through strong and resilient communities*.¹⁸⁰ As per this priority, territorial investments seek to invest in practical actions and community-based solutions to improve measurable outcomes in health, social well-being and local economies. In an effort to address family struggles with mental illness, addictions, suicide and domestic violence, the Government of Nunavut recognizes a role for both traditional and clinical approaches in healing people to regain their health and well-being. The Government of Nunavut is also committed

¹⁷⁸ Roos-Remillard Consulting Services, *UCYPC General Survey*, Question 19, p. 31; *UCYPC Frontline Survey*, Question 25, p. 48.

¹⁷⁹

<https://www.dropbox.com/home/Umingmak%20CAC%20Feasibility%20Study%20Project/Project%20Workplan/Research%20Sections/Funding%20Sources%20for%20Sustainability?preview=SCAN20032015.pdf>

¹⁸⁰ http://www.gov.nu.ca/sites/default/files/2015-2018_government_of_nunavut_and_territorial_corporations_business_plan.pdf

through the suicide prevention strategy as well as the *Collaboration for Poverty Reduction Act* to develop indicators to measure progress in reducing poverty through partnerships with non-governmental organizations, Inuit organizations and governments to improve the social and cultural well-being of all Nunavummiut. The UCYPC CAC is a best practice and evidence-based model that can significantly support measurable results for all participating departments through their strategic initiatives and service delivery priorities for children/youth and families in a collaborative way.

Department of Family Services

The Department of Family Services is the key mandated department to investigate reports of suspected child harm jointly with the RCMP, and determine protection needs. For 2015-2018, the Department of Family Services has committed \$14.7M for child protection services including foster care, investigations and interventions that are provided by child protection workers under the Child and Family Services Act. An additional \$2.7M is available for family violence services, \$29M for residential specialized care both within the territory and out-of-territory. A grants and contribution program of \$420K is also available to support initiatives for women and persons with disabilities. An additional \$46M is provided in income assistance to household heads and their dependents, which as noted earlier, represents approximately 50 percent of Nunavut's children and youth.

As at 2014, the department spent over \$9M annually on extraterritorial placements and residential treatment spaces for Inuit youth from Nunavut.¹⁸¹ Approximately \$200K is spent for children and youth in care within the territory, up to 19, 21 or 26 years of age, depending on the individual care plan. Based on the 2015-2018 strategic plan, there are plans to develop and implement a departmental strategic plan, program evaluation strategy and organizational capacity assessment. Other key actions include the implementation of the OAG 2014 recommendations, which are not detailed. As well, the department is tasked to implement the Homelessness Action Plan, Ilagiitsiarniq Family Violence Prevention Strategy and the Makimaniq Poverty Reduction Action Plan. All of these separate plans and strategies can be integrated within a single-window UCYPC CAC model for targeted case planning and implementation through a horizontal multidisciplinary team. Otherwise, the separate strategies are siloed approaches.

There was only one broad statement in the Government of Nunavut 2015-2018 Business Plan that the Department of Family Services was committed to take action on the Auditor General 2014 Follow-up Report management recommendations, such as:

- Address vacancies and develop a training strategy with the Nunavut Arctic College for employable graduates, and address sustainability in the departmental workforce;
- Develop workload standards for generic and specialized caseloads;
- Review other child welfare programs to define areas of practice against professional standards;
- Improve its tracking system of all community social service workers of mandatory training, learning plans and ensure all competencies are met in order to receive a child protection worker appointment;
- Review and expand the current training resources available to staff to promote parental engagement and community development work for improved joint care planning for their children;
- Deliver a case file standards training program for all supervisory staff;
- Revise the standards and procedures manual to ensure non-compliance is linked to performance appraisals;
- Establish a random audit file schedule to take corrective action in order to address non-compliance with standards;
- Establish in the short term, a regional reporting system to include information on the services, activities and resources available to support child safety through parental engagement and community development for case planning;

¹⁸¹ http://www.nunatsiaqonline.ca/stories/article/65674nunavut_family_services_minister_were_working_on_it/

- Ensure the headquarters tracking system that is under development, will include all basic information about children in care, and that regions abide by reporting standards to maintain this information. Resources will need to be secured in the medium-term for this initiative.

While the department indicated it would be seeking resources in the medium term to strengthen their information gathering on cases of children in their care, but no capital for computer hardware or software was allocated in the 2015-16 fiscal year budget to advance on that important tool¹⁸² and only a broad statement that the implementation of all the recommendations would be completed by 2017.¹⁸³

For these significant challenges facing the capacity and efficacy of the Child Protection role, the UCYPC CAC, through its joint development of specialized professional standards, practices, training and collaborative care planning, referrals and case management, would help address several of these priorities. It will be necessary to engage the Department of Family Services through its senior leadership to discuss strategic opportunities in the short term.

Department of Health

The Department of Health spends over \$271.5M annually for the provision of community-based care, out-of-territory treatment, mental health and addictions and medical transportation. The department and its professional staff is key partner for the UCYPC CAC and multidisciplinary team to provide clinical treatment, assessment and mental health support for children and youth after incidences of harm. Strengthening the overall financial and administrative management of Nunavut's health care system and social services delivery systems is crucial against the challenges. Of the total annual budget, the following divisions have clear links to the provision of acute complex care and long-term mental health services and referrals for children, youth and families within the UCYPC CAC model:

- Mental Health and Addictions - \$20M (though resourcing is estimated at \$18M in 2016-2018);
- Home Care and Community Care - \$2.6M
- Medical Transportation - \$59M
- Community Health Centres - \$40M
- Out-of-Territory Hospitals - \$54M

For the period 2015 to 2018, the department is taking a proactive approach to use innovative health solutions available through technology such as child and youth telepsychiatry, and the quality of care to ensure that clinical expertise is available through both local capacity as well as through southern clinical partnerships. A significant amount of work is underway to enhance mental health and addictions services, proposing legislative updates to the Mental Health Act to ensure compliance with other legislation; develop initiatives aimed at reducing suicide in Nunavut; health promotion and preventative care and identify gaps in the long-term care service continuum. The Department of Health is also actively developing a model for appropriate staffing levels required in the different communities, and looking at infrastructure design requirements to ensure that the needs are met in a cost efficient way.

The renewal of the health care model for Nunavut will be undertaken in the next few years and will include community engagement and ownership with a focus on strengthening service capacity, quality of care, patient safety, identifying the required service care providers (in-service or external) and streamlining the bureaucratic processes. In short, there is much momentum to "hook" the UCYPC CAC project within the community-based capital, clinical capacity review, health data system implementation of the Interoperable Electronic Health Record (iEHR) for patient information and reporting, and delivery needs to support children/youth and families after incidences of harm and complex care along the continuum of care.

