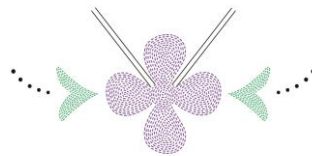


National Inquiry into
Missing and Murdered
Indigenous Women and Girls



Enquête nationale
sur les femmes et les filles
autochtones disparues et assassinées

**National Inquiry into Missing and Murdered
Indigenous Women and Girls
Truth-Gathering Process Part II
Institutional hearings: “Government Services”
Sheraton Suites Calgary Eau Claire
Calgary, Alberta**



Part II Volume III

Wednesday, May 30, 2018

Panel II: “Health Services”

**Dr. Valérie Gideon, Assistant Deputy Minister - First Nations and Inuit
Health Branch, Ontario Region**

**Jackie Anderson & Christine Duhaime, Ma Mawi Wi Chi Itata Centre,
Winnipeg Manitoba**

**Heard by Chief Commissioner Marion Buller & Commissioners
Michèle Audette, Brian Eyolfson & Qajaq Robinson**

INTERNATIONAL REPORTING INC.

41-5450 Canotek Road, Ottawa, Ontario, K1J 9G2

E-mail: info@irri.net – Phone: 613-748-6043 – Fax: 613-748-8246

II

APPEARANCES

Aboriginal Women's Action Network	Fay Blaney (Representative) MiKenze Jordan (Representative)
Assembly of First Nations	Julie McGregor (Legal Counsel) Stuart Wuttke (Legal Counsel)
Assembly of Manitoba Chiefs	Joëlle Pastora Sala (Legal Counsel)
Awo Taan Healing Lodge Society	Darrin Blain (Legal Counsel)
Canadian Association of Chiefs of Police	Ashley Smith (Legal Counsel)
Directeur des poursuites criminelles et pénales	Anny Bernier (Legal Counsel)
Eastern Door Indigenous Women's Association	Natalie D. Clifford (Legal Counsel)
Families for Justice	Suzan E. Fraser (Legal Counsel)
Government of Alberta	Nicole Pfeifer (Legal Counsel)
Government of British Columbia	Jean Walters (Legal Counsel) Rachel Holmes (Representative) Emily Arthur (Representative)
Government of Canada	Anne Turley (Legal Counsel) Anne McConville (Legal Counsel) Sarah Churchill-Joly (Legal Counsel) Tania Tooke (Paralegal) Jennifer Clarke (Paralegal)
Government of Manitoba	Coral Lang (Legal Counsel) Kendra Jarvinen (Legal Counsel)
Government of New Brunswick	Maya Hamou (Legal Counsel)
Government of Newfoundland and Labrador	Denise Spencer (Legal Counsel)

III

APPEARANCES

Government of Northwest Territories	Karin Taylor (Legal Counsel) Brad Patzer (Legal Counsel)
Government of Nova Scotia	Sean Foreman (Legal Counsel)
Government of Ontario	Julian Roy (Legal Counsel) Catherine Rhinelanders (Legal Counsel)
Government of Saskatchewan	Barbara Mysko (Legal Counsel)
Government of Yukon	Jennifer England (Representative) Fia Jampolsky (Legal Counsel)
Independent First Nations	Sarah Beamish (Legal Counsel) Diane Maracle-Nadjiwan (Representative)
Institute for the Advancement of Aboriginal Women	Lisa Weber (Legal Counsel)
Inuit Tapiriit Kanatami	Elizabeth Zarpa (Legal Counsel)
MMIWG Manitoba Coalition	Catherine Dunn (Legal Counsel) Hilda Anderson-Pyrz (Representative)
Manitoba Keewatinowi Okimakanak	Jessica Barlow (Legal Counsel)
Native Women's Association of Canada	Virginia Lomax (Legal Counsel)
Nishnawbe Aski Nation/Grand Council Treaty 3; Treaty Alliance Northern Ontario	Nishnawbe Aski Nation Deputy Grand Chief Anna Betty Achneepineskum Krystyn Ordyniec (Legal Counsel) Amanda Byrd (Law student)

IV

APPEARANCES

Ontario Federation of
Indigenous Friendship Centres

Niki Hashie (Representative)

Pauktuutit, AnânuKatiget
Tumingit, Saturviit, Ottawa
Inuit Children's Centre, and
Manitoba Inuit Association

Beth Symes (Legal Counsel)

Regina Treaty Status Indian
Services, Inc

Erica Beaudin (Representative)

Saskatchewan Association of
Chiefs of Police

Katrina Swan (Legal Counsel)

Winnipeg Police Service

Kimberly Carswell
(Legal Counsel)

TABLE OF CONTENTS

Truth-Gathering Process Part II Volume III

Panel II: "Health Services"

Chair: Jennifer Cox (Commission Counsel)

Second Chair: Thomas Barnett (Commission Counsel)

Witness: Dr. Valérie Gideon, Assistant Deputy Minister - First Nations and Inuit Health Branch, Ontario Region;

Counsel: Anne Turley for Government of Canada

Witnesses: Jackie Anderson & Christine Duhaime, Ma Mawi Wi Chi Itata Centre, Winnipeg Manitoba

Counsel: Jennifer Cox (Commission Counsel)

Heard by Chief Commissioner Marion Buller & Commissioners Michèle Audette, Brian Eyolfson & Qajaq Robinson

Grandmothers, Elders & Knowledge-keepers: Minnie Amidlak, Cynthia Cardinal (National Family Advisory Circle - NFAC), Barbara Dumont-Hill (Government of Canada), Spike Norton Eagle Speaker, Louise Haulli, Kathy Louis, Myrna Laplante (NFAC), Gerald Meguinis, Melanie Morrison (NFAC), Bernie Poitras, Sarah Nowrakudluk (NFAC), Gaylene Rain, Audrey Siegl, Laureen "Blu" Waters, John Wesley, Alvine Wolfleg, Charlotte Wolfrey (NFAC), Waasaanese (Government of Ontario)

Clerk: Maryiam Khoury

Registrar: Bryan Zandberg

VI

TABLE OF CONTENTS

	PAGE
Opening Comments	1
Drumming Ceremony	3
Opening Prayer	4
VALERIE GIDEON, Affirmed	6
Examination-in-Chief by Ms. Turley	7
JACKIE ANDERSON, Affirmed	77
Examination-in-Chief by Ms. Cox	78
CHRISTINE DUMAINE, Affirmed	130
Examination-in-Chief by Ms. Cox	130
VALERIE GIDEON, Cross-Examined by Mr. Wuttke	146
JACKIE ANDERSON, Cross-Examined by Mr. Wuttke	155
JACKIE ANDERSON, Cross-Examined by Ms. Lomax	158
VALERIE GIDEON, Cross-Examined by Ms. Lomax	165
JACKIE ANDERSON, Cross-Examined by Ms. Weber	169
VALERIE GIDEON, Cross-Examined by Mr. Blain	180
JACKIE ANDERSON, Cross-Examined by Mr. Blain	184
CHRISTINE DUMAINE, Cross-Examined by Mr. Blain	187
JACKIE ANDERSON, Cross-Examined by Ms. Zarpa	189
VALERIE GIDEON, Cross-Examined by Ms. Zarpa	193
VALERIE GIDEON, Cross-Examined by Ms. Beamish	199
JACKIE ANDERSON, Cross-Examined by Ms. Beamish	209
VALERIE GIDEON, Cross-Examined by Ms. Symes	212

VII

TABLE OF CONTENTS

	PAGE
JACKIE ANDERSON , Cross-Examined by Ms. Fraser	221
VALERIE GIDEON , Cross-Examined by Ms. Fraser	224
VALERIE GIDEON , Cross-Examined by Ms. Beaudin	232
JACKIE ANDERSON , Cross-Examined by Ms. Beaudin	244
CHRISTINE DUMAINE , Cross-Examined by Ms. Beaudin	246
CHRISTINE DUMAINE , Cross-Examined by Ms. Dunn	249
JACKIE ANDERSON , Cross-Examined by Ms. Dunn	251
JACKIE ANDERSON , Cross-Examined by Ms. Blaney	261
VALERIE GIDEON , Cross-Examined by Ms. Blaney	269
CHRISTINE DUMAINE , Cross-Examined by Ms. Clifford	270
JACKIE ANDERSON , Cross-Examined by Ms. Clifford	271
VALERIE GIDEON , Cross-Examined by Ms. Clifford	273
VALERIE GIDEON , Cross-Examined by Ms. Pastora Sala	282
JACKIE ANDERSON , Cross-Examined by Ms. Pastora Sala	291
VALERIE GIDEON , Cross-Examined by Ms. Ordyniec	296

IIX

LIST OF EXHIBITS

NO.	DESCRIPTION	PAGE
Panel 2A: Health Services in Remote Communities		
Witness: Valerie Gideon		
24(a)	Biography of Valérie Gideon (one page)	10
24(b)	Biographie de Valérie Gideon (une page)	10
25	"Overview of the First Nations and Inuit Health Branch Context and Select Key Activities Related to Violence against Indigenous Women and Girls, Indigenous Services Canada (15 pages)	11
26	First Nations Inuit Health Branch "What We Do," Indigenous Services Canada (two pages)	14
27	"Guidelines for the FNIHB eHealth Infostructure Program (eHIP)," (March 2016) Health Canada, First Nations and Inuit Health Branch, ISBN: 978-1-100-5406401 (23 pages)	47
28	First Nations Mental Wellness Continuum Framework (January 2015), Health Canada, ISBN: 978-1-100-25327-5 (58 pages)	54
29	Indian Residence Schools Resolution Health Support Program Policy Framework (June 2014), Health Canada (12 pages)	57
30	"Guide to Mental Health Counselling Services" (March 2018, last dated modified April 20, 2018), Government of Canada, Non-Insured Health Benefit Program & Indian Residence Schools Resolution Health Support Program (24 pages)	60
31	"Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada" (2011), Health Canada, ISBN: 978-1-100-19331-1 (100 pages)	67
32	First Nations and Inuit Component of Victims of Family Violence (VoFV) Investments, Health Canada, ISBN: 978-0-660-03153-8 (two pages)	73

All exhibits submitted by Anne Turley, Legal Counsel for Canada.

IX

LIST OF EXHIBITS

NO.	DESCRIPTION	PAGE
Panel 2A: Health Services in Remote Communities		
Witness: Jackie Anderson		
33	Tracia's Trust: Manitoba Sexual Exploitation Strategy brochure, Government of Manitoba, Sexual Exploitation Unit, Child Protection Branch (two pages)	83
34	Sexual Exploitation and Trafficking of Aboriginal Women and Girls, Literature Review and Key Informant Interviews (March 2014), Native Women's Association of Canada / Canadian Women's Foundation (81 pages)	145
35	"No more: Ending Sex-Trafficking in Canada," Report of the National Task Force on Sex Trafficking of Women and Girls in Canada (Fall 2014), Canadian Women's Foundation (137 pages)	146

All exhibits submitted by Jennifer Cox, Commission Counsel.

Panel 2A: Health Services in Remote Communities

Witness: Panel 2

36	"Montreal boarding home for Nunavik medical patients over capacity since opening," CBC News, posted July 25, 2017 12:25 CT, last updated July 25, 2017 (three pages)	197
----	----------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----

Exhibit submitted by Elizabeth Zarpa, Counsel for Inuit Tapiriit Kanatami.

1 Calgary, Alberta

2 --- Upon commencing on Wednesday, May 30, 2018 at 8:01 a.m.

3 --- **OPENING COMMENTS**

4 **MR. JASON GOODSTRIKER:** Our Inuit Elder,
5 Louise, has -- she's -- already has lit the -- lit the lamp.
6 It's a very -- Valerie, oh, my goodness. These are
7 adventures that we're having today at this Inquiry. Valerie
8 Gideon is going to be speaking a little bit later on. I've
9 got to use this time as best as I can, Valerie, because at
10 some point in time, they cut me off and I can't speak on the
11 mic.

12 **(LAUGHTER)**

13 **MR. JASON GOODSTRIKER:** So I'm going to say
14 that I'm very happy to see Valerie Gideon. Valerie's father
15 and my late grandfather, Rufus Goodstriker, were best
16 friends, and Valerie and I ended up in this business
17 together some 30 years later, and now here we are 20 years
18 later. But we're getting younger. Valerie, you're getting
19 younger every year, so she's looking very well.

20 Anyways, again, I'd like to thank Louise with
21 the lamp in accordance with the traditions from the Inuit
22 people. And us Blackfeet, although this is our land and our
23 area, and again, welcome to Calgary, we're very honoured to
24 have this teaching here with us. I can honestly say I don't
25 think it's ever been here in Calgary, this -- the -- the

1 lamp, and it's very special and it brings a nice piece of
2 spirit of -- of what's happening here and what we're
3 discussing. It's a very beautiful addition to this Inquiry.

4 Anyways, if you Google Map and you go above
5 -- above the Earth in this part of the country, Napi was one
6 of our -- our teachers. He was our trickster. Anyways,
7 when it became time for him to move on, he laid down and he
8 became a formation in the earth. And so his head is right
9 around near Edmonton and his body extends through Blackfoot
10 country and his feet down -- end up down towards Montana,
11 but this part of his body, we call it *Moh-kíns-tsis*. *Moh-*
12 *kíns-tsis*. That means the elbow. So if you look at Google
13 Map way above the Earth and you look at -- you can see Napi
14 laying down, and his body became Blackfoot territory. And
15 so we call it *Moh-kíns-tsis*.

16 Anyways, John Wesley and Spike Eagle Speaker
17 and our Elders, they're here to pray and to welcome you all
18 again to the Commissioners and to the witnesses on this very
19 special Wednesday. Anyways, it's all splashed all over the
20 media that this is going on, and everybody's watching it
21 online across the country.

22 So we're going to begin, and we'll sing a
23 song as we welcome everybody here, and then we'll ask our
24 Elders for our morning prayer. So you don't have to stand
25 up. We'll sing a -- we'll sing a song for each and every

1 one of you and the spirits of the people that are here and
2 for the spirits of the people who aren't here. We're going
3 to ask to sing a -- a flag song to start and then we'll sing
4 an honour song for this inquiry and for the -- and for the
5 day.

6 --- DRUMMING CEREMONY

7 MR. JASON GOODSTRIKER: Thank you. You can
8 give them a round of applause.

9 (APPLAUSE)

10 MR. JASON GOODSTRIKER: That was a beautiful
11 -- I had a chat this morning with my uncle over here, Mr.
12 Eagle Speaker, and he said, and he asked if I would
13 introduce them as our Elders today in terms of them saying
14 the prayer for each and every one of you. Some of you might
15 want to seek if -- their advice. They're here, they're on
16 behalf of the Commission, they're going to be here the
17 duration of the week, so if you wanted to visit with
18 somebody or have a chat, they're here at your service. And
19 this is on behalf of the Commission and for all of us.

20 And so we're going to ask the Eagle Speakers
21 and our stony Elder here to say a word of prayer for all of
22 us this morning as we begin and we'll take that into our
23 hearts and think about our families at home and think about
24 our very special people here, on the reason why we're having
25 this Commission. (Speaking in Native language).

1 And again, we don't stand in Blackfoot
2 country when we pray, so...

3 **MR. SPIKE EAGLE SPEAKER AND MS. ALVINE EAGLE**

4 **SPEAKER:** (Speaking in Native language).

5 --- OPENING PRAYER

6 **MR. GERALD MEGUINIS:** Hey. Thank you.
7 Touch your hearts, say "hey." That's the Blackfoot ending
8 of a prayer.

9 **MR. JASON GOODSTRIKER:** Thank you,
10 Mr. Meguinis and Mr. and Mrs. Eagle Speaker. Give them a
11 round of applause. That's -- thank you very much.

12 **(APPLAUSE)**

13 **MR. JASON GOODSTRIKER:** Chief, the floor is
14 yours. We're now ready to begin. So welcome again,
15 Michèle, and looking forward to hearing Valerie. She's the
16 smartest woman in Canada, so...

17 **(LAUGHTER)**

18 **UNIDENTIFIED SPEAKER:** Welcome,
19 (indiscernible).

20 **MR. JASON GOODSTRIKER:** Welcome. Okay.
21 The -- you're the other smartest women in Canada, so thank
22 you.

23 **UNIDENTIFIED SPEAKER:** Yes, thank you.

24 **MR. JASON GOODSTRIKER:** Welcome to Calgary.

25 **UNIDENTIFIED SPEAKER:** We're going to take

1 a break, so...

2 **CHIEF COMMISSIONER MARION BULLER:** We'll

3 take a short break and reconvene at 8:30.

4 --- Upon recessing 8:14 a.m.

5 --- Upon resuming at 8:28 a.m.

6 **MS. JENNIFER COX:** Good morning, everybody.

7 My name is Jennifer Cox, and I'm Commission counsel for the

8 National Inquiry Missing and Murdered Indigenous Women and

9 Girls.

10 So we're going to get started this morning,
11 and there's a couple of housekeeping matters that I'd like
12 to bring to your attention first before we get started with
13 the first witness. The parties with standing should have
14 turned in their numbers for the order of cross-examination.
15 If you haven't done so, can you please either find Maria
16 Dray (ph) or Francine Merasty, they will be in the Silver
17 Willow room.

18 In addition, the other witnesses that are
19 scheduled for this panel will not be joining until the
20 break or just after the break. I didn't, unfortunately,
21 tell them that they were supposed to be here first thing
22 this morning, so they will be here joining us at ten
23 o'clock.

24 So there will be three witnesses Commission
25 counsel are calling this morning. Dr. Valerie Gideon, who

1 is sitting beside me, is actually going to be giving
2 evidence with the assistance of her counsel Anne Turley.
3 Commission counsel is asking the Commissioners if
4 Ms. Turley, on the consent of Commission counsel, can lead
5 the evidence of Dr. Gideon pursuant to Rule 31, and I would
6 respectfully request that the order be made allowing that
7 to happen.

8 **CHIEF COMMISSIONER MARION BULLER:** Yes,
9 certainly, that's agreeable.

10 **MS. JENNIFER COX:** And in terms of other two
11 witnesses that will be participating later on, Jackie
12 Anderson and Christine Dumaine, I will be leading those
13 witnesses later on.

14 And those are the only housekeeping matters
15 that I have this morning, so if we could have our first
16 witness sworn, which is Dr. Valerie Gideon, Mr. Registrar.

17 **CHIEF COMMISSIONER MARION BULLER:** The
18 witness would like to be sworn; is that correct?

19 **UNIDENTIFIED SPEAKER:** The witness would
20 prefer an affirmation.

21 **CHIEF COMMISSIONER MARION BULLER:** Okay.
22 Good morning, Dr. Gideon, welcome.

23 **DR. VALERIE GIDEON:** Thank you.

24 **VALERIE GIDEON, Affirmed:**

25 **CHIEF COMMISSIONER MARION BULLER:** Thank

1 you, Doctor.

2 **MS. JENNIFER COX:** Ms. Turley.

3 **MS. ANNE TURLEY:** Thank you, good morning
4 Chief Commissioner, Commissioners. Before beginning, I'd
5 just like to acknowledge the traditional territories of
6 Treaty 7 and those of the Métis Nation Region 3. I would
7 also like to thank the Elders and the drummers for starting
8 us off in a good way today.

9 As one other housekeeping matter, I just
10 want to note for the Commissioners that we do have a book
11 of documents. These, again, are the same documents that
12 have already been provided to parties with standing, but
13 they are in a bound book just for ease of reference for the
14 witness and the Commissioners, and I will be seeking to
15 introduce them one by one as exhibits at the appropriate
16 time.

17 The other thing I would like to say before
18 beginning is you will hear that Dr. Gideon is the Senior
19 Assistant Deputy Minister of the First Nation Inuit Health
20 Branch and the acronym FNIHB may be used throughout the
21 testimony.

22 **EXAMINATION-IN-CHIEF BY MS. TURLEY:**

23 **MS. ANNE TURLEY:** Good morning, Dr. Gideon.

24 **DR. VALERIE GIDEON:** Morning.

25 **MS. ANNE TURLEY:** I'd just like to start with

1 a bit of your background. I understand you're a member of
2 the Mik'maq Nation.

3 **DR. VALERIE GIDEON:** That's correct.

4 **MS. ANNE TURLEY:** And presently you're the
5 Senior Assistant Deputy Minister of the First Nations Inuit
6 Health Branch of Indigenous Services Canada?

7 **DR. VALERIE GIDEON:** That's correct.

8 **MS. ANNE TURLEY:** And prior to the formation
9 of Indigenous Services Canada, FNIHB was under Health
10 Canada?

11 **DR. VALERIE GIDEON:** That's correct.

12 **MS. ANNE TURLEY:** And can you tell us why the
13 Department of Indigenous Services Canada was created?

14 **DR. VALERIE GIDEON:** So just before I answer
15 that question, I also want to acknowledge the traditional
16 territory of Treaty 7 First Nations and the Métis Nation of
17 Alberta, and I also just wanted to thank Barbara for the
18 smudge and the Elders for the prayer this morning and for
19 the drum.

20 So the Prime Minister, on August 28th of
21 2017, announced the creation of two new departments to
22 replace Indigenous and Northern Affairs Canada. Those two
23 new departments are Indigenous Services Canada and Crown-
24 Indigenous Relations and Northern Affairs. It was in
25 response to recommendations from the Royal Commission on

1 Aboriginal Peoples and there are many objectives to be
2 achieved through the creation of Indigenous Services Canada,
3 which are outlined in mandate matters that were provided to
4 both Minister Philpott as Minister of Indigenous Services
5 Canada and Minister Bennett as Minister of Crown-Indigenous
6 Relations and Northern Affairs.

7 Those mandate matters were made public in
8 October of 2017. They provide guidance to us while we are
9 in the process of developing with First Nations, Inuit, and
10 Métis a vision, principles, and strategic objectives for the
11 new department. But I would say that, fundamentally, it is
12 about breaking down barriers across sectors, across regions,
13 and in providing more flexibility to target investments in
14 partnership with First Nations, Inuit, and Métis to areas
15 that are needed in order to close the longstanding
16 socioeconomic and health gaps that have been experienced by
17 Indigenous peoples in this country.

18 **MS. ANNE TURLEY:** Thank you. Now, prior to
19 being appointed as a Senior Assistant Deputy Minister at
20 FNIHB, I understand that you held various positions within
21 Health Canada between 2007 and 2017?

22 **DR. VALERIE GIDEON:** That is correct.

23 **MS. ANNE TURLEY:** And prior to joining the
24 government, you worked in First Nations health advocacy?

25 **DR. VALERIE GIDEON:** That's correct.

1 **MS. ANNE TURLEY:** I'd ask you to look at tab
2 1 of the book of documents. And this is a copy of your
3 biography?

4 **DR. VALERIE GIDEON:** Yes, it is.

5 **MS. ANNE TURLEY:** And is this an up-to-date
6 version?

7 **DR. VALERIE GIDEON:** Yes, it is.

8 **MS. ANNE TURLEY:** Chief Commissioner, I would
9 ask that a copy of Valerie Gideon's biography be entered as
10 the next exhibit in these proceedings.

11 **CHIEF COMMISSIONER MARION BULLER:** The
12 biography of Dr. Gideon is Exhibit 24, please.

13 --- **EXHIBIT NO. 24(a):**

14 Biography of Valérie Gideon (one page)

15 --- **PIÈCE NO. 24(b):**

16 Biographie de Valérie Gideon (une page)

17 **MS. ANNE TURLEY:** And Dr. Gideon, if I could
18 ask you to turn to tab 2, this is a document entitled
19 "Overview of First Nations and Inuit Health Branch Context
20 and Select Key Activities Related to Violence Against
21 Indigenous Women and Girls." Why was this document
22 prepared?

23 **DR. VALERIE GIDEON:** It was prepared to
24 support and guide the testimony that I'll be providing
25 today.

1 **MS. ANNE TURLEY:** And were you involved in
2 the drafting and preparation of this document?

3 **DR. VALERIE GIDEON:** I was.

4 **MS. ANNE TURLEY:** And are you able to address
5 the issues dealt with in this document?

6 **DR. VALERIE GIDEON:** I believe I can, yes.

7 **MS. ANNE TURLEY:** And does it accurately
8 characterize the services and programs that FNIHB funds
9 delivers?

10 **DR. VALERIE GIDEON:** Yes.

11 **MS. ANNE TURLEY:** Chief Commissioner, I would
12 ask that this overview of FNIHB's context and select key
13 activities be entered as the next exhibit in these
14 proceedings.

15 **CHIEF COMMISSIONER MARION BULLER:** Okay. The
16 Overview of First Nations and Inuit Health Branch Context
17 and Select Key Activities Related to Violence Against
18 Indigenous Women and Girls is Exhibit 25, please.

19 **--- EXHIBIT NO. 25:**

20 "Overview of the First Nations and Inuit
21 Health Branch Context and Select Key
22 Activities Related to Violence against
23 Indigenous Women and Girls, Indigenous
24 Services Canada (15 pages)

25 **MS. ANNE TURLEY:** Thank you. Dr. Gideon, I'd

1 like to begin with you giving a brief overview of the health
2 services delivery context in order to situate FNIHB and what
3 they have to do with the funding and delivery of programs.
4 I know this is dealt with in pages 1 to 4 of this document,
5 which is now Exhibit 25, but if you could explain to the
6 Commissioners the -- FNIHB's mandate and role in this area.

7 **DR. VALERIE GIDEON:** Absolutely, and I'll
8 respond in English. However, *ça me ferait plaisir de*
9 *répondre à des questions, de répéter des questions en*
10 *français si vous préférez.* So the mandate of FNIHB
11 primarily stems from the 1979 Indian Health Policy that had
12 three pillars of community development, recognizing a
13 special relationship with the Crown and Indigenous peoples,
14 and also the inter-relationship between Federal, provincial,
15 and territorial health systems in supporting the advancement
16 of Indigenous health.

17 It is a dated document. However, those three
18 pillars continue to -- to guide the mandate of the branch.
19 We, in 2012, undertook an extensive exercise to develop a
20 strategic plan for the First Nations and Inuit Health Branch
21 that helps to situate the three pillars of the policy and
22 also broaden the language so that it was more up to date and
23 relevant with respect to the context at that point in time.

24 The mandate of FNIHB is really to provide
25 access to health services, namely through programs, in order

1 to supplement access that is offered through provincial,
2 territorial health care services and systems across the
3 country. We also offer health promotion, disease prevention
4 type of programs and supplementary health benefits, too, in
5 an attempt to close the gap and achieve more comparable
6 health outcomes for Indigenous peoples.

7 We also have a -- a -- another key element of
8 our mandate is the development of partnerships with First
9 Nations and in Métis leadership with respect to -- at the
10 community levels or regional levels or at the national
11 level, as well, and that's a big part of the success in
12 achieving a mandate of the branch.

13 **MS. ANNE TURLEY:** Thank you. And now if I --
14 I can have you look at tab 3 of the book of documents?

15 **DR. VALERIE GIDEON:** Okay.

16 **MS. ANNE TURLEY:** This is a document entitled
17 "First Nations Inuit Health Branch: What We Do." Can you
18 explain what this is and why it -- what it was prepared for?

19 **DR. VALERIE GIDEON:** It's really just a brief
20 overview of the roles and responsibilities that FNIHB
21 primarily exercises, the types of spending within the
22 context of the overarching envelope, and of the
23 expenditures. Information is from 2017-18. It also
24 attempts to explain the various roles in the delivery of
25 services between provinces, territories, FNIHB, and of

1 course, First Nations and Inuit government.

2 And then the second page is to talk about
3 some of the more recent initiatives in order to strengthen
4 the work with respect to the transformation of Indigenous
5 health systems, specific investments with respect to more
6 vulnerable populations, particularly in the areas of mental
7 health, which I know is a big interest of the Commissioners.
8 *Jordan's* principle, infectious diseases with respect to
9 Inuit, and also the most recent Federal budget investments
10 from budgets 2017-18.

11 **MS. ANNE TURLEY:** Thank you. Chief
12 Commissioner, I would ask that this document entitled "First
13 Nations Inuit Health Branch: What We Do" be admitted as the
14 next exhibit.

15 **CHIEF COMMISSIONER MARION BULLER:** "First
16 Nations Inuit Health Branch: What We Do" will be Exhibit 27,
17 please. Sorry, 26.

18 --- **EXHIBIT NO. 26:**

19 First Nations Inuit Health Branch "What
20 We Do," Indigenous Services Canada (two
21 pages)

22 **MS. ANNE TURLEY:** Dr. Gideon, you talked
23 about health services that would be funded by FNIHB. Can
24 you give a brief explanation of what type of services those
25 would be?

1 **DR. VALERIE GIDEON:** Absolutely. So it's a
2 pretty broad scope. We have about 114 programs within the
3 context of FNIHB, but I'll focus on some of the key themes.
4 So primary health care is a -- a -- a very important service
5 delivery responsibility. We fund or provide direct primary
6 health care services in about 79 communities across the
7 country, primarily through a nursing capacity but also with
8 multidisciplinary health teams. We have a -- a significant
9 suite of community-based health promotion, disease
10 prevention programs that are funded directly at First
11 Nations or Inuit community levels or through regional
12 organizations or tribal councils or through territorial
13 governments.

14 And so the primary themes of those community
15 health programs are, like, healthy child development, mental
16 wellness, public health type of programs. Home and
17 community care is another area. And we have public health
18 services that are also delivered through nursing staff, such
19 as immunization. We -- we also have environmental health
20 officers that we fund or hire in order to do public health
21 inspections in communities, whether that is for drinking
22 water, housing, or other types of inspections, public health
23 inspections. Like you would see in a municipality, the
24 public health inspectors. And then, of course, we have the
25 Supplementary Health Benefits program, non-insured health

1 benefits -- that offers benefits that are not covered by
2 provinces, territories, or through private insurance or
3 employer benefit programs -- in the areas of
4 pharmaceuticals, medical transportation, dental care,
5 medical supplies and equipment, and also vision.

6 We also support, or -- directly, or fund
7 about 700 health facilities across the country. That also
8 includes two hospitals that we continue to directly operate
9 in Manitoba, the Percy Moore Hospital and the Norway House
10 Hospital in Manitoba. So, I mean, I think, that's a --
11 that's a very brief overview. I'm sure that there will be
12 more in-depth questions throughout the day, but I would say
13 the majority of services are provided through contribution
14 agreements directly by First Nations, Inuit, or through
15 territorial governments in partnership with First Nations
16 and Inuit governments and organizations.

17 However, the department continues to have
18 direct service delivery responsibilities, primarily in
19 nursing; environmental health services; oral health, where
20 we have dental therapists and dental hygienists; and
21 environmental health services.

22 **MS. ANNE TURLEY:** And so with respect to that
23 last aspect, the services that FNIHB would actually be
24 involved in delivering, you just mentioned nursing. Can you
25 just explain in how many communities nursing services would

1 be offered, or delivered by FNIHB?

2 **DR. VALERIE GIDEON:** So we have -- we fund 79
3 primary healthcare centres in report and isolated
4 communities directly. We provide direct service delivery,
5 which means that we actually have employees providing the
6 service in 51 of those communities. It was very recently
7 52, and the KO Tribal Council took over the services in Deer
8 Lake. So that's a success story. So most of the services
9 that we directly provide are in northern Ontario and
10 northern Manitoba; however, we still have some direct
11 service delivery in Alberta and in Quebec. But in
12 Saskatchewan, for instance, all of the -- what you would
13 have called the nursing stations, which we like to call
14 primary healthcare centres, have been transferred to First
15 Nations control.

16 **MS. ANNE TURLEY:** And you just mentioned this
17 success story that brought you from 52 to 51 communities.
18 Can you tell us a little bit about that?

19 **DR. VALERIE GIDEON:** Well, I think we are
20 continuously, and for many decades now, since the 1988
21 Indian Health Transfer Policy, and I'm sorry, that's what it
22 was called at the time, have been supporting First Nations
23 to take greater control with respect to the over-arching
24 governance, management, design of service delivery,
25 assessment of service delivery for their communities. To

1 have the flexibility to be able to target federal funding
2 and adapt services to meet the specific needs of the
3 communities. So that includes the full suite of what I've
4 described earlier.

5 There are no programs or services that
6 are -- are not eligible for transfer. But, of course, the
7 service delivery model differs across the country. So, for
8 instance, in British Columbia, we have the largest health
9 transfer type of model where the British Columbia First
10 Nations Health Authority took over the regional office. And
11 also, many more other types of services that are also funded
12 provincially, and new services that they've also initiated.
13 That includes the non-insured health benefits program, and
14 includes, of course, primary care responsibilities that the
15 branch previously held.

16 Now, we also have community-level
17 arrangements. We have tribal council arrangements. In
18 Quebec, there is a significant degree of transfer -- long-
19 standing health transfer care agreements in communities,
20 including my own. And in Saskatchewan, there are not only
21 community and tribal council arrangements, but there's also
22 the Northern Inter-Tribal Health Authority that has been in
23 operation for second and third-level transfers, which means
24 that they took over functions for the regional office as
25 well. For many years, I would say since the '90s, we've

1 also transferred hospitals. So the All Nations' Healing
2 Hospital is an excellent example. If you're not familiar
3 with it in the Fort Qu-Appelle area, where they've been able
4 to do so much more with respect to the suite of services
5 that are offered in that hospital. It's a true success
6 story. In the James Bay Cree Moose Factory area, we also
7 signed integration agreement in 2007, where the hospital
8 there was transferred to First Nations governance within the
9 context of the provincial health system. Same type of
10 arrangement in Sioux Lookout as well with Meno Ya Win Health
11 Centre.

12 So there's a -- a large variability of how
13 the transfer has taken place. We also have self-
14 governments, of course -- self-government arrangements.
15 Nisga's, for instance, and Nunatsiavut in Labrador have
16 taken over, not only the community-based type programs, but
17 they also have taken over non-insured health benefits as
18 examples of that. So I don't want to take up too much time,
19 but I'm happy to elaborate as needed.

20 **MS. ANNE TURLEY:** Thank you. We've -- we've
21 segued pretty well into the first topic, which is access to
22 healthcare services, which is dealt with at pages 5 to 9 in
23 the document overview. In terms of looking at, something
24 that you've talked about, success stories or promising
25 practices in improving healthcare services and promoting

1 greater access to them in the communities, can you speak
2 about how collaborating, as you -- as you already addressed
3 with First Nations and Inuit partners, leads to greater
4 access?

5 **DR. VALERIE GIDEON:** Well, I mean, it's
6 absolutely fundamental. I think, the branch has had a long-
7 standing history of having the Assembly of First Nations and
8 Inuit Tapiriit Kanatami as part of its senior management
9 table. However, most recently we have ensured that they are
10 full-fledge members, which means that I don't meet with the
11 director generals or the regional executives without AFN and
12 ITK being invited to participate. They are there, not
13 necessarily to speak on behalf of all First Nations and
14 Inuit, but to access the information and to bring it back to
15 their regional members and representatives, and also, to
16 share that information more broadly. That has significantly
17 increased our transparency.

18 We also, over the past five years since the
19 publication of our strategic plan, mandated that every one
20 of our regional offices has partnership tables. Those vary
21 in terms of their membership and their terms of reference,
22 simply because, you know, they're -- the -- they're such a
23 diversity with respect to First Nations and Inuit
24 populations, and also governance systems across a region.

25 So we've adapted the model to whatever

1 leadership has mandated as appropriate. We have had long
2 standing co-management tables in Atlantic and Alberta
3 regions, where it is a shared decision-making approach. In
4 other regions, it is a partnership table, which means that
5 the branch invites input early on within the conducts of our
6 annual operational planning, the design of services, how
7 investments are allocated, and really sharing that
8 information at the regional tables.

9 And when I say a regional table, it doesn't
10 necessarily encompass the full province. So, for instance,
11 in Ontario, where there's a significant diversity with
12 respect to the First Nations population, we have several
13 tables. So we have the Trilateral First Nations Health
14 Senior Officials Committee, which is chaired by the chair of
15 the Chiefs Committee on Health. With respect to Ontario,
16 myself and an ADM at the provincial level. But we also have
17 northern tables. So we have the Keewatin table, which is
18 specific to Treaty 3. And with Treaty 3, it is also
19 trilateral. And with NAN, Nishbnawbe Aksi Nation, where we
20 established a joint action health table based on a charter
21 of relationship principles, that was signed in July of 2017,
22 it is a trilateral table also, and it includes a -- a NAN
23 representative. So we are flexible with respect to what is
24 the appropriate way to -- what is the appropriate governance
25 models for these types of partnership tables or shared

1 decision-making at tables.

2 And I'd just like to provide an example. So,
3 for instance, with respect to having -- so the permanent
4 bilateral mechanisms have been established by the Prime
5 Minister, which each First Nations, Inuit, and Métis, the
6 Inuit-Crown Partnership Committee, as an example, they're --
7 one of the key priorities is having an Inuit Nunangat policy
8 space. That is really adopted across federal departments.
9 So for our branch, one of the concrete ways in which we've
10 been able to implement that is when Budget 2017 announced
11 investments specific to First Nations and Inuit health, 828
12 million over five years.

13 We did a two-phased treasury board
14 submission, so that in the first phase, we were able to
15 identify some early investments that had already been
16 identified as priorities by the National Inuit Committee on
17 Health and the Inuit land claim organizations, but then we
18 actually worked together to develop what would be the
19 priorities and the mechanisms for allocating that funding
20 for years 2 to 5 and did a second submission so that we had
21 the opportunity and the proper time to engage with them and
22 to really develop the nuts and bolts of how the funding
23 would be allocated. So these are examples. There are many
24 across the country, but it is a significant proportion of
25 our time is to strengthen the relationship, the partnership,

1 and to encourage greater self-determination and
2 self-governance of Indigenous peoples with respect to
3 federal health investments.

4 **MS. ANNE TURLEY:** Thank you, Dr. Gideon.
5 I'm just going to go back to ask you for a little bit more
6 detail on some of the -- you talked about the protocol
7 agreement with AFN. When was that entered into?