Department of Justice

¹⁸² http://www.gov.nu.ca/sites/default/files/2015-16_capital_estimates_-_english_0.pdf p D-2

¹⁸³ http://www.gov.nu.ca/sites/default/files/2015-2018_government_of_nunavut_and_territorial_corporations_business_plan.pdf p. 122

The Department of Justice - Community Justice Division invests roughly \$5M annually in delivering a crime prevention strategy; providing support for victims of crime through the Victims Assistance Fund; victim travel for witness transport and accommodations for court appearances for court cases; options to improve the family mediation services, and; assistance to Community Justice Committees for community-based diversion programming. In 2015-16, the division is in the fourth year of a five year agreement with the Federal government to improve victim services including creating a travel fund for victims or families of victims who wish to travel to court proceedings, and to increase awareness and provide more support for victims of crime in Nunavut. Additional work will continue in 2016-2018 to develop Civil Forfeiture legislation, identify alternatives to court and community-based measures outside the court process, and continue participation in the Government of Nunavut steering committee on the UCYPC project to create a child and youth protection centre.

RCMP

Through the Department of Justice senior management contracts with Public Safety and Emergency Preparedness Canada (PSEPC) for the provision of RCMP community policing services under the Territorial Police Services Agreement. The Department of Justice and the RCMP, through a senior management committee, oversee the financial aspects of the \$36M annual federal/territorial policing agreement to ensure that high quality of policing services are provided in Nunavut, and to prioritize the resources and services required. There are currently 142 RCMP positions including officers, civilian and public servants. Key priorities are to strengthen the participation of Inuit members, the use of Inuktitut for crisis negotiations and suicide prevention and education. Other key child and youth focused initiatives vary in delivery by community, but may include the Aboriginal Shield Program, Firearms Safety Campaign, the SAFE Schools Initiative and the School Liaison/Youth Officer Program, but "V" Division is actively working to develop and implement the Youth Intervention and Diversion Program (YIDP) to screen low and no risk youth out of the criminal justice system altogether, while referring moderate and high risk youth to community services.

A YIDP Steering Committee has been formalized and is currently in the process of designing and implementing a YIDP pilot project for Iqaluit, with a goal to implement in all 25 communities. This steering committee and initiative would be a good addition to the UCYPC multidisciplinary team, which will identify risks and care plans within the Community Justice Outreach Worker, social worker and health, for intervention and supports.

Correctional Services

The strain on courts, corrections and policing may increase as the Federal government lengthens mandatory sentences and removes judicial discretion. Given Nunavut's young demographic and rapid population growth, as well as the associated influx of people and money into the territory due to resource extraction, will likely increase the level of involvement of youth in criminal activity. This will continue to put pressure on the policing resources as the scope of types of crime occurring, and the public's demand for charges to be laid and prosecutions sought for crimes against children and youth. As one general survey respondent noted, "The justice system is not hard enough on the ones committing the crimes."¹⁸⁴

The pressure also on the criminal justice system and correctional institutions, as well as resources required to support victims, offenders and communities, will also grow. Education and opportunities for young people are essential to keep youth in pro-social activities and out of the justice system.

Nunavut Corrections invests roughly \$35M annually in the delivery of care, custody, programming and counselling to young offenders and adults across the territory in healing facilities and institutions. Operational priorities for the department from 2015-2018 will continue capital improvements and repatriation of Nunavut inmates to correctional institutions across Nunavut, and training of correctional staff in counselling techniques, healing programs and suicide intervention.

¹⁸⁴ Roos-Remillard Consulting Services, *UCYPC General Survey*, Question 21, p 33.

The Department of Culture and Heritage provides \$400K for community-based grants and contribution projects for youth, and an additional \$400K for joint Elders and Youth initiatives, as well as minor capital renovations for youth facilities. The Inuit Qaujimajatuqangit Division also coordinates the development of Inuit societal values initiatives and provides \$400K in project contributions that support ISV initiatives: which may include assistance on how to develop tools for monitoring and measuring the implementation of IQ into UCYPC CAC services and programs.

Charitable Resources

While this is an easier model in urban centres, it is much more challenging in rural, remote and Northern regions, where there are limited corporate partners. Therefore, any sustainable financial approach for the UCYPC CAC, either as a non-co-located model, or larger co-located facility, will require solid multi-year corporate partners and charitable contributions, to provide a solid start-up budget and operational resources. This may be achieved through the establishment of a Foundation, UCYPC Trust or other financial mechanism to leverage income earned on the investment

For this project, we scanned the largest Canadian charitable donor database to identify the potential funders for the UCYPC CAC. Using a searchable indexing tool by sector, subject and types of support, there were hundreds of potential donors. However, it is incumbent then that the governance model and entity (such as the Arctic Children Youth Foundation) have not-for-profit (Corporations Canada) and charitable status with the Canadian Revenue Agency. Otherwise, the availability of funding from any donor is significantly limited, because donors of any substantial amount seek taxable donation receipts for their contribution.

There are a select few Northern-specific donors, which directly support projects in Nunavut such as Students for Canada's North: a University of Ottawa project to engage UOttawa students (preferably Northern students studying at the university) with projects in Nunavut or across the North.¹⁸⁵

By subject matter, the list expands considerably with a variety of very large donors, to large, medium and smaller value funders. For instance, for projects specific to child abuse prevention and child protection initiatives, organizations such as ConocoPhillips Canada can support very large project or sponsorship investments, while the Muriel McQueen Ferguson Foundation is a medium-sized donor, but will support operational funding requests. Funders such as The Thirteenth Angel Foundation or the IOF Foresters Prevention of Child Abuse Fund are small lenders for projects. Other major family donors such as the McLean, Asper and Jackman Foundations may provide capital resources, but more clarification is required whether they will support Northern projects. This is only a small sampling of potential charitable funders that could support the range of capital, operational, project and research-related activities for a CAC in Nunavut.

Waterloo Region Suicide Prevention Council has a funding partner interested in possibly support the UCYPC CAC with respect to connectivity for the database and other operational needs. More information will be sought.

Other potential donor lists were created based on relevant interdisciplinary topic searches including:

- Abused women/domestic violence
- Child abuse
- Family counselling
- Mental health disorders
- Mental health recovery
- Offender / Criminal Rehabilitation
- Paediatrics

¹⁸⁵ <https://servingothers.uottawa.ca/students-for-canadas-north>

as well as potential governance and multidisciplinary team training and development project funding for:

- Adult continuing education
- Career counselling
- Career education
- Charitable organizational Board Development / Leadership Development
- Volunteerism

A full listing of potential charitable funding sources will be provided to the ACYF as Annex Tab 4 for Steering Committee planning purposes.