8 **DR. VALERIE GIDEON:** M'hm. So we -- in
9 2014, we signed protocol agreements with the Assembly of
10 First Nations and Inuit Tapiriit Kanatami, but the protocol
11 agreements don't specifically only talk to the relationship
12 with the NIOs. They go into much greater detail with
13 respect to regional and community-level engagement. And
14 the goal of those protocol agreements was to ensure that
15 the relationship that we have with the NIOs is not
16 misinterpreted in terms of -- and -- and that it was also
17 clear with respect to our obligations for transparency,
18 mutual accountability, joint planning and decision-making,
19 where, of course, that's appropriate and mandated by the
20 leadership. And so with respect to Inuit, it is entitled
21 the Inuit Health Approach, and in fact, President Ovide
22 wrote about that in the Journal of Northern Affairs in 2015
23 as a best practice for -- as an example of how free, prior,
24 and informed consent could be implemented within the
25 federal public service context.

1 So these protocols were not signed at the
2 ministerial level. They were signed at the assistant
3 deputy minister level. But I -- they are important with
4 respect to ensuring that the federal public service fully
5 recognizes and understands its obligations at all levels of
6 decision-making in the organization.

7 **MS. ANNE TURLEY:** Thank you. And you also
8 referred to NAN's Charter of Relationship Principles. And
9 when was that signed?

10 **DR. VALERIE GIDEON:** We signed that in the
11 Iskotew Lodge, which is actually in Tunney's Pasture in a
12 federal building with the Grand Chief and the Minister of
13 Health at the time -- he's now my Minister of Indigenous
14 Services Canada -- and the provincial Minister of Health
15 and Mr. Hoskins at that time in July of 2017. It was in
16 response to a series of very alarming suicide crises across
17 NAN territory. This was not new in NAN territory, but
18 certainly was a very significant time of crisis
19 across -- affecting several communities across NAN
20 territory. And it was -- we were working in crisis
21 management for a long period of time of several, several
22 months. You know, staff were burning out on all ends. We
23 had difficulty finding mental health providers because, you
24 know, the usual providers with which we had all
25 relationships with, NAN, ourselves, the Province, were

1 just, you know, overstretched. We were bringing in crisis
2 teams from northern Manitoba and Alberta in order to
3 supplement the capacity.

4 And I think with respect to -- I don't want
5 to speak of behalf of Nishnawbe Aski Nation, but I think
6 that it was really a feeling that we needed to transform
7 the overarching health system in order to be able to
8 have -- identify the risks much earlier on before getting
9 into this spiral of crisis management. And even though
10 we've known that, of course, in the past, there was
11 momentum or there was very strong commitment and
12 collaboration among federal/provincial governments and
13 responsiveness to what NAN leadership was bringing at the
14 table.

15 So the *Charter of Relationship Principles* is
16 about, of course, addressing the needs of communities
17 today. But it's about, you know, like really supporting
18 the aspirations of NAN leadership to take ownership
19 control, self-determination, whatever language, of course,
20 is appropriate and that they wish to use, to express that
21 transformation that they are currently leading. And they
22 have identified Ovide Mercredi as their representative in
23 those discussions and negotiations.

24 **MS. ANNE TURLEY:** Thank you. And I would
25 just note that while we don't have the *Charter of*

1 *Relationship Principles* as an exhibit in the materials,
2 there is the link for parties.

3 Dr. Gideon, you referred to in British
4 Columbia that there is the largest transfer model. Can you
5 address that model when -- and when it was introduced?

6 **DR. VALERIE GIDEON:** It's a long-standing
7 initiative. I remember being in Kelowna in 2005 working
8 for the Assembly of First Nations and being asked by some
9 of the chiefs in BC to review their *Transformative Change*
10 *Accord* with Premier Campbell in order to ensure that the
11 language would be consistent with what we were negotiating
12 nationally. I think it was clear with respect to BC First
13 Nations leadership that they wanted to -- I mean,
14 you -- you're looking at, you know, over 200 communities,
15 incredible diversity, many smaller communities, isolated
16 communities. They certainly felt that the regional
17 operations of the federal government was not sufficiently
18 responsive to being able to adapt the approach in having
19 those First Nations voices at the table in decision-making,
20 which is, of course, absolutely correct.

21 And so they undertook a process over many
22 years to obtain that mandate from -- from the leadership
23 and communities, and to ensure that they would be able to
24 be informed with respect to the priorities of communities
25 by supporting every community, to develop a community

1 health plan, identifying actions that would need to be
2 taken, developing an interim First Nations Health Authority
3 and then having that recognized officially in the framework
4 agreement.

5 There are a number of -- of partnership
6 agreements that were signed over the course of that time
7 period in order to define what would be the appropriate
8 governance arrangement, the funding that would be required
9 to sustain that operation adequately, and -- and also, you
10 know, how does the federal government continue to
11 be -- which was very, very important for the
12 leadership -- a funder and a governance partner?

13 And, you know, what's interesting is now I
14 have the responsibility in my role to be that federal
15 representative at the public service level in supporting
16 the tripartite partnership, and I speak to the First
17 Nations Health Authority very regularly. So we are still
18 very much engaged in supporting them. We don't have a
19 decision-making role in the day-to-day operations and the
20 funding, but we are there to listen, to support them, to
21 think outside the box.

22 And actually, two weeks ago, I was at the
23 Gathering Wisdom conference that they have annually with
24 all of their communities to talk about health, and we made
25 an announcement, a tripartite announcement, specific to

1 mental illness transformation which was identified by
2 communities in their regional caucuses. That's still an
3 outstanding priority. And so 30 million over two years was
4 identified as a shared funding announcement.

5 So the First Nations Health Authority of BC
6 is contributing 10 million, we're contributing 10 million,
7 and the Province is contributing 10 million to enable a
8 draw-down of those resources in order to supplement what
9 communities and regional caucuses are able to do with their
10 funding to address key areas of needs such as the opioid
11 situation, which is affecting many, many individuals,
12 families, and communities and youth in BC, and also to
13 address, for instance, the very important needs of children
14 with respect to mental health.

15 **MS. ANNE TURLEY:** Now, Dr. Gideon, you just
16 talked about the success of the BC First Nations Health
17 Authority. Have there been, to your knowledge, any
18 evaluations or reports pointing to its success?

19 **DR. VALERIE GIDEON:** So we're in
20 the -- we're in the course of the tripartite evaluation,
21 but also there is a specific evaluation on the
22 implementation of the agreement that is currently underway.
23 However, the BC First Nations Health Authority is, of
24 course, very transparent, and they publish annual reports
25 which you can find online. And you can see in those

1 reports -- the report from this year, it's such a beautiful
2 story the way that it's laid out. And you can absolutely
3 see that they are seeing some concrete improvements in
4 health -- health outcomes just in the past five years.

5 And so I -- I don't want to tell their
6 story, but I would say that I do really welcome
7 people -- and they are -- they are receiving a huge amount
8 of invitations to go across the country and to provide
9 information and advice to First Nations who are interested
10 in health transformation or different types of health
11 governance models.

12 The AFN Chiefs Committee on Health in 2017
13 visited them and held a three-day, I believe, retreat or
14 strategic planning session to learn about what's happening.
15 So they are offering almost a peer support and advisory
16 service for First Nations across the country.

17 I think initially there was a bit of -- you
18 know, people weren't sure if they would trust that
19 arrangement across the country, is it offloading, is it,
20 you know, the federal government -- are they going to be
21 able to sustain their operations with the level of
22 resources that were negotiated. But I do think that people
23 can now see concretely, you know, what's happening.

24 And I have to say, being at the conference
25 even just for a short period of time -- I mean, I've spent

1 my whole career in First Nation Inuit health, and so
2 it's -- you can totally see the change in conversation.
3 You know, it is a celebration of culture, of ceremony, it
4 is youth speaking, it's not about the government.

5 The government is there, the government is
6 funding, the government is committed as a partner, but it
7 really is First Nations speaking, First Nations driving the
8 change, and also First Nations discussing how do we
9 continue to improve and address health and socioeconomic
10 outcomes in communities.

11 **MS. ANNE TURLEY:** Thank you, Dr. Gideon. I
12 know earlier you referred to examples in Sioux Lookout and
13 some other areas, are there any other examples of First
14 Nations looking to engage in a similar initiative to the BC
15 First Nations Health Authority?

16 **DR. VALERIE GIDEON:** There is a lot. I
17 would say -- I say a lot because I'm -- I'm judging it on
18 the basis of, you know, the last 20 years. I see
19 a -- really, a growing momentum. So we've had a protocol
20 agreement recently signed with MKO in northern Manitoba,
21 with Grand Chief North Wilson and our Minister.

22 And just to talk a little bit about that,
23 you know, what's interesting is that in northern Manitoba,
24 there is still such a significant shortage in basic access
25 to services, particularly physician services, and access to

1 specialist services, so it's recognized in that protocol
2 agreement where First Nations in northern Manitoba want to
3 establish a northern First Nations health authority, that
4 the Federal Government has to supplement investments in
5 order to compensate for a lack of access to provincially
6 insured services in those communities. So, you know, it's
7 a concrete recognition that we have to address service
8 gaps, in addition to looking at a new governance model that
9 will be driven by First Nations.

10 Treaty 8 in Alberta has recently -- just
11 recently met with our Minister to speak about their
12 interests with respect to First Nations health governance.
13 We have the -- all the non-self-governing First Nations in
14 Quebec, we have been working with them since 2014 to
15 support them financially, to have discussions among
16 communities and among leadership, of course, to look at a
17 new governance model. It is a tripartite initiative and it
18 is health and social services because those services are
19 brought together in a Quebec context.

20 And so it's very exciting, especially with
21 the creation of the Indigenous Services Canada, it also
22 means that they're not negotiating with two separate
23 federal departments, we are one department in the
24 negotiation, so we expect to sign a tripartite protocol
25 agreement shortly with them.

1 In Saskatchewan, our Minister on May 17th
2 announced a memorandum of understanding with Onion Lake
3 Cree Nation, and it will be the first time that we are
4 developing a treaty relationship-based funding agreement
5 with Onion Lake Cree Nation, or with any nation outside of
6 what is a modern treaty or self-government context.

7 And so this is a funding agreement that
8 recognizes that treaty relationship, it is a Treaty 6
9 Nation with the medicine chest clause, so we are working
10 very closely with Onion Lake in order to be able to reflect
11 that treaty relationship and a funding agreement, and our
12 Minister committed to that through an MOU on Onion Lake
13 territory on May the 17th.

14 So those are just examples. I know that the
15 M'kmaq of Nova Scotia have also expressed an interest in
16 exploring a similar arrangement for health, as they've had
17 with education, which has been extremely successful and
18 demonstrated some very concrete educational outcomes for
19 community members, and we're very excited also about that.

20 So wherever we are called, we will go, and
21 we continue to promote these types of arrangements because
22 we do see the incredible opportunity to improve health
23 outcomes through these arrangements.

24 **MS. ANNE TURLEY:** Thank you. I'm going to
25 now turn to ask you some questions about the primary health

1 care which you talked about earlier, and you spoke about
2 nurses delivering health care in communities. So in terms
3 of supporting these nurses, what can you talk about in
4 terms of education, best practices, to ensure that people
5 that are accessing these are -- receive good service?

6 **DR. VALERIE GIDEON:** Primary care nursing is
7 absolutely a challenge, and it's a challenge across the
8 country. It's certainly a challenge for all jurisdictions
9 that are delivering services in remote and isolated
10 community context.

11 There's a nursing shortage across Canada and
12 so we are competing for very scarce resources, particularly
13 nurses, and health practitioners overall, that are willing
14 and able to work in a more isolated geographical context.

15 A few years back, we introduced a national
16 nursing recruitment retention strategy to do a more
17 intensive marketing campaign, leveraging social media and
18 so forth. We did get a significant amount of interest and
19 continue to do so, but at the end of the day, it is about
20 identifying those health practitioners that are able to
21 stay for longer than a two to three years period in a
22 community, to establish those trust relationships and
23 really be able to fully become active participants in
24 community life, and so that is -- continues to be a
25 challenge.

1 Some of the nursing students that we hire,
2 for instance, will gain experience for two to three years,
3 but then they will move on to something else, or they will
4 marry or have kids, or, you know, do things that people do
5 and -- and as a result of that, often do leave the
6 community.

7 We have made in roads though with respect to
8 recruitment. We have a recent evaluation of our clinical
9 client care initiative, which essentially encompasses
10 primary care nursing which hasn't yet been released, it's
11 just in the process of going through approvals, but it does
12 demonstrate that we've been able to make progress through
13 the national strategy.

14 We also were able to streamline some of our
15 staffing processes by creating more consistent approaches
16 to staffing, assessment tools and so forth, to expedite the
17 process and have our regional offices do more of the right
18 fit kind of discussion with the nurse around, well, this
19 is -- which community would you be interested in and these
20 are the types of circumstances.

21 We've standardized our onboarding process as
22 well so that we have a very clear onboarding checklist that
23 everybody goes through, and we've standardized the
24 training, mandatory training, that nurses must complete
25 before they can actually work in the community.

1 In 2015, the office of the Auditor General
2 of Canada did an audit on this type of service and training
3 and found that we had not been adequately monitoring our
4 compliance with respect to mandatory training, so we've
5 significantly improved in that regard. It remains a
6 challenge for recertification because these training,
7 they're -- you know, they expire after two to three years.
8 If you get pediatric life support training, you can get it
9 as a parent, it expires after a few years, you have to come
10 back out, it's a face-to-face training, and then come back
11 in, so we always have, you know -- we always have a short
12 time period to be able to make that happen, have relief
13 nursing services available to come in and replace the nurse
14 when he or she needs to come out for training.

15 So there's also availability of training in
16 both official languages. *En français, c'est pas toujours*
17 *facile de trouver l'accès* and a lot of this training is not
18 yet available remotely, so using Telehealth or
19 Tele-education is not always possible, so we need to
20 modernize there.

21 We have implemented more quality assurance
22 such as internal audits of our operations. We are
23 advancing on accreditation. There have been First Nations
24 nursing stations that have been accredited, and we are in
25 the process of accrediting three of our nursing stations in

1 Alberta to begin that process.

2 A success factor, though, with accreditation
3 is the state of health infrastructure needs to be at par,
4 and so we had many resource constraints with respect to
5 health facilities, infrastructure funding. However, with
6 recent investments in social infrastructure funding by the
7 government, we are able now to really improve the state of
8 health facilities infrastructure across the country.

9 Maybe just to add, cultural safety training,
10 so that is a big priority for all Canadian health service
11 delivery organizations. It's a -- it's an emphasis in the
12 Truth and Reconciliation Commission Calls to Action and
13 multiple reports and evaluations. So all of our -- all of
14 the nursing staff that we hire have to complete cultural
15 competency and safety training.

16 We mainly use the BC Provincial Health
17 Authority training that has been supported by First Nations
18 in BC. However, we are developing a specific FNIHB
19 cultural competency and safety training program with First
20 Nations Inuit, we've invited Métis also to participate in
21 that curriculum development. We're doing that at the
22 moment.

23 So there are other things that I could say,
24 but I will stop now for the sake of time.

25 **MS. ANNE TURLEY:** Thank you, and what I'm

1 going to do, Dr. Gideon, is go back and ask you, there's a
2 lot of information there, some particulars on some of it.
3 You spoke about an evaluation of client care.

4 **DR. VALERIE GIDEON:** M'hm.

5 **MS. ANNE TURLEY:** And what did that entail?
6 Who did it involve?

7 **DR. VALERIE GIDEON:** So they -- they
8 obviously review all of the administrative data that -- that
9 we have. They also have done community site visits, they
10 also have done surveys. As a part of that, there's quite an
11 extensive methodology, and it includes client communication
12 and client survey and community member information.

13 I do think we want to and we have identified
14 that it's important for us to find a more systematic way to
15 gather client and community feedback with respect to
16 services that are delivered by the department, and in fact,
17 it's a priority for the entire department. As part of
18 Indigenous Services Canada, it's actually something that our
19 deputies see as fundamentally important to actually get that
20 retroactivity directly from First Nations, Inuit, and Métis
21 for across the department, and so it's something that we
22 need to find a way to do better, but it is absolutely part
23 of the evaluation process.

24 **MS. ANNE TURLEY:** And you also referred to
25 the fact that there's cultural safety training. Can you

1 explain for the sake of everyone what -- how would you
2 characterize or define cultural safety training?

3 **DR. VALERIE GIDEON:** Well, I would, I think
4 -- cultural competency is -- is really having the knowledge
5 with respect to Indigenous culture, history, socioeconomic
6 conditions, leadership, governance mechanisms. Cultural
7 safety, though, is -- is going much farther than that, which
8 is to recognize the power differentials between the
9 relationship of being a health provider and being a patient
10 and understanding what that means. Having more clear
11 sensitization with respect to how the -- the patient's
12 overarching experiences, their values, their ways of
13 communicating, making sure that the environment is safe,
14 nonjudgmental.

15 So those are the kinds of things, and we --
16 we have training in this regard, but we also have some
17 language in our clinical practice guidelines specific to
18 cultural competency and cultural safety. And we offer some
19 definitions in those materials, which is based on other
20 published experts such as Pauktuutit, for instance, has
21 published some materials in that regard. And so we leverage
22 material that's out there and evidence that has been
23 developed elsewhere.

24 And -- and this is a -- an emerging field as
25 well with respect to Canadian health care. We are currently

1 funding or in the process of providing resources, but have
2 confirmed the resources for the British Columbia First
3 Nations Health Authority, where they are interested in
4 developing a national standard for cultural safety and
5 humility. They have -- they developed successfully a
6 declaration for cultural safety and humility that all
7 provincial regional health authorities have signed onto. We
8 have confirmed that we're interested in being a signatory to
9 that as well.

10 It is specific to BC, but they will be taking
11 that experience and that work and working with the Health
12 Services Organization, which is affiliated with
13 Accreditation Canada, to develop a national standard. And
14 that was brought to the Assembly of First Nations Chiefs
15 Committee on Health, so it wasn't a decision sort of that
16 the department unilaterally made with the BC First Nations
17 Health Authority. But because they have such a significant
18 amount of expertise that they've built through their health
19 authority experience, they are sort of a natural place to
20 begin that process and, of course, to solicit input and --
21 and -- from First Nations across Canada in that effort.

22 So we're quite excited about that, and there
23 are mainstream Canadian health organizations that are also
24 very interested in that work and want to support the -- the
25 adoption of that standard beyond just federally funded, you

1 know, specific for health services for First Nations, Inuit,
2 but also for provincial and territorial health services that
3 may not be specific to Indigenous peoples but that impact
4 the ability to deliver effective and quality care to
5 Indigenous peoples when they come to the door.

6 **MS. ANNE TURLEY:** You just mentioned, Dr.
7 Gideon, clinical practice guidelines. Can you just explain
8 what those guidelines are and why they were produced?

9 **DR. VALERIE GIDEON:** They're meant as
10 educational tools in order to support nursing practice in a
11 remote and isolated community context. While they are
12 developed or supported by the branch, the First Nations
13 Inuit Health Branch, they are -- have also been used by
14 other jurisdictions such as the Yukon, Nunavut, and
15 Newfoundland and Labrador, and the BC First Nations Health
16 Authority.

17 Obviously, when nurses are educated through
18 their college, university-type environment, they receive a
19 -- a great deal of training and information and education,
20 but their scope of practice with respect to working in an
21 isolated geographic setting and also the type of information
22 that they would require is a bit different, right? It --
23 it's got some distinctions, and so it's reflecting that and
24 understanding the fact that they have to have knowledge with
25 respect to a broad, broad variety of health and social

1 issues that -- that come through the door of a primary
2 healthcare facility in First Nations communities. And also
3 to ensure that cultural competency, cultural safety is
4 factored in their practice.

5 And so that's what the guidelines are meant
6 to do. They are updated every few years and they do reflect
7 emerging evidence to the best extent possible. They're
8 developed by external consultants, reviewed by an advisory
9 committee process. I think that we are looking, though, for
10 external partners to support that process and greater First
11 Nations and Inuit engagement in the development of the
12 guidelines and are having discussions with respect to how we
13 could make that happen. They are publicly available on --
14 on the website.

15 **MS. ANNE TURLEY:** And I would note that,
16 again, we have not put them in as an exhibit because they're
17 quite voluminous with many chapters, but a link to the
18 guidelines have been produced in our materials.

19 Dr. Gideon, with respect to the nurses who
20 provide this primary care, can you tell us how many of them
21 would be First Nations or Inuit people themselves?

22 **DR. VALERIE GIDEON:** It's about a quarter,
23 which is low, I would say. We've, overall, in the branch,
24 set a target of 30 percent by 2020 through a very, very
25 targeted initiative which we introduced in -- 2015? Yes. I

1 hope it's not '14. I'm -- I'm pretty sure it's '15. And so
2 we -- and I'm the champion for Indigenous employees. I was
3 for Health Canada and now I am specifically for the branch
4 in the new department, so I've been very actively involved
5 in that initiative.

6 I think with respect to nurses and Indigenous
7 nurses, we are competing with many Indigenous organizations
8 that are delivering their own health services, and of
9 course, if you're an Indigenous health practitioner, you
10 probably prefer to work for an Indigenous organization in
11 your community and tribal councils and so forth. But we are
12 working with the Canadian Indigenous Nurses' Association.

13 For an example, on an Indigenous knowledge --
14 I forget the title of it, but an Indigenous knowledge
15 initiative to influence curriculum development in nursing
16 schools and continue to make them more welcoming for
17 Indigenous young or not-so-young people to be supported to
18 go through the nursing profession and potentially also other
19 health professions. We continue to fund Indspire for
20 specific bursaries relating to health professions. I think
21 that, over the past ten years, they've been able to fund 500
22 students, Indigenous students specifically, to support their
23 health careers. When we do have nurses that choose to work
24 within the branch, we, of course, try to support them with
25 respect to accessing other levels of nursing education, so,

1 for instance, doing their master's degrees and so forth, and
2 advance in the organization.

3 But absolutely, it's a challenge. It is a
4 big priority to increase representation, but at the same
5 time, we don't want to do it at the expense of First Nations
6 organizations or Inuit and Métis organizations that also
7 want to hire their own members in order to be able to
8 deliver services, so we don't want to work
9 counterproductively to the devolution of services, which is
10 also fundamental to our mandate. So it's a bit of a
11 balancing act.

12 **MS. ANNE TURLEY:** Thank you. Now, you spoke
13 earlier about Telehealth, and I'd like to turn to speaking
14 about these types of digital health technologies and perhaps
15 if you can address how leveraging these technologies would
16 promote access to healthcare services.

17 **DR. VALERIE GIDEON:** So I've been a long
18 believer of digital health technologies, as it's called
19 today, but was called telemedicine when I did my doctorate
20 degree in that field, which I won't say the date, but it's a
21 long time ago. I actually was involved in the first
22 Telehealth project in First Nations communities, supporting
23 two communities in particular to develop the first
24 tele-medicine initiatives at that time. And, you know,
25 it's -- although, of course, progress has been made,

1 certainly not at the speed that many of us championing this
2 area would have liked. I think connectivity, bandwidth
3 capacity, has been a longstanding challenge, and continues
4 to be across Indigenous communities, particularly in the
5 north.

6 We have had some successes, for instance, in
7 partnering with the province and other Federal departments
8 and Bell Aliant, to put in fiberoptic -- and NAN, to put in
9 fiberoptic across communities in northern Ontario. There
10 is a significant project underway now to support First
11 Nations community connectivity across Manitoba, but it's
12 still a challenge. I mean, I think in Saskatchewan most
13 communities now have some access to wifi services in their
14 health facilities, but it's relatively recent still.

15 We have about 250 active Telehealth sites
16 across communities, not including British Columbia. When I
17 say these stats, of course they are operating within their
18 own context.

19 Most of the Telehealth consultations that
20 are occurring are in the area of mental health, but also in
21 the area of dental care and oncology as follow-up consults.
22 We have -- we receive regular data and evaluations with
23 respect to those services.

24 Electronic health records, of course, are
25 another area of critical importance to ensure that health

1 practitioners in communities have access to a more complete
2 patient record because, of course, we know that our members
3 are travelling in and out of community on a regular basis,
4 and if you're, for instance, a nurse responsible for
5 childhood immunizations, if you don't know for sure if the
6 child accessed -- especially in areas where there is access
7 relatively close by to a rural health centre or to a
8 hospital, you're never really sure exactly, and you don't
9 really know if you've got the complete immunization record,
10 so you're sort of dependent on parents remembering which
11 vaccine their child received when or, you know, getting
12 access to that information.

13 So we've made some in roads there. We do
14 have many communities that have been able to select and
15 adopt a community health record or -- very few electronic
16 medical records though, which are more physician-based
17 systems. Wherever possible we, of course, encourage
18 communities to look at the intra-operability of systems
19 with provincial health systems just so that they are able
20 to share information with physicians' practices or
21 hospitals or -- or what other type of service delivery
22 agencies are involved in their community members' care, and
23 so we've been able to do that.

24 I think robotics is another area. We had
25 our first robotics initiative in Nain, Labrador, Rosie the

1 robot, which had very successful outcomes, but because of
2 connectivity, bandwidth and funding challenges, was not
3 able to be sustained. We're reactivating it now with the
4 Labrador-Grenfell Health Authority and the Nunatsiavut
5 government.

6 In Saskatchewan they have done quite a great
7 job of introducing robotics and Doc-in-the-Box technology,
8 which enables physicians to actually conduct remote rounds
9 of their patients and actually do follow-up consults. The
10 Athabasca Health Authority has been supporting that,
11 they've been doing clinics in Stony Rapids. Some of that
12 has been documented, so we've received funding in budget
13 2017 specifically to try to advance robotics in the area of
14 health care and introducing that.

15 You know, although people would think that
16 community members might be resistant to the use of those
17 technologies, there's actually quite a lot of acceptance
18 now of those technologies. You know, people who don't want
19 to travel out, they have children at home or so forth, or
20 to do post-op follow-ups after you've been discharged from
21 hospital, you don't necessarily want to go back into if the
22 city for that, so there is receptivity.

23 I think the key to success is to make sure
24 that it's not an either/or, that if a community member
25 wants to travel out, they have the ability to do that.

1 And, of course, we are trying to continue to
2 increase its use for tele-education, particularly with
3 health practitioners, to increase the level of compliance
4 with respect to ongoing training requirements of health
5 practitioners and their needs.

6 **MS. ANNE TURLEY:** If I can ask you to turn
7 to Tab 4 of the book of documents, this is the document
8 entitled Guidelines for the FNIHB eHealth Infrastructure
9 Program dated March 2012. Can you give a brief explanation
10 about what this is?

11 **DR. VALERIE GIDEON:** It basically just
12 provides guidelines for some of the types of activities
13 that Federal, FNIHB, eHealth funding provides support to
14 with respect to communities. That's really what it does
15 and it speaks to many of the things that I talked about
16 just briefly in terms of an overview of projects that are
17 occurring.

18 **MS. ANNE TURLEY:** Chief Commissioner, I
19 would ask that this -- these guidelines be admitted as the
20 next exhibit in these proceedings.

21 **CHIEF COMMISSIONER MARION BULLER:** Yes, the
22 guidelines for the FNIHB Health Infrastructure -- Info
23 Structure, sorry, Program, (EHIP) March 2012, is Exhibit
24 27, please.

25 --- **EXHIBIT NO. 27:**

1 "Guidelines for the FNIHB eHealth
2 Infostructure Program (eHIP),"
3 (March 2016) Health Canada, First
4 Nations and Inuit Health Branch,
5 ISBN: 978-1-100-5406401 (23 pages)

6 **MS. ANNE TURLEY:** Now, in terms of
7 challenges or barriers to accessing health services, you
8 spoke earlier about recruitment and retention of community
9 health care workers, and you talked about a recruitment and
10 retention strategy. Is there anything else that FNIHB is
11 doing to address this and try to ensure more continuity?

12 **DR. VALERIE GIDEON:** Well, I mean, I think
13 the nursing recruitment retention strategy is fairly broad,
14 and it tackles everything from student bridging and
15 preceptorships, to the marketing aspects, to providing
16 cultural safety and competency training and so forth. I've
17 tackled a lot of those areas. You know, I think what
18 continues to -- what we continue to miss is a dedicated
19 educational environment for students who know and are
20 interested in entering a northern nursing context.

21 We used to have that years ago, it doesn't
22 exist anymore, and I think that that is something that we
23 are looking for partners to be able to re-establish. I
24 think it is important. The Northern Ontario School of
25 Medicine is an example which is, of course, respect to

1 training physicians, has been successful in demonstrating
2 that they've been able to recruit students, train them and
3 then have them continue to work in the northern context,
4 right.

5 So I do think that it would be helpful
6 to -- to have something that's more specifically targeted
7 with respect to that type of education environment, to
8 better prepare people to come forward.

9 **MS. ANNE TURLEY:** Any other challenges or
10 barriers that you see to accessing health services in these
11 communities?

12 **DR. VALERIE GIDEON:** Oh, there's a -- I
13 mean, geography I have spoken about. Demographics is a
14 real factor. We have a significantly growing population,
15 and while we recognize, of course, that it's a younger
16 population compared to in other Canadian communities, it's
17 also more rapidly aging as a population, you know, where I
18 believe -- well, I wouldn't say a percentage because I'm
19 not exactly -- I'm not sure I'm going to remember it right.
20 But, you know, it definitely demonstrates that the
21 population over 45 is going to grow significantly by 2026,
22 and so there's a need to support that aging population and
23 to bring in services that are adapted to them in
24 communities.

25 You know, obviously provincial health

1 systems, territorial health systems, the way in which they
2 organize their services is a big determining factor with
3 respect to access in communities. The more that health
4 systems are centralizing services in large urban centres,
5 it has been -- it has created longer distances that
6 community members have to travel to in order to access
7 services.

8 You know, several provinces have had to
9 close rural hospitals, for instance, so that means longer
10 medical transportation, less access to regular physician
11 visits or primary care. So, you know, I do think that that
12 has contributed to being a barrier.

13 Of course, there are continued higher rates
14 of chronic and communicable diseases in communities. We
15 have certainly done or made a lot of investments in the
16 area of health promotion to raise awareness about risk
17 factors in communities with respect to certain diseases,
18 but we continue to lack access to early diagnostic tools in
19 communities, point of care testing and so forth.

20 And where we have been able to have point of
21 care testing, for instance, in communities in Saskatchewan
22 we have actually -- communities have been able to show that
23 they have been able to exceed the World Health Organization
24 target in HIV, for instance, of 90/90/90, which is 90 -- 90
25 percent aware of their HIV status, 90 percent accessing

1 treatment and 90 percent having viral suppression.

2 So it's not that these objectives can't
3 be achieved in communities. It's that it is absolutely
4 important to collaborate with provincial/territorial health
5 systems in order to be able to access those areas such as
6 physician support, specialist support, and diagnostic
7 technology, laboratory, pharmacy services, that really,
8 within the FNIHB context, is not something that we have
9 direct funding and responsibility for. So
10 it's -- it's -- it's creating those linkages with
11 provincial/territorial health systems that is extremely
12 important in order to increase access to services and
13 communities.

14 **MS. ANNE TURLEY:** Thank you, Dr. Gideon.
15 We're going to turn now to focus on mental wellness
16 services. And this is dealt with at pages 9 to 13 of your
17 overview. So in terms of ensuring there are culturally
18 appropriate services, what is being done in order to
19 achieve that?

20 **DR. VALERIE GIDEON:** Well, within the area
21 of mental wellness, communities are receiving -- and when I
22 say "community", I just -- for the sake of time, I'm using
23 that language in a very broad sense. Obviously, tribal
24 councils and other health organizations have been mandated
25 by leadership to exercise varying roles in supporting the

1 delivery of mental wellness services to First Nations and
2 Inuit, so I'm just -- you know, I'm going to use broad
3 language. But, you know, they -- the federal government
4 itself is not directly delivering the services with respect
5 to mental wellness. However, we do, through the
6 Non-Insured Health Benefits Program and the Indian
7 Residential School Health Support Program, fund directly
8 services of registered providers who are providing mental
9 wellness services to individuals, families, or communities.
10 And then, of course, communities are receiving funds
11 through contribution agreements to deliver those programs
12 and services.

13 In 2015, the First Nations Mental Wellness
14 Continuum Framework was released. It had been endorsed by
15 Chiefs in Assembly in 2014 in the summertime at the -- at
16 the FNAGA. That framework was developed by First Nations.
17 We are a partner in the initiative, which is why we are
18 able to -- to include it in our exhibits, but, really, it
19 was driven from a First Nations perspective with First
20 Nations mental health experts and First Nations
21 representatives coordinated by the AFN.

22 That Mental Wellness Continuum Framework
23 really speaks to a total transformation with respect to how
24 the federal government has made investments in the area of
25 First Nations mental wellness. It speaks to culture as the

1 foundation, moving up away from a program by program
2 approach, creating that continuum of service, following
3 evidence-based practices, but not just Western evidence,
4 right? We're talking about recognizing Indigenous
5 evidence, Indigenous knowledge within that context. It
6 talks about the fundamental approach of hope, belonging,
7 meaning, and purpose, and connecting that to teachings such
8 as by Elder Dumont. And it has really -- it's -- it's very
9 heavily utilized across the country by First Nations in
10 terms of informing the work that they are doing. It has
11 led to, for instance, the training on trauma-informed care
12 approaches.

13 And for us, since the last three federal
14 budgets where we've received funding for mental wellness,
15 significant funding for mental wellness, to increase, for
16 instance, the present -- the presence of mental wellness
17 teams across the country going from -- I think it's 11 to
18 43, you know, going from a significant amount of additional
19 resources, those are all based on a continuum framework.
20 And so I think that the Continuum Framework really embeds
21 and entrenches culture as that foundation of any current or
22 future federal investments within the area of mental
23 wellness.

24 **MS. ANNE TURLEY:** Dr. Gideon, if I can ask
25 you to turn to tab 5 of the book documents?

1 DR. VALERIE GIDEON: M'hm.

2 MS. ANNE TURLEY: Is this the Mental
3 Wellness Continuum Framework that you're speaking about?

4 DR. VALERIE GIDEON: I am, yeah. That's the
5 one.

6 MS. ANNE TURLEY: Chief Commissioner, I'd
7 ask that the First Nations Mental Wellness Continuum
8 Framework would be entered as the next exhibit.

9 CHIEF COMMISSIONER MARION BULLER:
10 Certainly. First Nations Mental Wellness Continuum
11 Framework is Exhibit 28, please.

12 --- EXHIBIT NO. 28:

13 First Nations Mental Wellness
14 Continuum Framework (January
15 2015), Health Canada, ISBN: 978-1-
16 100-25327-5 (58 pages)

17 MS. ANNE TURLEY: Now, you mentioned that
18 this was -- you're a partner in this, and it was a
19 co-development. Any other examples of this in terms of
20 the -- of access to mental wellness services?

21 DR. VALERIE GIDEON: Well, I mean,
22 it's -- it's even informed recent changes to the mental
23 health benefit under the Non-Insured Health Benefits
24 Program where we've seen an alignment between that
25 counselling benefit and the Indian Residential Schools

1 Health Support Program counselling benefit, so that the
2 benefit is more open. And we, in budget 2017, we
3 were -- so that it's not specific to crisis. I should just
4 specify. Where previously it was specific to crisis, it's
5 now any counselling requirements that individuals or
6 families require. We are also now have designated
7 resources to also be able to support traditional healers,
8 not, of course, directly, but through communities to
9 provide mental wellness services, where in the past, that
10 was not something that was part of the Non-Insured Health
11 Benefits Program, although it was part of the Indian
12 Residential School Health Support Program. So we've been
13 able to bridge the differences between those programs,
14 having seen that the Indian Residential School Health
15 Support Program has in -- in -- in a recent evaluation,
16 even just from July 2016, has such an incredibly high rate
17 of client satisfaction with respect to how the program has
18 been delivered.

19 So taking those lessons and applying them to
20 the Non-Insured Health Benefits mental health counselling
21 and not requiring administrative documentation such as a
22 treatment plan, making sure that prior approval is not
23 required for the first number of counselling sessions, and
24 also using funding agreements, like contribution
25 agreements, to be able to better deliver the benefit so

1 that it's just not dependent on an individual coming
2 forward, but when tribal councils or First Nations health
3 organizations say, you know, we've -- we really are going
4 to need ongoing providers in addition to what we can
5 support in our communities to provide counselling to our
6 members, we need to leverage this benefit and control it
7 and deliver it. And so we have been able to, over the
8 years, do that. So it has had a very significant
9 influence.

10 **MS. ANNE TURLEY:** I'm just going to stop you
11 there for a minute. You're -- you mentioned the Indian
12 Residential Schools Resolution Health Support Program. If
13 I can ask you to turn to tab 8 of the book of documents?
14 Is this the relevant program policy framework?

15 **DR. VALERIE GIDEON:** It is at the moment,
16 yeah. M'hm.

17 **MS. ANNE TURLEY:** And this is dated June
18 2014?

19 **DR. VALERIE GIDEON:** That's correct.

20 **MS. ANNE TURLEY:** And you were mentioning
21 about the most recent budget. And can you explain what in
22 the most recent budget was announced with respect to this
23 program?

24 **DR. VALERIE GIDEON:** So we received an
25 extension for another three years. So quite pleased to see

1 that. And, you know, what's interesting about this
2 initiative is that the uptake has been very different
3 across the country where in the -- I mean, even though it's
4 been in existence now for a significant period of time, in
5 the first years, you would see a lot of uptake, for
6 instance, in the Prairie provinces, right? But not a lot
7 in the North and -- and when I -- the Territories, but also
8 even in northern pockets of provinces. And in the most
9 recent years, we've seen a huge surge in access to the
10 initiative. So not everybody is going through, obviously,
11 their healing journey at the same time in the same way.
12 And so we -- we do believe that it's very important for
13 this initiative to continue to be extended for that other
14 three-year period, because we do see continued strong
15 uptake in -- in pockets of the country where there wasn't a
16 lot of uptake in the early years.

17 **MS. ANNE TURLEY:** Chief Commissioner, I
18 would like to enter as the next exhibit the Indian
19 Residential Schools Resolution Health Support Program
20 policy framework dated June 2014.

21 **CHIEF COMMISSIONER MARION BULLER:** Yes. The
22 Indian Residential Schools Resolution Health Support
23 Program policy framework June 2014 is Exhibit 29, please.

24 --- **EXHIBIT NO. 29:**

25 Indian Residence Schools

1 Resolution Health Support Program
2 Policy Framework (June 2014),
3 Health Canada (12 pages)

4 **MS. ANNE TURLEY:** Some of these are
5 tongue-twisters.

6 **CHIEF COMMISSIONER MARION BULLER:** No
7 kidding.

8 **MS. ANNE TURLEY:** Dr. Gideon, you mentioned
9 an evaluation of the program. And how -- how was that
10 evaluation undertaken?

11 **DR. VALERIE GIDEON:** So it was
12 a -- a -- what we call a cluster evaluation. It was an
13 evaluation of the suite of mental wellness initiatives at
14 the community level, like community-based programs, that
15 the First Nations Inuit Health Branch funds. These
16 evaluations are mandated by the Treasury Board every five
17 years, and they are done by the Office of Audit Evaluation
18 outside of the branch. It is still within the federal
19 context, but these evaluators are independent from those
20 that are funding or delivering or developing policies.
21 They are experts, so with respect to evaluation, we -- they
22 have separate protocol agreements signed with the Assembly
23 of First Nations and Inuit Tapiriit Kanatami with respect
24 to ensuring that evaluations that are conducted on programs
25 that are funded by the First Nations Inuit Health Branch

1 include First Nations and Inuit perspectives at the design
2 stage, the scoping stage, through to the -- the review of
3 the final evaluation report to make sure that the reports
4 have -- have recommendations that would be supported by
5 First Nations and Inuit, and that are reflective of the
6 realities and the perspectives that they've expressed in
7 the context of the evaluations.

8 **MS. ANNE TURLEY:** Thank you. And earlier you
9 were speaking about the Non-Insured Health Benefit Program,
10 and some of the mental health counselling that would be
11 available. If I can have you turn to tab 7 of the book of
12 documents.

13 **DR. VALERIE GIDEON:** M'hm.

14 **MS. ANNE TURLEY:** Is this reflective of what
15 you were speaking about?

16 **DR. VALERIE GIDEON:** Correct. And it was
17 very recently changed. So it was published in March of
18 2018, and again, it's to reflect the comments that I made
19 earlier. And I -- I would also like to mention that since
20 2015, we have been involved with -- could be 2014, I'm
21 sorry, I keep confusing those two years. I should have
22 never gone on maternity leave. But they have -- the
23 Assembly of First Nations requested that we conduct a joint
24 review of the Non-Insured Health Benefits Program benefit,
25 by benefit, by benefit, by benefit. Not only with them, of

1 course, so that they are coordinating the effort, and
2 includes First Nations representatives from across the
3 country. It includes Non-Insured Health Benefits
4 navigators, which are First Nations employees of First
5 Nations organizations that help in -- community members to
6 navigate the program.

7 So the Minister of Health at that time,
8 Minister Ambrose, committed to the joint review process.
9 And we have been going through a very in-depth analysis of
10 all of the community-level input that was gathered
11 through -- by First Nations on all of the issues with
12 respect to accessing the program. They also, of course,
13 engaged with service providers through professional
14 associations or more directly.

15 And so as a result of all of those
16 recommendations, we developed action plans for the Mental
17 Health Counselling Benefit. And so the new guidelines are a
18 product of that review process. And we are going through
19 that with all of the other benefit areas at this time.

20 **MS. ANNE TURLEY:** And so what we see at tab
21 7, this is the updated guide?

22 **DR. VALERIE GIDEON:** Correct.

23 **MS. ANNE TURLEY:** Chief Commissioner, I would
24 ask that the Guide to Mental Health Counselling Services be
25 admitted as the next exhibit.

1 **CHIEF COMMISSIONER MARION BULLER:** Yes. The
2 Guide to Mental Health Counselling Services is Exhibit 30,
3 please.

4 **--- EXHIBIT NO. 30:**

5 "Guide to Mental Health Counselling
6 Services" (March 2018, last dated
7 modified April 20, 2018), Government of
8 Canada, Non-Insured Health Benefit
9 Program & Indian Residence Schools
10 Resolution Health Support Program (24
11 pages)

12 **MS. ANNE TURLEY:** Dr. Gideon, you spoke about
13 the work with First Nations partners. Can you address
14 whether FNIHB has also been working with Inuit partners?

15 **DR. VALERIE GIDEON:** So we have always
16 invited Inuit to be part of our review of the benefits as
17 well. They have a different process in which they provide
18 input to us. They do so through bilateral discussions and
19 as well as -- as full participants in our Senior Management
20 Committee. We've continued to share the information with
21 them with respect to the joint review process. And -- and
22 they would be continued to be invited to participate in
23 whichever way they would wish to do so.

24 **MS. ANNE TURLEY:** Thank you. We've --
25 we've -- you've given some examples of the mental wellness

1 services available, the Indian Residential Schools Program,
2 are there any other services that you would see as promising
3 practices in order to promote greater access to mental
4 wellness services in the communities that you could
5 highlight?

6 **DR. VALERIE GIDEON:** In -- as a result of
7 investments that were made in Budget 2016, we also
8 established with a First Nations organization, a Hope for
9 Wellness line that is available 24/7 for individuals that
10 feel the need to call and to talk to someone. There's
11 actually been quite a good uptake of that Hope for Wellness
12 line. We've had close to 5,000 individuals call in since it
13 was put into place. It -- the services are available in
14 French, and English, and as well in three Indigenous
15 languages. We've recently introduced a chat function,
16 particularly to try to get a -- a greater reach with youth.
17 We haven't found that we've had a lot of young callers in
18 the Hope for Wellness line. So the Kids Help Phone has a
19 chat function, and so in working with the Kids Help Phone
20 the company that is administering the First Nations company
21 that is administering the line, was able to introduce a chat
22 function for the Hope for Wellness line very recently.

23 So, I mean, that -- that's initiative that we
24 directly fund, but there are so many initiatives that First
25 Nations and Inuit have put into place across this country to

1 support their members. And there is a lot of increasing
2 activity. I think, the fact that we've been able to
3 quadruple the number of mental wellness teams just over the
4 last two years, there has been a significant increase in
5 capacity. And those teams are completely designed by First
6 Nations and Inuit. There are no policy guidelines, you need
7 to have this or that, or you know, it -- it is a very open
8 approach. And -- and so, you know, some teams are focusing
9 on children. Some teams are focusing on post-traumatic
10 stress disorder, trauma-informed Care, so there -- they have
11 variety of priorities that they are -- that they've
12 identified in a different mix of providers, which, of
13 course, include in many cases Elders or traditional healers.

14 So, I mean, I think we will -- we have seen
15 evidence already, from the 11 mental wellness teams that
16 pre-existed those investments, but I think that the next
17 evaluation will definitely show a significant amount of
18 improvements. We know that we have raised awareness with
19 respect to mental health issues. Increases in individuals
20 seeking access to help, where before there was more stigma
21 with respect to accessing help for mental wellness related
22 issues. A -- a significant amount of recognition on the
23 inter-generational impacts of residential schools, which are
24 very well documented, and other impacts of colonization,
25 such as the 60s Scoop. We've seen documented evidence of

1 increased healthy behaviours in communities, such as
2 parenting involvement, individuals being able to seek and
3 maintain employment. And reduced instances of -- of at-risk
4 behaviours, such as substance use in communities. So those
5 are all things that were documented in the 2016 evaluation.

6 **MS. ANNE TURLEY:** Thank you. If I can have
7 you turn to tab 6 of the book of documents. This is a
8 document entitled, "Honouring our Strengths." Can you
9 explain what this document is?

10 **DR. VALERIE GIDEON:** So pre-dating the First
11 Nations Mental Wellness Continuum Framework, there was an
12 interest in relooking at the National Native Alcohol and
13 Drug Abuse Prevention Program, which is a program from many
14 years ago, and really the first First Nations driven program
15 that actually was fully managed and delivered by First
16 Nations, you know, in that history of the federal
17 government. And we celebrated over the years the
18 anniversaries of NNADAP, you know, it's a significant part
19 of the history of the federal government's funding with
20 respect to First Nations community programs and services.

21 But definitely there's been a significant
22 amount of emerging needs with respect to substance use and
23 addiction beyond alcohol, you know, everything from crystal
24 meth to prescription drug abuse, and now, you know, the
25 opioids issues with respect to fentanyl. So at that time,

1 First Nations experts, with respect to addiction services,
2 wanted to relook at, and -- and so did the department,
3 wanted to relook at the program and say, how do we modernize
4 it? How do we look at moving from a strict AA model,
5 Alcoholics Anonymous model, or sobriety model, to also look
6 at potentially other evidence-based approaches that
7 communities and treatment centres may want to explore?

8 Also, recognizing the lack of after-care in
9 communities, which continues to be an important gap. The
10 need for earlier identification of risks and prevention
11 efforts, and issues with respect to access to harm-reduction
12 measures, support services for pregnant women, for youth.
13 Although, there's been success with respect to the Youth
14 Solvent Abuse Program, with respect to inhalants, youth are
15 still significantly impacted by rates of cannabis use and
16 other -- and other substances.

17 So the Honouring Our Strengths framework
18 was, again, more of, like, a First Nations developed
19 framework in which we participated to be able to speak to
20 the new evidence and emerging best practices, and encourage
21 treatment centres and communities to look at these various
22 models in order to be able to deliver a more -- a multiple
23 disciplinary approach to addictions and substance use
24 supports.

25 Funding, of course, is always an issue, and

1 until budget 2018 we had not seen a significant increase
2 with respect to addictions funding outside of what we were
3 able to receive through what was called the Canadian Drug
4 Strategy, and then it was called the National Anti-drug
5 Strategy, and now it's the Canadian Drugs and Substances
6 Strategy, and in budget 2017 we were able to continue to
7 receive increased funding with respect to the broader
8 Canadian strategy in addition to funding for the FNIHB
9 specific programs.

10 But in budget 2018, 200 million over five
11 years was announced to support high risk communities, and
12 that will enable us to really ramp up treatment centre and
13 community-based addiction services I would say for the
14 first time in quite a long time.

15 One of the big priorities that First Nations
16 have identified is wage parity measures, wage parity issues
17 with respect to treatment centre workers. Although we've
18 been able to offer training and support for the
19 certification of treatment centre or workers and also the
20 accreditation for treatment centres across Canada, which is
21 a big success story for them, they derive that and are able
22 to achieve that, wage parity continues to be an issue, and
23 so we're hopeful that we're going to be able to address
24 that.

25 Infrastructure also will be a big priority

1 with respect to increasing capacity of existing treatment
2 centres, but also looking at new services and introducing
3 new services.

4 And then I would just finish by talking
5 about the on the land initiatives that have grown
6 significantly over the past five years, and that are now
7 well recognized with respect to successful approaches that
8 communities and nations have undertaken in order to better
9 support their members, including women with respect to
10 their healing journeys. You know, there's a -- there's an
11 on the land collaborative in the Northwest Territories, as
12 an example. We see NAN communities doing a lot of on the
13 land work, and they have been doing that really since the
14 prescription drug abuse crisis that hit them early on in
15 the mid 2000s. They started doing even on the land detox
16 services and some very, very innovative practices, and so
17 that is a growing area that communities have expressed a
18 lot of interest in.

19 **MS. ANNE TURLEY:** I'm going to go ask you,
20 Dr. Gideon, for the record, you referred to -- used an
21 acronym, NADAP, could you just for the record explain what
22 that refers to?

23 **DR. VALERIE GIDEON:** The National Alcohol
24 and Drug Abuse Prevention Program.

25 **MS. ANNE TURLEY:** Thank you. Chief

1 Commissioner, I would ask that the document entitled
2 "Honouring Our Strengths" be admitted as the next exhibit
3 to this proceeding.

4 **CHIEF COMMISSIONER MARION BULLER:** Yes,
5 Honouring our Strengths is Exhibit 31.

6 --- **EXHIBIT NO. 31:**

7 "Honouring Our Strengths: A Renewed
8 Framework to Address Substance Use
9 Issues Among First Nations People in
10 Canada" (2011), Health Canada, ISBN:
11 978-1-100-19331-1 (100 pages)

12 **MS. ANNE TURLEY:** In terms of accessing
13 mental health services, you've spoken about some of the
14 challenges and barriers; anything else that you would like
15 to add?

16 **DR. VALERIE GIDEON:** Having culturally
17 competent or trauma informed care providers remains a
18 challenge, and it's not only about funding, it's also about
19 finding these individuals and identifying them and bringing
20 them in.

21 There is a lack of search capacity across
22 many regions, particularly when you see several communities
23 in more of a crisis situation. It is difficult, and so, I
24 mean, we're confident with the increases in mental wellness
25 teams maybe we will be able to -- now that we have more

1 stable and growing funding that communities and Tribal
2 Councils and organizations will be able to recruit, train
3 and retain workers and service providers more effectively.

4 But that has definitely been an issue with
5 the Indian Residential School Health Support Program, for
6 instance, which is for the counselling component,
7 identifying these individuals and having them sort of
8 provide trauma informed services.

9 I'd also say that having safe spaces, I know
10 that that has come out in hearings, and it is absolutely a
11 challenge for communities. You know, not all community
12 members want to go to the health facility in the community
13 in order to access counselling. They're concerned about
14 being identified, and that is an absolute issue. You know,
15 a lot of the health facilities were designed or constructed
16 years prior to this more significant focus on mental
17 wellness, and so they are not equipped to house a
18 counselling room or culturally safe space in a health
19 facility with potentially a separate entrance area or a
20 mechanism to really maintain confidentiality. So as new
21 health facilities are being built and designed that is
22 absolutely a top of mind consideration, but we're still
23 dealing with health facilities that were constructed, 5,
24 10, 15, 20, 35 years ago, and so they're not properly
25 adapted for this purpose.

1 And I would say that's a concern overall in
2 the mainstream context, but it's much more accentuated when
3 you're working in a community that is smaller and that has
4 a lot of family connections and lots of connectedness,
5 maintaining that confidentiality is very difficult.

6 **MS. ANNE TURLEY:** Dr. Gideon, I'd like you
7 to turn to the last tab of the book of documents, Tab 9.
8 This is entitled "First Nations and Inuit Component Victims
9 of Family Violence Investments". Could you explain to the
10 Commission what this is about?

11 **DR. VALERIE GIDEON:** So in 2015 there was
12 recognition that -- by the Minister of Health at that time,
13 that victims of violence was an underserved area within the
14 health portfolio, and the health portfolio refers to Health
15 Canada and the Public Health Agency of Canada. So we
16 worked collaboratively to look at what we could do to more
17 specifically reach and support victims of violence, not
18 just in community, but also outside community.

19 And so in partnering with the Public Health
20 Agency of Canada, we put forward two streams of funding,
21 and it's over a ten-year period, but really in order to be
22 able to assess whether or not meaningful outcomes are being
23 reached through that, there's been about 50 or so projects
24 funded through the First Nations and Inuit specific streams
25 of funding. There are Indigenous initiatives also funded

1 through the Public Health Agency of Canada aspects of the
2 resources.

3 For the First Nations and Inuit specific
4 targeted funding, targeting victims of violence in terms of
5 their access to counseling services in shelters or other
6 areas where they would be seeking access to service,
7 recognizing, as I mentioned earlier, that victims of
8 violence in communities are not necessarily going to feel
9 comfortable going to the health facility in order to access
10 counselling.

11 So if they are in a -- in a safe house or
12 they're in a shelter environment, many of these
13 organizations were not necessarily aware of the counselling
14 supports that could be offered, for instance, through the
15 Non-Insured Health Benefits Program, so it was creating an
16 initiative that would specifically draw those linkages.
17 Often, they might have been trying to resource counselling
18 on their own within their own constrained budgets. So it
19 was basically creating greater outreach with respect to
20 programs and services that were funded through FNIHB, but
21 tailoring them and adapting them so that they would be more
22 flexible and would be more effective in terms of supporting
23 victims of violence.

24 It also offers case navigation, case
25 management type supports or services, trauma for

1 trauma -- training for trauma informed care for different
2 workers in shelters or other environments supporting
3 victims of violence. There are some youth specific
4 initiatives that are funded across the country.

5 And the decisions are made through the
6 regional partnership tables with First Nations and Inuit at
7 the tables, they're not made through, you know, just within
8 the FNIHB context or environment. And I think there
9 continues to be a growing interest in leveraging those
10 investments and increasing investments. So all of the new
11 investments that we've received from 2016 to '18, they are
12 all open to be able to support also victims of violence in
13 that context, so this is not an exclusive initiative.

14 It is a targeting initiative, but there is
15 an ability leverage recent investments to also more
16 effectively support victims of violence in that context.

17 **MS. ANNE TURLEY:** And in the first three
18 years of the ten-year funding, are you able to give any
19 examples of how the funding is making a difference?

20 **DR. VALERIE GIDEON:** I don't think that we
21 have any more specifically measured outcomes yet, but I
22 would say that there's definitely been new relationships
23 formed across organizations, health organizations and
24 social organizations or child and family
25 serviced -- services agencies through this initiative. I

1 think there's definitely increased access to the mental
2 health counselling through the projects that have been put
3 in place. And, for instance, in the Yukon, they were able
4 to leverage different sources of -- of resources in order
5 to create a more concerted approach to supporting First
6 Nations in the Yukon in accessing mental health supports,
7 so that it wasn't based on wherever they had -- whichever
8 organization they had come to, but that there's a central
9 coordination mechanism to support individuals that are at
10 risk, that are in distress, or that are victims of
11 violence, to have more wrap-around access to services. On
12 the land is also something that's been reinforced through
13 many of these initiatives, as well, as well as
14 trauma-informed care and awareness of trauma-informed care
15 and a greater capacity to deliver trauma-informed care to
16 victims of violence.

17 **MS. ANNE TURLEY:** Thank you. Chief
18 Commissioner, I would like to enter the exhibit referred to
19 as First Nations and Inuit Component of Victims of Family
20 Violence Investments as the next exhibit.

21 **CHIEF COMMISSIONER MARION BULLER:** Yes.
22 First Nations and Inuit Component of Victims of family
23 Violence Investments is Exhibit 32.

24 --- **EXHIBIT NO. 32:**

25 First Nations and Inuit Component of

1 Victims of Family Violence (VoFV)
2 Investments, Health Canada, ISBN: 978-
3 0-660-03153-8 (two pages)

4 **MS. ANNE TURLEY:** Thank you. Dr. Gideon,
5 those would be my questions to you, and I thank you for
6 sharing your wealth of knowledge with us. Is there
7 anything else that perhaps I didn't ask you or that you
8 haven't said that you think the Commissioners would want to
9 know?

10 **DR. VALERIE GIDEON:** You know, I just -- I
11 think maybe in just closing as I -- you know, I was asked
12 to bring forward evidence that would talk about more
13 specifically mental health and also talk about some of the
14 promising practices, as well, and the work that's
15 happening, but I also don't want to minimize the challenges
16 and the issues that remain with respect to, you know,
17 federal investments, federal approaches to programs and
18 services. I think we have really significant growing
19 momentum to effect change, but I also don't want to
20 minimize the experiences that individuals and communities,
21 nations, are having with respect to the types of services
22 that I've talked about today. I don't want to overly
23 present a positive approach, you know, in isolation of very
24 much understanding those challenges. I've had the
25 opportunity to visit many, many communities in my career

1 and speak to a significant number of community members,
2 Elders, youth, leadership. I'm always humbled by listening
3 to them and their experiences. And so, you know, it's not
4 outside the recognition of all of those -- all of those
5 experiences that I present my evidence. It's very much in
6 connection with -- with that knowledge and experience.

7 **MS. JENNIFER COX:** So, Chief Commissioner,
8 that would conclude the examination-in-chief of Dr. Valerie
9 Gideon. So at this time, I'd like to take a break. But
10 before we take a break, I'd like to remind the parties with
11 standing that with respect to communication with the
12 witness, that no counsel or representative of a party is
13 allowed to speak to Dr. Gideon at the moment until she's
14 finished her examination. I also need to remind you that
15 you have until the end of this break to assign your time
16 for cross-examination to another party. And you can also
17 pool your time. So please see Ms. Girard or Ms. Mirasty in
18 the Silver Willow -- for whatever reason, I have a hard
19 time saying that this morning -- Willow Room -- if you're
20 going to give your time to another party. And in terms of
21 returning from the break, Chief Commissioner, we are going
22 to set up a bit of another panel here. So there -- the
23 second part of a panel. So perhaps if we could have 25
24 minutes?

25 **CHIEF COMMISSIONER MARION BULLER:** Okay.

1 I'll give a specific time. We will reconvene at 10:30.

2 **MS. JENNIFER COX:** Sure. Thank you.

3 **MS. ANNE TURLEY:** I'm sorry. If I can just
4 make a clarification? In order -- with respect to the
5 parties not being able to speak to Dr. Gideon, Dr. Gideon
6 knows a number of people on a personal level, and I just
7 want to be clear that she can speak to people --

8 **MS. JENNIFER COX:** Just not --

9 **MS. ANNE TURLEY:** -- just not about her
10 evidence.

11 **MS. JENNIFER COX:** Yes.

12 **MS. ANNE TURLEY:** Because I would hate for
13 her to be isolated and not be able to speak to people that
14 she does know.

15 **(LAUGHTER)**

16 **MS. ANNE TURLEY:** Thank you.

17 --- Upon recessing at 10:06 a.m.

18 --- Upon reconvening at 10:34 a.m.

19 **MS. JENNIFER COX:** So, Commissioners, we're
20 going to start the second part of the -- the panel by
21 hearing from Jackie Anderson, who is in the red to my left,
22 and Christine Dumaine, who is directly beside me. I also
23 note that there was a revised summary of anticipated
24 evidence and the narrative, Christine's story, that was
25 provided to me during the break. I also note that we've

1 spelled Christine's last name incorrectly, so for the
2 purposes of the record, it's D-U-M-A-I-N-E. And --

3 **CHIEF COMMISSIONER MARION BULLER:** Excuse me,
4 could you spell that again? You got ahead of me.

5 **MS. JENNIFER COX:** D-U-M --

6 **CHIEF COMMISSIONER MARION BULLER:** A-I --

7 **MS. JENNIFER COX:** A-I --

8 **CHIEF COMMISSIONER MARION BULLER:** N-E?

9 **MS. JENNIFER COX:** N-E. Not M. And I also
10 provided you with a copy of a document, "Tracia's Trust" --

11 **CHIEF COMMISSIONER MARION BULLER:** Thank you.

12 **MS. JENNIFER COX:** -- which you would have
13 been provided with before, but it's my intention that that
14 will become an exhibit during Jackie's evidence. So we're
15 going to begin first with Jackie and I'm wondering if we
16 could have a either oath, affirmation, or promise to tell
17 the truth. Mr. Registrar?

18 **MS. JACKIE ANDERSON:** I'm sorry, I didn't
19 hear the answer.

20 **MS. JENNIFER COX:** What would you like to do?
21 Would you like to do an oath, an affirmation, or promise to
22 tell the truth?

23 **MS. JACKIE ANDERSON:** I don't care. Either
24 way is fine.

25 **MS. JENNIFER COX:** She's -- she's fine with

1 anything.

2 **JACKIE ANDERSON, Affirmed:**

3 **MS. JENNIFER COX:** And the other thing that I
4 forgot to mention is, second chair behind me, Thomas
5 Barnett, is working with me as well during this panel, and I
6 didn't note for the record that he was with me the last
7 -- when we began this morning.

8 **EXAMINATION-IN-CHIEF BY MS. COX:**

9 **MS. JENNIFER COX:** So, Jackie, I'm wondering
10 if you could tell the Commissioners a little bit about who
11 you are and where you work.

12 **MS. JACKIE ANDERSON:** All right. I guess,
13 first and foremost, I would like to acknowledge the
14 Indigenous territory that we are on here today and say
15 *migwetch* for having us here to share our frontline and
16 survivor stories of our women that have been affected by
17 this issue. I also want to acknowledge that this is a very
18 visual presentation that we are doing here today and, as
19 it's important that when we hear and we learn that we also
20 take care of our spirit and not allow the trauma that it
21 could potentially trigger in different forms. So I
22 encourage -- I understand there's a healing room here onsite
23 to be able to use if needed.

24 My name is Jackie Anderson, and I am from
25 Winnipeg, Manitoba. I am a Métis woman and a mother of

1 three children. I work for a phenomenal organization called
2 the Ma Mawi Wi Chi Itata Centre, which is based in Winnipeg,
3 which has been around since 1984, and this is a non-mandated
4 social service agency that was developed by community and
5 it's run by community. We are situated in 13 different
6 locations within Winnipeg that deliver service to our
7 community through volunteer, through programming, through
8 children and care programs, through healing centres, through
9 learning centres. We have well over 250 Indigenous
10 employees that work for our organization.

11 I have had the honour to work with the
12 organization since 1996. I was a student at the time, so
13 when I came into the organization, I was considered
14 capacity-building, which is something we extremely value
15 within our organization, that we are building the capacity
16 of our community and those with lived experience.

17 **MS. JENNIFER COX:** So -- and one of the --
18 the hallmarks of your time with Ma Mawi, perhaps you can
19 talk a little bit about one of the -- the big achievements
20 that you've had while you've been there.

21 **MS. JACKIE ANDERSON:** Okay. So my -- my
22 background, I guess, I -- you know, I should start off with
23 sharing, is that I also sit here as a survivor, warrior, of
24 all forms of child abuse through childhood trauma, and
25 personally, as someone with lived experience, this was an

1 area of working with children in care and helping our young
2 people through the traumas they're experiencing, which is
3 something very passionate to me.

4 I -- at a very young age, I -- I started
5 working in the field as a child and youth care worker, and
6 through coming through our organization, they invested in
7 the capacity of my gifts and my strengths and provided me
8 opportunities of learning. So over the -- well, actually,
9 it'd be 20 years that I've been with the organization, I've
10 had the opportunity to learn how to deliver programs as well
11 as the opportunities to engage in relationships with our
12 community and our young people to be able to learn what it
13 is that our community needs in order to address some of the
14 issues to support them through their own healing.

15 I've been in a position of program
16 development and coordination, so two of the programs that
17 I'd like to be able to speak about today as it relates to
18 working with sexually exploited, trafficked young people, is
19 a safe home that we currently have in Winnipeg, and it's a
20 six-bed safe home specifically for sexually exploited
21 trafficked young people between the age of 13 and 17. And
22 furthermore to that, one of our rural traditional healing
23 lodges, which we call HOME, which is Hands of Mother Earth.

24 **MS. JENNIFER COX:** And prior to or during
25 the time that you worked -- prior to working with Mawi, you

1 also worked for the Province of Manitoba, correct?

2 **MS. JACKIE ANDERSON:** Correct. I did
3 actually take a three-year break along my journey at the Ma
4 Mawi Wi Chi Itata Centre, and worked for the child
5 protection branch for three years as their provincial
6 sexual exploitation specialist.

7 **MS. JENNIFER COX:** And, Jackie, I'm just
8 going to show you a document here, I'm wondering if you can
9 identify that document?

10 **MS. JACKIE ANDERSON:** Yes, this is Tracia's
11 Trust Manitoba Sexual Exploitation Strategy, which was
12 developed within our province. And I think it's very
13 important that when we, you know, discuss or share the
14 different initiatives within Manitoba, it's very, very
15 important to understand that all of the initiatives in our
16 province was led and directed and recommended by our women
17 with lived experience.

18 Again, I want to claim that what we are
19 sharing with you today, we are not, you know, lawyers or
20 doctors or working for government. And when I think about
21 the term expert information, "expert" to me are those that
22 have been affected and those with the lived experience. So
23 it's important to acknowledge that when we look at me
24 sharing with you today some of the initiatives that have
25 come out of Tracia's Trust, which is Manitoba Strategy For

1 Sexually Exploited Children and Youth, did derive by the
2 community.

3 And that was done through the early 2000s,
4 when there was a very, very high number of children and
5 youth who were being preyed on within our province in
6 different forms, and many of the service providers and
7 women with lived experience were coming together to sit at
8 that table to discuss, you know, what the risks are and
9 what types of supports and programming that our young women
10 and young men needed. And due to that, a coalition was
11 established within our community, which is today called the
12 Sexually Exploited Youth Community Coalition.

13 And this coalition has well over 100 members
14 and well over 50 different organizations that are doing
15 different bits of programming and services to our -- for
16 our young people.

17 We have faithfully since the early 2000s
18 been coming together as a coalition once a month, and more
19 if needed, to be able to look at the trends and to be able
20 to look at the needs of our young people and what it is
21 that they do need. Because prior to 2000, one of the
22 things that we learned is that our young people were being
23 placed in residential homes that were not specialized, that
24 didn't have the education or the lived experience to be
25 able to provide, you know, that healing that our young

1 people absolutely need.

2 So when the coalition litigation came
3 together, a partnership of co-coordination with the
4 Province of Manitoba was established, and that is how the
5 Manitoba strategy was developed within our province.

6 In 2008, I believe it was, our Minister at
7 that time had summits in the north and in the south, where
8 he brought a couple of people -- a couple hundred folks
9 together in the north and south, community folks and voice
10 of the experienced, to ask them what it is that they felt
11 they needed to protect our young people. And through those
12 consultations, it was identified how important it was that
13 safe space was created that fully understood the entire
14 continuum of safety and risk that our young people are
15 going through as it relates to being preyed upon through
16 sexual exploitation.

17 **MS. JENNIFER COX:** So just a procedural
18 issue, Chief Commissioner, if we could have the document,
19 the Tracia's Trust marked as exhibit -- the next exhibit,
20 so it would be exhibit?

21 **CHIEF COMMISSIONER MARION BULLER:** Tracia's
22 Trust Manitoba Sexual Exploitation Strategy is Exhibit
23 number 33.

24 --- **EXHIBIT NO. 33:**

25 Tracia's Trust: Manitoba Sexual

1 Exploitation Strategy brochure,
2 Government of Manitoba, Sexual
3 Exploitation Unit, Child
4 Protection Branch (two pages)

5 **MS. JENNIFER COX:** And just to go back to
6 the document that we just referred to, Jackie, can you tell
7 the Commissioners a little bit about your work with that
8 particular document and that process?

9 **MS. JACKIE ANDERSON:** Well, I have been
10 involved with the Manitoba strategy in multiple ways, not
11 only working for the province. I was also responsible for
12 the three years that I was there; however, I have been an
13 active member since day one. And I say active member
14 because my passion and my experiences is on the front lines
15 with our young people and with our families.

16 And I had the honour to be trusted to be
17 able to ensure that when I'm coming to events such as this,
18 or speaking across Canada, or even internationally, that
19 when it comes to providing recommendations on what needs to
20 happen, that that consult and what I do present is always
21 driven by the voice of lived experience.

22 So if I can maybe just elaborate a little
23 bit about some of the initiatives that have come out of
24 Tracia's Trust and the work of our community coalition is,
25 as I mentioned, we've created two safe homes within our

1 province. And one of those homes, again, was -- is one of
2 our rural traditional healing lodges, and that was a
3 program that our young people were telling us over the
4 three years prior to the development, that they needed,
5 they needed that safe place where they can be out of the
6 city, away from the risks, and somewhere where they could
7 be that they could reconnect to their spirit as -- as
8 Indigenous young people.

9 And so we were very fortunate to have been
10 able to secure property and build on sacred land that is a
11 rural community, and it really is about -- it's in the
12 middle of the bush, and it's sacred land where grandmothers
13 have healed over the years and those spirits are there to
14 take care of our young people.

15 When I talk about program development,
16 again, it's important that we take the step back as
17 professionals and be able to give the opportunity of
18 creating space for lived experience to develop those
19 programs, and in both of our homes honouring the spirits of
20 our Little Sisters and Hands of Mother Earth. It was
21 completely 100 percent developed by an experiential
22 advisory committee who were at different age frames
23 and -- and different healing times within their journey.

24 And many of the advisory members that I had
25 the honour to work with were also former children in care

1 that the care system wasn't able to intervene when they
2 were younger, so it was very, very important to them that
3 although at the end of the day we have to hold a
4 residential care licence and follow those standards, but
5 how we operate our homes is 100 percent based on values and
6 culture, and that when we care for our young people, that
7 we do not refer to them as clients, that we refer to them
8 as family.

9 So you will hear me use the term "our little
10 sisters," "our little brothers," and it's important that we
11 acknowledge that because they need to be able to know and
12 allow somebody to love them, to be in their life, to never
13 give up on them, to create an understanding that there is
14 always a reason to the behaviours, rather than reacting to
15 those behaviours.

16 And that was something firsthand that I had
17 learned, being very young and naive, 19, 20 years old,
18 moving into the city, wanting to work in -- you know, in
19 group homes. That was -- you know, that was my vision at
20 the time and, you know, be able to work with our young
21 people. And my -- unfortunately, one of my first positions
22 that I held was a non-Indigenous children in care program,
23 and my experience there wasn't very positive as an
24 Indigenous young person. And that was based on the way the
25 program was operated, was that you were given a rule book

1 to tell you how to do your job, how to deal with specific
2 situations and behaviours, where there was no ability to
3 create an understanding that maybe that child that's
4 yelling, screaming, swearing, putting a hole in the wall,
5 is reacting at that moment because of trauma or a situation
6 that they may have just come with.

7 However, the rules at that time would not
8 allow you to be able to create an understanding, be able to
9 support them in a holistic way, in the environment as well,
10 which was very difficult for me, was that our culture was
11 not respected and in order for us to be able to use our
12 medicines, you know, that had to be done outside, or in the
13 garage. And I -- I stayed in this place for, you know, a
14 little over two years, and had to make the decision to
15 leave because it was also affecting my spirit. And it was
16 very difficult having to follow through something that were
17 not true to my own values.

18 So when I came to the Ma Mawi Wi Chi Itata
19 Centre and had the opportunity to work under some of the
20 initiatives that under -- under the Manitoba Strategy and
21 the Sexually Exploited Youth Coalition, is first and
22 foremost, it's always about our lived experience, and what
23 it is that they are telling us that they need. So when we
24 developed our two safe homes, it was based on traditional
25 values rather than rules. It was being able to, as I said

1 earlier, to be able to love them, to help them connect to
2 their spirit, to have medicines, to have our ceremonies on
3 the land. And that is what I see at the end of the day most
4 successful, is to be able to provide that value-based care,
5 and not giving up on them. You know, when they put a hole
6 in the wall and, you know, the way that I see that is it
7 would take me \$2 to fix that hole in the wall, but it
8 wouldn't -- there's no amount of money in this world that
9 would take to repair that hurt and that trauma and damage of
10 giving up on them.

11 And, you know, unfortunately in -- in some of
12 the homes that -- the two homes that we work with, these are
13 young people that have been through system. It -- it's so
14 horrendous. You know, I -- I had a 14-year-old little girl
15 that was in 103 placements at the age of 14. So, you know,
16 you can imagine, you know, the -- the lack of attachment.
17 You know, the trauma, just the everyday trauma that they
18 are, you know, experiencing by, you know, going through that
19 system. And a system that sometimes often is based on rules
20 and too much structure.

21 So, again, I just want to emphasize that
22 when, you know, we are looking at, you know, developing
23 programs, that we are ensuring, you know, that the experts
24 are at the table, and those are with lived experience.

25 **MS. JENNIFER COX:** So I'm wondering, Jackie,

1 if you could tell me a little bit about the funding for --
2 particularly the Little Sisters and -- and HOME. Where --
3 where does that funding come from?

4 **MS. JACKIE ANDERSON:** We are provincially
5 funded through the child protection branch. I can say,
6 under the Manitoba Strategy there's allocated funds, and I
7 believe it's up to \$10,000,000 that are funding programs
8 that are specifically for sexually exploited trafficked and
9 youth. So aside from children in care programs, there's a
10 lot of other very important initiatives that have been
11 funded through our province. And one of those is, we have a
12 child and youth care program that is run out of one of our
13 Indigenous organizations in partnership with Red River
14 College, and that's with Ndinawe. And this is a certified
15 child and youth care program specifically for survivors of
16 exploitation and human trafficking, and it's phenomenal to
17 see the work and the healing that's being done with women,
18 and then having those survivors come into the environment
19 and providing care for children.

20 And again, that's one of the other unique
21 aspects within our two homes, is that 100 percent of our
22 staff are coming with some form of lived experience. So
23 they are able to connect and understand what our young
24 people are going through. And our young people will often
25 be empowered to see and have hope, you know, that they too

1 can be where they really want to be, and they want to be
2 helpers.

3 **MS. JENNIFER COX:** So in terms of the beds
4 that are available in the homes that we've talked about,
5 Little Sisters and -- and HOME. How many beds are
6 available?

7 **MS. JACKIE ANDERSON:** With Little Sisters and
8 with HOME, both homes are six bed. It was also important to
9 our advisory counsel that we had the ability within our
10 licence to be able to support, love, and nurture female and
11 two-spirited transgendered youth. The other important
12 aspect is that our homes, our young people are not forced to
13 be in. They're not -- their social worker, the courts, the
14 police. It's very important that it's youth engaged. And
15 again, when you look at this form of violence and abuse that
16 our young people are faced with every day, is that somebody
17 has taken total control over their lives. And it's so
18 important that when you're providing healing opportunities,
19 that they're given an opportunity to be able to have a
20 choice on what it is that they need.

21 I mentioned that 14-year-old in 104
22 placements. She never had a choice until she was referred
23 to us, and that was very challenging for her to know that
24 she had a say whether or not this is where she wanted to be.
25 And why I say that is because it's -- it's very common that,

1 you know, when our young people do come to live with us,
2 they will -- they will absolutely challenge us. They will
3 break, you know, what they think are the rules. They will
4 do everything to push us away, to be able to test us if
5 we're actually going to be true to our values, and whether
6 we will continue to love them and be in their lives.