Inuit Organizations

The wellbeing of Inuit children/youth and families is a key goal of the Inuit representative organizations. While Nunavut Tunngavik Incorporated (NTI) provides funding for various initiatives, projects, training and business investments that advance the interests of Inuit, the Steering Committee will need to engage the organizations on areas for potential funding partnership and contribution.

Private Partners - Extraction industry/Northern mining partners

A key aspect of corporate social responsibility (CSR) contributions by industries operating in a local area, is the investment back into the local communities to advance socio-economic and socio-cultural priorities. There are particularly strong opportunities to approach key Nunavut extractive industry partners in support of child and youth wellness initiatives, particularly if there is an opportunity to make meaningful and positive change.

As a fundraising partnership strategy, it is recommended that the Steering Committee engage potential partners such as Agnico Eagle (Kivalliq), Nuna Group of Companies, Areva, Sabina Gold & Silver Corp, Golder Associates, BLCA/Petro-Canada, Kitikmeot Cementation Mining & Development Ltd., Baffinland Iron Mines Corporation (Qikiqtani Region), Urecon Ltd., and Advanced Exploitations Inc.

Once a clear idea on the functional needs, space requirements and location is identified for the UCYPC CAC, a facility plan will be required. This will require a solid business plan and fundraising strategy will need to be developed with public and private contribution targets for capital and sustainable operations.

Staffing Considerations

The staffing complement is a key component of any feasibility study for a CAC. The most important considerations are identifying the key positions required for the local CAC based on the service model, recruitment and retention strategy, and being clear about the personal behavioural suitability, soft skills and abilities required to work in cases involving child harm. There are also cultural competencies, security screening and mental health safety considerations for staff, required to work safely in diverse communities and in the field of child maltreatment.

Staffing Complement

As all organizations started off small and grew over time based on referrals, rising caseloads, professional capacity and financial resources, there are some variations in the required staffing complement depending on the operations of various CACs. In some cases CACs, the staffing complement differs due to their organizational choice of service model, focus of their efforts on specific types of harm for response and support, or the addition of delivering public education and outreach activities. Based on information received through the frontline worker survey, Nunavut professionals believe that the UCYPC CAC must prioritize resources for the investigation, protection and case planning in order of priority of types of harm as follows¹⁸⁶:

1. Sexual abuse
2. Physical abuse
3. Neglect
4. Emotional abuse
5. Witnessing family violence

The following chart provides a comparison of other CACs based on the caseload per year and core team members as at June 2015, whether co-located or not, to support their respective program:

# of Cases Per Year	Police-Social Worker Responder Complement	Multidisciplinary Care Plan Members	CAC Operational Staff Complement
<50 - Yukon	1 – RCMP 1 – Social Worker		1 – YGT Victim Services Coordinator
Saaffik	Police will bring cases to the centre	1 - Psychologist 1 - Psychotherapist 1 – Social Worker	1 – Project Manager
50-100 - Simcoe-Muskoka	Police will bring cases to the centre, but no formal partnerships	Part-time onsite service of Paediatrician, Nurse Practitioner and RN from the local hospital Clinic is offered bi-weekly when cases require appointments	1 – Executive Director 1 – Fundraising Coordinator 1 – Receptionist/Intake Worker 1 – Family Advocate/Social Worker
100-250 - Barnabus	Police will bring cases to the centre	Physician and 2 Nurses attend bi-weekly for examinations 4 – Forensic Interviewers/Psychological Therapists	1 – Manager ½ - Admin Assistant
250-500 - SeaStar	1 – Police 1 – Social Worker	1 – Paediatrician 1- Counsellor	1 – Family Advocate/Administrator
500-800 - BOOST	Toronto Police Service 14 - Frontline officers	5 – Mental health clinicians (from 4 different agencies)	1 – President & Chief Executive Officer

¹⁸⁶ Roos-Remillard Consulting Services, UCYPC Frontline Worker Survey, Question 9, p. 19

	2 – Supervising Detectives 1- S/Sgt 1 – Admin Clerk <u>Children’s Aid Society of Toronto</u> 10 – Social workers (rotating) 2 – Supervisors (offsite) 1 – Director (offsite) <u>Catholic Children’s Aid Society</u> 5 – Social workers (rotating) 1 – Supervisor (offsite) 1 – Director (offsite)	3 – Mental health supervisors (from 4 difference agencies) 1 – Nurse practitioner (SCAN Sick Kids) 1 – Victim Witness rep (Joint Management Team/offsite)	1 - Operations Director 1 – Manager, Advocacy Program and Mental Health 4 – Family Advocates
500 – 800 – Sheldon Kennedy	<u>Calgary Police Service</u> 25 – Detectives 27 – Child welfare assessors	3 – part-time Paediatricians 12 – Therapists 1 – psychologist 1 – Nurse practitioner and team	1 – Executive Director 1 – Child Life Worker
800-1000 – Zebra	<u>Edmonton Police Services – co-located</u> 1 – S/Sgt – Child Protection Section/CART 1 – Administrative Sgt 12 – Child Protection Section Detectives 1 – CART Sgt 1 – Admin Asst 1 – Database Analyst 6 - CART Social Workers 6 – 24/7 coverage Police 1 - RCMP	<u>Edmonton Child & Family Services</u> 2 – Forensic Child Interviewers Refer to community-based counselling services	<u>Zebra Centre</u> 1 – CEO 1 – Director, Business and Community Development 1 – Program Development 0.5 – Contracted Payroll 1 – Intake Coordinator 1 – Center Assistant 1 – Director of Daytime Child Support Services 1 – Director of Evening Child Support Services 1 – Family Support Coordinator 2 – Child Advocates 55 – Volunteers (3 Admin; 6 Crisis; 15 Event; 8 Court Accompaniment; 22 Child Advocate; 6 Fundraisers) 1 – Assigned Crown Prosecutor

It is unknown at present what the caseload will be for the UCYPC CAC, so a base complement of in-house staff should reflect the division of core management, technical administration and child/youth and family support activities. The multidisciplinary team members are determined by the GN and RCMP, for those who will be delegated to represent the respective department and agency; mandated to negotiate the required joint protocols and MOUs for senior level approval; as well as the technical procedures and standardized tools for use as the Nunavut model, and later roll-out to frontline colleagues at the community level. Therefore, a base staffing complement is outlined in the Proposed Model for Nunavut.

Frontline workers were asked what supports are recommended for case management and staff retention. Survey respondents noted in priority order as follows:

- 1) Support staff safety with regular compassion fatigue, supervisory support and case debriefing;

- 2) Deliver skills training that is trauma-informed to assess the behavioural capacity of individuals to work on child abuse cases;
- 3) Manage caseload effectively to avoid burnout;
- 4) Provide regular vacation and/or personal leave opportunities to mitigate burnout;
- 5) Address the safety of child/youth and family clients from the impact of vicarious trauma experienced by staff;
- 6) Provide regular clinical supervision of multidisciplinary teams to monitor the mental health of the healers;
- 7) Identify any personal safety issues for risk management.