7 In fact, it's so important in -- in the work
8 that I've done over the years, and I see it very -- it's an
9 extreme honour for me for a young person, and for our adult
10 survivors, to allow me in their life, and that is something
11 that I truly honour and cherish. And when somebody has
12 allowed me in their life, you know, I ensure that they know,
13 and I -- and I ensure that they see that and feel that, is
14 that I'm going to be in your life forever, and that's what
15 they need to see. And that's what they need to feel.

16 **MS. JENNIFER COX:** So in terms of who is
17 eligible to come to those two homes that we've talked about,
18 Little Sisters and HOME, can you tell the Commissioners a
19 little bit about how that works? The -- you mentioned that
20 there was an age range.

21 **MS. JACKIE ANDERSON:** Yes.

22 **MS. JENNIFER COX:** But are there other
23 conditions before people can access that program?

24 **MS. JACKIE ANDERSON:** Yes. One of the things
25 that were very important is that when you're looking at

1 providing support services to young people faced with this
2 type of victimization, is that you're also ensuring that
3 you're not putting them at further risk.

4 So Little Sisters and HOME were specifically
5 dealt -- developed with the intention to provide support to
6 young people who would be identified as, the word used as,
7 entrenched. And this is where young people already have
8 been, you know, recruited, and lured, and groomed into
9 sexual exploitation, whether it's visible, non-visible
10 trafficking. There's a level of exploitation that's already
11 happening in their lives. And why I say it's important,
12 that when we look at where our young people are at is that
13 it's -- it's challenging to put someone who may be at risk
14 of because, you know, unfortunately, one of the largest risk
15 factors for vulnerable people is "A", they're a girl, and
16 second, they're Indigenous. So if you put girls that may be
17 at risk of with girls that are entrenched, it could increase
18 the risk level.

19 So the young people that are referred to us
20 already have an identified level of exploitation. And
21 again, that is very challenging when they come to meet with
22 us and we start to establish, first and foremost, is that
23 relationship, but it's also creating education and awareness
24 to them that they are victims of sexual exploitation. They
25 are not in prostitution. They are not prostitutes. They

1 are children, and what's happening to them is child abuse
2 and others are taking advantage of them. And that's often
3 something that they -- when they come to us, they don't
4 understand because they're carrying so much of that shame
5 and self-blame that others have put on them, for them to be
6 able to understand and let down those walls. But the first
7 thing that I celebrate, is that after you create that
8 awareness and those relationships with our young people, and
9 at the end of the day they say, "Yes, this is where I want
10 to be." That is the start of their healing.

11 And, you know, and again, I can't emphasize,
12 you know, language across Canada is different from province
13 to province, you know, in how it's being explained and --
14 and awareness and education. I -- I've very, you know, a
15 very, very strong message that I, you know, carry, is that
16 we need to be -- we need to be using the correct terms.
17 Whether they're children, they're youth, or they're adults.
18 And this sexual exploitation, it's -- it's not a choice.
19 There's, you know, in -- in all my years I've been working
20 in this, I've never had, you know, somebody say to me that
21 I'm choosing to do this. You know, I've now, you know,
22 somebody say to me that I'm choosing to do this. You know,
23 I now have, you know, survivors, warriors today that, 20
24 years ago, she may have said that it was a choice, but when
25 you look at, you know, 20 years later, where she is now, she

1 absolutely sees, you know, the trauma and, you know, the
2 effects, you know, of that situation of her control and how
3 it's affecting her, you know, her holistic well-being and
4 her everyday health, you know, that she's experiencing, so
5 the language is so important that we change.

6 And I understand it's so easy, you know, you
7 say the word prostitute, everybody knows what that means,
8 you know, but we all need to take, on behalf of our young
9 people, that additional two minutes to actually describe,
10 you know, the realities of what it is that's happening to
11 our young people. Because if we continue to use that
12 language that's so easy to identify, we're normalizing the
13 behaviour for the perpetrators, because they see this as the
14 oldest profession in the world when, in fact, it's the
15 oldest oppression in this world. And it's up to us, you
16 know, to be able to make change and create awareness and to
17 be able to educate, you know, at all levels and to be able
18 to work together and not in isolation. It's important that
19 we change, you know, that norm in society on behalf of our
20 young people and -- and our survivors.

21 **MS. JENNIFER COX:** So one of the requirements
22 of the young people that are staying in those homes -- do
23 they need to be in protective care?

24 **MS. JACKIE ANDERSON:** Yes, and unfortunately,
25 you know, that is a barrier, absolutely. Because we are

1 funded through our province, the children that are referred
2 are under a child and care status, which -- why I say that
3 that is a barrier is that, you know, if, you know, one of my
4 children, you know, was struggling and needed services, you
5 know, that would -- that would kill me to know, you know,
6 that I had to give up my rights as -- as her parent in order
7 to be able to access a service that I do also know, at the
8 end of the day, could potentially save her life. But to be
9 able to give up -- you know, have to put your child, you
10 know, into the system in order to access services is -- that
11 -- that's -- that's not okay.

12 **MS. JENNIFER COX:** And -- and Jackie, do you
13 have an example of a situation where somebody did have that
14 happen, right?

15 **MS. JACKIE ANDERSON:** Absolutely. We had
16 this amazing, powerful mother who, you know, was just doing
17 that, was, you know, desperate to, you know, help her
18 daughter and to get her the support that she needed, and
19 unfortunately, other than addictions treatment centres, for
20 her to be into a specialized program that specifically works
21 with exploited young people, she was told that she couldn't
22 access the service unless she signed a voluntary placement
23 for her child. And even signing a voluntary placement, you
24 also have to prove your income, because you may have to
25 contribute to the care of your child, and that was a really

1 huge challenge for her.

2 And how we were able to support her was to be
3 able to engage in that relationship and to be able to have
4 mom and her daughter be a part of, you know, the process at
5 Hands Of Mother Earth and to be able to come and access our
6 support and establish a safe environment for her, for her
7 daughter, and she then ended up signing a voluntary
8 placement for her daughter to come and -- and live with us
9 and, you know, again, it's -- healing doesn't happen
10 overnight, and, you know, this young woman I'm so proud of
11 today being a 21-year-old survivor warrior woman who is out
12 there as an advocate for our young people and making change.

13 **MS. JENNIFER COX:** So one of the other
14 things, too, that you've identified is the use of language,
15 and -- and so some of the work that you've done is to -- to
16 educate and go into communities. And you want to tell the
17 Commissioners a little bit about your experience with that?

18 **MS. JACKIE ANDERSON:** Sure. It's so
19 important that, when, you know, looking at within your
20 province, that you don't see this only as -- as a -- as an
21 urban issue, and so our -- our programming within our
22 province is for the entire province, and one of the things
23 that we have learned, you know, over the years and we've
24 seen from our own eyes is that some of our most vulnerable
25 children are children that are coming from some of the

1 northern isolated communities. Whether they're coming in
2 for, you know, medical reasons or education reasons, there's
3 a huge risk and vulnerability that our young people from the
4 North are experiencing when they're coming to the larger
5 urban settings.

6 And my -- an example of that is my -- my
7 husband, he comes from a -- an isolated community, Berens
8 River First Nations, and it's a beautiful community, and,
9 you know, although I would have loved to have raised my
10 three daughters, you know, in their First Nations community,
11 I think about, you know, some of the risks that they may
12 have faced when they would have had to have left my home to
13 come to the larger urban setting in order to value their
14 education. Unfortunately, in that community, their high
15 school only goes up to grade 9, so when I think about my
16 youngest daughter, for her to leave home, she would have
17 been 13 years old. You know, and if I would have been in
18 the community having no awareness how to protect my children
19 from predators that are out there looking for the most
20 vulnerable, she would have absolutely been at risk.

21 And our recruiters are very organized. They
22 know what to look for. They know how to identify kids that
23 may be coming from the North. They use some of the things
24 that we cherish and value as Indigenous people, such as our
25 language. You know, they will stand around, and when they

1 see them in shopping malls or in drop-in centres or
2 libraries to hear if they have a certain slang of how
3 they're speaking, if they're talking to their peers within
4 their language. Because not a lot of our kids that have
5 been raised in the system or raised in the urban setting
6 have their language or have been taught their language. So
7 they use those things as indicators that this is a child
8 coming from the North who is probably isolated, who probably
9 doesn't have a lot of family, that may be here for school,
10 and that are craving friendship.

11 And when I've done some travelling within
12 some of the rural communities, in particular with our young
13 people, you know, I ask them, how many of you been to the
14 city? Maybe a handful. How many of you want to go to the
15 city? They all put their hand up. Where is it that you
16 want to go when you go to the city? They all want to go
17 downtown, where, to them, our downtown is to us, you know,
18 Toronto, Young Street, or New York, Times Square. They want
19 to come where they're seeing on TV and they're learning, you
20 know, about the -- the lights and, you know, the billboards
21 and the music and the gatherings. And unfortunately, that's
22 where our recruiters are hanging out looking to identify,
23 you know, their next victim.

24 So it's important that education and
25 awareness is created within our First Nations communities,

1 and one of the ways that that was done over the last few
2 years, I believe it was 2014, '16, and '17, is that there
3 was a partnership with the province and Assembly of Manitoba
4 Chiefs where they went into some of the First Nations
5 communities. This was called Our Circle to Protect Sacred
6 Lives, and there was teams that went into multiple First
7 Nations communities to create awareness and education to
8 community on risk factors and indicators that they need to
9 be watching for.

10 And again, one of the findings that we found
11 is that, in a lot of our communities, they were not aware,
12 you know, of some of those indicators that their young
13 people were being put at risk. In fact, some of those
14 communities just recently received or have internet access,
15 so many of the parents that were in the communities never
16 grew up with internet access, so don't know how to use that
17 and don't know how to be able to keep their children safe
18 because they have no way to navigate, or they don't know the
19 dangers of the internet.

20 So this project, Our Circle to Protect, I did
21 participate in the first phase of 2014, where we travelled
22 into those First Nations communities and assisted them,
23 looking at their strengths and assisting them to create
24 community protection plans, that they could create that
25 specifically for their community. And there was a lot of

1 really great work that was created within those
2 consultations, and education and awareness, but I can't
3 emphasize enough at the end of the day the importance of
4 funding, because when you're -- when you're a victim and
5 you're accessing services for healing, this doesn't happen
6 overnight. And for many, it takes many, many attempts
7 before they've found the right resource or the right program
8 or the time in their life to make that change. So when we
9 have these pilot projects that are funded for, you know, one
10 year, two years, three years, that doesn't help, you know,
11 those that need it the most because, you know, even for a
12 survivor, surviving -- the survival is forever. You know,
13 going to a program for one year, three years, and saying,
14 "Okay, you're done," or "We don't have the funding anymore,"
15 often puts people back in distress.

16 So I can't emphasize enough at the end of
17 the day how important it is that we're looking at
18 sustainable funding to Indigenous-led organizations that
19 incorporate the importance and value of hiring those with
20 lived experience.

21 **MS. JENNIFER COX:** So, Jackie, in terms of
22 the programming that you are offering with Little Sisters
23 and -- and HOME, I'm wondering if you could talk a little
24 bit about some of the types of programming that you offer
25 that specifically targets children who are exploited.

1 **MS. JACKIE ANDERSON:** Again, coming from the
2 advisory committee, recommendations that they had made was
3 that it was important that we just didn't provide care,
4 that we were also building their capacity for healing by
5 educating them on the dangers and realities of
6 exploitation. So we have programs that are being provided
7 to our young people within our homes that are, again,
8 facilitated by lived experience that are teaching them the
9 dangers and what they need to look out for and/or when
10 they're vulnerable, you know, how to be able to access
11 safety. And so such things as creating safety plans, we
12 will -- we're available to our young people 24 hours a day.
13 You know, and although we have a curfew because we have to
14 have a curfew, you know, we celebrate that -- if they're
15 not home at curfew but they're calling at 1 o'clock in the
16 morning, saying, "I want to come home," we're going to
17 bring them home and we're going to praise them for that
18 because those little steps that they're taking, we need to
19 celebrate.

20 So we do that programming through the
21 Realities of Sexual Exploitation, which is facilitated
22 weekly. We -- culture, you know, is -- is so important.
23 And, you know, it's so important that it's embedded in
24 everything that we do. You know, putting up, you know, a
25 picture or hiring one Indigenous staff on your team is not

1 culturally appropriate, you know. And unfortunately, I see
2 a lot of places that, you know, say that they are
3 culturally sensitive and culturally appropriate, but
4 they're not environments that are -- you know, I heard the
5 word "trauma-informed", you know, used a lot over the last
6 couple of days, you know, and those are not trauma-informed
7 environments. So it's important that in everything that
8 you do, that that culture is part of that.

9 And as I mentioned earlier, our young people
10 that come to us, part of their -- their largest risk is
11 that they're disconnected to their spirit. They don't know
12 who they are as Indigenous people, you know. So it's
13 important that, you know, we are there for them when
14 they're ready to be able to start experiencing and learning
15 who they are and where they come from because, again, as
16 far as I'm concerned, if you don't know where you come
17 from, how do you know where you're going? So it's
18 important that we provide those opportunities by having
19 Elders on site, by having ceremonies. On our
20 traditional -- at our traditional rural healing lodge, we
21 have a sweat lodge ceremony that's right on the property.
22 You know, so it's -- it's important that those are things
23 that are ingrained in everything that we do.

24 It's also important that, you know, when we
25 look at providing services that are sometimes not

1 accessible for our young people for multiple reasons is
2 that we're able to bring those services to the environment,
3 to the home, you know. In particular, when I look at
4 health services, those are things when our young people are
5 coming, you know, we're trying to -- we're required, you
6 know, by residential licencing to have them see a doctor, a
7 dentist, an optometrist, all of those different things, you
8 know, within a time frame of them moving in with us. And
9 those are all services that our young people haven't really
10 been raised, you know, as something that has been stable
11 within their environment.

12 So trying to get them to a doctor and access
13 those services is very, very challenging. To go and sit in
14 the doctor's office for three hours, you know, to have to
15 explain to a nurse who may not understand, you know, the
16 victimization and trauma that they're experiencing, you
17 know, having to explain, you know, multiple partners and
18 they could -- to be able to explain why they might have an
19 STI, those are just shameful situations to be putting
20 our -- further shameful situations to put our young women
21 through.

22 So it's important that we bring those
23 services into the environment, and we've been able to do
24 that by creating partnerships with public health, having a
25 specialized public health nurse come into the home to be

1 able to do some of those testings for them, but also
2 create -- create awareness and education for them in
3 multiple areas that they be experiencing because
4 there's -- there's multiple health risks, you know, that
5 are -- that our young people and our adult women are
6 sometimes, for the rest of their life affected with.

7 You know, I think about anxiety, panic
8 disorders, you know, major depression, you know, the
9 addictions, eating disorders, that PTSD from the trauma
10 that they're experiencing. And that's why I say, you know,
11 healing doesn't happen overnight. You know, even coming
12 from myself, being a survivor of, you know, child abuse as
13 a child, my healing started well over 30 years, and there's
14 still times, you know, where that PTSD or that trigger
15 still hits me, and I have to be able to have the tools to
16 be able to -- to help me with that.

17 You know, unfortunately, we have a young
18 people -- a lot of young people that are not only masking
19 with the drugs, but also masking with the self-harming, you
20 know.

21 And then just looking at those physical
22 health, you know, problems and -- you know, dental issues
23 right now is a really huge thing, you know, with this
24 epidemic of -- of meth use. You know, a lot of people are
25 faced with, you know, very high painful dental needs,

1 and -- and that's even very difficult for them to access,
2 you know, some of those services.

3 I guess, you know, one of the challenges, as
4 well, that we do see is sometimes the -- the definition,
5 you know, between mental health and through addictions and,
6 you know, sometimes when we're out there trying to access,
7 you know, through our mental health or through our
8 hospitals, support for our young people who might be going
9 through drug-induced psychosis, unfortunately, there are
10 few services because they see this as an addiction issue,
11 not a mental health issue. So those are, you know,
12 challenges that we're faced with.

13 Our treatment centres right now, you know,
14 there's up to a 90-day waiting list, you know, and even
15 with that, the challenges and barriers for someone to even
16 access that service is very challenging, you know, where
17 you have to get a medical. You then get an appointment to
18 go into detox to set a date. You've got to stay. You
19 know, all of those things are -- are huge barriers for
20 people to follow through because, I tell you, with, you
21 know, all those that I've worked with over the years, when
22 they say, you know, "I need treatment, I need it now," we
23 need to be able to provide it to them now. When they say,
24 "I need to get out of the city, get me out of the city
25 now," we need to be able to have, you know, those -- those

1 traditional healing spaces to be able to take them now, not
2 make an appointment or take them, you know, in 90 days when
3 the waiting list is done. Those are very, very important
4 that things that we need to look at when we are providing
5 support and services to our most vulnerable.

6 **MS. JENNIFER COX:** So some of the incentives
7 that you -- because you've used some program incentives to
8 encourage through your outreach to -- to encourage young
9 people. Can you tell the Commissioners a little bit about
10 some of the ways that you -- you draw the young people in?

11 **MS. JACKIE ANDERSON:** Again, you know, when
12 we come from an organization that really values capacity
13 building and empowerment, it's important that, you know, we
14 use those tools through a strength-based way of how we're
15 supporting our young people. And many of them, when they
16 come to us, they don't know their gifts and their
17 strengths. And for many, it's hard for them to even
18 identify that they do have personal gifts. So it's
19 important that we are looking at, you know, not only ways
20 to help them heal through this, but to be able to provide
21 them opportunities of empowerment.

22 And -- and the only way that we can do that,
23 as I said earlier, is to not work in isolation of one
24 another, you know. Although we're providing this beautiful
25 care and home and love and nurture and to many family, to

1 our young people, we can't do that alone. Those
2 partnerships that we have, you know, are very, very
3 important.

4 So we've had the opportunity, through some of
5 those partnerships, to be able to have our young people
6 engaged at having that voice at the table. You know, for
7 example, Christine here with me, at the age of 15, attended
8 a National Youth Drug Strategy conference in Ottawa and
9 participated and shared her voice on what it is that our
10 young people need. She had an opportunity to write her
11 story in Voices, which is a youth and care network, to be
12 able to educate others that, you know, experience this from
13 a child and care perspective.

14 We need to ensure that we're engaging them,
15 you know, in that process and providing them the
16 opportunities. So within our organization, we also employ
17 our young people. You know, every summer, you know, we're
18 hiring anywhere up to 24 of our young people that are now in
19 positions of being helpers and mentoring our young people.
20 So again, we -- we really look at providing that capacity
21 and engagement, and that can only be done through the
22 partnerships and relationships and allies that we have
23 within Manitoba and across Canada.

24 **MS. JENNIFER COX:** And -- and would you say
25 that's part of their healing journey as well, that -- that

1 work that they're doing?

2 **MS. JACKIE ANDERSON:** Absolutely. As I said,
3 it's extremely empowering for them to even be a part of that
4 type of process, to -- to know that their voice is valued
5 and it's heard and it's strong, because for too long, our
6 voices were silenced. Our situations were silenced. You
7 know, some people believed that you wouldn't -- you should
8 never publicly share your story, you know. However, you
9 know, we learn from our Elders that part of your healing is
10 to be able to share your story. It's to, you know, be able
11 to release and to be able to heal and to be able to be that
12 helper.

13 You know, one teaching that was provided to
14 me by one of my Elders is that, when you look at that
15 medicine wheel, it's so important that when we're helping
16 young people that have -- and adults that have faced trauma
17 and -- and forms of victimization is that, first and
18 foremost, you have to help them understand that they are a
19 victim. You know, however, we can't keep them in that
20 victim stage. We need to help them move along those aspects
21 of that medicine wheel, becoming that survivor, to then
22 moving into that warrior, to one day becoming that teacher,
23 and it's important that -- you know, that we look at those
24 teachings when we're working with our young people.

25 **MS. JENNIFER COX:** So in terms of attracting

1 young people to some of your sessions, Christine mentioned
2 one -- one thing that she thought was a -- a -- sort of got
3 her to attend sometimes, and those were shopping trips. Do
4 you have any sort of examples of those kinds of things that
5 you've offered to young people to attend some of your
6 sessions?

7 **MS. JACKIE ANDERSON:** Yeah. And again, you
8 know, we always ask our young people, you know, what it is
9 that you want, what is it that you need? We need -- they
10 need to be a part. We used to get criticized, actually. We
11 were told, you know, that our girls run the house, you know,
12 in -- in a negative way, and I'm thinking, I -- I was very
13 proud to say, "Yes, absolutely, they do." You know, they --
14 they guide, you know, what it is that they need, what they
15 want to learn, what they want to eat, you know, and that's
16 important. So I -- I took pride in that, you know, that
17 people observed that our -- our young people were, you know,
18 running our program, because that's the way it should be.

19 So, you know, one of the -- you know, things
20 that we did, too, with our young people, and it -- and it
21 was -- it didn't need to be done, but we also felt that we
22 need to find ways to celebrate their growth. So, you know,
23 for example, you know, after 15 weeks, if they completed
24 their Realities of Sexual Exploitation program, we felt
25 self-care was something that we needed to value. So, you

1 know, we would take them to get their nails done or go for
2 dinners wherever they choose or do shopping sprees with
3 them.

4 And again, it's important to, I guess,
5 acknowledge that, you know, when you're running delivery
6 programs, you -- unfortunately, at the end of the day, we
7 always have to try to find those extra funds. You know,
8 because what you're provided is you're provided for the
9 basic needs of the child, but all those other things that
10 are so important, you know, for the healing overall well-
11 being of our young people is to be able to find
12 opportunities to take them, you know, to one-week, you know,
13 trips, you know, and to the -- on -- by the lake, or, you
14 know, I think we took the girls one time to Edmonton, you
15 know, to experience, you know, the mall.

16 And these are all things that our young
17 people never experienced and never thought that they could
18 experience. You know, I have the luxury of being able to
19 provide those opportunities to my children, you know, but
20 when I think about these young people, they shouldn't be
21 treated any differently. We should be able to provide them
22 the same opportunities, but unfortunately, at the end of the
23 day, we're always fundraising, which can be very, very time-
24 consuming and taking away from the actual heart medicine
25 work that we do so well with our young people.

1 **MS. JENNIFER COX:** So, Jackie, one of the
2 things that you also wanted to talk about today was your
3 work with the reunification, and this is a fairly new
4 project that you've been working on. I'm wondering if you
5 can tell the Commissioners a little bit about the background
6 first and then talk about what it's been like.

7 **MS. JACKIE ANDERSON:** So currently my role
8 within the organization is I've had the honour to be the
9 program coordinator for the Family Group Conferencing
10 Program that was recently expanded within our organization
11 through different funding partners, federally, provincially,
12 as well as a philanthropic Winnipeg foundation.

13 So Family Group Conferencing, although it is
14 a new -- newly funded, it's not a new model to us as
15 Indigenous people, and, I mean, if anything, the best way
16 that I can describe it is that this is how we did things
17 pre-colonization. Prior to systems coming in and taking our
18 Indigenous ways of knowing and being away from us, when
19 there was concerns or issues within our community, the
20 community got together in ceremony and made decisions on
21 what needed to happen for the parents or the family or for
22 those children, and in some situations, community or
23 extended family would step in to provide care for the
24 children that needed immediate care.

25 But Family Group Conferencing within the Ma

1 Mawi Wi Chi Itata Centre was kind of gifted to us in the
2 year of 2000, and that was through a relationship that was
3 established with our Maori brothers and sisters in New
4 Zealand. And we've had the opportunity over the years for
5 them to come and spend time with us to help us, you know,
6 reclaim our Indigenous ways of knowing and bringing that
7 model within to our organization.

8 So we have been facilitating Family Group
9 since the year of 2000; however, our funding only allowed us
10 to be able to respond to so many families in regards to our
11 capacity. So last year, in 2017, our organization was
12 provided over the next three years \$2.5 million to be able
13 to expand our team to nine facilitators, who are all
14 minimally responsible for facilitating up to 15 family group
15 conferences per year. And I say minimum because we're only
16 six months in and they're almost at that minimum.

17 And our focus and our goal, again, is that
18 -- and this was also extremely important by our Maori, was
19 that when they gifted us this model, that we would protect
20 this model. You know, that it was -- it would be within an
21 Indigenous organization, and my other importance was that it
22 was being facilitated by a non-mandated community
23 organization. And that's for a number of reasons, is that,
24 you know, non-mandated community organizations such as us
25 has the ability to truly invest time that is needed to build

1 those relationships not only with the parents, the children,
2 but with extended family, and we have the ability to be
3 involved in their lives post-Family Youth Conferencing.

4 Our funding states that we're involved with
5 them for up to a year where we provide that monitor, review,
6 and support, you know, of strength, of being able to keep
7 our families together. However, as I mentioned, they're
8 stuck with us forever. We would find ways to, you know,
9 make sure that they're still part of our community and
10 organization, whether volunteering or working for us.

11 But I think what's really important is that,
12 when we look at this model, it's about bringing children
13 home, where they need to be. And it's bringing the
14 families, who are the experts, together in ceremony where
15 they can make their plan that they -- they're the experts.
16 They know what it is that their family needs and they're
17 going to be accountable to each other and support each other
18 to be able to be successful, for the kids to come home. And
19 if that means it's been reunified to mom, dad, mom or dad,
20 to kokum, to auntie, to uncle. You know, to us that
21 celebration of reunification, it's kids need to go home to
22 their community. But our families also need the resources
23 to be able to be successful, in order to be able to provide,
24 you know, all those resources. They can provide the love
25 and nurturing, but the need the support to be able to

1 rebuild their families.

2 So that is what we are doing within our
3 organization, right. And it's been very successful. I
4 mean, yesterday, my stats, we've reunified and/or prevented
5 up to 73 children just over the last few months. And we
6 have 160 other children that will be reunified within the
7 next three to six months. So we need to -- we need to, like
8 I said, at the end of the day, bring our kids home.
9 Manitoba, right now, has well over 11,000 children in care.
10 You know, and my last, you know, look at any type of
11 research was 9,400 of those children are Indigenous. So we
12 need to -- we need to be able to use our Indigenous ways of
13 knowing and being and make sure that we are there to support
14 our families to be successful. And we need this program to
15 be sustainable. Not three years of being able to
16 demonstrate if it works or not. We know it works as
17 Indigenous people. We know it works. You know, but --

18 **MS. JENNIFER COX:** So in the Family Group
19 Conference process, are you able to provide resources to
20 families? Are you able -- how -- how does that work?
21 Because one of the things that you said was that, you know,
22 we need to be able to provide resources to families so that
23 they can -- they can reunify.

24 **MS. JACKIE ANDERSON:** M'hm.

25 **MS. JENNIFER COX:** How -- how -- can you

1 explain how the Family Group Conference model is able to
2 assist?

3 **MS. JACKIE ANDERSON:** Yes. So when I, you
4 know, talk about the funding that's provided, it's also
5 giving us the ability because those are some of the barriers
6 that we've been able to identify is that many of agencies
7 are telling our parents, "Yeah, sure. You can have your
8 kids back, but, you know, you got to get housing, you got to
9 get beds, you know, you got to go to treatment, you got to
10 do all these things." Which, you know, when we're being
11 faced with that and also still dealing with some of your
12 own, you know, trauma, those are extreme challenges for them
13 to be able to navigate. You know, and unfortunately, it
14 delays, you know, those children going home. And the way
15 that I look at it is, every day that child continues to be
16 away from family, that's added trauma that that child's
17 going to have to, you know, deal with when they become that
18 age and start looking at ways of how to, you know, mask that
19 trauma.

20 So our programming, through Family Group
21 Conferencing, has the ability to help our families rebuild.
22 If that means assisting them with housing, you know, damage
23 deposits. I mean, our families that are on EI, "A," you
24 know, you're only allowed one damage deposit. And if you
25 move multiple times, you always got to come up with your own

1 damage deposit. So there's -- there's those aspects we're
2 able to have -- we're able to help with. Furnishings, and
3 some of those emergency services that they may face with,
4 you know, even once kids are home. You know, again, I -- I
5 know what it's like to live in poverty. I know what it's
6 like to have two incomes, but still struggling with pay day
7 to pay day. And, you know, somebody who may not, you know,
8 have enough food for the next few days, you know, should not
9 be looked at as child protection concern, they should be
10 connected to resources that can step in and help them.

11 So, you know, those are ways that we help our
12 families, is to make sure that any barrier that they're
13 faced with, that is, keeping -- from their children coming
14 home, we will cover, you know, that resource to help them.
15 And/or, again, that partnership, that collaboration, that we
16 have, that outer-circle of supports, including our mandated
17 organizations, because there's an important role for them to
18 play in this as well. You know, we all hold a piece of the
19 puzzle, but none of us hold the entire puzzle. It's the
20 family that holds that puzzle. And we need to help them
21 rebuild that puzzle. So those relationships are extremely
22 important that being an non-mandated, I need to be able to
23 establish and build those relationships with our nan
24 (phonetic) -- non -- with our mandated services as well, so
25 that we can work together a success at the end of the days

1 for our families.

2 **MS. JENNIFER COX:** So when you -- when you
3 use the term, non-mandated, perhaps, you should explain that
4 a little bit in terms of what you mean by that.

5 **MS. JACKIE ANDERSON:** Okay. So I can --
6 well, mandated is Child and Family Services hold a mandate
7 for the protection of children and kid -- kids, and
8 responding to those protection concerns, and has the ability
9 to make decisions on apprehensions of children. When I
10 refer to us as being non-mandated, is we don't hold that
11 mandate. We don't apprehend children. We have been asked,
12 because of the work that we do, and the relationships we
13 have in the community, to develop Children in Care Programs.
14 But again, at the end of the day, it's about bringing those
15 kids into our care, treating them as our family, and getting
16 them out of our care as quick as possible, where they're
17 going back to family.

18 **MS. JENNIFER COX:** So -- and one of the
19 elements of this Family Group Conferencing model that you're
20 working through now is transitioning -- so out of care.

21 **MS. JACKIE ANDERSON:** Right.

22 **MS. JENNIFER COX:** This is -- so, perhaps,
23 you could talk a little bit about that as well?

24 **MS. JACKIE ANDERSON:** Okay. So, again,
25 our -- our referrals are all coming from different

1 situations, whether, you know, again, the children are
2 currently in care, they're on the verge of coming into care,
3 and/or our internal Children in Care Program.

4 So we have two foster care programs within
5 our organization, actually three. The Ozosunon, which is
6 considered longer-term care, but even that, now that we have
7 Family Group Conferencing, we're getting our children out of
8 our care quicker because, again, we recognize even the
9 children that we've had for longer periods of time, they
10 still have families, and they still have communities. And
11 then we have the CLOUT and the Eagle Horse, which are
12 shorter-term in-care programs for our children. Aside from
13 that, we also have five specialized residential -- and I
14 hate using that term, but for the purposes of today, we have
15 five residential homes that specialize specifically in
16 different areas. So as I mentioned, we have Little Sisters
17 and Hands of Mother Earth, which specializes in sexual
18 exploitation. We also have a -- a home called Isobel's
19 Place, which is a home for teen moms, where they can come
20 and live with us in a self-contained apartment, which is
21 supported 24 hours, and learn the -- the skills to prepare
22 for baby, and for once baby comes. And we work through them
23 through all those stages. We also have two others, which is
24 Luke's Place and Circle of Care.

25 So Family Group Conferencing, now that it has

1 been expanded, is we're able to now use it within all of our
2 programs within our organization. So not just community
3 care sites through our community referrals, but also within
4 our Children in Care Program.

5 So Christine here, you know, is what we call
6 a Ma Mawi babe, and you're going to hear her story. And a
7 very, very powerful story, you know, where she grew up
8 in -- in our -- in, actually, Little Sisters. And, you
9 know, ended up working at Little Sisters. She was working
10 there as a youth helper for two years. And I -- I don't
11 want to steal her thunder with her story, but today we now
12 have her as part of our team, our Family Group Conferencing
13 family. And her role is specifically for Hands of Mother
14 Earth and honouring the spirits of our little sisters. To
15 help those young people that have been entrenched with such
16 horrendous victimization, to use the model to be able to
17 start helping to connect and build their strengths within
18 their families, and within their communities, and/or using
19 the model to help them as they transition out of care into
20 independent living. So that we can help them with all of
21 those challenges and barriers and making sure that they have
22 all of their needs being met.

23 **MS. JENNIFER COX:** And finally, Jackie, you
24 had indicated that you have a number of recommendations that
25 you were asked to, sort of, bring forward from your partners

1 that you wanted the Commissioners to hear. So I'm wondering
2 if you want to share those?

3 **MS. JACKIE ANDERSON:** I'll, you know, very
4 briefly, you know, refer to some of these things, but I
5 think it's important to acknowledge, you know, that there
6 has been a lot of really great, amazing work that has
7 happened across Canada, you know, over the last, you know,
8 five, ten years. In particular, there was the National Task
9 Force on human trafficking that was done and led by,
10 actually, my executive director. And she's one of my hugest
11 mentors, and that's with Diane Redsky. And so there's been
12 a lot of different, you know, initiatives across Canada that
13 has -- has been happening where the voice of lived
14 experience has been providing recommendations. But again, I
15 -- it's -- it's important that when I came here today, you
16 know, that I also reached out, you know, to my sisters and,
17 you know, said to them, what is it that you need me to for
18 sure, you know, be able to speak upon, you know, at
19 this -- this inquiry, this hearing? So I'm just going to
20 kind of go over some of the recommendations that they wanted
21 me to be able to share with you today.

22 And one of those is, you know, stronger laws
23 that focus on the demand and, you know, for the police to
24 currently, you know, be actively using what they do have.
25 And I'm -- you know, I'm not saying that what we currently

1 do have is the end-all, you know, and is the strongest,
2 but, you know, we do have, you know, *Bill C-36*, which is
3 the *Protection of Communities and Exploited Persons Act*.
4 And I can say, you know, coming from the province that I
5 represent here today in Manitoba, that one of the strengths
6 that we have in our community is that there's a strong
7 partnership between community and the police as it relates
8 to the Counter-exploitation Unit. And this *Bill* is being
9 actively used within our province. In fact, I learnt this
10 week that in the year of 2017, there was 100 convictions of
11 the demand, which are considered johns. I consider them a
12 lot worse, but I won't use that term today. But there
13 was -- there was many arrests that had been made, and as I
14 said, just from January, there's been, you know, well over
15 40 arrests. So it's so important, you know, that we -- we
16 have those laws in place to be able to, you know, protect
17 our young people and our -- and our adult women.

18 One that was very, very strong is that
19 sometimes the voice of our -- of our survivors and
20 warriors, they feel that it's also being exploited, you
21 know, where they're asked to come sit at tables, provide
22 recommendations, and then not seeing those recommendations
23 being followed through and/or never hearing about what
24 they're working on or what they have worked on. And
25 something that's very strong and valuable to them is that

1 they've identified that they need to have national survivor
2 summits where survivors from across Canada can come
3 together in a safe place to be able to, you know, share
4 their truths and to be able to share those recommendations
5 of what it is that their communities need. Because as I
6 mentioned, every community across Canada is unique
7 and -- and has different challenges and barriers. And
8 every year, it changes, you know, when you look at, you
9 know, the demand and tactics that are being used, it
10 changes. So we can't have it once and then, you know, use
11 the same thing for the next ten years. It needs to be
12 something that is yearly that we're including the voices.

13 And again, just looking at rural traditional
14 healing lodges that are Elder and survivor-led, and that's
15 one of the challenges that we are experiencing in Manitoba
16 is that we don't have 24-hour supports and services for
17 adult women that are being victimized. You know, and
18 that's something that, you know, we need as a place where,
19 you know, a woman can come where there's wrap-around
20 services, multiple organizations working together to fit
21 the -- the needs that our young women are experiencing.

22 Another is, you know, we have -- and this
23 is one of the strengths that we have right now is that we
24 have -- and it was established out of the Sexually
25 Exploited Youth Community Coalition, the Winnipeg Outreach

1 Network, and we call it WON. We have a WON committee
2 that's comprised of multiple youth and adult serving
3 organizations, and they meet weekly, again, to work
4 together to discuss and look at the issue, but also work
5 together on -- in outreach teams to be able to address
6 and -- and work with our -- our most vulnerable on the
7 street and/or looking for missing children and helping to
8 facilitate them back to families and to homes. And -- and
9 that's extremely important, that there is funding provided
10 to be able to do this 24 hours a day because,
11 unfortunately, you know, the funding that's provided now
12 has an end time, you know, where it can go until midnight
13 or go until one, and we know, you know, between midnight
14 and -- and 8 a.m. is most vulnerable time for our young
15 people. Again, you know, just that sustainable funding for
16 healing programs. Healing doesn't happen overnight.

17 And I guess one of the -- you know,
18 important things, too, is looking at the research and the
19 recommendations that was done through the National Task
20 Force is not all provinces across Canada has their age at
21 the age of 18 to be able to receive services. You know, in
22 fact, I know there are some that when you turn 16, you age
23 out of the system, and you're basically on your own.
24 And -- and that just hurts my heart to know that that
25 happens because, again, when I look at our 16-year-olds

1 we're working with, the trauma that they've experienced,
2 they've not even functioning at 16. You know, once they
3 start their healing, they've got to go back, often, to
4 where that trauma and victimization started. You know, and
5 if that's going back to the age of 4 and working your way
6 back up, you know, so at the age of 16 telling someone
7 you're old enough to take care of yourself, go navigate the
8 system, well, that's -- that's -- that's horrendous. And
9 unfortunately, you know, we've heard stories where 16 is
10 that age that, you know, that there's folks that are just
11 waiting for those kids to turn 16 because now they're going
12 to teach them how to, you know, be victims to exploitation
13 and be controlled.

14 And again, I just -- I can't emphasize, you
15 know -- and again, you know, the -- there's a lot of really
16 great work that's happening within our First Nations
17 communities, and we have very amazing leaders, you know,
18 and -- and leadership that are really on the ground,
19 looking at the needs within our community. And I can
20 understand at the end of the take their frustrations and
21 their hands are tied. And coming from, again, a front-line
22 perspective, I've shared with you my story that, you know,
23 if my daughter at the age of 13 had to leave my home, you
24 know, I -- I don't know, you know, where she would be today
25 because she would have been extremely vulnerable. She

1 would have been that kid who would have went downtown on
2 Portage Avenue. Some guy would have walked up to her and
3 told her she was beautiful and she could make millions of
4 dollars and be a model, and she would have been flattered,
5 you know, because I wouldn't have even had the capacity to
6 teach her how to be safe. So our high schools, there needs
7 to be high schools go up to grade 12 to support our young
8 people rather than them to leave home being babies.