Inuit Recruitment

It was noted that while there is a strong call for more Inuit to work as community social service workers for obvious cultural awareness reasons, there is a general stigma in being a social worker that affects both Inuit and non-Inuit equally. Overt distrust of those working in frontline positions in the communities is the biggest challenge. It can be even more challenging for Inuit who are often viewed as functionally policing their own communities. They are regarded as traitors in some cases, and from the pressure, are pushed out of communities. Many who started in the social services go into human resources or justice positions. This lack of retention in the social services sector is a key issue, both for Inuit staff as well as non-Inuit.

Gender

As a trauma-informed program, it is important to have a man and a woman available as forensic interviewers and other staff, in the event that a child/youth is less comfortable with one gender than another due to trauma. This can occur so it is an important consideration when assessing the child/youth's needs and assigning staff to cases.

Workload Management

Those who are working on the multidisciplinary team, particularly in forensic interviewing or child protection, need to be dedicated staff to perform those functions. The individual will not be effective if they are pulled to manage other caseload issues outside of the UCYPC cases. Social workers and RCMP members work demands and caseload often well exceed the regular 40-hour work week with upwards of 80 to 100 hours logged in for a week: all for a passion to help children and youth from abuse. Given the high caseloads in Nunavut, it would be inevitable, unless there is a designated position and clarity on the role and responsibilities.

Staff Supervision

Performance management, coaching and providing technical oversight are core requirements for any team. Throughout the consultation project, frontline workers note that there is always room for improvement in the area of supervision, case review, technical guidance and skills-development coaching, to build the confidence and capacity of staff in Nunavut. Nunavut attracts newly graduated incumbents across all sectors and in all communities. While direct supervision may be in another community through the Regional or Headquarters office, staff must have significant one-on-one and team supervision in order to develop the required capacity to do their work; be provided feedback or corrective action as they undertake their roles, and at minimum, must be provided the time to take all the mandatory and core required for their professional accreditation and members within their professional bodies; ensure they are

covered for any professional error or omission while working during the course of their duties; and develop their skills over time with confidence for career progression.

The UCYPC CAC allows for direct supervision through assigned supervisors to provide oversight, reporting and accountability within the specialty of child protection or paediatric primary care or mental health. In the case of counselling, it will be important to implement the supervisor model, which can include external OOT clinical supervisor, for case review, debriefing and performance oversight. This ensures that the integrity of the therapeutic work with children/youth and families is within the professional standards; procedures are being followed; cases receive regular review and supervision, and; that staff receive the necessary coaching, correction and oversight, to support retention and mitigate burnout. Strong supervision is the best recruitment and retention strategy, and is the foundation to individual and organizational capacity for long term success.

Providing the Required Information Management Tools and Procedures

Current staff also noted that it is critical to have clear policies and procedures developed for the multidisciplinary team, to know what the protocol is in each type of situation. Otherwise, case management is disorganized. Clear documentation and guidelines enables the team to maintain service standards, monitor service provision without a decrease in quality, or having cases falling off the radar, as what currently happens. A case management database that supports interagency collaboration is critical for full data entry, case reviews and follow-up on referrals and results.

Employee Assistance and Self Care

It is incumbent upon people to identify, receive help for their personal histories of trauma and develop solid self care skills to listen to stories of harm on a daily basis. Otherwise, cumulative impact of the sights, sounds, smells and stories stay with you and can trigger negative behaviours, emotions and even somatic reactions. It is very important that the UCYPC CAC team members, from the general staff to the multidisciplinary team, have adequate clinical supervision and have access to debriefing and self care. See Annex Tab 16 for a self care assessment tool.

In many cases, staff in Nunavut are new recruits, fresh out of school, so they bring a low to moderate skill level of practical knowledge and capacity. However, many burnout within 2 years: they never get to the expert stage of solid capacity so the overall organizational and team capacity fails to achieve full efficiency. Otherwise, the vicarious trauma experienced on-the-job working in child maltreatment can be emotionally overwhelming and will result in compassion fatigue and burnout. This is often seen through issues of attendance and harmful behaviour to self and to others. Hence, it is very important to develop a recruitment strategy and pipeline of talent that include senior and junior, with a very strong coaching component for incremental development and supervision.

Recruitment and Retention

The issue of staffing vacancies in social services and mental health as key local resources was a key point of frustration in community consultations and survey responses. The rate of position turnover is high: from recruitment to start date can take 4+ months with committees formed and selection as a group including interview and evaluation (HR, CFS, Director). The GN must improve the HR planning process recruit and maintain a pipeline of approved candidates and strengthen the retention of staff, so that service delivery is more consistent. Retention is also key to ensure that strong management and supervision those staff and teams in human helping professions. Supervisors must monitor the impact of compassion fatigue and burnout, personal safety and workplace violence and harassment, which all contributes to high turnover rates.¹⁸⁷ When staff are left unsupported both within their division, department and community of professionals, staff will leave, particularly with a negative opinion of the community and employer.

¹⁸⁷ Watson E. and J. Lawford. *Caring Has Its Costs: Vicarious Trauma and Compassion Fatigue*. Canadian Mental Health Association. London, ON: January 29-30, 2015.

Training and Transition Planning

It is vital to bridge the knowledge gap and corporate memory, either through strong information documentation and case management, as well as allowing some period for transition and training of the outgoing staff member with the incumbent, to effectively all the warm hand-off of the child, family and team members, so relationships and a clear understanding of one's role and the processes. We need to change the experience and perception among youth and Nunavummiut about GN staff. They should be the superheroes and team that seamlessly supports a child/youth after an incident of trauma through to long-term healing. Instead, staff quickly feel the pulse of the community, their departments and clients and know that they are not welcomed and plan their exit strategy for self protection.

Then the staffing is not triggered to fill a vacancy until that person is gone. There is no adequate human resource planning with a targeted training strategy for Inuit or local Nunavummiut with the qualifications required as a BSW or MSW (to strengthen the number of Inuit in management positions as per Article 23) to establish a ready pipeline of approved, trained and ready individuals for implementation. Staff housing is also a key requirement to support any staffing, which is a chronic issue in communities. The key child protection and family support links are weak and ineffective.

Language Competency

The issue of language is of course a key factor in many hamlets, which children/youth and families using Inuktitut as their mother tongue and language of thought and expression. There was discussion in the community meetings that the RCMP and social services forensic investigators will need to be bilingual Inuktitut/English speaking, when interviewing youth from the communities, or translators that are well versed in terminology relating to child maltreatment, mental health and concepts of harm. Training to undertake video interviews, or peer review of video interviews conducted in Inuktitut, Innuinaqtun or French will be a key consideration for staffing and management. As an official language in Nunavut, French speaking competency is also required, though there are few cases of French-speaking children or parents.

Maintaining Organizational Capacity

A key issue noted by everyone was the capacity to staff the UCYPC in Nunavut. Success will require finding a balance in the right personnel. Staff must blend the necessary requirements of cultural awareness, competency and linguistic/dialectical ability. Staff and volunteers must be trained personnel in the respective professions, yet be inclusive of Inuit historical and cultural knowledge and wisdom. However, most importantly the staff must have the maturity, objectivity and self care ability to mitigate any revictimization or harm to others, where trauma is pervasive.

There is mistrust in general of the length of time the recruitment process is taking to fill vacancies and ensure seamless support and services to children, youth and families. While the recruitment and human resources planning issue is due in part to the challenge to secure subsidized housing for staff, there was also significant input that any staffing of the regular UCYPC CAC administrative and family support team must be done externally of the government.

For those supporting the UCYPC CAC within the multidisciplinary team, either as seconded or assigned professionals, a key issue with current staff is that given the high turnover, and relatively young staff just entering their careers in social work, they require a significant amount of supervision, coaching and mentoring in the first year. This is in particular to assist initially on calls to identify key intervention skills, support decision-making, case file entries and debriefing to build professional competency skills and confidence.¹⁸⁸

¹⁸⁸ Personal conversation with Courtney Henderson, February 19, 2015. Ottawa, ON.

There is an opportunity to be creative and develop a CAC training strategy that would include a professional training and coaching component through Zebra Centre's CARRT team, to help be available to build the capacity in a tangible way for Nunavut. This corporate knowledge, along with a robust information case management database, ensures that new staff can acquire the necessary knowledge quickly. The Sheldon Kennedy CAC Orientation APP would also be an excellent use of technology to expedite onboarding, orientation, transition planning and corporate knowledge transfer.

Bracketing

Another key issue is the need to effectively "bracket" individuals along the continuum of investigation and post-care.¹⁸⁹ This was a significant concern when reviewing the current process of child protection response and continued care for the child or youth. Where Nunavut social workers are involved with the child or youth from the time of disclosure, investigation, protection placement, crisis counselling, advocacy for referrals, ongoing case management and emotional assistance during the Court proceedings, the social worker is risking the integrity of the case by being involved in each phase of the continuum of care. The social worker/child protection worker may be viewed as "coaching" the child or youth; or could potentially be called as a witness in proceedings. The CAC structure and approach through the multidisciplinary team structure, and the effective use of individual Advocates, effectively contains the discrete roles and responsibilities of each official along the life of the case, and the needs of the child and family.

This is also critical to mitigate vicarious trauma, stress and burnout among the team of social workers. If they continue to have to bear the full burden for each child, they will only have the resources and time to address crisis response only, which is currently the case. This is inefficient and not serving the needs of the children, youth and families of Nunavut. A more strategic and balanced approach is required, which the CAC model clearly provides by leveraging and consolidating key specialists on an as-needed and discrete manner through a coordinated approach.

¹⁸⁹ Consultation interview and site tour, Zebra Centre. Edmonton, AB. March 10, 2015.

Proposed Model

Umingmak Child/Youth and Family Support Centre (UCYSC) 3-Year Demonstration Project

Medical Model Non-Co-Located Interview Site

Based on our analysis, it is recommended that the name of the project be renamed the *Umingmak Child & Youth Support Centre (UCYSC)*, and remove Protection from the name. Community members reacted negatively to the word protection in the title and asked that it be omitted from the name of the Centre, as it does not encourage children or families to want to seek assistance, particularly if they have fears about the child welfare system. While most centres within the model either use Child Advocacy Centre (CAC) or Child & Youth Advocacy Centre (CYAC) in their title, the use of the term Advocacy remains confusing for Nunavummiut who believe that the new Nunavut Office of the Child & Youth Representative (ORCY) is the main advocacy office. As well, the positive regard that the Umingmak project and the CAC model engendered among all project informants was that any facility and its services would provide a highly supportive role to children/youth and families seeking support both from incidences of child maltreatment and with links to other partners and tools to help address conflict and mitigate incidences before they escalate, either through the engagement of Elders through the Community Justice Outreach role and legislation, or other interventions. Therefore, it is recommended that the title be specific in what it offers, reflect the positive supportive role it can provide to children/youth and families, while not adding to the confusion by adding the advocacy term.

There was full support to establish the UCYSC CAC within the standard framework, best practices, professionals standards of forensic investigation, coordinated response and wraparound care to children/youth and families affected by child maltreatment in Nunavut.

It was found that the establishment of the UCYSC is feasible as a non-co-located Interview Site based primarily on a Medical Service Model to strengthen the access to seamless and coordinated primary care and mental health supports from the time of disclosure to the full continuum of care, which may include the phases of the anxiety up to and after court appearances. The medical model also leverages the key drivers within GN Health of professional skills capacity, leadership in paediatric primary care as well as child/youth mental health framework as strategic operational levers to improve access to and delivery of acute care and mental health supports. The momentum is both within Nunavut through the QGH, PCCC complex care table and developing referral agreements across key health facilities in Iqaluit and Nunavut, as well as through strong external clinical treatment service delivery partnerships including the NPOP-C, CHEO, Winnipeg Children's Hospital and other potential specialized residential treatment centres such as the Be Brave Ranch. The model also supports the inclusion of community-based and culturally relevant healing programming for children/youth and families through case planning and referrals. This also builds on key community leaders delivering excellent initiatives such as Ilisaqsivik Society, the Qaujigiartiit Health Research Centre, and many other organizations, to support children through fun, traditional and inclusive programs.

Advancing the response to suspected cases or disclosures of child maltreatment through a standardized medical and mental health assessment process will help quantify the rate and nature of harm occurring in Nunavut. Working through a medical model also helps standardize professional protocols, documentation to be used, referrals and build the necessary expertise within Nunavut. Responding to reports or suspected cases of harm also leverages other key tools available to youth and families, where family violence is suspected, or where child protection is required. However, the issue of child maltreatment across Nunavut can be better broached for discussion, education, information and response through the lever of primary care, at the local health centre, hospital, public health discussions and promotion. The impact of trauma on children, youth and adults is an issue that starts with prenatal appointments and continues through each health intervention as a topic of reflection and support. Through a holistic

approach for effective care planning, case review and referral support to families to support their healing first; support through the criminal justice system (where charges are laid and proceed to prosecution) second.