9 And -- and again, just some of the
10 prevention programs in all -- all communities. You know,
11 the -- the great work that was done with AMC, you know,
12 needs to be -- needs to be sustainable because they created
13 some quite amazing protection care plans that had
14 activities that were lifelong activities within their
15 communities. But unfortunately, if you don't have the
16 funding to be able to, you know, be able to -- to roll out
17 what the community needs, it's -- you're back to, you know,
18 where you started.

19 And I guess lastly is I just wanted to, you
20 know, emphasize how important it is to create awareness
21 within your communities that this is not acceptable, that
22 this is child abuse. And one of the initiatives that the
23 Sexually Exploited Youth Community Coalition and Tracia's
24 Trust had led within our provinces to create campaigns
25 of -- within our -- within our city. So, for example, for

1 Grey Cup, and we had soccer, world soccer. You know, so
2 there was campaigns that were created of "buying sex is not
3 a sport" because we also know that where -- where there's a
4 large gathering of transient people, it puts your community
5 at higher risk. And when those large sporting events
6 happened, it increased, you know, the victimization and
7 risk within our community where our young people were being
8 preyed upon online as well as on the street. So it's
9 important to be able to have those strategic plans within
10 your community to be able to create that awareness, because
11 at the end of the day, you know, and why it's important for
12 me when I come out to speak about these things is that when
13 I share their truths, I know at the end of the day that I
14 have now created awareness to multiple people that have the
15 ability to be able to create change. And -- and we need
16 those allies in order for us even as front-line to -- to be
17 able to be there to help us, you know, when we need those
18 supports. It's so important that those partnerships
19 are -- are created.

20 And lastly, I want to end with a quote by
21 one of my little sisters who said -- was asked the question
22 about, you know, what -- what is it that our young people
23 need in regards to programs? And she had said, "Programs
24 don't change people. Relationships do." And so that's
25 always something that we need to keep in mind. We can't

1 just develop programs and expect, you know, that that's
2 going to work. Those relationships are the first and
3 foremost value in everything that we do.

4 **MS. JENNIFER COX:** So, Jackie, I just have
5 one more question, and that really relates to the risks
6 that you see as a result of evacuations because you talked
7 a little bit about some of the work that you're doing right
8 now, just before you came here to Calgary?

9 **MS. JACKIE ANDERSON:** Yeah.

10 **MS. JENNIFER COX:** I'm wondering if you can
11 explain to the Commissioners how that -- the evacuations
12 and removal from the communities sort of creates the
13 vulnerabilities for young people as my last question?

14 **MS. JACKIE ANDERSON:** Absolutely. And, you
15 know, as Jennifer mentioned, I'm actually right now also
16 working remotely as I'm sitting here today. We most
17 recently in our province, a little over a week and a half
18 ago, two of our First Nations communities were evacuated,
19 and rescue missions in most instances was put in place to
20 get our families, so we have 20 -- well over 2,200 people
21 that are currently right now displaced in 12 different
22 hotels within Winnipeg.

23 And we also responded last summer as an
24 emergency response support when there was other communities
25 that were brought into Winnipeg. And one of the things

1 that we had observed, that we had planned for this time,
2 with this tragedy, is that, again, when vulnerable children
3 and communities are brought into urban settings, those
4 recruiters out there right now are -- are just tag teaming,
5 you know, some of those communities where they're, you
6 know, hanging out in the hotels, they're sitting in
7 vehicles, they're, you know, doing drug drop offs.

8 So it's really important, and why I'm saying
9 I'm working right now is that we're coordinating safety
10 response activity camps through the Ma Mawi Wi Chi Itata
11 Centre in partnership with multiple other partners where
12 we're providing children's activities in some of the
13 hotels, where we're engaging and keeping the children busy,
14 but we're also being watchdogs on the outside.

15 And we have outreach teams that are -- like
16 the Winnipeg Outreach Network is visiting all the hotels,
17 because they're the ones that know how to be able to
18 observe somebody that might be in distress, or they know
19 who the recruiters and the perpetrators are, so they're
20 watching around those environments.

21 So, again, it's important that we have those
22 emergency responses in place, and it's important that, you
23 know, those that are on the frontline that know what to
24 watch for are the ones that are engaged.

25 I just want to really quickly share with

1 you, you know, last night -- and, again, because I come
2 from, you know, that frontline perspective, so, you know,
3 wherever I go, you know, my -- sometimes those movies are
4 going and feelers are on, I'm always looking, assessing the
5 environment. We, as frontlines, can -- could spot a very
6 vulnerable situation or somebody that may be in distress.

7 And, you know, I just want to mention that,
8 you know, last night we were faced with a situation here in
9 the lobby of the hotel, you know, of a young woman. And
10 one of our beautiful Elders was, you know, down there
11 comforting her and helping her. And, you know, so when I
12 think about, you know, the few hours we were, you know,
13 with her looking to bring her somewhere safe, there was an
14 amazing team that happened here in Calgary, and I think
15 that needs to be praised.

16 And, you know, going right from the staff
17 here in the hotel were very supportive and nurturing and
18 helpful to having our Elders, you know, being there and
19 helping and supporting her, to be able to call services
20 here in Calgary and to be able to get her a response and to
21 get her somewhere safe where she needed to be.

22 But, you know, when you come from that
23 frontline perspective, and that's why it's important that
24 frontline and lived perspective is always a part of, you
25 know, this research, you know, or these discussions, is

1 because we see things very differently than, you know,
2 policy, if you're in a position of policy.

3 And really at the end of the day, that's why
4 I didn't survive, you know, working at the government level
5 for three years, because that was a very challenging thing
6 for me to be at that level and not be able to be on the
7 ground where I felt my passion and my heart needed to be,
8 and that was with the community. However, I learned lots
9 while I was there that I was able to bring back with me,
10 so -- it's always good to fill up your toolbox.

11 **MS. JENNIFER COX:** So those are all my
12 questions for Jackie, Commissioners, so I'm wondering if we
13 could hear now from Christine. But before we hear from
14 Christine, we will either have to have her promise to tell
15 the truth -- is that -- promise to tell the truth in a good
16 way.

17 **CHIEF COMMISSIONER MARION BULLER:** Christine
18 Dumaine, do you promise to tell your truth in a good way
19 today?

20 **MS. CHRISTINE DUMAINE:** Yes.

21 **CHIEF COMMISSIONER MARION BULLER:** Thank
22 you.

23 **CHRISTINE DUMAINE, Affirmed:**

24 **EXAMINATION-IN-CHIEF BY MS. COX:**

25 **MS. JENNIFER COX:** Before we start with

1 Christine, Commissioners, there was a narrative that was
2 provided to you that Christine is actually going to read,
3 so it was placed in front of you at the break.

4 So, Christine, take it away. Make sure the
5 mic is close to you.

6 **MS. CHRISTINE DUMAINE:** Hello, my name is
7 Christine, I'm 27 years old and a mother to a daughter and
8 a son, along with my supportive boyfriend. My First Nation
9 community is Lake St. Martin in Manitoba.

10 I am honoured to have been asked here -- to
11 be here today to share a bit of my story and offer some
12 recommendations on what our Indigenous children and youth
13 need.

14 Unfortunately, as a youth, I thought that
15 none of those bad things could happen to me. I thought I
16 was smart, I knew how to pick out dangers and risks. I
17 wanted to believe that there was no such thing as bad
18 people who are out there looking for vulnerable children
19 and youth to harm.

20 By the age of 13, I was put into the care of
21 child and family services as I was living the life that I
22 thought I could do what I want, when I want, and would not
23 listen to the values within my family. It wasn't too long
24 after being brought into the care I met other girls who
25 were lost and trying to find their way on the streets of

1 Winnipeg. I felt a sense of belonging with these girls
2 because we were all faced with similar situations.

3 It wasn't too long after coming into care
4 that I also learned how to cope with the eternal hurt I was
5 feeling inside and was introduced to drugs as a way to deal
6 with the pain. The drugs may have helped for the moment
7 but never took the full pain away. In fact, it actually
8 made me more vulnerable, as I had no clue to what I was
9 doing half the time.

10 Parties became an everyday thing for me and
11 the girls, hanging out with older men who would buy us
12 drugs, alcohol, and give us rides, places to party. I
13 didn't see anything wrong with that at that time due to
14 feeling so lost and not knowing where I belonged.

15 At the age of 14, my worker decided to place
16 me in a girls home that was called Honouring the Spirits of
17 Our Little Sisters. This was a safe home for the girls
18 with the Ma Mawi Wi Chi Itata Centre in Winnipeg, Manitoba.

19 The girls who chose to live there were all
20 vulnerable to sexual exploitation. This was the only place
21 I was ever placed that I was not forced to live at, as the
22 home believed it was important I took back my choice of
23 where I wanted to be.

24 I still remember the day I went there for a
25 tour. I actually thought this was going to be just another

1 group home, but I was wrong. I remember feeling so welcome
2 by the staff, the home was beautiful, warm, cupboards were
3 not locked up. I had -- I had my own bedroom, the staff
4 were cool, and what really inspired me was to learn that
5 many of the staff had lived experiences similar to mine and
6 were now working in the field to help us girls.

7 After about a year of living at Little
8 Sisters, I was back in school making my own decisions in a
9 healthier way on where I was going and who I was hanging
10 out with. I thought I now had a good sense of being able
11 to identify someone who was genuine, compared to someone
12 who just wanted to hurt me.

13 My school was downtown, so sometimes my
14 friends at lunch or after school would go to Portage Place
15 to hang out and have lunch. We would be there maybe a few
16 times a week. We met some boys who also would hang out
17 there almost daily, and soon became friends. So I thought
18 anyway. These boys were about a year or two older, they
19 were nice to us and they came from good families in good
20 areas of the city, so I didn't see that there could be
21 anything wrong with them wanting to be our friends.

22 Shortly after we met them, they would offer
23 to drive us home after school, sometimes they would pick us
24 up from school, we would hang out, go to the movies,
25 supper, and do things that normal friends would do. They

1 were interested in wanting to know who we were, where we
2 came from, things about our family. They sounded like they
3 cared when we would share anything personal that we may
4 have dealt with, and again, they did what normal friends
5 would do, they were there whenever I needed them.

6 After about three months of hanging out with
7 these guys, they asked me and my friend if we wanted to go
8 to Regina with them for one night, as there was a party
9 with these people they were close to. We thought it was a
10 family thing and didn't see any risk to it. We agreed to
11 go.

12 On that Friday, we were trying to find a way
13 to sneak out of the house, as we knew our staff would not
14 let us go. One of the girls went and told site manager,
15 Jackie at the time, as they were scared for us. We were
16 then confronted with all the dangers of what could happen,
17 but we would not listen, as we thought the staff were just
18 trying to keep us from having age appropriate friends and
19 we didn't think anything could happen, as we trusted our
20 friends.

21 We managed to find a way to get out of the
22 house and run down the street to meet our friends. I
23 remember seeing my site manager running down the street
24 behind us yelling for us to stop, but we jumped in anyway,
25 and off we went.

1 While we were at the -- while we were on the
2 Manitoba highway on the way to Regina the guys told us we
3 should check in with our staff so they don't worry. They
4 let us use their phone to call. I remember calling twice,
5 staff were worried and tried to convince us to get out of
6 the vehicle and they would come and get us. I remember
7 telling them to calm down and that if they really wanted to
8 hurt us they wouldn't be letting us use their phone and
9 checking in.

10 I remember getting stopped by the RCMP just
11 before the Saskatchewan border. They just did a spot
12 check, didn't ask us to get out of -- get out or ask us our
13 name. If they would have done so, they would have seen
14 that we were listed as missing persons and they would have
15 found all the drugs and alcohol in the car.

16 Once we got to Saskatchewan we were not
17 allowed to use the phone. I really didn't think anything
18 of it until we got to Regina, which was when the red flags
19 of what I was told could happen to us by my staff started
20 to become reality.

21 Once we got to Regina our friends changed
22 the license plate of the vehicle we were in, they also
23 picked up this white guy who was about 500 pounds and he
24 had suitcases. We later learned he was from Vancouver.

25 We continued to drive to Saskatoon, we were

1 told they just needed to go there for a quick ride to drop
2 off this guy.

3 My friend who at the time was with -- my
4 friend who was with me at the time was pretty wasted and
5 crashed out. When we got to Saskatoon they went downtown
6 and picked up an older woman who was working the streets
7 and went to Wal-Mart and gave her some money and ordered
8 her to order -- ordered her to go inside and buy some
9 lingerie. When she returned to the car we then all went to
10 the hotel where guys -- where the guys continued to party.
11 By this time I was freaking out inside, I knew something
12 wasn't right.

13 I asked to use the phone and I was told no,
14 I couldn't leave the room. I was afraid to even try, so I
15 pretended I was cool as to what was going on so they
16 wouldn't get suspicious and hurt me.

17 The old guy was trying to come on to us
18 girls. This grossed me out, but I knew if I pretended I
19 was interested that maybe I can get his phone and call for
20 help, so this is what I did. I managed to get his phone
21 and made an excuse that I needed the washroom. I then
22 called my staff, Jackie, cried for help. I had no idea
23 what hotel we were in, all I remembered is that we were in
24 Saskatoon. Jackie asked me to look around the washrooms to
25 see if there was any names on the soap labels, and

1 thankfully I was able to spell out the Howard Johnson. She
2 asked me to stay on the phone while she got help. It felt
3 like forever, but within a couple minutes there was
4 pounding on the door. The hotel security was at the door
5 and within minutes the Saskatoon police were also there.

6 I remember all of us getting arrested and
7 brought into the police station. My friend was still
8 pretty out of it and didn't really understand what was
9 going on.

10 When we got to the police station the cops
11 told me that our staff contacted them and explained the
12 situation and that they have asked for them [sic] to be
13 kept at the police station until they could get there in
14 eight hours to come and get us.

15 I remember by the -- I remember the police
16 asking us what was going on in the hotel? Why did we come
17 with these guys? Did anything bad happen? All I could
18 think of at that time was that I needed to protect my
19 family and my home. I was scared to say anything out of
20 fear that these guys will try and hurt me or my loved ones
21 more. I told them nothing was going on, and later learned
22 that these guys were almost -- were released almost
23 immediately.

24 I now know the intent of the situation was
25 my friend and I were about to be sold and trafficked. This

1 guy, being from Vancouver, was most likely going to buy us
2 and take us away. It scares me to think where I may have
3 been or what could have happened to me.

4 Sadly, by that time we got back to Winnipeg,
5 we had to drive by Portage Place and those so-called
6 friends, who I now know are recruiters, were already parked
7 outside Portage Place, already back at it looking for their
8 next vulnerable girls.

9 This experience could have turned out very
10 badly for us. I am grateful for my staff at the time who
11 never gave up on us, who did everything in their power to
12 save us and protect us. I learned from this experience to
13 never share anything with strangers, that danger is real,
14 to not trust so easily and to protect my spirit.

15 Unfortunately, the trauma I experienced is
16 real and I will not -- and I will be -- unfortunately, the
17 trauma is real, the trauma I experienced is real, this will
18 be something I have to continue to heal from for the rest
19 of my life. There are times when I think how could I have
20 been so stupid to make these choices, to put myself in
21 these situations, then I remember and self-reflect, this
22 was not a choice I made, I was a child. Those who preyed
23 on me took away my choice. I was forced, felt threatened,
24 and feared that if I told the police my life and the life
25 of my family would be at risk. The only choice that I felt

1 I had control over at the time was to try and protect my
2 family the best way I could.

3 When I look back to what had the most impact
4 in my healing I have to say that having mentors with lived
5 experience was the most helpful. I lived in other homes
6 where the staff had no clue what I was experiencing and had
7 no idea how to help lessen my risk. They would use terms
8 such as you shouldn't be prostituting yourself, which made
9 me feel a lot of shame and pushed me away to isolation even
10 further.

11 As a child I didn't know anything about my
12 culture, who I was as an Indigenous child. I think it's
13 hard -- I think this had a lot to do with me not feeling
14 connected to my spirit. I felt empty and disconnected, I
15 didn't have an identity.

16 Ma Mawi Little Sisters Home not only
17 had -- how do you say that?

18 **UNIDENTIFIED SPEAKER:** Experiential.

19 **MS. CHRISTINE DUMAINE:** -- experiential
20 staff working with us, but they were also Indigenous. They
21 helped me connect to my spirit through teaching
22 and -- teachings and ceremonies, and this is something I am
23 still proud of today.

24 When I see that -- what I see that still
25 needs to happen in our communities for children, youth and

1 women is having more 24-hour safe spaces and outreach teams
2 on the streets helping our women. We need more homes for
3 our youth that are Indigenous led and hire women with lived
4 experience as the helpers, as they are truly the ones who
5 know what we need.

6 It is also important that when organizations
7 develop programs for children and youth that they are
8 supporting and listening to those with lived experience as
9 we are the true experts in this issue. We cannot put the
10 responsibility on our girls and women to change their
11 perpetrators in order to stop and -- to stop the controlled
12 violence. When you are in a vulnerable state, daily
13 threatened if you tell anybody that you will be harmed, you
14 will not tell. We will not put our loved ones at risk.

15 Laws need to continue and strengthen to give
16 the police the ability to -- the ability to go after the
17 men and those who are controlling our women and girls.

18 When it comes to children and youth in care,
19 please do not use secure settings as a way to keep them
20 safe. When I was young I was told if I didn't stop doing
21 what I was doing I would be put in a locked up placement.
22 This threatened me -- this threat put me more at risk as I
23 would run away to places where it was harder to find me,
24 which was often in places that were not safe. I was a
25 victim, not a criminal, and I shouldn't have been the one

1 who was locked up.

2 I recommend that we need more traditional
3 healing lodges out of the city, similar to Hands of Mother
4 Earth that is operated by the Ma Mawi Wi Centre, a place
5 where girls can connect to their land with Elders and
6 ceremony while feeling safe and with staff who understand
7 how to help you heal.

8 Lastly, I cannot express enough how
9 important it is for me that my healing only started when I
10 came to a place that had Indigenous staff with lived
11 experience that helped me reconnect to my culture. Our
12 home was based on Indigenous values, teachings and
13 ceremonies, these were things non-Indigenous placements
14 could not give me. This is what brought peace to my life
15 and empowered me to commit to the healing I so desperately
16 needed and wanted in life.

17 I am proud to stand here today as a
18 27-year-old mother of two, along with working for the place
19 that saved my life. My staff used to say to me that one
20 day you are going to be working here, and I would laugh
21 about that as I never saw my own worth, I never thought I
22 could be in that position.

23 When I was old enough to age out of care and
24 move on to my own, the staff wouldn't let me go, they still
25 remained involved in my life. The staff were there when my

1 babies were born, they were there if I was struggling or
2 just needed a good talking to. They loved me and
3 encouraged me to follow my dreams.

4 I am a -- I am now employed with Little
5 Sisters, I am now a big sister working with the girls that
6 once was I. I love that I can use my own lived experience
7 in a helpful manner to help others as my big sisters -- as
8 my big sisters helped me.

9 I love being able to tell the girls who are
10 trying to pull a fast one on me that it's not -- it's going
11 to work, I already tried that. I love to be able to help
12 the girls with the trauma they are experiencing when they
13 feel helpless and hopeless, that they can do it too. I
14 love to be able to go to work each day to a place that once
15 was home for me for many years. I love who I am and the
16 journey I have chosen.

17 I love my big sisters and my little sisters,
18 who I consider family. I don't know where I would be today
19 if it wasn't for them entering my life. I would like to
20 thank the MMIWG Inquiry for inviting me today to share my
21 story. I am proud and honoured to be here today. My
22 participations and truths today is dedicated to my sister-
23 friends, who I have lost in my life to this issue. I will
24 continue to stand strong for them and ensure their voice is
25 heard through mine. Thank you for having me.

1 **MS. JENNIFER COX:** Christine, thank you very
2 much for reading that. I have one question for you. You
3 have a recommendation in terms of a service that you'd like
4 to see provided; do you remember?

5 **MS. CHRISTINE DUMAINE:** Yes. I would like to
6 see rehab for the ones that are -- who are under 18 because
7 in Winnipeg we don't have that. When I was growing up,
8 struggling with drugs, there was nowhere to go.

9 **MS. JENNIFER COX:** So in terms of
10 rehabilitation for drugs and alcohol?

11 **MS. CHRISTINE DUMAINE:** What do you mean?

12 **MS. JENNIFER COX:** What -- what specific
13 service do you want them to provide?

14 **MS. CHRISTINE DUMAINE:** Just a placement for
15 girls for treatment, like, long-term.

16 **MS. JENNIFER COX:** From drugs and alcohol?

17 **MS. CHRISTINE DUMAINE:** Yes.

18 **MS. JENNIFER COX:** Yes, okay. Those are all
19 my questions, Commissioners, so I think that would end the
20 direct examination of the two witnesses.

21 **CHIEF COMMISSIONER MARION BULLER:** I --

22 **MS. JENNIFER COX:** So --

23 **CHIEF COMMISSIONER MARION BULLER:** Go ahead.

24 **MS. JENNIFER COX:** That's fine, go ahead.

25 **CHIEF COMMISSIONER MARION BULLER:** Okay, then

1 we'll stop for lunch and we'll return at one o'clock.

2 **MS. JENNIFER COX:** And before we conclude,
3 I'm going to ask the parties to meet at the beginning of the
4 lunch period to get their order and the times for their
5 cross-examination, please. So we will return at one
6 o'clock, 45 minute break. Thank you.

7 --- Upon recessing at 12:11 p.m.

8 --- Upon reconvening at 1:19 p.m.

9 **MS. JENNIFER COX:** So we're ready to get
10 started this afternoon. A couple of housekeeping matters
11 before we get going with respect to the cross-examination.
12 There were a couple of documents that Jackie referred to
13 briefly in her testimony this morning, and the parties --
14 some of the parties would like to have the opportunity to
15 cross-examine. They were disclosed to the parties, but they
16 weren't entered as exhibits, so I'm going to ask if we can
17 enter two documents. The first one is the report prepared
18 by the Native Women's Association of Canada, dated March
19 2014, "Sexual Exploitation and Trafficking of Aboriginal
20 Women and Girls Literature Review and Key Informant
21 Interviews." And Jackie, this is one of the documents that
22 you're familiar with?

23 **MS. JACKIE ANDERSON:** Yes.

24 **MS. JENNIFER COX:** So --

25 **CHIEF COMMISSIONER MARION BULLER:** Could I

1 have the title again, please? I'm -- there was --
2 background noise there.

3 **MS. JENNIFER COX:** Sure. "Sexual Exploitation
4 and Trafficking of Aboriginal Women and Girls Literature
5 Review" and you will see the Native Women's Association of
6 Canada stamp. So --

7 **CHIEF COMMISSIONER MARION BULLER:** March
8 2014?

9 **MS. JENNIFER COX:** Yes.

10 **CHIEF COMMISSIONER MARION BULLER:** Okay.
11 "Sexual Exploitation and Trafficking of Aboriginal Women and
12 Girls Literature Review and Key Informant Interviews," March
13 2014 is Exhibit 34, please.

14 **--- EXHIBIT NO. 34:**

15 Sexual Exploitation and Trafficking of
16 Aboriginal Women and Girls, Literature
17 Review and Key Informant Interviews
18 (March 2014), Native Women's Association
19 of Canada / Canadian Women's Foundation
20 (81 pages)

21 **MS. JENNIFER COX:** And one additional
22 document. It's a document commissioned by the Canadian
23 Women's Foundation. It's entitled "No More: Ending Sex
24 Trafficking in Canada, Report of the National Task Force."
25 So you recall that Ms. Anderson referred to the National

1 Task Force. So, Jackie, is this the -- the document you
2 were referring to that is considered the National Task
3 Force? I would ask that that be marked as Exhibit 35,
4 please.

5 **CHIEF COMMISSIONER MARION BULLER:** Yes. The
6 document entitled "No More: Ending Sex Trafficking in
7 Canada, Fall, 2014." It is Exhibit 35, please.

8 **--- EXHIBIT NO. 35:**

9 "No more: Ending Sex-Trafficking in
10 Canada," Report of the National Task
11 Force on Sex Trafficking of Women and
12 Girls in Canada (Fall 2014), Canadian
13 Women's Foundation (137 pages)

14 **MS. JENNIFER COX:** Thank you. So unless
15 there are other issues, Commissioners, we're ready to begin
16 the cross-examination for the witnesses of the second panel,
17 and the first party with 13 minutes is the Assembly of First
18 Nations.

19 **VALERIE GIDEON, Previously Affirmed:**

20 **CROSS-EXAMINATION BY MR. WUTTKE:**

21 **MR. STUART WUTTKE:** All right, good
22 afternoon, Dr. Gideon, Jackie Anderson and Christine -- is
23 it Dumaine? I'd like to thank you for the presentations
24 and testimony you gave earlier today. My name is Stuart
25 Wuttke and I'm general counsel with the Assembly of First

1 Nations. And before I start I'd like to recognize that
2 we're on Treaty 7 territory.

3 I'll begin by asking Dr. Gideon a number of
4 questions and then I'll move on to the other panelists.
5 I'll hopefully have enough time to ask all my questions.

6 Dr. Gideon, are you aware of the Canadian
7 Human Rights Tribunal decisions, the main decision back in
8 2016 and the four subsequent decisions?

9 **DR. VALERIE GIDEON:** Yes, I am.

10 **MR. STUART WUTTKE:** All right. I just want
11 to ask a clarification question for you. During the last
12 expert hearing on human rights a number of the panelists
13 spoke to the Human Rights Tribunal decision, but they were
14 really only referring to the first decision where there
15 were issues raised with respect to lack of prevention
16 services and supports that First Nations had or didn't have
17 available to them. Since that time, though, I understand
18 that prevention services is now a funded line of -- stream
19 of funding for First Nation CFS agencies; is that correct?

20 **DR. VALERIE GIDEON:** That's correct.

21 **MR. STUART WUTTKE:** And what would that
22 entail?

23 **DR. VALERIE GIDEON:** Well, we've just
24 recently established a consultation committee with all the
25 parties of the Canadian Human Rights Tribunal complaint,

1 we've signed a formal protocol to -- that in part
2 establishes the consultation committee, and through that
3 process we will be discussing how the new funding that's
4 been announced will be allocated in consultation with those
5 parties.

6 **MR. STUART WUTTKE:** Okay. And prevention
7 services would incorporate what type of activities or
8 services?

9 **DR. VALERIE GIDEON:** I don't know if I can
10 speak with authority on that point. I think it is subject
11 to the discussions at the consultation committee level.
12 But I do think that the objective is to take a broad-based
13 approach to encompass as many services as possible in order
14 to support children and families.

15 **MR. STUART WUTTKE:** Okay, thank you.
16 Earlier today you mentioned the 1979 health policy. Has
17 this policy been updated since 1979?

18 **DR. VALERIE GIDEON:** No.

19 **MR. STUART WUTTKE:** It hasn't. You also
20 mentioned earlier today the supplementary health benefits
21 applying to Métis and First Nation peoples. Is Métis
22 correct with that or is that Inuit?

23 **DR. VALERIE GIDEON:** It's First Nations and
24 Inuit, so it's applicable to registered First Nations and
25 recognized Inuit, regardless of where they live in Canada.

1 **MR. STUART WUTTKE:** But it doesn't apply to
2 the Métis population?

3 **DR. VALERIE GIDEON:** It does not.

4 **MR. STUART WUTTKE:** Thank you. Now, you
5 also talked this morning about -- you mentioned there were
6 some gaps in services that are inherent in the non-insured
7 health benefits program. Can you identify some of those
8 gaps?

9 **DR. VALERIE GIDEON:** I wouldn't be able to
10 give you a fully exhaustive list, but one of the things
11 that we've noted with the Jordan's Principle initiative is
12 the allied health services not being covered with a
13 non-insured health benefits. So that includes
14 physiotherapy, speech therapy, occupational therapies.
15 Sorry, I'm trying to think of other types of gaps in
16 services.

17 We're addressing a lot of respite care needs
18 within the context of Jordan's Principle as well. I think
19 the broadening of the mental health counselling benefit
20 will go a long way towards addressing some of the gaps that
21 previously we would see because the counselling was limited
22 to crisis. So those would be examples.

23 **MR. STUART WUTTKE:** All right. And just for
24 the benefit of the Inquiry, can you describe what Jordan's
25 Principle is?

1 **DR. VALERIE GIDEON:** Jordan's Principle is
2 an initiative legal order, it's a set of legal orders and a
3 decision by the Tribunal to ensure that First Nations
4 children that have unmet needs for public health, social,
5 education or other services will receive those services,
6 and that the government agency, the federal government
7 agency of first contact must provide those services and pay
8 for those services without engaging in case conferences in
9 order to determine responsibilities within the context of
10 varying jurisdictions.

11 **MR. STUART WUTTKE:** Okay, thank you. You
12 mentioned this morning actually quite a bit about Health
13 Canada's nursing stations in northern areas, isolated
14 areas. Now, I note that in most of those nursing stations
15 there's not a lot of capacity for actual doctors or
16 physicians; is that correct?

17 **DR. VALERIE GIDEON:** That would be correct.
18 I mean, there's been growing access in some provinces, and
19 these are provincially insured services, but it remains a
20 significant gap, particularly, I would say, in some
21 provinces like in Manitoba.

22 **MR. STUART WUTTKE:** M'hm. And with respect
23 to the nurses that are on staff, they are really making
24 assessments that in southern areas it would be doctors
25 making medical assessments; is that correct?

1 **DR. VALERIE GIDEON:** Well, they have access
2 to physician consults by phone or by tele-health or
3 tele-medicine and sometimes on site, so they do need
4 to -- and the clinical practice guidelines do specify when
5 nurses need to have access to a physician consult before
6 actually administering a treatment.

7 **MR. STUART WUTTKE:** M'hm. And I also lived
8 in a northern community, my home community is Garden Hill,
9 I lived there for a while, and we had a nursing station up
10 there. Are you aware of any situations where there are
11 misdiagnoses as a result of a nurse practitioner examining
12 a individual?

13 **DR. VALERIE GIDEON:** I'm not aware of a
14 specific instance with respect to Garden Hill, but, of
15 course, it doesn't mean that it hasn't happened. I mean,
16 there are a number of communities across the country and a
17 lot of instances of patient services being provided.

18 **MR. STUART WUTTKE:** All right. And does
19 your department keep track of the -- any number of
20 misdiagnoses that happened on an annual basis?

21 **DR. VALERIE GIDEON:** We have received
22 incident reports when a patient passes away or if there's a
23 situation that nurses feel need to be reported. And we
24 will conduct patient safety reviews or incident reviews.
25 And we have a system, a protocol, that directs what are the

1 steps to be taken within the context of those patient
2 safety reviews.

3 **MR. STUART WUTTKE:** Okay, thank you. With
4 respect to mental health, you mentioned these programs are
5 based on contribution agreements; is that correct?

6 **DR. VALERIE GIDEON:** The majority of mental
7 health services are provided through contribution agreement
8 through the non-insured health benefits program, which
9 could be by directly paying a service provider that's
10 registered by the program, and the Indian Residential
11 School Health Support Program, where I can -- we can
12 directly pay a service provider to provide counselling
13 services. So it's not solely through contribution
14 agreement, but definitely the majority of resources
15 are -- are provided through contribution agreements.

16 **MR. STUART WUTTKE:** Okay. And these are
17 largely proposal driven processes?

18 **DR. VALERIE GIDEON:** No. It would be
19 through community health plans that are submitted, and they
20 don't have to be submitted on an annual basis. If the
21 community has a five-year funding agreement, for instance,
22 they don't need to every year submit a request for mental
23 wellness funding, it's part of their core funding that they
24 receive.

25 But that being said, sometimes proposals are

1 submitted by communities if they feel that there's
2 additional supplementary resources that are required, if
3 there are unmet needs or special circumstances. Also
4 through Jordan's Principle we are receiving some group and
5 individual requests in the area of mental health
6 specifically for First Nations children through that
7 initiative.

8 **MR. STUART WUTTKE:** Through the -- that's a
9 result of the Human Rights Tribunal decision, right?

10 **DR. VALERIE GIDEON:** That's correct.

11 **MR. STUART WUTTKE:** Prior to the Human
12 Rights Tribunal are you aware of the Wapakika proposal?

13 **DR. VALERIE GIDEON:** Wapakika.

14 **MR. STUART WUTTKE:** Wapakika, yes, that's
15 it.

16 **DR. VALERIE GIDEON:** Yes, Wapakika First
17 Nation proposal, yes, I am.

18 **MR. STUART WUTTKE:** Can you explain to the
19 Tribunal what that proposal is about?

20 **DR. VALERIE GIDEON:** I can. Wapakika
21 submitted a proposal to have access to youth counselling
22 services based in their community. They were concerned
23 that they had a possible suicide pact among some of the
24 young people in their community, and they submitted a
25 proposal to the department at that time in order to be able

1 to access supplementary funding from their funding
2 agreement.

3 Wapakika does receive -- they have a block
4 funding agreement, so they have the highest level of
5 flexibility in their agreement outside from a grant, that
6 you would access through self-government. They have a
7 dedicated mental wellness funding in their community, which
8 included a special initiative that they had started years
9 ago, and SOS conference to support youth suicide
10 prevention, and bring together workers and families
11 affected by youth suicide prevention workers in the area.
12 And that was embedded in their block funding agreement.

13 **MR. STUART WUTTKE:** Okay. But the original
14 proposal they did submit wasn't funded; is that correct?

15 **DR. VALERIE GIDEON:** It was pending. It
16 wasn't that it was rejected. It was that there were no
17 available resources at that time.

18 **MR. STUART WUTTKE:** Okay. Thank you. Now,
19 you also talked about the B.C. Model, and MKO looking at
20 certain aspects of that. But you also mentioned that there
21 were some gaps in services that would apply to northern
22 areas. Can you shed some light on what those potential gaps
23 would be?

24 **DR. VALERIE GIDEON:** I just want to make sure
25 I understood the correct -- the question correctly. You

1 were speaking about MKO?

2 MR. STUART WUTTKE: Yes.

3 DR. VALERIE GIDEON: Gaps and access to
4 services. So I think that there -- we are seeing a rising
5 amount of medical transportation coming from northern
6 Manitoba. I think, overall, in Manitoba we're spending
7 about \$150,000,000 a year on medical transportation. So
8 part of that is greater access to physician services, and
9 greater access to specialized services, diagnostic services.
10 So that patients who don't want to travel out to access
11 services, would be able to do that more in the communities.
12 I think infrastructure has been a challenge. We have made
13 some significant infrastructure investments in northern
14 Manitoba, such as the Cross Lake community, which is a large
15 community in northern Manitoba, is now in the process of
16 designing a Primary Healthcare Centre of Excellence that
17 will enable them to provide more services.

18 And just to clarify, the Wapekeka issue, that
19 was the -- the proposal was funded early in 2017, but I
20 imagine that you are asking me the question about when it
21 was initially submitted. So I just wanted to clarify that
22 it's been funded, and they have received a -- a quite
23 supplementary funding now for the past, almost, two years.

24 JACKIE ANDERSON, Previously Affirmed:

25 CROSS-EXAMINATION BY MR. WUTTKE:

1 **MR. STUART WUTTKE:** All right. Thank you.
2 Now, my next questions are for -- for Jackie. I don't have
3 much time left, but you discussed people going into fosters
4 homes and falling through cracks. What -- what usually
5 happens to those individuals?

6 **MS. JACKIE ANDERSON:** Well, I mean,
7 unfortunately, they're -- they're raised within the system.
8 They're taken away from their communities, from their
9 culture, from their identity, from their families. And
10 long-term, you know, effects is that being unattached, that
11 they -- they have severe attachment issues. And again, like
12 I -- I was emphasizing this morning about multiple
13 placements that our children are being in, is -- is not --
14 it's not good for their overall well-being. And when they
15 become young adults, that is when the trauma really hits
16 them, and vulnerabilities of all kinds of levels of
17 victimization --

18 **MR. STUART WUTTKE:** All right. Thank you. I
19 think I have one more time -- for one last question. You
20 mentioned that your organization has developed some safe
21 homes. You said there was six beds. My first question with
22 respect to this, does that serve the needs of all the people
23 in Winnipeg that needs this help, or is there more types of
24 home, or beds that are needed for that? And secondly,
25 linking to culture, with respect to the programs, are there

1 -- but you also mentioned that child -- the parents
2 sometimes have to put their kids in voluntary placement
3 programs. What happens when you have a parent with three or
4 four kids and they put one of them into a voluntary
5 placement program? Does that jeopardize the other kids in
6 the current Child Family Service?

7 **MS. JACKIE ANDERSON:** I think you had two
8 questions. First one, to address, within the Ma Mawi Wi Chi
9 Itata Centre, we have a combined 12 beds with --
10 with -- between our two safe homes. One of the important
11 aspects of the development of the safe homes was that our
12 experienced advisory felt that there should be no more than
13 six because the larger number of children, then you have --
14 then the harder it is to reach the needs of each of the
15 individuals within our home. There's other organizations
16 within our province that are also providing different levels
17 of specialized service to exploited youth. As I mentioned,
18 kids that are at risk of, and/or kids that are aging out, or
19 have been extended in care up until the age of 21. It --
20 it's not nearly enough beds. I can absolutely say that,
21 within -- within our province, and what we're dealing with.

22 Your other question in regards to the
23 voluntary placement. With a voluntary placement, a parent
24 still has the guardianship of their child, however, have to
25 sign this VPA with the province in order for them to access

1 the funding to receive the services.

2 **MR. STUART WUTTKE:** Okay. All right. Thank
3 you very much. Those are my questions.