It is recommended that the Steering Committee coordinate a next phase proposal to undertake a 3-year Demonstration Project to:

1. Obtain GN and RCMP senior official support to proceed with negotiations and agreements on the UCYSC CAC governance structure, Memoranda of Understanding to mandate designated representatives on the Steering Committee to undertake the necessary Service Model and joint protocol work, and provide a multi-year funding commitment to support the next phase of the UCYSC CAC project;
2. Establish a Community Member UCYSC Advisory Committee with representation of youth, caregivers and Elders to review terminology, service objectives for the model regarding child/youth and family support and public education priorities;
3. Coordinate the necessary protocols and training to develop the Nunavut Centre of Excellence and community of practice on child maltreatment in key disciplines including:
 - a. Joint GN-RCMP forensic interviewing;
 - b. Medical and mental health assessment techniques using standardized documentation and processes and coordinated case planning and review;
 - c. Supporting youth and families through family violence FAIA interventions and support referrals;
 - d. Seamless support through to the Nunavut criminal justice system, and
 - e. Frontline professional and community-based training delivery on Duty to Report and how to access supports on suspected cases of child maltreatment, and how to strengthen local multidisciplinary teams for efficacy.
4. Bring together the multidisciplinary team in culturally sensitive child-friendly designated spaces as proposed below to conduct forensic interviews, medical and mental health assessments to inform case planning/review and family referral supports.

Proposed Facility Use

While there is desperate need to establish 24/7 safe houses for youth in communities across Nunavut, the focus of the Demonstration Project phase will need to focus on establishing the foundations for the UCYSC CAC, in order to work toward expansion and community-based delivery over time.

However, it is possible for the ACYF or other organizations to support the establishment of safe spaces as parallel projects at the community level to provide respite and protection, while linking to the UCYSC CAC and multidisciplinary team. These initiatives would be outside the core CAC initiatives, but respond to the immediate need for safety and support. For children between 8 and 12 years of age, who have experienced sexual abuse, it is recommended that the Be Brave Ranch be contacted for immediate respite and therapeutic support. As long as a disclosure has been reported to CFS/RCMP, any parent or service provider can refer children to that program.

As a short-term Demonstration Project, where the bulk of the initial work requires the formal approval, coordination of the partners and development of the joint collaborative tools and processes, it is more cost efficient and prudent to establish discrete physical branded spaces that leverages existing facilities in the short term to test the seamless coordinated response to child maltreatment. Planning for a larger space could be undertaken after the evaluation of 3-year demonstration project, where the partners can better assess the form to support the required functions, and integrate any capital needs and costing into government capital planning processes and/or other fundraising strategy.

With any future facility needs, whether a co-located new build or larger space rental, selling the naming rights to various rooms or building can be undertaken through corporate donor fundraising, like what has been done as a fundraising approach by other CACs for high cost infrastructure items, such as the integrated database, or the acquisition of capital building costs, renovations or computer and furniture equipment not usually covered by federal or territorial government funding supports.

Child-friendly Designated Spaces

Our recommended model for the UCYSC is a pragmatic and cost-efficient approach in the short-term to build on existing facilities; leverage the professional leadership and pockets of collaboration already underway, and; consolidate the framework of the CAC into action as a 3-year demonstration project in Nunavut. It was largely recognized that the UCYSC CAC would be located in Iqaluit as the main territorial Hub for the development of the Centre of Excellence on child maltreatment response. While the broader vision is to support every community in Nunavut, the UCYSC CAC needs some time to develop the senior level support and approvals across the mandated partnerships and the development of required tools and training to put in place the seamless, coordinated multidisciplinary response team as the CAC best practice model. The support to frontline workers in other communities tasked to respond to disclosures of child maltreatment will have access to the standardized tools and trained professionals within their respective department and discipline to assist in responding.

After the initial Demonstration Project phase it will be necessary in the implementation of the UCYSC CAC to engage families, community committees and Elders in each individual community

The following provides an overview of the proposed spaces for the UCYSC Demonstration Project.

UCYSC Demonstration Project Office

8-Storey Building (new space)

It is recommended that new rental space be acquired in the secure space of the 8-Storey building to establish a UCYSC Interview Site space. The location in the 8-Storey in Iqaluit is strategic in that many people attend the building throughout the day for a variety of business as well as social activities, so it is viewed as a common area that would not overtly compromise their safety or identify as entering a specific space due to child maltreatment. The 8-Storey also has non-descript common parking in the rear of the building and access is secured to the ACYF and proposed UCYSC office space, meaning that children/youth and families coming to access support are greeted and escorted to the UCYSC office for intake, assessment and support, and multidisciplinary staff have a controlled area to meet and have a dedicated space for their work.

A dual adjoining office space can be rented for the period of the project and retrofitted for use by the UCYSC Project Coordinator/Manager (Year 1-3) under the ACYF as project proponent to prepare the project proposal, liaise with the Steering Committee and undertake the project work planning and delivery of the key activities of the 3-year Demonstration Project.

After an initial evaluation of the Demonstration Site, additional or additional designated space for a drop-in Child/Youth and Family Support Centre for expanded and more open access to counselling services, information and programming. However, this should be determined incrementally once the foundation activities and Interview Site has been tested and assessed on its efficacy for the multidisciplinary team, caseload/need and case management. Key space requirements are:

Closed Offices

3 office spaces to accommodate:

- Year 1 - 3 – UCYSC Project Coordinator/Manager
- Year 2 - 3 – UCYSC Team Coordinator/Case Manager/Database Administrator
- Year 2 - 3 – UCYSC Client Intake / Child & Family Support Worker
- Year 1 - 3 – Student position

The space will facilitate the effective administrative and support coordination of the multidisciplinary team, IM/IT set-up, team training and confidential information management. The office spaces may also provide for part-time student positions to assist with administrative and/or research projects to support the set-up of the UCYSC. Such projects may include governance and/or procedural document drafting, research and data entry into the case management database to support case referrals for:

- 1) All available in-service and OOT clinical treatment partners for case referrals contact information, and;
- 2) Contact information community-based organizations with programming for use by the Child/Youth and Family Support Worker

Boardroom Space

A boardroom will be established for use throughout Year 1 - 3 to provide space to support the governance, service model, multidisciplinary team training, case planning/review meetings and other partner team activities during the Demonstration Project phase. Furniture and teleconferencing/ videoconferencing equipment will be required in Years 1-3 to support the meetings and organizational development activities.

In Year 3 the boardroom will be used for interview viewing, joint case planning and joint case review, FAIA family mediation sessions, and child/youth or guardian consultations, as required.