4 **MS. JENNIFER COX:** So the next party on this
5 list is the Native Women's Association of Canada, with 13
6 minutes.

7 **JACKIE ANDERSON, Previously Affirmed:**

8 **CROSS-EXAMINATION BY MS. LOMAX:**

9 **MS. VIRGINIA LOMAX:** Thank you. So my name
10 is Virginia Lomax. I'm legal counsel to the Native Women's
11 Association of Canada. And before I begin, I would like
12 thank Treaty 7 and Métis Nation, or the Metis Region 3, for
13 welcoming us to this territory. And I would like to begin
14 with Ms. Anderson and Ms. Duhaime, if that's all right. As
15 was just entered into exhibit -- into evidence as Exhibit, I
16 believe, it was 34. I might have heard that number wrong.
17 But there was a report from NWAC, The Sexual Exploitation
18 and Trafficking of Aboriginal Women and Girls Literature
19 Review and Key Informant Interviews. I'd like to point you
20 to page 9 of this report, and there are some statistics
21 here. We don't need to go into the details of it, but it
22 does demonstrate a link between childhood abuse and sexual
23 exploitation and trafficking. Would you agree with the
24 statement that in order to prevent sexual exploitation of
25 Indigenous women and girls, we must also address and develop

1 strategies for prevention of childhood abuse?

2 **MS. JACKIE ANDERSON:** Absolutely.

3 **MS. VIRGINIA LOMAX:** And do you have any
4 recommendations based on your experience for preventing
5 childhood abuse?

6 **MS. JACKIE ANDERSON:** Again, emphasizing, you
7 know, recommendations right across Canada over the years is
8 that there needs to be awareness and education strategy in -
9 - in all communities and in schools. And not just for
10 girls, for our boys as well. We don't just focus on, you
11 know, teaching them what to watch out for, but also to
12 ensure that, you know, we're -- we're preventing our -- our
13 young people from also becoming abusers as they're getting
14 older. And, unfortunately, we're dealing with, you know,
15 social media that glamorizes exploitation to a very young
16 audience, you know, through video games, through Halloween
17 costumes, through all different types of music. And those
18 are all things that we need to -- we need to keep in mind
19 and create awareness on.

20 **MS. VIRGINIA LOMAX:** And so you discussed
21 today with us that giving a child to the system is one of
22 the only ways that parents can access care and resources
23 that those children need; am I understanding that correctly?

24 **MS. JACKIE ANDERSON:** Yes.

25 **MS. VIRGINIA LOMAX:** Would you agree with the

1 statement that this policy causes further trauma to already
2 traumatized parents and children?

3 **MS. JACKIE ANDERSON:** Absolutely.

4 **MS. VIRGINIA LOMAX:** And so would you agree
5 with the statement that this policy should be revisited with
6 culturally trauma and gender-informed lens in order to
7 develop policies that better meet the needs of Indigenous
8 parents and children experiencing trauma?

9 **MS. JACKIE ANDERSON:** As priority.

10 **MS. VIRGINIA LOMAX:** And would you agree with
11 the statement that revisiting this policy must be led by
12 those with lived experience?

13 **MS. JACKIE ANDERSON:** Absolutely.

14 **MS. VIRGINIA LOMAX:** And would you agree with
15 the statement that revisiting this policy with those with
16 lived experience must see those people as equals, and not
17 from a top-down approach?

18 **MS. JACKIE ANDERSON:** They need to be seen as
19 the experts.

20 **MS. VIRGINIA LOMAX:** And so now, I'd like to
21 direct you to a quote on that same NWAC report, that's on
22 page 19. And so I'll read the quote:

23 For myself, if I had been informed
24 as a child, I think I would have made
25 better choices as a teenager and an

1 adult. In school, the children are
2 learning to learn, so why not teach them
3 everything else too? Especially, if it
4 can prevent something.

5 So I wanted to ask you, would you agree
6 with this statement, that it is a good idea to teach about
7 bodily autonomy and sexual exploitation as early as grade
8 school?

9 **MS. JACKIE ANDERSON:** Yes.

10 **MS. VIRGINIA LOMAX:** And can you provide some
11 age-appropriate examples of how this could be accomplished
12 within your experience that you may have come into contact
13 with?

14 **MS. JACKIE ANDERSON:** Well, I can refer to
15 the Canadian Centre for Child Protection in Winnipeg, who
16 has developed tools for parents on how to have those
17 discussions with their children as well as tools for schools
18 and service providers that are working with that population
19 of children. Those need to be used. We need to be teaching
20 our kids at a very, very young age what those dangers and
21 what they need to look out for. And teaching them about,
22 you know, relationships and what a healthy relationship is
23 and having and creating those boundaries.

24 **MS. VIRGINIA LOMAX:** And so today you
25 testified that your program is also a safe place for two-

1 spirited, LGBTQ+, and gender-diverse youth. Am I
2 understanding that correctly?

3 **MS. JACKIE ANDERSON:** Yes.

4 **MS. VIRGINIA LOMAX:** And so could you please
5 comment on how you've achieved this safe place for two-
6 spirit, LGBTQ+, and gender-diverse youth?

7 **MS. JACKIE ANDERSON:** It was advocated right
8 from the get-go, again because our program was developed by
9 our experiential advisory committee. So there was no
10 question asked. When we applied for our residential care
11 license, that -- and -- and again, I think there's some
12 language change that needs to happen as well within, you
13 know, those standards, but our -- our license reflects male
14 and female for the fact of being able to support two-
15 spirited, transgender. But again, I think that language
16 also needs to change. So it was -- it was right from the
17 get-go, it was expected when we developed a vision of the
18 home.

19 **MS. VIRGINIA LOMAX:** And so could you comment
20 on some best practices for building safe and trusting
21 relationships with two-spirit, LGBTQ, and gender-diverse
22 youth?

23 **MS. JACKIE ANDERSON:** Strength-based,
24 absolutely. Relationship-based. It's important that
25 there's inclusion and their voice is heard. You know, that

1 was one of the -- one of our members that were on our
2 advisory council was -- was two-spirited, and she had
3 shared, you know, her life of being in care, and because she
4 was born male, she was placed in a males' residential care
5 site where she was further bullied and exploited, which put
6 her risk factors a lot higher and her -- her stability was
7 really affected.

8 **MS. VIRGINIA LOMAX:** And so I'm not sure if
9 you'll be -- if you -- if you can, but if you could, can you
10 comment on any link that you know between natural resource
11 extraction and human trafficking and sexual exploitation?

12 **MS. JACKIE ANDERSON:** Sorry, what was the
13 first mention?

14 **MS. VIRGINIA LOMAX:** If there is a link
15 between natural resource extraction and human trafficking
16 and sexual exploitation.

17 **MS. JACKIE ANDERSON:** I'm not sure what
18 you're referring to as natural distraction.

19 **MS. VIRGINIA LOMAX:** Natural resource
20 extraction.

21 **MS. JACKIE ANDERSON:** Extraction. Can you
22 further explain that?

23 **MS. JENNIFER COX:** Just give her an example,
24 like perhaps mining?

25 **MS. VIRGINIA LOMAX:** Yes. Mining, pipelines.

1 **MS. JACKIE ANDERSON:** Are you talking about,
2 like, so in, like, transient -- or companies that are in ...

3 **MS. VIRGINIA LOMAX:** Yes.

4 **MS. JACKIE ANDERSON:** Okay. Yeah,
5 absolutely, that is a risk that we have, again, explored and
6 seen, in particular in some of our rural, isolated
7 communities. It's -- it's evident that, where there is a
8 high number of transient workers coming into the
9 communities, that the exploitation in that community rises,
10 you know, and it's unfortunate. I mean, I -- I grew up, you
11 know, in a community where there was the Abitibi Paper Mill,
12 and as a teenager, you know, as teenagers within our
13 community, we were extremely at risk with being approached
14 by, you know, men all across Canada that were coming there
15 for work.

16 **MS. VIRGINIA LOMAX:** And could you finally
17 comment if there is a link between cultural and social
18 exclusion and sexual exploitation?

19 **MS. JACKIE ANDERSON:** Again, if I -- if what
20 you're asking me is -- majority of the young people that are
21 coming to us, you know, our first interaction is their
22 identity and who they are as Indigenous people has been hurt
23 and has been damaged. And a lot of them don't know where
24 they come from. So that's always something that we always
25 got to keep in mind to help our young people reconnect to

1 their spirits, to their families, and to their community, to
2 the ceremony, and to their culture.

3 **MS. VIRGINIA LOMAX:** Thank you so much for
4 bringing your expertise to us today.

5 **MS. JACKIE ANDERSON:** Thank you.

6 **MS. VIRGINIA LOMAX:** And now for Dr. Gideon.

7 **VALERIE GIDEON, Previously Affirmed:**

8 **CROSS-EXAMINATION BY MS. LOMAX:**

9 **MS. VIRGINIA LOMAX:** Is it correct to say
10 that the F-N-I-H-B, or, I guess, we're calling it FNIHB, has
11 a responsibility to address gaps in healthcare services for
12 all Indigenous people?

13 **DR. VALERIE GIDEON:** At the moment, our
14 mandate is First Nations and Inuit-based. However, we do
15 have some non-status-related programs. Very few, but
16 examples would be the Indian Residential School Health
17 Support Program. That is available to all residential
18 school survivors and their family members, regardless of
19 status.

20 **MS. VIRGINIA LOMAX:** And so would you agree
21 that that includes First Nations and Inuit women who are in
22 prisons?

23 **DR. VALERIE GIDEON:** The Indian Residential
24 School Support Program -- I'm sorry, I can't -- I can't
25 confirm that with you. I have not looked into that issue in

1 particular for sure.

2 **MS. VIRGINIA LOMAX:** And so would you agree
3 that, if that is not within the purview of FNIHB, that this
4 is an -- an identifiable gap in healthcare service delivery
5 for Indigenous women that may not be addressed thoroughly at
6 the moment?

7 **DR. VALERIE GIDEON:** I -- I can't speak to
8 the Correctional Services Canada federally and what they
9 include with respect to their health services programs, but
10 I do know that they have a number of initiatives that are
11 specific to Indigenous peoples in Federal correctional
12 facilities.

13 **MS. VIRGINIA LOMAX:** So does FNIHB have
14 specific strategies in place for addressing issues that
15 create further gaps in health care even within Indigenous
16 populations, and specifically speaking about the two-spirit
17 LGBTQ+ community?

18 **DR. VALERIE GIDEON:** We do partner with
19 Indigenous organizations, such as the Canadian AIDS --
20 Aboriginal AIDS Network, that have a voices of women, for
21 instance, advisory committee, that have developed tools and
22 strategies with respect to this issue. I -- we also have
23 partnered with the Native Women's Association of Canada with
24 respect to -- specific to sexually transmitted and
25 bloodborne illnesses, for instance, to ensure that there is

1 trauma-informed care approaches and training for workers.
2 With Pauktuutit, for instance, we also have supported them
3 to develop an Inuit Sexual Health Network to address a -- a
4 -- a wide array of issues. Within our clinical practice
5 guidelines, even, for primary care nurses that are working
6 in remote and isolated communities, there are specific
7 guidelines that refer to this issue as well.

8 **MS. VIRGINIA LOMAX:** And so today in your
9 testimony, you covered a great deal about physical, mental,
10 and emotional health, but I'm wondering what FNIHB has done
11 to make progress towards promoting spiritual wellness and
12 health for Indigenous peoples.

13 **DR. VALERIE GIDEON:** It is absolutely a -- a
14 -- a big part of the First Nations mental wellness continuum
15 framework. Spiritual health, and by now having the
16 inclusion of traditional healers even within the context of
17 the non-insured health benefits program, it really is
18 opening doors for enabling communities to be able to support
19 activities relating to spiritual health. All of the on-the-
20 land type of approaches that communities are also
21 undertaking definitely includes that within the context of
22 the Victims of Violence Initiative. There have been
23 spiritually focused initiatives and on-the-land initiatives,
24 as well, within that context, so I say that there has been a
25 -- a growing amount of support for making sure that

1 spiritual health is part of a -- a -- community-based
2 initiatives or First Nations, Inuit, Métis organization-
3 based initiatives.

4 **MS. VIRGINIA LOMAX:** And so when you have
5 these mental wellness teams and they are trained to provide
6 services, is there specific training on issues specific to
7 two-spirited, LGBTQ+ communities, and gender-diverse people?

8 **DR. VALERIE GIDEON:** They're all governed by
9 Indigenous organizations, First Nations and Inuit
10 organizations. So they design them, they build them, they
11 guide them. So there's no prescriptive federal guidelines
12 with respect to that. I am sure that, out of the 43 that
13 have established, this is an issue that they are paying
14 attention to, but again, we're not directing that.

15 **MS. VIRGINIA LOMAX:** M'hm.

16 **DR. VALERIE GIDEON:** It is based on their own
17 initiatives.

18 **MS. VIRGINIA LOMAX:** Well, thank you very
19 much to all of you for your time today and for your
20 expertise.

21 **DR. VALERIE GIDEON:** (Speaking in Native
22 language).

23 **MS. JENNIFER COX:** So the next party is the
24 Institute of -- for the Advancement of Aboriginal Women,
25 with 13 minutes.

1 **MS. LISA WEBER:** Good afternoon,
2 Commissioners, panelists. Thank you for the opportunity to
3 hear your very powerful presentations this morning. I was
4 number 6, I wasn't expecting to come up so soon, sorry. And
5 so my questions mostly are for Jackie, and she spoke about
6 her wealth of experience working in Winnipeg with the Little
7 Sisters.

8 **JACKIE ANDERSON, Previously Affirmed:**

9 **CROSS-EXAMINATION BY MS. WEBER:**

10 **MS. LISA WEBER:** And it really struck me when
11 you were talking about -- excuse me -- what I perceived to
12 be objectification of the girls that -- that you're working
13 with. And in my experience as a lawyer working with -- I --
14 I do a lot of work as child's counsel and I often hear
15 reference to "the file" as opposed to the individual or the
16 name. And I'm just wondering if you can comment as to
17 whether you've had similar observations in your work with
18 professionals or front-line workers who are working
19 with -- with your girls, whether they similarly are referred
20 to as "the file" and what is the impact of that.

21 **MS. JACKIE ANDERSON:** Absolutely.
22 I've -- as I mentioned, I did have, you know, experience
23 working behind the computer at the desk and reviewing those
24 files. And then coming from a front-line perspective, and
25 I think that was one of the most challenging things for me

1 at being two different levels. When our referrals come
2 into our homes, we, in fact, don't even read the file, the
3 referral. Our first point of contact is -- is meeting with
4 the young person and learning who they are. And
5 unfortunately, when children have been involved in the
6 system for so long and/or multiply moving around, social
7 workers are also changed multiple times that come in with
8 different perceptions and different language.

9 So files can be very controversial, as well,
10 based on -- based on the child with different -- different
11 perspectives. That -- that file follows them throughout
12 their -- their child in care history.

13 **MS. LISA WEBER:** Thank you. Which leads me
14 to my next question. A lot of your comments to me talked
15 about identity and the importance of identity for -- for
16 the individuals you're working with. And I just wondered
17 in terms of program funding, is there recognition of the
18 importance of a solid identity for the girls and women that
19 you might be working with, and is there any criteria that
20 could perhaps be improved to enable you to work on those
21 important issues?

22 **MS. JACKIE ANDERSON:** I think that there's
23 mutual acceptance within our community of the importance of
24 the cultural aspect being the number one component. As I
25 mentioned earlier, we are bound by residential care

1 licensing standards. However, we have the ability to
2 define how we operate within our homes, and -- and we do
3 that in such a way that is respectful and mindful to our
4 young people that we're working with.

5 I -- unfortunately, as I mentioned, funding
6 only covers the cost of caring for that child, and other
7 funding is needed to continue to be able to nurture, you
8 know, to be able to take our -- our young people to
9 Sundances, to travel to other ceremonies, to, you know,
10 travel to the Powwow Trail, and those are things that we're
11 not funded for. And -- and again, it's just something we
12 naturally do. However, there's -- there is actually direct
13 costs related to being able to do some of those things. So
14 we spend a lot of time fund-raising, as I mentioned.

15 **MS. LISA WEBER:** Okay. In -- at least in
16 the province I'm from, which is Alberta, I would assume
17 Manitoba is similar, often when children come into care, in
18 order to receive services, parents must give up some
19 or -- and often all of their parental rights as a guardian
20 in order for their child to receive services. Did I
21 understand you correctly that in order to receive -- to
22 have a -- a child or a girl come into your facility, that
23 that is not an issue? The parent does not need to give up
24 their guardianship rights?

25 **MS. JACKIE ANDERSON:** No, they do.

1 **MS. LISA WEBER:** They do need to?

2 **MS. JACKIE ANDERSON:** They need to -- well,
3 I mean, they would sign a voluntary placement with the
4 agency, which they still, as I mentioned, remain the
5 guardian of the child. However, they now have an open
6 protection file with Child and Family Services where they
7 have a social worker and funding coming through the
8 province to cover their costs.

9 **MS. LISA WEBER:** So is that requirement
10 rooted in the provincial legislation, then, that they give
11 up those rights?

12 **MS. JACKIE ANDERSON:** Yes, I believe so.

13 **MS. LISA WEBER:** And do you know if parents
14 and children, especially if they're youth, are explained
15 the legal implications of giving up those rights?

16 **MS. JACKIE ANDERSON:** Not necessarily,
17 and/or if it's being explained, the language that's being
18 used is not understandable to a parent and/or English may
19 not be their first language. So we often will hear those
20 stories from families after the fact, that they didn't
21 understand what it was they were signing or participating
22 in.

23 **MS. LISA WEBER:** And in your opinion, in
24 order to receive services through your program or your
25 centre, would it necessarily be -- would they need to give

1 up those rights?

2 **MS. JACKIE ANDERSON:** Unfortunately --

3 **MS. LISA WEBER:** If the province didn't have
4 that requirement?

5 **MS. JACKIE ANDERSON:** -- the -- yeah.
6 Unfortunately, because we're funded through the province,
7 that is the way that the -- the funding agreement is
8 established. However, I think it's very important that
9 there's not -- not situations like this where children are
10 having to. There should be funding allowed to support
11 those parents, to be able to have services for their
12 children without having to put their child in the system
13 and having a file open on CFIS.

14 **MS. LISA WEBER:** Okay. One of the previous
15 parties asked about, or made mention to the First Nations
16 Child and Family Caring Society, litigation and the
17 resulting focus or -- or provisions to -- to provide
18 funding for prevention. And I'm just wondering whether, in
19 providing the services that you do, whether or not you have
20 yet seen any effects of that change in program funding from
21 the Federal government.

22 **MS. JACKIE ANDERSON:** Not nearly enough, I
23 can say that. I think more is needed, and, as I also
24 mentioned, it can't be in, like, piecemeal funding. This
25 is -- this is going to be, you know, an awareness that

1 needs to be happening forever, not just for a year or two
2 years or a three-year pilot project.

3 **MS. LISA WEBER:** M'hm. You made mention of
4 family group conferencing, which I know is also a concept
5 or a practice that's used in -- in child welfare
6 proceedings generally. I'm just -- just for clarity, is
7 the family group conferencing you mentioned, is that
8 specific to your organization or is that the group
9 conferencing that occurs as part of a conventional child
10 welfare file?

11 **MS. JACKIE ANDERSON:** Family group
12 conferencing is the gift that was given to us directly from
13 the Maori of New Zealand. Part of that gift was done
14 through ceremony, and with that ceremony came great honour
15 that we ensured that an Indigenous organization that
16 doesn't have mandated status are the ones that facilitate
17 and work with the family. I mean, it's common knowledge.
18 A lot of our families are -- are -- have fear, you know, of
19 Child and Family Services. And it's difficult for them to
20 let down those fears and be able to work with them in a way
21 that we can -- and -- and our ability to be able to help
22 repair those relationships, to be able to work with all the
23 different partners that need to be a part of that circle,
24 to support this family.

25 **MS. LISA WEBER:** Do you know or is it your

1 experience that your family group conferencing is accepted
2 by the Province as that component of their provision of
3 services to the family or to the child?

4 **MS. JACKIE ANDERSON:** Yes. We have a very
5 active Minister that is supporting and funding our
6 initiative because the -- again, the expansion is still
7 very new. We are working very hard right now with creating
8 those partnerships and relationships and creating awareness
9 on the model within all of our authorities and agencies
10 within our Province.

11 **MS. LISA WEBER:** As part of your
12 recommendations, Jackie, you said clearly that one of them
13 was if -- if the law were followed. And I was wondering,
14 in your experience, and you have a wealth of experience, if
15 you could describe any new laws, perhaps, that need to be
16 contemplated in addition to what is existing.

17 **MS. JACKIE ANDERSON:** Again, I'm not no
18 expert in -- in that area, but I think my recommendations
19 would probably be very harsh and -- but right now, what we
20 do have that needs to be used is Bill -- Bill C-36. And
21 that's a new bill over the last couple of years, but within
22 our province we have a very active police force that are
23 using this. And although it's not nearly as enough as what
24 I would like to see at the end of the day for these
25 perpetrators, it is a start. And these discussions need to

1 continue to happen to continue to be able to have that as a
2 tool for police to be able to use and to be able to
3 strengthen and -- and create newer laws that are a lot
4 harsher that focus on the demand.

5 **MS. LISA WEBER:** Thank you. One of the
6 issues that I often hear about, again, in Alberta, and I
7 would assume it might be similar in Manitoba, is issues
8 around the fact that there is a publication ban on the
9 identity of children if they're receiving services, and I'm
10 just wondering, given the nature of the work and services
11 that your organization provides, whether or not that's ever
12 been a -- if it's negatively impacted the ability to
13 provide needed services or finding individuals who may go
14 missing, as an example?

15 **MS. JACKIE ANDERSON:** Are you talking about
16 if a child has gone missing or -- is that what you're
17 referring to?

18 **MS. LISA WEBER:** Yeah, I'm referring to any
19 legislative prohibitions on publishing the identity of
20 person -- individuals, children, under age, and whether
21 that's negatively impacted your ability to provide
22 services?

23 **MS. JACKIE ANDERSON:** Not necessarily. I
24 mean, there's a couple of things that, you know, when
25 missing persons reports are going out they're identifying

1 them as a vulnerable child and youth. And although it's
2 important that there's a response to be able to safely
3 locate and bring our young people home, it's -- it's
4 socially -- or it's on, you know, social media where
5 perpetrators are also watching. Is that what you're
6 referring to or --

7 **MS. LISA WEBER:** Yeah, whether or not
8 there -- there has been a negative impact of the inability,
9 for example, to publish the name or the identity of youth
10 who may be missing?

11 **MS. JACKIE ANDERSON:** I don't think so.

12 **MS. LISA WEBER:** Okay. I know the focus of
13 the Commission's work and your work is women and girls, and
14 I am just wondering if you could comment in my closing
15 question if you have any observations or knowledge about
16 the situation of boys and men perhaps in your province and
17 what's being done to address issues that they may be
18 also --

19 **MS. JACKIE ANDERSON:** M'hm.

20 **MS. LISA WEBER:** -- feeling the impact of?

21 **MS. JENNIFER COX:** Those are -- that's a
22 question that's sort of beyond the scope of the mandate of
23 the National Inquiry.

24 **MS. LISA WEBER:** Okay, so she's not going to
25 answer that then?

1 **CHIEF COMMISSIONER MARION BULLER:** Is this
2 an official objection?

3 **MS. JENNIFER COX:** I guess it is, yes.

4 **CHIEF COMMISSIONER MARION BULLER:** Stop the
5 clock, please, and submissions.

6 **MS. LISA WEBER:** Thank you very much. Those
7 are all my questions. Thank you.

8 **CHIEF COMMISSIONER MARION BULLER:** And for
9 the record --

10 **MS. LISA WEBER:** I'm sorry, I forgot to tell
11 you my name yesterday too. Lisa Weber, counsel for the --

12 **CHIEF COMMISSIONER MARION BULLER:** That's
13 okay, you're consistent.

14 **MS. LISA WEBER:** Thank you.

15 **COMMISSIONER QAJAQ ROBINSON:** Can we have
16 that explained a little bit more, why the objection?

17 **MS. JENNIFER COX:** Why did I object?

18 **COMMISSIONER QAJAQ ROBINSON:** Yes.

19 **MS. JENNIFER COX:** Because it's beyond the
20 scope of the terms --

21 **COMMISSIONER QAJAQ ROBINSON:** No, I know
22 how, but she asked how are -- because -- perhaps it was
23 because I wasn't sure exactly the scope of the question.
24 I'm just wondering, we've heard about the need to educate
25 boys, we've heard the needs to include men, so I wasn't

1 sure if your question was about violence that the boys are
2 experiencing or their role in the situation?

3 **MS. JENNIFER COX:** Yeah, is it a follow-up,
4 I guess, would be -- yeah, and that would be a proper
5 question. I wouldn't object to that.

6 **MS. LISA WEBER:** Fair enough. I just
7 wondered in her experience because Jackie has a wealth of
8 experience, clearly, and I was just wondering if she had
9 any closing comments that she might be willing to make just
10 in regards to boys and men in Manitoba and the experiences
11 they are having?

12 **MS. JACKIE ANDERSON:** Could I answer?

13 **MS. JENNIFER COX:** Yes.

14 **MS. JACKIE ANDERSON:** Okay, I'm completely
15 comfortable with answering that as well because often our
16 little brothers are forgotten, you know, and unfortunately
17 it is something that we come across every day, where young
18 boys are also being exploited and being hurt and harmed,
19 and I think that a lot more work needs to be done to also
20 be able to address some of the special needs that our
21 young -- our young men need to have as it relates to the
22 violence and exploitation they are experiencing.

23 There was research that was done, and I
24 can't say what year it is, but it's called Under the Radar,
25 I believe it is, and it was done by Dr. Sue McIntyre who

1 travelled across Canada and held summits and spoke to boys
2 and men who were also being affected through exploitation.

3 **MS. LISA WEBER:** Thank you very much. Those
4 are all my questions. Thank you, Commissioners.

5 **MS. JENNIFER COX:** So the next party is Awo
6 Tran Healing Lodge Society.

7 **VALERIE GIDEON, Previously Affirmed:**

8 **CROSS-EXAMINATION BY MR. BLAIN:**

9 **MR. DARRIN BLAIN:** Good afternoon, Chief
10 Commissioner Buller, Commissioners, panelists, my friends
11 in the legal profession and the people behind me who are
12 representing parties. My name is Darrin Blain and I'm a
13 lawyer in private practice here in Calgary. I've just
14 finished my 800th Indian residential school hearing. And I
15 don't tell you that to play my violin, I tell you that
16 because I might be talking about some perspective that I've
17 gotten from that process.

18 I'm also a proud member of the Peguis First
19 Nation in Manitoba, which I'm sure a couple of you on
20 the -- on the board have heard about, so thank you for
21 having me.

22 To the representative from Health Canada,
23 good afternoon. Would you agree with this statement: That
24 the physical, emotional and spiritual health of the
25 Aboriginal women and girls in this country, and how those

1 are not being met by your agency and other agencies that
2 are responsible for delivering them, constitute a national
3 emergency, or they are of national emergent concern?

4 **DR. VALERIE GIDEON:** So I just wanted to
5 clarify that I'm not with Health Canada, just for the
6 record, I'm with the Department of Indigenous Services
7 Canada under the First Nations Inuit Health Branch.

8 I would say that it wouldn't be for me to
9 define that, it would be for Aboriginal women and girls to
10 define that from their own experience with respect
11 to -- and from the leadership in the communities and First
12 Nations Inuit and Métis organizations.

13 **MR. DARRIN BLAIN:** So your organization or
14 who you work for, doesn't -- you wouldn't call that of
15 national urgent concern?

16 **DR. VALERIE GIDEON:** It would not be for us
17 to declare an emergency. For instance, in First Nations
18 communities, First Nations communities have sometimes
19 declared emergencies due to social crises, it would be up
20 to them to do that. It wouldn't be something that we would
21 feel that we would have the mandate to do.

22 **MR. DARRIN BLAIN:** Do you think that this
23 issue of the health of First Nation women and girls in this
24 country ought to receive principal discussion by these
25 Commissioners in their report?

1 **DR. VALERIE GIDEON:** It isn't for me to say
2 what the Commissioners should be focussing on in the
3 report. My job is to provide evidence and advice, if
4 asked, on specific issues, but I certainly would not
5 pretend to tell the Commissioners what they should or
6 should not be focussing on.

7 **MR. DARRIN BLAIN:** And do you agree with me
8 that we ought to be hiring more First Nation nurses,
9 doctors and psychologists in this country?

10 **DR. VALERIE GIDEON:** Absolutely. I would
11 agree with that.

12 **MR. DARRIN BLAIN:** And can we make that a
13 joint recommendation to the Commission?

14 **DR. VALERIE GIDEON:** I would certainly --

15 **MR. DARRIN BLAIN:** Because I agree with it.

16 **DR. VALERIE GIDEON:** -- support the
17 recommendation that there needs to be more Indigenous
18 health human resources. In fact, that's a recommendation
19 that the Royal Commission on Aboriginal Peoples made in the
20 '90s -- or, sorry, in 2006, and they actually called for,
21 if I believe it, 10,000 Indigenous health human resources
22 professions to be trained by that point in time. They had
23 specified a target.

24 **MR. DARRIN BLAIN:** And do you agree with me
25 that First Nations women and girls represent, in a lot of

1 cases, the most vulnerable segment of our society, and they
2 really deserve the best care with the most talent? Would
3 you agree with that?

4 **DR. VALERIE GIDEON:** The evidence definitely
5 shows that First Nations women and girls are often at risk,
6 at greater risk, of -- from health conditions to other
7 social issues and factors, absolutely. There is a growing
8 body of evidence that demonstrates that.

9 **MR. DARRIN BLAIN:** And to the next part of
10 that question, would you agree that they deserve the
11 best -- the best medical talent this country has to offer?

12 **DR. VALERIE GIDEON:** I would agree that
13 First Nations women and girls absolutely deserve attention
14 in this country and quality services to address their
15 needs.

16 **MR. DARRIN BLAIN:** Bear with me, please.
17 You mentioned a 24/7 help line for people contemplating
18 suicide that's available in French, English and I think you
19 mentioned three or four First Nation languages; is that
20 right?

21 **DR. VALERIE GIDEON:** The same languages that
22 is -- that are used in the 24/7 line of the Commission.

23 **MR. DARRIN BLAIN:** Could it be a
24 recommendation to the Commissioners that any 24/7 help line
25 that is established or continues in this country to help

1 Aboriginal women and children, particularly girls, that are
2 contemplating suicide be made available in every First
3 Nation language in this country?

4 **DR. VALERIE GIDEON:** Are you asking me a
5 question or you're making a recommendation to the
6 Commission?

7 **MR. DARRIN BLAIN:** I'm asking if you agree
8 with my recommendation.

9 **DR. VALERIE GIDEON:** I honestly don't know
10 how feasible it would be for that to happen. But I
11 certainly believe that in community, it would be -- it is
12 important for First Nation women and girls to have access
13 to services in their language to the maximum extent
14 possible.

15 **MR. DARRIN BLAIN:** All right. Very well.
16 Time is of the essence this afternoon. I've got some more
17 questions here. I need to move on to the other presenters.
18 Thank you for your comments.

19 **JACKIE ANDERSON, Previously Affirmed:**

20 **CROSS-EXAMINATION BY MR. BLAIN:**

21 **MR. DARRIN BLAIN:** Ms. Anderson. Good
22 afternoon.

23 **MS. JACKIE ANDERSON:** Hi.

24 **MR. DARRIN BLAIN:** I think you know where
25 I'm from, do you not?

1 **MS. JACKIE ANDERSON:** Peguis.

2 **MR. DARRIN BLAIN:** Yeah. Nice to finally
3 meet you.

4 **MS. JACKIE ANDERSON:** (Indiscernible).

5 **MR. DARRIN BLAIN:** Bear with me, please.
6 Have you attended the funerals of any of your clients that
7 have slipped through the cracks and not made it through
8 your program?

9 **MS. JACKIE ANDERSON:** Yes.

10 **MR. DARRIN BLAIN:** Do you feel like better
11 funding and better resources may have prevented that?

12 **MS. JACKIE ANDERSON:** Absolutely.

13 **MR. DARRIN BLAIN:** Is that one of the
14 recommendations to this Commission, that your program and
15 programs like it receive the maximum funding available, and
16 that the programs be reviewed and receive principal
17 consideration by this Commission?

18 **MS. JACKIE ANDERSON:** I -- I think it needs
19 to be a priority. We're here today to, you know,
20 honour -- honour our victims, those that are still being
21 victimized and those that we have lost. And yes, sadly,
22 today I -- I sit here, and I've had to, you know, bury
23 three of our little sisters. And, in fact, behind me on
24 this wall, some of them are -- are behind us.

25 **MR. DARRIN BLAIN:** M'hm.

1 **MS. JACKIE ANDERSON:** M'hm.

2 **MR. DARRIN BLAIN:** You mentioned the
3 effectiveness of something called the National Survivor
4 Summit?

5 **MS. JACKIE ANDERSON:** Yes.

6 **MR. DARRIN BLAIN:** And is it a
7 recommendation to the Commission that the National Survivor
8 Summits be funded by Health Canada or a health agency of
9 the Government of Canada, and that they receive significant
10 and fulsome review?

11 **MS. JACKIE ANDERSON:** I can't say who would
12 be responsible, I guess, for the funding piece of it. But
13 when you look at, you know, the life of a survivor, the
14 ongoing, it's -- health is absolutely a number one priority
15 for the ongoing healing that they need. And in regards to
16 that summit, that is an absolute need. And not, again,
17 something that happens once every ten years. I believe it
18 needs to be happening every year.

19 **MR. DARRIN BLAIN:** Let's make that a
20 recommendation to the Commission today. Is that all right?

21 **MS. JACKIE ANDERSON:** M'hm.

22 **MR. DARRIN BLAIN:** Okay.

23 **MS. JENNIFER COX:** So for the purposes of
24 the record, it has to be yes or no.

25 **MR. DARRIN BLAIN:** Oh. Sorry.

1 **MS. JACKIE ANDERSON:** Yes.

2 **MR. DARRIN BLAIN:** I have one more question
3 for you, then I'll move on to Ms. Dumaine. Are you
4 involved in criminal law. Are you involved in criminal law
5 reform or are you being asked by the criminal law experts
6 in this country about criminal law reform, and
7 specifically, sentencing for these people that are preying
8 on -- on the women and girls that you see?

9 **MS. JACKIE ANDERSON:** Not directly involved
10 at that level. However, my involvement is education and
11 awareness. As I mentioned earlier, it's important that, in
12 the work that we do, that there is collaboration with
13 police and all the different systems that we're needing in
14 order to share what we're seeing and what we're
15 experiencing and what needs to happen for our young people.

16 **MR. DARRIN BLAIN:** Okay.

17 **CHRISTINE DUMAINE, Previously Affirmed:**

18 **CROSS-EXAMINATION BY MR. BLAIN:**

19 **MR. DARRIN BLAIN:** Okay. Christine, good
20 afternoon.

21 **MS. CHRISTINE DUMAINE:** Good afternoon.

22 **MR. DARRIN BLAIN:** I was impressed by your
23 testimony, and I'm not sure you noticed this, but when you
24 were speaking, the room went very quiet. And I think that
25 everyone that I talked to was remarkably impressed by your

1 testimony.

2 **MS. CHRISTINE DUMAINE:** Thank you.

3 **MR. DARRIN BLAIN:** Thank you for being here.
4 Thank you for being a survivor. Thank you for being a role
5 model to the woman who's watching this on the internet
6 right now from a women's shelter with bruises and a lack of
7 hope. Thank you for speaking to her today. I appreciate
8 that, and I'm sure that everyone in this room does.

9 **MS. CHRISTINE DUMAINE:** Thank you.

10 **MR. DARRIN BLAIN:** I had a couple of
11 questions for you. I think something you said today was
12 just the most -- the -- I'm going to -- when I -- when I
13 conclude this week, I'm going to take something that you
14 said with me that was remarkable. I'm just going to repeat
15 it. "We need Indigenous-led homes run by people with
16 experience that are First Nation." Now listen, here's the
17 important part. "As they are the true experts." I just
18 love what you said there. And I thought that was really
19 telling about your own healing, and in many respects,
20 you're the most important person giving evidence or
21 comments today.

22 So I take it, then, that if we were to ask
23 the Commissioners for something out of your testimony, that
24 we would be asking them for funding or to make it a
25 principle or a really important part of their report that

1 for women and girls in crisis, like you were, that they
2 make available or consideration of the availability of
3 Indigenous-led homes, just like you mentioned, and that
4 funding ought to come for that so people don't need to
5 worry about how to pay to get in there and how to run the
6 organization, and that we source out the best Aboriginal
7 talent to help people just like you were in their road to
8 recovery. Are we asking the Commission for that today?

9 **MS. CHRISTINE DUMAINE:** Yes.

10 **MR. DARRIN BLAIN:** Thank you again for being
11 here. The Commission. Good afternoon. Those are my
12 questions.

13 **MS. JENNIFER COX:** So the next party with 13
14 minutes is ITK.

15 **JACKIE ANDERSON, Previously Affirmed:**

16 **CROSS-EXAMINATION BY MS. ZARPA:**

17 **MS. ELIZABETH ZARPA:** Good afternoon. I
18 want to start -- start off and say I want to thank Treaty 7
19 Nation for allowing us to be here on their territory again
20 all throughout the week. The Blackfoot and the Métis,
21 thank you. And I also want to say thank you, too, for the
22 wonderful testimony today and the questions. So I'm going
23 to start -- going to start with you, Ms. Jackie Anderson
24 and Ms. Christine Duhaine?

25 **MS. CHRISTINE DUMAINE:** Dumaine.

1 **MS. ELIZABETH ZARPA:** Dumaine. Oh, sorry.
2 Okay. I -- I want to highlight a little bit about the
3 experience that was expressed by you, Ms. Anderson, around
4 Indigenous people who come from sort of rural northern
5 areas, and they go into urban settings, and there's
6 predators there. I -- I wanted to question whether there
7 was any programs or any sort of initiatives that you're
8 aware of that seeks to address the predatorial behaviour of
9 those individuals that prey on vulnerable and young
10 Indigenous women.

11 **MS. JACKIE ANDERSON:** Programs for the
12 perpetrators or programs for the -- the young people coming
13 in from rural?

14 **MS. ELIZABETH ZARPA:** I would like to speak
15 to the experience of the predatorial behaviour, like the
16 predators somehow being targeted in this experience. Are
17 they -- are they targeted for -- to change their
18 behaviours?

19 **MS. JACKIE ANDERSON:** The predators? Sorry.

20 I --

21 **MS. ELIZABETH ZARPA:** Yeah.

22 **MS. JACKIE ANDERSON:** As -- as far as I
23 know, the only program that is for predators or
24 perpetrators is john school, and that's based on their
25 first arrest. They have an opportunity to go to john

1 school. But there's no actual program specifically
2 targeting the demand on changing behaviours or -- or
3 confronting their behaviours and what they're doing to our
4 young people.

5 **MS. ELIZABETH ZARPA:** And upon entering into
6 this john school, are -- is there a -- criminal charged, or
7 that you're aware of, or if you're not aware of that?

8 **MS. JACKIE ANDERSON:** I'm not totally sure.
9 But I do know that if it's your first charge, you have the
10 opportunity to pay a fine or go to john school. You also do
11 have to pay for the -- the john school yourself.

12 **MS. ELIZABETH ZARPA:** And it's mandatory?

13 **MS. JACKIE ANDERSON:** Yes.

14 **MS. ELIZABETH ZARPA:** And is that, sort of,
15 experience of looking, seeking of johns, is that something
16 that's used extensively, say, in Winnipeg, around the place
17 that you mentioned? Like, the areas where young Indigenous
18 people hangout?

19 **MS. JACKIE ANDERSON:** M'hm.

20 **MS. ELIZABETH ZARPA:** Are -- is that, sort
21 of, monitored to make sure that johns are not praying on
22 young Indigenous women?

23 **MS. JACKIE ANDERSON:** I'm sorry. I don't
24 know what your -- understand your question.

25 **MS. ELIZABETH ZARPA:** So is -- how do you --

1 how -- how -- in your experience --

2 **MS. JACKIE ANDERSON:** M'hm.

3 **MS. ELIZABETH ZARPA:** -- are johns, sort of,
4 sought out? Are they --

5 **MS. JACKIE ANDERSON:** Being identified?

6 **MS. ELIZABETH ZARPA:** -- policed? Yeah.

7 **MS. JACKIE ANDERSON:** Oh, okay. Again, we
8 have some very, very strong community outreach teams working
9 on the front lines and working on the streets. And it's a
10 collaborative approach of multiple organizations that are
11 going in different areas within our city that we know are
12 identified stroll areas that perpetrators are out seeking.
13 So there's that collaborated, coordinated approach where
14 licence plates of -- of vehicles that are coming into our
15 communities that we know have no other reason why they
16 should be in that community. We're tracking, we're doing
17 suspect trafficking forms, and they are meeting weekly,
18 these teams, and -- and giving this information over to the
19 police.

20 **MS. ELIZABETH ZARPA:** Okay. And are -- are
21 those -- are those volunteer, or are they funded?

22 **MS. JACKIE ANDERSON:** The outreach teams?

23 **MS. ELIZABETH ZARPA:** Yes.

24 **MS. JACKIE ANDERSON:** They are -- they are
25 funded within different organizations.

1 **MS. ELIZABETH ZARPA:** Okay. Great. And you
2 mentioned that some of the most vulnerable people are the
3 ones who come from the north.

4 **MS. JACKIE ANDERSON:** M'hm.

5 **MS. ELIZABETH ZARPA:** And would you classify
6 Inuit who travel to Winnipeg, they -- they're from the
7 north?

8 **MS. JACKIE ANDERSON:** Pardon me? Who?

9 **MS. ELIZABETH ZARPA:** Inuit.

10 **MS. JACKIE ANDERSON:** Inuit. Yes.

11 **MS. ELIZABETH ZARPA:** Okay. And do you know
12 if there is any specific programming for young Inuit women
13 who go to Winnipeg who, say, are vulnerable as well? Or
14 getting caught up in the systems?

15 **MS. JACKIE ANDERSON:** I do know that they do
16 have a community centre specifically for Inuit families that
17 are coming in. Our programs are -- are open to all
18 Indigenous peoples.

19 **MS. ELIZABETH ZARPA:** Okay. Thank you so
20 much.

21 **MS. JACKIE ANDERSON:** Thank you.

22 **VALERIE GIDEON, Previously Affirmed:**

23 **CROSS-EXAMINATION BY MS. ZARPA:**

24 **MS. ELIZABETH ZARPA:** Okay. So my next
25 questions are for Ms. Gideon. So you mentioned that First

1 Nations and Inuit Health Branch includes First Nations and
2 Inuit. Could you please elaborate to me what -- what that
3 means? Who -- who classifies as Inuit?

4 **DR. VALERIE GIDEON:** Well, our mandate does
5 include providing a number of programs and services to
6 Inuit. It does work differently in the Inuit context
7 because of Inuit land claim agreements, and the role of
8 territorial governments. However, we do provide funding
9 specific to Inuit for a variety of community health programs
10 in the area of mental health, and the area of a -- a healthy
11 child development, home and community care, and as well,
12 Inuit have coverage for non-insured benefits regardless of
13 where they live in Canada.

14 We have an Inuit health approach specifically
15 within the First Nations Inuit Health Branch that we
16 developed with ITK and the National Inuit Committee on
17 Health in 2014 that spells out how we work collaboratively
18 with Inuit land claim organizations across the country. And
19 when we receive new investments, we work with the National
20 Inuit Committee on Health and each of the individual land
21 claim organizations to discuss how those resources would be
22 best invested.

23 In Nunavut, we have a tripartite partnership
24 table, so that NTI, the Government of Nunavut, and
25 ourselves, discuss very openly working together to address

1 needs of -- of Inuit. In Nunavut, specifically, there is a
2 tripartite MOU that was signed to support a ten-year funding
3 agreement --

4 **MS. ELIZABETH ZARPA:** Right.

5 **DR. VALERIE GIDEON:** -- for Nunavut.

6 **MS. ELIZABETH ZARPA:** M'hm.

7 **DR. VALERIE GIDEON:** Which includes a lot of
8 these programs and initiatives that I mentioned.

9 **MS. ELIZABETH ZARPA:** Okay. Wonderful. So
10 with all of these different agreements, and these different
11 strategies, and these different guidelines, and these
12 different meetings, are there Inuit doctors that you're
13 aware of?

14 **DR. VALERIE GIDEON:** I believe that there are
15 a few. We do not employ physicians specifically that work
16 in Inuit Nunangat. It's done through either a provincial,
17 territorial, or an Inuit government. So my knowledge is
18 more superficial with respect to who is providing direct
19 service delivery in Inuit communities. But, I think, health
20 human resources is a significant priority --

21 **MS. ELIZABETH ZARPA:** And --

22 **DR. VALERIE GIDEON:** -- within the context of
23 Inuit Nunangat.

24 **MS. ELIZABETH ZARPA:** And would you agree
25 that having individuals who have lived experiences in

1 northern regions, such as Inuit communities, are best
2 equipped to deal with in the health system -- the population
3 in which they're serving?

4 **DR. VALERIE GIDEON:** Hundred percent.

5 **MS. ELIZABETH ZARPA:** Right.

6 **DR. VALERIE GIDEON:** Especially, even just
7 from the perspective of language.

8 **MS. ELIZABETH ZARPA:** Great. And are you
9 aware of -- are there hospitals in Nunatsiavut?

10 **DR. VALERIE GIDEON:** There's not a hospital
11 in Nunatsiavut. They have health centres, primary
12 healthcare clinics, and -- that are -- that are run in
13 partnership between the Nunatsiavut Government and the
14 provincial government.

15 **MS. ELIZABETH ZARPA:** Okay. I'm actually
16 going to ask if I can have a CBC news article entitled,
17 "Montreal Boarding Home for Nunavik Medical Patients Over
18 Capacity Since Opening." It's a CBC News article that was
19 posted in July 2000 [sic] -- 2017. Have you seen this?

20 **DR. VALERIE GIDEON:** I only saw it today when
21 it was handed to me.

22 **MS. ELIZABETH ZARPA:** Okay. I'm going to ask
23 the Commissioners and counsel whether I can enter this as an
24 exhibit?

25 **CHIEF COMMISSIONER MARION BULLER:** Is this by

1 consent?

2 **MS. ANNE TURLEY:** It's by consent.

3 **CHIEF COMMISSIONER MARION BULLER:** It is.

4 Okay. Then the CBC article, "Montreal Boarding Home for
5 Nunavik Medical Patients Over Capacity Since Opening," post
6 July 25th, 2017 will be the next exhibit, which is, sorry,
7 number 36. And while I have the mic, counsel's name for the
8 record, please?

9 **MS. ELIZABETH ZARPA:** My name is Elizabeth
10 Zarpa. Thank you.

11 --- **EXHIBIT NO. 36:**

12 "Montreal boarding home for Nunavik
13 medical patients over capacity since
14 opening," CBC News, posted July 25, 2017
15 12:25 CT, last updated July 25, 2017
16 (three pages)

17 **MS. ELIZABETH ZARPA:** So I'm going to quote
18 on the last part. I'm just going to quote a couple of
19 things from the article. And it says, Nunavik director sees
20 load is, "Not sustainable." "Would like to see hospital
21 built in Nunavik."

22 The idea of having a regional hospital
23 in Nunavik is a must - it's a
24 necessity -- because unless certain
25 specialties are repatriated back to

1 Nunavik in a regional hospital, the
2 number of our clients arriving will only
3 be increasing.

4 I'm not entirely sure whether if the First
5 Nations and Inuit Health branch deals directly with this;
6 does it?

7 **DR. VALERIE GIDEON:** So Nunavik is under a
8 land claim agreement. The Nunavik Health and Social
9 Services Board is part of the provincial health system. So
10 it is not directly related to the First Nations and Inuit
11 Health Branch. The only thing that I would say is that
12 boarding home capacity is a national issue.

13 With respect to patients coming from Inuit
14 Nunangat, particularly with the high birth rate and prenatal
15 escorts also requiring a lot of accommodation in urban
16 centres. So I would say that we're aware of the needs for
17 more accommodation for Inuit patients coming south or in
18 Iqualuit for services, but we're not directly related to --
19 we're not directly linked to the care system in Nunavik
20 because it's governed under the land claim agreement.

21 **MS. ELIZABETH ZARPA:** So because it's
22 governed under the land claim agreement in its provincial
23 jurisdiction, in order for them to put a hospital in, say,
24 Kuuujuaq?

25 **DR. VALERIE GIDEON:** That's right. But we do

1 meet with them regularly to talk about what we can do to
2 help support their needs in a partnership model. So we meet
3 with Minnie Grey, the Executive Director of the Nunavik
4 Health and Social Services Board. And I'm sure that we
5 would be open to speaking with her about what her thoughts
6 are on this matter.

7 **MS. ELIZABETH ZARPA:** And would you -- would
8 you provide any suggestion in terms of how to make this
9 process a little less administratively challenging for Inuit
10 who want to build a hospital in Nunavik?

11 **DR. VALERIE GIDEON:** I mean, they are -- they
12 are governing the health services in their particular
13 territory under the land claim agreement, so I -- I just
14 don't feel like I could provide or impose my advice to them.

15 **MS. ELIZABETH ZARPA:** And is it common in
16 your experience that Inuit travel from, say, Iqaluit or
17 Inuvialuit to go down south to go to the hospitals?

18 **DR. VALERIE GIDEON:** Absolutely.

19 **MS. ELIZABETH ZARPA:** So this experience in
20 the CBC news article is something that's very common?

21 **DR. VALERIE GIDEON:** It is common, yes.

22 **MS. ELIZABETH ZARPA:** And it's not the
23 jurisdiction of the First Nations or First Nations Inuit
24 Health Branch to deal with this?

25 **DR. VALERIE GIDEON:** That's right. Not

1 specifically, no.

2 **MS. ELIZABETH ZARPA:** Okay. Thank you so
3 much. That's all the questions I have today.

4 **MS. JENNIFER COX:** The next party is
5 Independent First Nations and they have 17 minutes.

6 **VALERIE GIDEON, Previously Affirmed:**

7 **CROSS-EXAMINATION BY MS. BEAMISH:**

8 **MS. SARAH BEAMISH:** Hello, my name is Sarah
9 Beamish, I'm counsel for Independent First Nations, which
10 is a group of 12 Anishinaabe, Haudenosaunee and Oji-Cree
11 First Nations. Thank you all for your testimony today.

12 I'd like to start with a few questions for
13 Dr. Gideon. So, firstly, the projects about digital health
14 technology, I think there's a lot of promising stuff in
15 there, but from an IFN perspective there's one -- at least
16 one barrier to implementing them that I want to ask you
17 about.

18 So in some of the IFN communities a major
19 barrier would be electricity. Some of these communities'
20 electricity grids are basically maxed out, such that they
21 can't even be building new houses at this point, so any new
22 programs or services that would put significant demand in
23 terms of electricity would be a problem.

24 So my question for you is whether the plans
25 and efforts regarding digital health technologies have

1 anticipated this problem and whether there are any plans to
2 deal with it?

3 **DR. VALERIE GIDEON:** So absolutely when we
4 look at community infrastructure requirements, it
5 absolutely is a consideration, and it's not just with
6 respect to digital technologies, it's also with respect to
7 construction of new health facilities, right? You also
8 have to make sure that they -- the water plant, the waste
9 water system, all of those elements of community
10 infrastructure can sustain a new health facility,
11 particularly if the capacity is maximized.

12 So, you know, it's -- within the context of
13 Ontario, however, we have been successful, as I noted
14 earlier, in terms of being able to make investments to
15 increase connectivity through the fiber optic network, and
16 that has seemed to work well for a number of northern and
17 isolated communities across Ontario. But, of course, I'm
18 not familiar with each situation of each of the Independent
19 First Nations, but I recognize that community
20 infrastructure is part of the -- could be part of the
21 barriers to access for greater health care services, not
22 just digital, but also new health care infrastructure in
23 general.

24 **MS. SARAH BEAMISH:** Okay. So my next
25 question is about dental care. I notice that in the

1 Exhibit 25 about the Non-Insured Health Benefits Program,
2 it talked about providing coverage for medically necessary
3 dental care. And in the Independent First Nations there
4 are women who have had their teeth damaged or lost because
5 of violence, and it affects their self-esteem and dignity,
6 it affects their sense of wellbeing, it sometimes affects
7 their ability to get employment.

8 They experience it as a major impact of
9 violence on them and one that potentially increases their
10 vulnerability to future violence, but they
11 experience -- their experience in trying to get dental care
12 in these situations has sometimes been that they can't get
13 coverage for it because it's deemed to be a cosmetic issue
14 rather than a medically necessary issue. So my question is
15 whether currently you know if the -- if this health
16 benefits program would fund repair or replacement in a
17 situation where it was only deemed to be cosmetic?

18 **DR. VALERIE GIDEON:** The program that we
19 have with respect to orthodontics I think is what you're
20 referring to specifically, it absolutely is based on severe
21 and functionally handicapped malocclusion. With respect to
22 general oral health care services though, there are a
23 number of dental services that are available, as well as
24 preventative services, such as fluoride varnishes and a lot
25 of sort of very basic accesses to dental services. 97

1 percent of the dental benefit doesn't require any
2 predetermination whatsoever, and so it would -- I think
3 that what would probably be the barrier that you're
4 referring to would be in the case of orthodontic coverage,
5 so it is based on medically required services.

6 **MS. SARAH BEAMISH:** Okay. Would you agree
7 that coverage for tooth repair or replacement in the kind
8 of situation I'm talking about, where there is -- where it
9 is maybe a cosmetic issue, is -- would still be beneficial
10 for Indigenous women's overall health and wellbeing?

11 **DR. VALERIE GIDEON:** I mean, the mandate of
12 the program is based on medical necessity. The mandate of
13 the program dates back to 1997 and -- and we used clinical
14 criteria based on evidenced best practices. We have a
15 national oral health advisory committee made up of
16 independent experts that advise us with respect to coverage
17 within the context of the benefit, so it really isn't about
18 sort of my opinion, it really is on the basis of research
19 evidence, evidence-based practice and independent advice
20 from oral health experts, of which I am not one.

21 **MS. SARAH BEAMISH:** Okay. All right, I hope
22 you can answer this next question, it's about sort of
23 cooperation between the health care agencies and other
24 parts of government. So as some background of what
25 I'm -- to my question, in some IFN communities they see

1 that what appear to be non-health related decisions by
2 other parts of government have significant health impacts
3 that the health system is not always sort of prepared to
4 address. So as one example of where that has happened,
5 there was one remote IFN community where there was a high
6 rate of use of an addictive drug by the residents there,
7 and there was a bust by the police that abruptly shut down
8 the communities sources of that drug, and as a result in
9 the following days and weeks there was a sudden unplanned
10 widespread experience of going through withdrawal --

11 **DR. VALERIE GIDEON:** M'hm.

12 **MS. SARAH BEAMISH:** -- and there weren't
13 appropriate detox or other support services for the people
14 there. And so their experience with this was that
15 this -- this police intervention had caused a health crisis
16 and had actually increased safety risks in the community.

17 So in that kind of situation, if the police
18 had contacted health care officials in your agency or
19 another federal agency, do you think that it's possible
20 that a plan could have been made to proactively address
21 those foreseeable health risks?

22 **DR. VALERIE GIDEON:** Absolutely. And, in
23 fact, my experience early in my days at what was Health
24 Canada -- we were part of Health Canada at the time, I ran
25 the Ontario region with respect to First Nations Inuit

1 Health Branch, and in that period of time prescription drug
2 abuse was extremely common, the use of Oxycontin in
3 communities illegally, and we worked together with
4 Nishnawbe Aski Nation police services in order to be able
5 to ensure that we were providing community safety plans and
6 the use of harm reduction measures, such as Suboxone, which
7 is an opioid agonist treatment, available to support
8 individuals to manage through their symptoms of withdrawal
9 and also to manage their addiction and provide a safer
10 environment for communities. And we were able to do that
11 in a number of communities, isolated communities in
12 northern Ontario that were affected so that we would
13 prevent these types of measures.

14 I would absolutely agree that collaboration
15 between multiple Federal, or Federal and provincial, or
16 Federal provincial First Nations agencies is extremely
17 important to ensure that community safety planning and
18 community wellness planning is -- is in place.

19 **MS. SARAH BEAMISH:** Okay. So you would
20 recommend a more systemic approach to that kind of thing
21 then?

22 **DR. VALERIE GIDEON:** Yeah, we actually set
23 up community wellness development teams during that time
24 that are still available and resourced federally and
25 provincially in order to support communities to develop

1 this type of plan.

2 **MS. SARAH BEAMISH:** Okay.

3 **DR. VALERIE GIDEON:** And to invest in some
4 targeted interventions and measures.

5 **MS. SARAH BEAMISH:** Okay, thank you. I may
6 just ask you one or two more questions. My next one is
7 about ID. In some of the -- in some of the Independent
8 First Nations, girls and women have had difficulty
9 accessing health care services when they don't have the
10 proper ID for whatever reason, and sometimes, as a result,
11 they don't seek out health care that they need because they
12 anticipate having -- having issues with ID. Is it right
13 that Indigenous people often need to present ID to receive
14 the health services through the programs that you've
15 discussed today and the ones that are discussed in your
16 materials?

17 **DR. VALERIE GIDEON:** So within the context
18 of the provincial health system, I'm not sure what the
19 province would do if someone didn't have an OHIP card. I
20 mean, I know that in the nursing station or health centre
21 context people are not asked for their status card when
22 they walk through the door, they are served by nurses.
23 Regardless of whether or not the health facility is run by
24 the Federal Government or operated by Federal Government
25 employees or by First Nation employees, the services are

1 provided. Emergency health services in the province will
2 be provided to people who need it.

3 Within the context of the Non-Insured Health
4 Benefits Program, you know, I think that we've not seen
5 that as a major barrier to access that I'm aware of in all
6 of my years. But we have intervened in cases where we've
7 had First Nation women that lost their ID or couldn't find
8 their ID in order to contact the office of the Indian
9 Registrar to do an emergency issuance of a letter that
10 actually just validates that they do have status in
11 that -- but that is for transportation purposes, in the
12 sense of them being able to -- if they need air travel to
13 return home or whichever, we've been able to do that. The
14 Office of the Indian Registrar will work collaboratively
15 with us to issue emergency validation of identification if
16 it -- particularly if it's an urgent situation or if -- if
17 it's a woman who's at risk or finds herself in a situation
18 where she can't access service.

19 **MS. SARAH BEAMISH:** Okay. My next question
20 is about childhood sexual abuse. Do any of the Federal
21 programs -- health programs for Indigenous people directly
22 address childhood sexual abuse as a health issue, as far as
23 you know?

24 **DR. VALERIE GIDEON:** Well, our clinical
25 practice guidelines include that aspect of it. In fact,

1 we're right now in the process of updating the pre-pubertal
2 -- sorry, my French sometimes comes out -- child abuse
3 guidelines specifically. We -- again, we offer a lot of
4 flexibility with respect to the parameters of community-
5 based programming so that they can identify their
6 priorities. The Chiefs of Ontario recently contacted us
7 because they are setting up a task force specific to child
8 abuse and also Nishnawbe Aski Nation has done the same thing
9 in order to be able to develop some more targeted
10 interventions to address the issue in community. So we
11 absolutely fund that and support those types of initiatives
12 initiated by First Nations.

13 And I think, you know, the increase in amount
14 of resources and services available within the context of
15 mental wellness broadly, regardless of, you know, what is
16 the need of the child, which is not for the Federal
17 Government to -- to know about, but is just something that
18 is supported. I mean, all those services are available to
19 children that have experienced sexual abuse.

20 **MS. SARAH BEAMISH:** Okay. Are any of the --
21 the services you're talking about -- do any of them take a
22 proactive prevention approach to childhood sexual abuse, or
23 are they responding after the fact?

24 **DR. VALERIE GIDEON:** Our clinical practice
25 guidelines for frontline nursing staff absolutely do talk

1 about detection and identifying, really, risk factors within
2 that context. We also have the Maternal Child Health
3 Program, as an example, which includes the supports for home
4 visiting. Home visiting has actually been demonstrated as
5 an effective practice for community health professionals to
6 -- or health workers to come into communities and be able to
7 build that trust relationship with families early on, from
8 birth until early childhood. The Aboriginal Head Start
9 program also is a program that's widely utilized in
10 communities to help support preschool children.

11 And within the context of those guidelines,
12 there's also, you know, identifying risk factors and also
13 having provincial -- parental involvement and parental
14 engagement in the child's development at an early age. So
15 there are a number of healthy child development type of
16 initiatives where proactivity is encouraged, absolutely.

17 **MS. SARAH BEAMISH:** Okay. I do have more
18 questions, but I think I'd like to leave a few minutes for
19 -- for the next witness, so thank you for your answers.

20 **JACKIE ANDERSON, Previously Affirmed:**

21 **CROSS-EXAMINATION BY MS. BEAMISH:**

22 **MS. SARAH BEAMISH:** All right. So, Ms.
23 Anderson, first, I just want to say I was moved to hear of
24 the Centre's relationship with Maori people in developing
25 your services. I belong to the Ngāruahine Maori people, and

1 so I am sure they would support me in bringing special
2 greetings to you and the Centre on their behalf.

3 I just -- I think I only have two questions
4 for you.

5 **MS. JACKIE ANDERSON:** Yeah.

6 **MS. SARAH BEAMISH:** My first one is, in your
7 experience, would you say that childhood sexual abuse at the
8 community level, including by family members, is a common
9 and significant risk factor related to Indigenous girls and
10 women ending up in situations of sex trafficking and
11 exploitation?

12 **MS. JACKIE ANDERSON:** Yes.

13 **MS. SARAH BEAMISH:** Yes?

14 **MS. JACKIE ANDERSON:** Absolutely. A very
15 high number of our children have experienced that child --
16 that childhood -- child abuse, all forms of child abuse.
17 That absolutely has an effect on their vulnerability.

18 **MS. SARAH BEAMISH:** Yeah. Okay. Well, I
19 think -- I would just like to leave a few minutes, because I
20 wanted to ask you your recommendations to the Commission on
21 this issue specifically, on the issue of childhood sexual
22 abuse at the community level, including by family members,
23 and its connection to violence, other violence, later on in
24 -- in -- in people's lives. If you want to take a few
25 minutes to talk about any recommendations you have about

1 addressing this.

2 **MS. JACKIE ANDERSON:** About -- sorry?

3 **MS. SARAH BEAMISH:** About childhood sexual
4 abuse.

5 **MS. JACKIE ANDERSON:** Well, again, I think it
6 really has to -- to go with creating that awareness and
7 education and supporting, you know, our young people with
8 being able to deal with that trauma and being able to create
9 safe environments for when children are disclosing or
10 talking about, you know, experiences that they have
11 experienced and not re-victimizing them by having to
12 continuously tell their story of what's going on or what's
13 happened to them. I think that's very important.

14 **MS. SARAH BEAMISH:** Okay. All right. Well,
15 I think that's all -- those are all my questions for you,
16 then. Thank you. So did we want to have a break?

17 **CHIEF COMMISSIONER MARION BULLER:** Yes. We
18 will reconvene at three o'clock.

19 **MS. SARAH BEAMISH:** Three o'clock.

20 --- Upon recessing at 2:46 p.m.

21 --- Upon reconvening at 3:10 p.m.

22 **MS. JENNIFER COX:** The next party is
23 Pauktuuitit for 13 minutes.

24 **MS. BETH SYMES:** Good afternoon. My name is
25 Beth Symes, and I represent Pauktuutit, the Inuit women of

1 Canada, the Labrador Inuit women, Saturviit, the Ottawa
2 Inuit Children's Centre and the Manitoba Inuit Association,
3 and I'm going to try and focus on prevention, prevention of
4 violence and death for Inuit women and girls.

5 I want to thank you, Jackie and Christine,
6 for coming. One of the really memorable times was hearing
7 the story in Rankin Inlet of the death of Jessica Michaels
8 who was an Inuk girl from Chesterfield Inlet taken into
9 care in Winnipeg, and she became trafficked and probably
10 was killed. And so the services that you do has a range
11 that is geographically probably even bigger than you think.
12 But her story was told beautifully by her cousin's sister.
13 So thank you.

14 **VALERIE GIDEON, Previously Affirmed:**

15 **CROSS-EXAMINATION BY MS. BETH SYMES:**

16 **MS. BETH SYMES:** Dr. Gideon, I'm going to be
17 concentrating my questions on you and as it relates to
18 Inuit, Inuit women.

19 The health care that -- would you agree
20 with me that health care is an essential service for all
21 Canadians?

22 **DR. VALERIE GIDEON:** I would.

23 **MS. BETH SYMES:** And that includes Inuit
24 women?

1 DR. VALERIE GIDEON: Yes, I would agree.

2 MS. BETH SYMES: And that the failure to
3 provide health care is actually a breach of right to life,
4 lint, and the security of the person?

5 DR. VALERIE GIDEON: So -- so that's a
6 legal -- more a legal question. And I -- what I would say
7 is that the provision of health care services for Inuit
8 women is extremely important for their ability to thrive.

9 MS. BETH SYMES: Thank you. The standards
10 of health care, I'm a bit confused about what you have
11 written in the overview. So the standard of health care on
12 page 1 says to attain health levels comparable to other
13 Canadians living in similar locations. Now, is that for
14 Inuit, the standard as compared to non-Inuit living in,
15 say, a remote community such as, I don't know -- let's pick
16 Hall Beach. Is that the standard that you say Inuit women
17 can achieve? That's all?

18 DR. VALERIE GIDEON: So comparability
19 is -- definitely has its pitfalls because in many
20 circumstances across Canada, there are no comparable
21 circumstances with respect to where Indigenous people live.
22 So, really, it's about achieving -- and closing the gap is
23 often language that people use whereby there should be a
24 comparable state of health outcomes at minimum with respect
25 to Indigenous peoples and non-Indigenous peoples in Canada,

1 and that is something that I think most people would agree
2 with, and certainly there are many political commitments
3 that have been made. And it's written over and over with
4 respect to policy documents.

5 But when we were developing the strategic
6 plan for First Nations Inuit health, the National Inuit
7 Committee on Health really advised that it is about healthy
8 community members, families, healthy communities, healthy
9 nations, and that -- however those communities are defining
10 health, really, that is what we should be supporting and
11 what we should be aspiring to.

12 **MS. BETH SYMES:** It's not a race to the
13 bottom.

14 **DR. VALERIE GIDEON:** Pardon me?

15 **MS. BETH SYMES:** It is not a race to the
16 bottom for Inuit women in terms of health care.

17 **DR. VALERIE GIDEON:** No. So --

18 **MS. BETH SYMES:** (Indiscernible).

19 **DR. VALERIE GIDEON:** -- the goal is to
20 continue to improve health outcomes for Inuit women and
21 Inuit across Ananaakatiget -- or regardless of where they
22 live in Canada.

23 **MS. BETH SYMES:** Dr. Gideon, isn't the only
24 appropriate standard for health care for Inuit women to be
25 the standard of health care for all Canadians? Isn't that

1 the aspiration?

2 **DR. VALERIE GIDEON:** So the issue is what
3 would you define as a standard of health care for all
4 Canadians? I would just say that that's, again, the
5 pitfalls of comparability. So what would be an acceptable
6 basket of services for an urban-based non-Indigenous
7 population may be very different to what an Inuit community
8 needs. An Inuit community may need higher degrees of
9 services for mental wellness, as an example. They may need
10 more family-centered care.

11 So I would just say that I don't think
12 that -- I've never heard from the National Inuit Committee
13 on Health a desire to define a national standard of care.
14 What I have heard is we are developing our strategies. We
15 are developing the needs and -- or we are identifying our
16 needs and the strategies required to meet them, and we
17 would like federal, provincial, and territorial governments
18 to respond effectively to support us in addressing those
19 needs.

20 **MS. BETH SYMES:** Well, Dr. Gideon, we've
21 heard over the last year stories from Inuit families,
22 talking about the very poor quality of physical health and
23 the abysmal quality of mental health services in Inuit
24 Ananaakatiget. And you've -- you've read those stories,
25 haven't you?

1 DR. VALERIE GIDEON: I've certainly --

2 MS. BETH SYMES: (Indiscernible).

3 DR. VALERIE GIDEON: Yes, absolutely.

4 MS. BETH SYMES: And let's just look
5 objectively at some numbers because qualitative things are
6 always tricky. You'd agree with me that the life
7 expectancy of an Inuit woman in Canada is 11 years less
8 than a non-Inuit woman in Canada?

9 DR. VALERIE GIDEON: So I haven't studied
10 those statistics specifically or have the source validated
11 before me, but I -- I certainly wouldn't argue that there
12 is a gap in life expectancy between Inuit women and other
13 Canadian women in the country.

14 MS. BETH SYMES: And you'd agree with me
15 that the birthrate for Inuit women in Nunavut is almost
16 twice the birthrate of Canadian women not in Nunavut?

17 DR. VALERIE GIDEON: I am aware that the
18 birthrate among Inuit women is higher than other Canadian
19 women.

20 MS. BETH SYMES: And that the infant
21 mortality rate for Inuit children is three times the
22 Canadian average?

23 DR. VALERIE GIDEON: Again, I am aware that
24 there are higher infant mortality rates among Inuit
25 compared to the mainstream Canadian population.

1 **MS. BETH SYMES:** And I think that Census
2 Canada but -- or Statistics Canada must be looking over
3 your shoulders, Commissioners, because today, they released
4 the violence rates for women in the three territories, as
5 well as each province in Canada. And that the rate for
6 Inuit women in Ananaakatiget -- pardon me, in
7 Nunavut -- apologies -- is ten times the national average
8 for all of Canada. Now, does that surprise you,
9 Dr. Gideon, in terms of the rates of violence for Inuit
10 women being many times the rates for Canadian women?

11 **DR. VALERIE GIDEON:** It does not surprise me
12 that Inuit women are at greater risks of violence.

13 **MS. BETH SYMES:** Now, maybe because it's
14 2018, you said that in developing health initiatives, NFIHB
15 uses a gender-based analysis. You wrote that, didn't you?
16 In your report?

17 **DR. VALERIE GIDEON:** I spoke about how all
18 federal departments are implementing gender-based plus
19 analysis in the development of policies or programs and
20 services.

21 **MS. BETH SYMES:** And do you also --

22 **DR. VALERIE GIDEON:** It's a mandatory
23 element. Sorry.

24 **MS. BETH SYMES:** Sorry. It's mandatory?

25 **DR. VALERIE GIDEON:** Yeah.

1 **MS. BETH SYMES:** And you said that your
2 department looks at issues and solutions through a gendered
3 lens? Is that right?

4 **DR. VALERIE GIDEON:** It is part of the
5 mandatory GBA plus assessment.

6 **MS. BETH SYMES:** I was really taken by your
7 description of these partnership tables where having
8 Indigenous people at the decision-making table, not just to
9 give their input, not just to advise, but also to be part
10 of or be a decision-maker. That's what you described,
11 right?

12 **DR. VALERIE GIDEON:** That's correct. It's
13 variable with respect to the mandate that are provided
14 through leadership for these tables, but absolutely. Where
15 possible, we have been including them with respect to the
16 decision-making process at the branch level.

17 **MS. BETH SYMES:** And that's the decision
18 where and how health dollars will be spent?

19 **DR. VALERIE GIDEON:** That's correct. There
20 are decisions made, for instance, with the National Inuit
21 Committee on Health with respect to where health dollars
22 would be allocated. Now, the ITK board also plays a role
23 in that. We're not at that table, but we understand that
24 they are part of the decisions, as well.

25 **MS. BETH SYMES:** Now, I understand from what

1 you said today that the two representatives of Indigenous
2 people at the table are the AFN and ITK?

3 **DR. VALERIE GIDEON:** So they are members of
4 the committee, but they do go back and seek advice and also
5 decisions of their regional organizations. So in the Inuit
6 context, the National Inuit Committee on Health provides
7 advice, as well, to the ITK board, and decisions are
8 relayed back. So ITK at that table does not make the
9 decision. ITK brings the information back and consults
10 within the Inuit governance structure, and then comes back
11 to us with the decision that has been agreed to at those
12 tables.

13 **MS. BETH SYMES:** And Pauktuutit, the voice
14 of Inuit women in Canada, is not at that partnership table.

15 **DR. VALERIE GIDEON:** The Pauktuutit is
16 invited to the National Inuit Committee on Health. They are
17 definitely in the room. I don't know the -- all of the
18 interplays between Pauktuutit, specifically, and the
19 National Inuit Committee on Health members or governance.
20 Obviously within the First Nations Inuit health branch, we
21 do not specify to First Nations or Inuit how to organize
22 their decision-making process or their government
23 structures. We rest back and recognize those government
24 structures.

25 **MS. BETH SYMES:** Dr. Gideon, I'm having

1 difficulty understanding how you're going to carry out your
2 mandate to do a gender base analysis plus, or to look at
3 this issue through a gendered lens, if you don't have Inuit
4 women at the table with the right to vote, to say how the
5 money is spent with respect to health.

6 **DR. VALERIE GIDEON:** So Inuit governments are
7 represented on the National Inuit Committee on Health, and
8 we respect and recognize their authority as Inuit
9 governments to provide that decision-making to us.

10 **MS. BETH SYMES:** Well, Dr. Gideon, you told
11 us that you use Pauktuutit's health care materials, in terms
12 of provisions of services.

13 **DR. VALERIE GIDEON:** We have funded
14 Pauktuutit to undertake various initiatives over the years
15 that they have identified as priorities through their board
16 of directors.

17 **MS. BETH SYMES:** Now, you know that
18 Pauktuutit was without a contribution agreement from FNIHB
19 from 2012 to 2017 under a previous government?

20 **DR. VALERIE GIDEON:** I -- I was not directly
21 involved during that period, but I -- I am aware through
22 their Executive Director, who communicated that to me in
23 2017.

24 **MS. BETH SYMES:** And so now there is just one
25 project that FNIHB has with Pauktuutit for \$150,000 on

1 sexual health?

2 **DR. VALERIE GIDEON:** I wouldn't be able to
3 verify the number, but I -- I'm sure that's likely correct.
4 The Minister -- our Minister has met with the Pauktuutit
5 president, and I believe attended or is attending a board of
6 director's meeting to discuss future partnership with
7 Pauktuutit, and so it -- it continues to be something that
8 we are open to discussing.

9 **MS. JENNIFER COX:** Excuse -- time's up.

10 **MS. BETH SYMES:** I still -- I'm sorry, thank
11 you.

12 **MS. JENNIFER COX:** Thank you. So the next
13 party is the Families for Justice. And 13 minutes as well,
14 Mr. Registrar.

15 **MS. SUSAN FRASER:** Good afternoon,
16 Commissioners. Good afternoon, witnesses. My name is Susan
17 Fraser. I am here on behalf of 20 families, many of
18 Canada's provinces, and from different territories across
19 this land, and I have some questions for all of you. Quite
20 grateful for you being here, and I'm -- so I'm going to be
21 asking both from the families' perspective, and also on some
22 broader issues.

23 Just starting with Jackie, Ms. Anderson.
24 Thank you for your very beautiful description of the HOME,
25 and for making it a home.

1 JACKIE ANDERSON, Previously Affirmed:

2 CROSS-EXAMINATION BY MS. FRASER:

3 MS. JACKIE ANDERSON: M'hm.

4 MS. SUSAN FRASER: And wanted to ask you to
5 follow up on the question on the voluntary, so called
6 voluntary service agreement, where children are given-up
7 into care in order for them to have access to health
8 services that they would not be able to access without being
9 put into care, okay? In Ontario, that practice was outlawed
10 because children were thought to be entitled to services.
11 Would you support a recommendation outlying the practice of
12 children being put into -- into voluntary care for the
13 purposes of accessing health services?