Forensic Interview Room

The UCYSC Project Coordinator office can be outfitted in Year 3 into the Forensic Interview Room. The room will require soundproofing and discrete installation of video/audio equipment to the recording system for videotaped interviews. The monitor will be linked to the Boardroom for team viewing; the recording system can be installed in a secure location by the RCMP in the space.

Open Office Spaces

It is important to have separate spaces where the Child/Youth and Family Support Worker can greet, place and meet separately with those coming into the support centre. While the child/youth is being prepared for the interview and next steps, the parent has an opportunity decompress and await the assistance of the support worker. Each space must be age appropriate and relaxing, but can be efficient and small spaces.

- Year 3 – Child/Youth Waiting and Assessment Room
- Year 3 – Parent/Guardian Waiting and Assessment Room

Over the 3-year period of the project, through the involvement of community partners such as a Youth Advisory Committee and Elders, install Inuit culturally relevant décor and child-friendly elements that welcome all Nunavummiut in the UCYSC.

Other Amenities

At minimum the space will require small bathroom facilities and a small kitchenette for basic refreshments. A closet for outerwear will also be required.

UCYSC Medical Assessment Space

Qikiqtani General Hospital (QGH)
Paediatric Unit (existing space)

After careful consideration, it is recommended that the UCYSC Demonstration Project be rooted in the Primary Care/Complex/Complex Care medical model as a solid foundation upon which to build a sustainable coordinated response to child maltreatment and engage the full range of partners within a seamless and coordinated case planning, case review and case management process.

The medical model further supports the GN's recognition that a blend of clinical treatment and traditional community-based approaches are required for individual and family healing after trauma. Moreover, the medical model is strengths-based in that it builds on the professional capacity, capital facilities and burgeoning acute care/mental health and external clinical partnerships. It will effectively integrate the leadership and efforts of the Paediatric Complex Care Committee that recognizes the complex needs of children after experiencing polytrauma after abuse, within the UCYSC multidisciplinary team approach, and leveraging the local medical and mental health supports for:

1. Technical paediatric forensic medical assessment and documentation;
2. Paediatric mental health assessment and clinical/traditional therapeutic supports;
3. Referrals to inservice for community-based supports or OOT service partners for residential and/or specialized treatment programs.

Bridging the leadership, capacity and strategic efforts of GN Health within the primary care and mental health for the UCYSC is necessary to ensure that case planning and case review is linked to the range considerations affecting Nunavut child/youth safety planning, protection, family violence supports and other IPC partners for wellbeing of the whole child/youth and family unit. The interdepartmental silos must be collapsed to enable a child-focussed approach, and enable collaboration for improved documentation and case planning/review for the benefit of Nunavut's children.

It is further recommended that child and youth/teen referrals from all sources (including the family practice clinic, public health clinic, schools or private disclosures) are referred to the QGH Paediatric Unit for screening for violence, sexual assault and medical assessment. This will provide an opportunity to identify red flags for follow-up and discussion with the broader multidisciplinary team for broader care planning and referrals.

To best support the medical model and UCYSC Demonstration Project, the team members from GN Health along with external partners from CHEO (Paediatrics, child protection and sexual assault unit) and the Northern Psychiatric Outreach Program (Sick Kids/CAMH) will provide key advisory support to develop the required screening protocols, standardized documentation and procedures to standardize the collection of key data, forensic medical evidence and procedures for referrals.



UCYSC CAC Multidisciplinary Team

The following is recommended for the composition of the core multidisciplinary team, and expanded case planning/case review partners, as required.

- Joint Forensic Investigation Team
 - GN Family Services, Child Protection Worker
 - RCMP Officer
- Medical and Mental Health Complex Care Committee
 - Chief Paediatrician, QGH
 - Nurse Practitioner
 - Child & Youth Mental Health Worker
 - OOT or External Services Specialist Partners, as referred:
 - Northern Outreach Program
 - Occupational Therapist
 - Rehabilitation Worker
 - Dietician
 - Psychiatrist
 - Psychologist
- Child and Family Support Team:
 - Community Social Services Worker

- Community Justice Outreach Worker (may include Elder)
 - Education
- Criminal Justice Support Team
 - Victim Services Worker
 - Court Witness Worker
 - Crown Attorney
- UCYC Case Manager
 - UCYC Case Coordinator and Database Administrator
- UCYC Personnel
 - Demonstration Project Coordinator / Manager
 - Child/Youth and Family Support Worker – Intake and Referrals
 - P/T Administration and Bookkeeper

Nunavut-wide Community Reach

Additional regional hubs and community-based UCYSCs may be developed over time through the eventual integration of the approved standardized protocols, tools, frontline worker training, community engagement on child harm and facility planning to accommodate the work of multidisciplinary team in hamlets. Community members clearly indicated that family and community engagement as well as the training of key frontline professionals in each hamlet across Nunavut, will vital for improved understanding of the duty to report, standardized procedures (once developed), terminology for shared understanding, and the establishment of multidisciplinary teams to function and/or refer cases to the UCYSC in Iqaluit for action.

UCYSC Staffing Strategy

The UCYSC Demonstration Project must endeavour to recruit qualified and experienced technical and child/youth and family support staff who have a strong performance background in collaborative team management, case planning and case management and the ability to work in mentally stressful environments. Recruitment should be based on the principles of merit, professional competencies in social services, health, justice or information management, and include accredited training or a combination of training and experience, with the goal to reflect the diversity of Nunavut's population.

A variety of language profiles will be required, but it is recommended that mandatory Inuktitut/English bilingualism will be required for the Child/Youth and Family Support Worker positions, with one also able to provide service in French.

Tact, discretion and confidentiality of information is imperative for the safety of the child/youth and family and the public integrity of the UCYSC, but is a key concern raised by youth and community members. It is also recommended that all staff working directly with youth, if they have had their own personal exposure to harm or family histories of violence, be well screened, supervised and supported with opportunities for debriefing and counselling, to mitigate transference, compassion fatigue and burnout for the safety of the children/youth and families.

Rigorous screening including a criminal background check, vulnerable sector, sex registry check and references are necessary for anyone working in the UCYSC including the:

- 3-year Project Coordinator/Manager;
- 2-year terms for Team Coordinate/Database/Case Manager and Child/Youth and Family Support Worker(s) and
- any student positions (such as a 6-month or 9-month part-time FESWEP Student Placement).

It is not recommended to develop a Volunteer corps during the initial Demonstration Project period of the UCYSC CAC, as that requires dedicated time and expertise as a separate program and service, and should be reviewed after the formative evaluation based on caseload and safety concerns.

Annual training resources for the positions are also included to build the necessary capacity within the CAC professional standards and model to undertake the roles and responsibilities of the respective position.

It is further recommended that students from the Nunavut Arctic College *Social Services Worker* program (social work stream) be given priority for student and Child/Youth and Family Support Worker positions. Nunavut Arctic College Inuktitut Translation students would also be a priority group for strategic work to support terminology development to support the field of child maltreatment, mental health and forensic interviewing.

For the period of the Demonstration Project it is not recommended to provide subsidized housing within the staffing strategy. In lieu, staff salaries reflect levels commensurate to the professional skills level required and include a \$15,000 Northern living allowance offset to encourage recruitment and retention.

Proposed UCYSC CAC Demonstration Project Proposal Elements and Draft Budget

It is further recommended that the Steering Committee secure senior official support to develop a proposal for federal, territorial government and targeted charitable partners, to secure project resources to undertake a 3-year Demonstration Project, with the key activities to be undertaken to advance the creation of the UCYSC CAC in Nunavut:

- Undertake facilitated meetings to negotiate the required senior level governance and management accountability framework, operational/service agreements, information sharing agreements and protocols with key government and agency partners to support the UCYSC Demonstration Project;
- Undertake facilitated meetings to explore the key principles, service objectives and evaluation indicators for the medical service model, for use to develop a 3-year results-based project plan, budget and communications strategy to support the demonstration project;
- Upon senior level approval and mandate, undertake a series of facilitated joint partner review meetings to clarify organizational and team member roles, responsibilities, response protocols, team procedures, assessment and selection of an integrated case management database, and intake assessment tools to support the work of the multidisciplinary team;
- Coordination of the UCYSC staff job descriptions, recruitment and training to support the IM/IT and child and family referral services;
- Design a customized training strategy and accredited learning sessions for the multidisciplinary team members building on Nunavut socio-historical context, established expertise of professionals in Canadian CACs, technical skills learning (forensic interviewing, database, etc.), team building, professional coaching and peer review;
- Design and deliver a UCYSC Nunavut Medical Model Summit to explore:
 - Key research in paediatric/adolescent primary care;
 - Key research in trauma-focussed CBT and culturally-grounded mental health therapies to support care planning for children/youth
 - Primary care and mental health referral mapping, identify protocol and tool requirements, and community health worker training needs;
- Coordinate facility spaces to implement the UCYSC response:

- Secure approvals to use the Qikiqtani General Hospital Paediatric Unit for medical assessments;
- Secure resources to rent additional space and retrofit, equip and design a space in the 8-Storey as an operational space for the Demonstration Project activities, eventually transitioning the space and staff as the Interview Site;
- Identify key in-service and OOT clinical treatment partners to coordinate and expedite referrals for children/youth and families, so there is no delay in accessing necessary treatment during the formative period of the Demonstration Project. Partners were adamant that no child/youth should need to wait for assistance and improved services immediately;
- Contract a formative evaluation of the 3-year demonstration project on all phases of development, lessons learned, best practices and next steps.

A rough order budget to support the UCYSC 3-year Demonstration Project is provided to help inform a funding proposal and identify potential partners among GN mandated departments, the RCMP and charitable donors, including Inuit organizations and extractive industry partners. Working through the ACYF as the project proponent for the Demonstration Project phase of the UCYSC will leverage the not-for-profit charitable status the organization enjoys to advance this benevolent endeavour.

UCYSC Demonstration Project Draft Budget*

Facility Model	Year 1	Year 2	Year 3
Capital Costs			
8-Storey office space rental (@\$3,500/mth)	\$42,000	\$42,000	\$42,000
Integrated database		\$200,000	0
Computers (3), printer	\$2,500	\$2,500	\$2,500
Forensic video/audio equipment, monitors (2) and software, teleconferencing unit		\$6,000	0
Furniture – Child/family waiting rooms / interview room / team boardroom / project manager/ case manager office / family pathfinder offices	\$5,000	\$5,000	\$500
Salaries & Benefits			
CAC staff (3) salaries, student and Northern living allowance (annual)	\$90,000	\$300,000	\$320,000
	UCYC Project Coordinator Student Position	UCYPC Project Coordinator Student Position Team Case Manager/Database Administrator	UCYPC Project Coordinator Student Position Team Case Manager/Database Administrator Child/Youth & Family Support Worker
Operations & Maintenance			
Telecommunications cost	\$3,000	\$3,500	\$4,000
Child-friendly equipment (play therapy, décor)		\$3,500	\$500
Programming materials		\$3,500	\$3,500
Training – Medical Model Summit (Year 1); CAC Staff training	\$17,500	\$5,000	\$5,000
Contracted Services Governance and process facilitation, legal review, team training strategy, UCYC business and charitable status registration, formative evaluation	\$150,000 Governance and process facilitator	\$150,000 UCYC business registration and charitable status (legal review and filings) Team training strategy and delivery	\$60,000 Formative evaluation
Administration			
Rental/Contents Insurance	\$2,500	\$2,500	\$2,500
E&O Insurance	\$3,500	\$3,500	\$3,500
Annual Financial Audit	\$5,000	\$5,000	\$5,000
ESTIMATED TOTAL	\$329,000	\$649,700	\$467,000

* Note: This budget is a rough order estimate as a baseline for discussion purposes. Figures may be vary and be refined through further Steering Committee and project partner discussions.

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ACRONYMS

ACYF	Arctic Children and Youth Foundation
CAC	Child Advocacy Centre
CAMH	Centre for Addictions and Mental Health
CHEO	Children's Hospital of Eastern Ontario
CPT	Child Protection Teams
CSA	Child Sexual Abuse
CYAC	Child & Youth Advocacy Centre
FAIA	Family Abuse Intervention Act
FASD	Fetal Alcohol Spectrum Disorder
GN	Government of Nunavut
IQ	Inuit Qaujimajatuqangit
ISV	Inuit Societal Values
ITK	Inuit Tapiriit Kanatami
LSB	Nunavut Legal Services Board
MOU	Memorandum of Understanding
NCAC	National Children's Advocacy Centre
NLCA	Nunavut Land Claims Agreement
NPOP-C	Northern Psychiatric Outreach Program
NSPS	Nunavut Suicide Prevention Strategy
NTI	Nunavut Tunngavik Inc.
OHSNI	Ottawa Health Services Network Inc.
ORCY	Office of the Representative for Children and Youth

PPRC	Placement Planning Review Committee
PPSC	Public Prosecution Service of Canada
PTSD	Post-Traumatic Stress Disorder
QGH	Qikiqtani General Hospital
QTC	Qikiqtani Truth Commission
RCMP	Royal Canadian Mounted Police
SWOT	Strength, weakness, opportunity, threat – A strategic planning exercise
UCYPC	Umingmak Child & Youth Protection Centre
UCYSC	Umingmak Child & Youth Support Centre