14 MS. JACKIE ANDERSON: Yes, I would agree.

15 MS. SUSAN FRASER: Okay, thank you. And
16 members of our group -- one member of the group of families
17 described to the Inquiry her experience of coming into care.

18 MS. JACKIE ANDERSON: M'hm.

19 MS. SUSAN FRASER: Having a breakdown of the
20 foster care placement and being sent from her First Nation
21 to the city of Winnipeg on a bus, at the age of 12, where
22 she came into contact with people who would come to exploit
23 her.

24 MS. JACKIE ANDERSON: M'hm.

25 MS. SUSAN FRASER: Are you aware of this

1 practice continuing?

2 **MS. JACKIE ANDERSON:** I -- I would say so,
3 yes. Again, we are seeing that recruiters are associating
4 around places where the most vulnerable children and youth
5 are, it is known. And I've heard a number of instances
6 where bus depots, airports are also places of recruitment.

7 **MS. SUSAN FRASER:** Okay. So it would be
8 recommendation for you that First Nations and Indigenous
9 children be protected around places where they are
10 vulnerable, which is backing it up a step that -- that child
11 welfare not put them in situations like that.

12 **MS. JACKIE ANDERSON:** Absolutely.

13 **MS. SUSAN FRASER:** Okay. Are you aware of
14 other children being put unescorted on public
15 transportation?

16 **MS. JACKIE ANDERSON:** I -- I'm aware of one
17 situation that an adult woman actually experienced that
18 situation when she was very young.

19 **MS. SUSAN FRASER:** It's possible that we're
20 talking about the same person because she is from the
21 Winnipeg -- she did end up in Winnipeg. Also have heard in
22 through the media, the practice of young girls being placed
23 while in the care of the Children's Aid Society or the -- I
24 can't remember the Manitoba name, Child and Family Services.

25 **MS. JACKIE ANDERSON:** M'hm.

1 **MS. SUSAN FRASER:** Being placed as a
2 residential placement in a hotel, when there are no foster
3 care or group home placements available. Is this something
4 that you have heard about?

5 **MS. SUSAN FRASER:** In the past, yes, but it's
6 not a practice they currently use today.

7 **MS. SUSAN FRASER:** Okay. Is it -- is it a
8 practice that is prohibited in -- to your knowledge?

9 **MS. JACKIE ANDERSON:** Yes, I believe so.

10 **VALERIE GIDEON, Previously Affirmed:**

11 **CROSS-EXAMINATION BY MS. FRASER:**

12 **MS. SUSAN FRASER:** Okay, Thank you. I want to
13 just turn then to Dr. Gideon. Dr. Gideon, you have
14 described this morning a myriad of promising sounding
15 strategies and initiative and practices that are emerging
16 from Indigenous Services Canada. And you also mentioned in
17 your evidence this morning, and this is how I'd understood,
18 that it's not clear that -- of how the funding is making a
19 difference.

20 **DR. VALERIE GIDEON:** We have evidence with
21 respect to a series of evaluations, even that I referred to
22 this morning, such as the July 2016 evaluation of the mental
23 wellness suite of programs. I talked about a number of
24 outcomes that have resulted from those investments. I also
25 spoke about an evaluation that will be released publicly,

1 shortly with respect to clinical and client care, and that
2 we've seen some demonstrated progress and outcomes from
3 that. So I would not say that we do not have outcomes data,
4 in fact we do in a number of areas.

5 I think health data is a -- the challenge
6 with respect to a comprehensive picture of Indigenous health
7 information, is that multiple government are involved in the
8 delivery of services, and that there isn't a connection
9 between all of those data collection systems. It is a --
10 something that all governments are aware of. There isn't,
11 also, an ability to disaggregate the information that's
12 captured, for instance, in a lot of provincial or
13 territorial health systems to specifically identify who is
14 First Nation, who is Inuit, who is Métis, that also makes it
15 a challenge. But wherever possible we are supporting
16 partnerships to improve access to data that are driven by
17 First Nations and Inuit, specifically, and Métis as well,
18 who've just recently received funding in budget 2018 for
19 Métis health data and surveillance.

20 Budget 2018 also committed to an Inuit
21 health survey with ongoing resources in order to support
22 Inuit to develop their own source of health information, and
23 we also fund directly the First Nations information
24 government centre to issue the Longitudinal Regional Health
25 Survey. They have done that for a number of years. They've

1 just recently released their latest national report at
2 conference a few months ago, and they're planning the next
3 wave, so we are making investments for First Nations, Inuit,
4 and Métis to collect their own data to -- under the OCAP
5 principles: ownership control, access, and possession of
6 information. So there is growing data with respect to
7 health outcome measures.

8 **MS. SUSAN FRASER:** Okay. So that -- and that
9 -- agree that it is a critic -- the health, in understanding
10 health, is a critical part of understanding a person's well-
11 being?

12 **DR. VALERIE GIDEON:** Absolutely.

13 **MS. SUSAN FRASER:** Okay. And it's also --
14 health is -- also in how people are doing is also a critical
15 part of understanding a community's well-being?

16 **DR. VALERIE GIDEON:** Yes, I would agree.

17 **MS. SUSAN FRASER:** Okay. And I understand
18 that Indigenous Services Canada has a measure of social and
19 economic well-being on reserves, called the Community Well-
20 Being Index.

21 **DR. VALERIE GIDEON:** So the former --

22 **MS. SUSAN FRASER:** Have you heard of that?

23 **DR. VALERIE GIDEON:** Yes, I've heard of that.
24 It -- it was developed through what was Indigenous and
25 Northern Affairs Canada, to mirror the United Nations

1 Development Index and their methodology, in order to offer a
2 comparability between international nations and First
3 Nations with in the context of Canada. So it was one
4 specific measure to offer some comparability within the
5 United Nations Development Index. It's not, of course, the
6 only measure that the federal government would take with
7 respect to measuring health or socio-economic measures or
8 statistics with respect to First Nations, Inuit, and Métis.

9 **MS. SUSAN FRASER:** Right. The -- the
10 measurements of outcomes are important, and the Community
11 Well-Being Index is something that Indigenous Service Canada
12 uses in order to measure how communities are doing, fair?

13 **DR. VALERIE GIDEON:** It was actually
14 developed with First Nations at that time. Because First
15 Nations --

16 **MS. SUSAN FRASER:** I'm -- I'm sorry to cut
17 you off, but I'm -- I'm not interested in the history of it,
18 I'm just wondering, the question really was -- was whether -
19 - Dr. Gideon, was whether this is something that Indigenous
20 Services Canada uses to measure the socio-economic health of
21 First Nations Communities?

22 **DR. VALERIE GIDEON:** The information has been
23 provided in analysis, but I can't tell you, even most
24 recently, when that would have been. So I -- I have not --
25 my -- my knowledge of the Community Well-Being Index and the

1 use of it, is dated. It was when I was at the Assembly of
2 First Nations.

3 **MS. SUSAN FRASER:** Okay. Because yesterday,
4 and, Commissioners, I think I'm going to be -- you're going
5 to be hearing more from me on this topic this week, so this
6 is why I'm -- I'm leading this way. I expect to be able to
7 tender, later in the week, the Auditor General's Report.
8 And the Auditor General, I expect, we're going to hear
9 through that report, if it's received by this Inquiry,
10 that --

11 **DR. VALERIE GIDEON:** Excuse me.

12 **MS. SUSAN FRASER:** -- that there -- there is
13 an incomprehensible failure in Canada to address the gaps in
14 First Nations community as against Indigenous -- not --
15 Indigenous people as against non-Indigenous people, all
16 right? And so -- and the Auditor General goes directly in
17 looking at the economic -- the social economic Well-Being
18 Index as -- and is critical of it not including health. So
19 are you -- do you have any knowledge as to why the Community
20 Well-Being Index does not include health?

21 **DR. VALERIE GIDEON:** At the time, and the
22 knowledge that I have, which again, dates back to when I was
23 at the Assembly of First Nations, they were developing a
24 methodology that mirrored what the United Nations was using
25 in terms of the Human Development Index. So it was not a

1 deliberate exclusion of health, it was trying to achieve
2 comparability with respect to a global measurement tool.

3 **MS. SUSAN FRASER:** All right. And I also
4 understand that -- that the -- and I ask you to consider
5 this -- this point, the Auditor General says that,
6 Indigenous Services Canada is not using the data that is
7 readily available in order to provide a comprehensive
8 picture of the health of First Nations Communities. I'm
9 paraphrasing. I can give you the exact --

10 **DR. VALERIE GIDEON:** So I haven't read the
11 report. It was released yesterday, and I was travelling.
12 These reports are embargoed and only shared with certain
13 officials prior to them being released. So I'm afraid I
14 can't comment. I have not had the opportunity to read the
15 report.

16 **MS. SUSAN FRASER:** All right. It -- what the
17 Auditor General said, and I don't expect you to know it, but
18 I want to know, what he's critical about is that the
19 department could have used the volumes of available data
20 from multiple sources, I think you've given us information
21 about some of those sources, to more comprehensively compare
22 well-being relative to other Canadians and First Nations
23 communities but did not. So
24 in -- in terms of using data, do you have any knowledge as
25 to why the department would not use this available data,

1 which you've told us is quite rich in comparing Indigenous
2 Canadians to non-Indigenous Canadians?

3 **DR. VALERIE GIDEON:** The data that I was
4 referring to was specific to health. So my knowledge is
5 limited, and I don't have the expertise to answer that
6 question with respect to other areas of the department.
7 Acknowledging that we have just been transferred into the
8 creation of a new department of Indigenous Services Canada,
9 so my knowledge has been grounded and my long-standing
10 experience in working in First Nations and Inuit Health
11 specifically, I'm more familiar with health data than other
12 sources of information.

13 **MS. SUSAN FRASER:** All right. You -- you
14 said in your evidence that there's much more to be done, or
15 words to that effect, that you recognize that there's a -- a
16 lot of work to be done. But I -- I don't have time to go
17 into that. I want to ask you this last question as to
18 whether you're -- you're familiar with the Child's Rights
19 Impact Assessment, and whether that's something that your
20 department uses to assess the impact of its programs?

21 **DR. VALERIE GIDEON:** I'm not familiar with
22 it. What is the source of it?

23 **MS. SUSAN FRASER:** Child's Rights Impact is a
24 tool that is available. It's promoted by the -- through
25 UNICEF Canada, other organizations. It's a way of assessing

1 a government's compliance with child -- children's rights
2 and convention rights.

3 **DR. VALERIE GIDEON:** So I'm not familiar with
4 it, but I think it's something we should -- we would bring
5 to the senior management table.

6 **MS. SUSAN FRASER:** You would support a
7 recommendation, that in addition to using a gender-based
8 analysis, that -- that the programs be evaluated with a view
9 to child's rights? And in -- impact on child's rights?

10 **DR. VALERIE GIDEON:** We make decisions with
11 First Nations and Inuit representatives at the table. And
12 so what I would say is that, if it's of an interest to them,
13 we would certainly look at it within the context of the
14 senior management table with First Nations and Inuit.

15 **MS. SUSAN FRASER:** Right. And I
16 appreciate --

17 **MS. JENNIFER COX:** Counsel, time is up.

18 **MS. SUSAN FRASER:** Oh, thank you. My -- the
19 clock still shows seconds, so I just -- if -- if that's --
20 thank you.

21 **MS. JENNIFER COX:** It's negative. The next
22 party is the Regina Treaty Status Indian Services. And they
23 have 21 minutes.

24 **VALERIE GIDEON, Previously Affirmed:**

25 **CROSS-EXAMINATION BY MS. BEAUDIN:**

1 **MS. ERICA BEAUDIN:** Are we -- same issue as
2 yesterday. Good afternoon. Thank you to the Elders,
3 drummers, and singers for their prayers and songs we've all
4 been privilege of. Is what -- as well, once again, as a
5 citizen of Treaty 4, I acknowledge the continued welcome to
6 Treaty 7 and bring well wishes from our Treaty area. I will
7 walk softly on your lands. My name is Erica Beaudin. I'm
8 the Executive Director of the Regina Treaty Status Indian
9 Services. I have several questions; therefore, I'm going to
10 speak faster than I normally do. And please feel free to
11 answer yes or no if it's an easy answer. So question one
12 is, Dr. Gideon, *wela'lin* for your presentation this morning.
13 It was very educational, and I appreciate the information.
14 I would like to provide a bit of background, oh, as I'm
15 talking about, I'm wasting my own time. I would like to
16 provide a bit of background before I get to my questions.
17 The tribal councils who own my organization, own and operate
18 two adult domestic violence safe shelters; a hospital, the
19 All Nations Healing Hospital that you talked about this
20 morning; a social housing corporation; an economic
21 development corp.; a youth treatment facility; and as well
22 as a casino. As their urban services delivery agency, we
23 provide womb to tomb services including accredited adult
24 education, training and an employment agency, various
25 restitution programs, a family support centre, and programs

1 prioritizing various priorities. Two of these programs that
2 we have contribution agreements with is for the Indian
3 residential school and missing and murdered Indigenous women
4 and girls programming to family members, survivors, and
5 loved ones.

6 At our tribal council, that being the File
7 Hills Qu'Appelle Tribal Council, we're committed to wrap-
8 around care for all people who access our services. In
9 working with FNIHB, it is often difficult to provide
10 comprehensive case management to our people when we're bound
11 by CAs, and I'll use the term CAs, if you don't mind, that
12 are very specific in their deliverables. Do you believe
13 that CAs, that Tribal Councils, or organizations assigned to
14 deliver services, should have CAs that allow for more
15 flexibility so that the agreements can meet the needs of the
16 clients for better outcomes?

17 **DR. VALERIE GIDEON:** Yes, I do.

18 **MS. ERICA BEAUDIN:** If so, how could this be
19 accomplished, or are there current opportunities that
20 haven't been mentioned?

21 **DR. VALERIE GIDEON:** So we are very open to
22 looking at more block funding agreements for Tribal
23 Councils. In the past those were offered more to
24 communities, but a few years ago we opened it up to
25 PTOs -- or political territorial organizations -- for the

1 French translators, and also offering that to Tribal
2 Councils.

3 So I think with the richness of the degree
4 of capacity and governance of the organization that you've
5 described, it seems to fit very well with that opportunity.
6 So you would be able to do a comprehensive plan of the
7 priorities of the community members that you're serving and
8 be able to direct funds to those priorities without being
9 tied to any cluster or program silos.

10 **MS. ERICA BEAUDIN:** Thank you. My
11 organization has had a CA with FNIHB for the Indian
12 residential school program for several years. I'd like to
13 commend FNIHB for the ability to meet the needs of our
14 clients in a more wholistic way. In my mind all other CAs
15 should have the types of ability for eligible expenditures
16 for the sake of survivors and families of survivors.

17 Saying all of this, one trend that emerged
18 in our time working with IRS survivors, that many have
19 experienced loved ones who are, were missing and/or
20 murdered. Conversely, every single family we've worked
21 with in the area of missing and murdered Indigenous women
22 and girls are survivors or intergenerational survivors of
23 Indian residential school, that's 100 percent.

24 Do you believe that FNIHB should utilize the
25 Indian residential school program and expand it so that it

1 includes MMIWG, and if it is included, increase resources,
2 including program training and human resources to agencies
3 who are meeting these specific needs of survivors?

4 **DR. VALERIE GIDEON:** I believe that that's a
5 recommendation of the interim report of the commission,
6 which the government is currently in development of its
7 response, and that will be considered as part of the
8 response.

9 **MS. ERICA BEAUDIN:** Okay. You mentioned the
10 IRS program has been extended for another three years.
11 Does FNIHB understand and are you moving towards healing
12 programs for -- whether it's IRS, maybe MMIWG, that could
13 be decades long in length, and acknowledge the types of
14 long-term healing that survivors require to move beyond
15 survival?

16 **DR. VALERIE GIDEON:** So recent federal
17 budget investments have provided some ongoing -- most of
18 them, ongoing funding, so that it actually is part of our
19 base. The Indian residential school health support
20 program, because it was tied specifically to a court order,
21 is associated with that, but a lot of the mental wellness
22 investments that I described earlier are part of our core
23 permanent funding, so they can be utilized for decades long
24 planning for Tribal Councils or communities.

25 **MS. ERICA BEAUDIN:** Thank you. Often times

1 we hear that ISC or FNIHB fund mainly on-reserves programs.
2 Many Indigenous people live in urban areas. Is FNIHB
3 studying the unique needs of urban Indigenous people and
4 creating, supporting or adjusting programs that would best
5 serve their needs?

6 **DR. VALERIE GIDEON:** So this is a huge
7 priority of our Minister, she's spoken about it several
8 times, how do we provide better reach to community members
9 that are living outside their communities, sometimes for
10 shorter or longer term durations. So, for instance, as
11 part of the budget 2018 investments with respect to
12 addressing addictions issues for high risk communities, one
13 of the areas that we're specifically looking at is how do
14 we ensure that there is that outreach to community members
15 that are living outside their communities.

16 **MS. ERICA BEAUDIN:** Thank you. I understand
17 that health districts receive monies to serve the needs of
18 Indigenous people in cities. Overall, do you believe the
19 health districts are meeting the needs of urban Indigenous
20 clients?

21 **DR. VALERIE GIDEON:** You mean within the
22 context of the provincial context?

23 **MS. ERICA BEAUDIN:** Yes.

24 **DR. VALERIE GIDEON:** You know, I just -- all
25 I could say is that I think that, you know, in speaking

1 with First Nations representatives across Saskatchewan at
2 the health director and at the leadership level, they have
3 expressed concerns that they are not receiving a sufficient
4 amount of services that are adapted to their needs within
5 the provincial health services context.

6 **MS. ERICA BEAUDIN:** How could FNIHB work
7 with Indigenous organizations, Tribal Councils, leadership,
8 to better meet the needs of the people who require
9 healthcare services in urban areas?

10 **DR. VALERIE GIDEON:** Well, we actually have
11 a 2008 memorandum of understanding that was signed with the
12 Provincial Government with First Nations leadership and
13 ourselves, specifically to develop a First Nations health
14 and wellbeing plan, which was endorsed by all Chiefs and
15 Assembly and Federal and Provincial Ministers. So we have
16 a tripartite table in Saskatchewan specifically to
17 support -- to do our part, but also to support First
18 Nations to advance their interests with respect to
19 provincial health services.

20 **MS. ERICA BEAUDIN:** Thank you. You spoke of
21 increased mental health teams that are being supported by
22 FNIHB, are any of these in urban areas?

23 **DR. VALERIE GIDEON:** So, yes, but I -- in
24 Saskatchewan I know that communities have access to the
25 mental wellness teams, but I'm sorry, I just off the top of

1 my head cannot confirm for you if in Saskatchewan we have
2 one that is close to an urban centre or run by a Tribal
3 Council in an urban centre. I believe that we do, I
4 believe that the Saskatoon Tribal Council, as an example,
5 but I would have to verify that information just off of the
6 top of my head.

7 **MS. ERICA BEAUDIN:** Are there any plans, or
8 do you believe that the department should have more in the
9 urban areas?

10 **DR. VALERIE GIDEON:** I think that what we
11 need to think about is a continuum of service for First
12 Nations that -- so that it isn't -- it doesn't create a
13 barrier, which government is responsible for funding what,
14 and that essentially funding available by the two arms of
15 government are brought together and provided to First
16 Nations so that they can serve their community members
17 regardless of where they live.

18 So an example is the British Columbia First
19 Nations Health Authority, where because of their incredible
20 partnership with regional health authorities across the
21 province and provincial ministries, and also with the
22 Federal Government, they are able to leverage that funding
23 to offer those types of flexible interventions and
24 strategies so that they can reach their community members
25 living outside their communities.

1 **MS. ERICA BEAUDIN:** Thank you. You
2 discussed addiction services this morning. What is the
3 priority of FNIHB to fund agencies to have dedicated NNADAP
4 workers to meet the addictions services needs of urban, in
5 particular, the MMIWG families?

6 **DR. VALERIE GIDEON:** I'm sorry, do you mean
7 First Nation service discovery agencies or child and family
8 service agencies?

9 **MS. ERICA BEAUDIN:** Whatever it would look
10 like.

11 **DR. VALERIE GIDEON:** Just First Nations
12 agencies. I think what we would be doing with the new
13 investments, for instance, is bringing that to the regional
14 partnership committee that we have in Saskatchewan where
15 all Tribal Councils have the opportunity to participate and
16 bring -- as well as the Federation of Saskatchewan Indian
17 Nations, Indigenous Nations and so forth, and actually come
18 together to talk about what are the best areas of
19 investment, right? So that there is that flexibility and
20 First Nations can derive where there's those investments
21 should be.

22 **MS. ERICA BEAUDIN:** Okay, thank you. So
23 you're talking about STAG, the STAG table of the --

24 **DR. VALERIE GIDEON:** No, we actually had --

25 **MS. ERICA BEAUDIN:** -- FSIN?

1 **DR. VALERIE GIDEON:** So STAG is absolutely a
2 critical partner, but we actually have a regional
3 partnership committee that the Saskatchewan regional office
4 has invited folks to participate in so that they can
5 transparently share information about funding, operational
6 plans and so forth, and where they can invite feedback and
7 hopefully share decision making with respect to where funds
8 are invested.

9 **MS. ERICA BEAUDIN:** Thank you. Speaking
10 specifically of MMIWG, our organization has worked with
11 some families for up to 14 years and we have now just
12 started to work with fourth generation survivors.
13 Wraparound agencies like ours walk with families from
14 sometimes the day a person has gone missing, right to
15 assisting families to learn how to live and be independent
16 again.

17 What -- what possibilities are there for
18 FNIHB to create opportunities for agencies and
19 organizations working in this comprehensive and years long
20 process with families to know that families won't fall
21 through the crack on their healing journey, due to either,
22 A, lack of funding or underfunding by government agencies
23 such as FNIHB?

24 **DR. VALERIE GIDEON:** Oh, that's an -- it's
25 an excellent question. One of the ways in which this could

1 happen is by having comprehensive funding agreements that
2 brings together multiple sectors of education, social,
3 health, so that you have more global agreements where you
4 have that flexibility to design services that are
5 wraparound for families.

6 I think that is the goal of the new
7 department of Indigenous Services Canada, is to be able to
8 offer those types of opportunities where before we had
9 silos, where we were separated by two different departments
10 and also even within departments by sectors. So I think
11 the -- the reason for establishing the new department, or
12 one of them, is to bring together all of the needs and
13 support systems for families so that First Nation service
14 delivery agencies can support them and provide that
15 wholistic approach to service delivery.

16 **MS. ERICA BEAUDIN:** Thank you. This is a
17 bit off the path of the questions I've been asking. Our
18 young women become vulnerable when they leave home, there
19 are many reasons for this, but acceptance and confidence in
20 our place -- of our place in community can be one of the
21 reasons. When a young woman enters womanhood, this is very
22 difficult for her, especially if she doesn't live with a
23 trusted woman. Simple items such as birth control and
24 feminine hygiene supplies are not accessible. Or even the
25 self-care measures that can promote healing and strong

1 identity. How can FNIHB play a role in supporting the
2 confidence of young woman through programing or eligible
3 expenditures and current programming, so that young women
4 receive these items without embarrassment, so that in -- in
5 essence, their vulnerabilities will lessen?

6 **DR. VALERIE GIDEON:** So that's an interesting
7 question, because within Saskatchewan in particular, First
8 Nations communities do manage their own health services, and
9 they have flexibility with respect to supplies, equipment or
10 whatever it is that they wish to purchase with respect to
11 supporting families. So I think I would need to speak with
12 the Tribal Council in more detail with respect to what are
13 the gaps that they're seeing and -- and why that can't be
14 offered within the context of their agreements, because they
15 do have the highest degree of flexibility that's offered
16 outside of a self-government agreement to be able to design
17 health services and benefits to -- that matches the needs of
18 the population.

19 **MS. ERICA BEAUDIN:** Okay. Thank you. The
20 reason why I ask that question is that we have several,
21 especially in the north, many communities where this is an
22 issue for our young women. And in the south, we actually
23 have drives in order to get those -- those types of things
24 that young women need, and then we send them to the north.

25 **DR. VALERIE GIDEON:** Okay.

1 **MS. ERICA BEAUDIN:** So there is that need in
2 Saskatchewan, in the north for sure.

3 **DR. VALERIE GIDEON:** Okay.

4 **MS. ERICA BEAUDIN:** So our organization works
5 directly with families of MMIWG. I've been told
6 by -- I've been told one of their wishes for resources is a
7 family treatment facility where families could stay up to
8 six months that concentrates on PTSD, intergenerational
9 traumas, addictions, life skills, et cetera. All being
10 delivered on the land, and grounded in traditional ceremony,
11 language and arts. Do you believe this dream could be a
12 reality for these families? And if so, what would be the
13 process?

14 **DR. VALERIE GIDEON:** Family treatment is
15 absolutely needed and where we've had family treatment
16 centre's that have been developed, including one in isolated
17 community, it has been very successful with respect to
18 outcomes. So you know, I mean, it's -- it's -- do I believe
19 that it's a possibility? I like to believe that everything
20 is a possibility. We have to start from that perspective to
21 provide hope. It is very important to do that. I think we
22 would need a partnership model, and I think it is something
23 that we would be very open to meeting with the Tribal
24 Council about to discuss how we would get started in terms
25 of a planning effort.

1 **MS. ERICA BEAUDIN:** Thank you so much, Dr.
2 Gideon.

3 **JACKIE ANDERSON, Previously Affirmed:**

4 **CROSS-EXAMINATION BY MS. BEAUDIN:**

5 **MS. ERICA BEAUDIN:** Ms. Anderson, *Mashi Cho*
6 for your presentation this morning. It was in the early
7 2000s that I toured your facilities, and I was very
8 impressed and inspired by both the youth and the staff.
9 It's often difficult to create long-term programming for the
10 youth when CBO's, community-based organizations, we are
11 often juggling several grants and contribution agreements.
12 Many of them only for months long initiatives, and
13 definitely not many past a year. Is this -- do you find
14 this to be true?

15 **MS. JACKIE ANDERSON:** It was important that
16 with our HOME's is that there's not a timeframe for how long
17 our young people can actually reside in our HOME's. Again,
18 recognizing the fact that healing doesn't happen overnight.
19 Christine, for example, resided with us at Little Sisters
20 for almost four years.

21 **MS. ERICA BEAUDIN:** M'hm. I'm speaking
22 specifically about contribution agreement as opposed to
23 length of stay for -- for youth.

24 **MS. JACKIE ANDERSON:** Okay. In -- within --

25 **MS. ERICA BEAUDIN:** Full grants, contribution

1 agreements, those types of things. Like, for example, if
2 you bring in a beading project.

3 **MS. JACKIE ANDERSON:** M'hm.

4 **MS. ERICA BEAUDIN:** And it usually comes from
5 a small grant that has a lot of reporting requirements
6 attached to it.

7 **MS. JACKIE ANDERSON:** Okay. We do -- we do
8 have within our organization some of those small grants.
9 And as I mentioned earlier, these are not things that we can
10 bring to our people and to our young people and run it for a
11 short period of time and say it's done, it's over. If we
12 want to engage and bring our young people back to their
13 identity and to their culture, and if that means teaching
14 them how to make their skirt or teaching them how to do
15 beading or make their moccasins, it's not something that is
16 a very short-term, you know, project. One off of one
17 program. It needs to be an ongoing.

18 **MS. ERICA BEAUDIN:** Right. As well, have you
19 noticed the amount allowed for administration? Staffing is
20 decreasing, and we are expected to do more with less. The
21 only more we have experienced is more reporting for those --
22 those types of grants. Would you say this has been your
23 experience?

24 **MS. JACKIE ANDERSON:** Well, Child and Youth
25 Care Workers in itself are not -- are not paid a lot for the

1 work that we do, and the extra work that we do. I'm not
2 sure what you're asking in regards to administrative grants.

3 **MS. ERICA BEAUDIN:** Several times when we
4 have these contribution and grants, and it has been my
5 experience, and I was seeing if it was your experience, that
6 we are expected to do more with less. So we can't bring on
7 extra staffing. We have more administration with less
8 dollars towards the administration. And we're expected to
9 do more, basically five cents on the dollar.

10 **MS. JACKIE ANDERSON:** Yes, absolutely. We
11 run into those situations, and again it's not always having
12 the capacity to respond to the needs of our families and our
13 young people.

14 **CHRISTINE DUMAINE, Previously Affirmed:**

15 **CROSS-EXAMINATION BY MS. BEAUDIN:**

16 **MS. ERICA BEAUDIN:** Okay. Thank you. Ms.
17 Dumaine, I'm not quite sure if your community is Ojibwe or
18 Cree?

19 **MS. CHRISTINE DUMAINE:** Ojibwe.

20 **MS. ERICA BEAUDIN:** So *Miigwetch* for your
21 courage and telling your story this morning. The first time
22 I stood here, I disclosed some very personal information
23 about my journey from young adulthood. And not only did my
24 voice shake, but I almost broke down. So thank you for
25 adding your voice to legitimize and support the lived

1 experiences many of us Indigenous women live.

2 In the discussion this morning, you spoke of
3 your -- your agency, your HOME, and I'm not Ojibwe so I'm
4 -- I don't want to butcher how the HOME is called, provided
5 and how the HOME had provided years' long and supportive
6 services for you and because of this, you are able to create
7 a life you are comfortable and safe in. You now work at the
8 HOME and you are giving back. Would you state that the best
9 opportunity for other youth women or families who are
10 struggling would be long-term uninterrupted services?

11 **MS. CHRISTINE DUMAINE:** Yes.

12 **MS. ERICA BEAUDIN:** Ms. Dumaine, how
13 important on the scale of one to ten is the accessibility to
14 Indigenous traditions, languages, and customs to create a
15 strong identity for our youth and women?

16 **MS. CHRISTINE DUMAINE:** Okay. Can you say
17 that again?

18 **MS. ERICA BEAUDIN:** How important on a scale
19 of one to ten is the ability to access Indigenous
20 traditions, languages and customs to create a strong
21 identity for our young people and our women?

22 **MS. CHRISTINE DUMAINE:** It's -- I would say
23 ten, 'cause it's very important.

24 **MS. ERICA BEAUDIN:** Okay. Ms. Dumaine, you
25 also spoke of legitimacy of helpers and helping agencies

1 even though you didn't frame it that way. I've heard this
2 many times from many other individuals and families. Many
3 agencies have had generations of people who have paid
4 mortgages, schooling and vehicles off the misery industry of
5 our people. That is basically off the suffering of where
6 we're going when we go seek help. Many of them are non-
7 Indigenous, or the wily agencies often put one brown face on
8 their board to state they're Indigenous. Do you believe
9 funding agencies should add to their eligibility
10 requirements, and that there should be some sort of
11 requirement by agencies to prove they are legitimate helpers
12 of vulnerable children, youth and families? So in other
13 words, how should the voice of the people who are accessing
14 services be heard and listened to right down to the legal
15 agreements that agencies sign?

16 **MS. CHRISTINE DUMAINE:** I don't -- I'm not
17 too sure on -- like, can you give me an example?

18 **MS. ERICA BEAUDIN:** So do you -- how do you
19 believe that voice like, your voice as a young -- when you
20 went to the HOME, your voice even now as a person of lived
21 experience and has gone back to the HOME, how do you believe
22 that that voice should be heard even with the funding
23 agencies to make it part of that legal obligation that
24 agencies provide these services?

25 **MS. CHRISTINE DUMAINE:** I'm not sure. Like,

1 I'm not too sure. I -- like, I can't -- I don't know what
2 you're saying. Like --

3 **MS. ERICA BEAUDIN:** Okay.

4 **MS. JENNIFER COX:** So are you asking how
5 would she be reported? The staff -- the staff --

6 **MS. ERICA BEAUDIN:** Like, how do you -- how
7 would you like to be heard to make sure that agencies do
8 what they say that they are going to do for youth?

9 **MS. CHRISTINE DUMAINE:** Maybe tell my story
10 to them and let them know how I felt when I was little.

11 **MS. ERICA BEAUDIN:** Okay. Thank you very
12 much. I'm actually ten seconds left, so thank you to
13 everyone on the panel today. May you journey home safely
14 and find your home's fires burning strong and bright when
15 you get home. Thank you very much.

16 **MS. JENNIFER COX:** So the next party is the
17 Manitoba Murdered and Missing Indigenous Women and Girls
18 Manitoba Coalition and 13 minutes.

19 **MS. CATHERINE DUNN:** Good afternoon,
20 Commissioners. My name is Catherine Dunn and my questions
21 this afternoon are going to be restricted to Ms. Anderson
22 and Ms. Dumaine.

23 **CHRISTINE DUMAINE, Previously Affirmed:**

24 **CROSS-EXAMINATION BY MS. DUNN:**

25 **MS. CATHERINE DUNN:** Firstly, Ms. Dumaine,

1 you stated this morning that, if you had a recommendation,
2 and you did have a recommendation for the Inquiry, that you
3 would like to see rehabilitative residential centres for
4 youth under age 18. Is that correct?

5 **MS. CHRISTINE DUMAINE:** Correct.

6 **MS. CATHERINE DUNN:** Why did you make that
7 recommendation?

8 **MS. CHRISTINE DUMAINE:** I know we have AFM in
9 Winnipeg, but we just need something, like, on sacred land
10 with teaching, ceremony. Something where a family can go in
11 right away, not wait 60 days.

12 **MS. CATHERINE DUNN:** And in your view,
13 waiting lists for addiction treatment -- why is that a bad
14 thing?

15 **MS. CHRISTINE DUMAINE:** Please, can you say
16 that again?

17 **MS. CATHERINE DUNN:** Why is having to wait to
18 get addiction treatment not a good thing?

19 **MS. CHRISTINE DUMAINE:** Because they can --
20 they can get worse.

21 **MS. CATHERINE DUNN:** And it -- would it be
22 fair to say that, when you have reached a decision to turn
23 away from alcohol and drugs, that it is important to have
24 people respond to that decision immediately?

25 **MS. CHRISTINE DUMAINE:** Yes.

1 **MS. CATHERINE DUNN:** All right. Because if
2 you don't respond immediately, it may be that you won't make
3 that decision again in 60 days? Is that fair?

4 **MS. CHRISTINE DUMAINE:** Correct.

5 **MS. CATHERINE DUNN:** Thank you.

6 **JACKIE ANDERSON, Previously Affirmed:**

7 **CROSS-EXAMINATION BY MS. DUNN:**

8 **MS. CATHERINE DUNN:** My questions now are for
9 Ms. Anderson. Ms. Anderson, you have a great deal of
10 knowledge in the area of sexual exploitation, and in
11 particular, as part of your background, you were part of the
12 development of Tracia's Trust, Manitoba's sexual
13 exploitation strategy. Is that correct?

14 **MS. JACKIE ANDERSON:** Yes.

15 **MS. CATHERINE DUNN:** Do you know who Tracia
16 was?

17 **MS. JACKIE ANDERSON:** Yes. She was a young
18 Indigenous woman who, unfortunately, was taken from her
19 community and put into care of Child Family Services in
20 programs that didn't understand who she was and what she was
21 experiencing. And unfortunately, she's no longer here with
22 us.

23 **MS. CATHERINE DUNN:** And this young girl
24 committed suicide, did she not?

25 **MS. JACKIE ANDERSON:** Yes.

1 **MS. CATHERINE DUNN:** And if I recall
2 correctly, she was 15.

3 **MS. JACKIE ANDERSON:** Yes.

4 **MS. CATHERINE DUNN:** Thank you. And Tracia's
5 Trust came about as a result of the -- the inquest into the
6 death of that young person. Is that fair to say?

7 **MS. JACKIE ANDERSON:** It actually started
8 prior.

9 **MS. CATHERINE DUNN:** Okay.

10 **MS. JACKIE ANDERSON:** But it was formalized
11 in 2008, where, again, summits were held in the north and
12 the south to provide recommendations of what else was needed
13 within our province to address the issue.

14 **MS. CATHERINE DUNN:** And in terms of the
15 young people that come to your programs, would it be fair to
16 say that -- is there a -- I know you -- what -- what is the
17 common age of young people coming to your programs?

18 **MS. JACKIE ANDERSON:** The common age of
19 referrals that are coming into -- in our home is between 14
20 and 16. However, when you're looking at the average age of
21 -- of exploitation, we're looking at anywhere from 12 to 13
22 years old.

23 **MS. CATHERINE DUNN:** All right. And can you
24 speak about the issue of addiction for the young people who
25 come to your program? Is that a common symptom that they

1 **MS. CATHERINE DUNN:** And would it be fair to
2 say that the young people who come into your program have
3 high degrees of mental health issues other than trauma?

4 **MS. JACKIE ANDERSON:** Absolutely, because, I
5 mean, just with the trauma they're experiencing, the mental
6 health issues that are attached to that as well as the
7 addictions, the drugs, there's the drug-induced -- that's
8 also affecting them.

9 **MS. CATHERINE DUNN:** And would you say that
10 these issues that you have described in your evidence now
11 and this morning, that is, addictions, trauma, mental health
12 issues, are issues that are not easily addressed in short
13 periods of time?

14 **MS. JACKIE ANDERSON:** Correct, and again, as
15 I spoke earlier, you're looking at, you know, anywhere up to
16 90 days to access an adult treatment centre. You know, we
17 have different tools for our young people, but when our
18 young people are saying, I want help, I want it now, you
19 need to be able to provide it now.

20 **MS. CATHERINE DUNN:** And with the young
21 people who come into your program, are you the only
22 organization that is able to provide culturally appropriate
23 services for sexually exploited Indigenous youth?

24 **MS. JACKIE ANDERSON:** Well, we are an
25 Indigenous organization, as I mentioned.

1 **MS. CATHERINE DUNN:** Right.

2 **MS. JACKIE ANDERSON:** Hands of Mother Earth
3 is the only rural traditional healing lodge that we know
4 across Canada that is providing culture and ceremony and
5 healing on sacred land.

6 **MS. CATHERINE DUNN:** How important, in your
7 view, is the issue of culture and culturally appropriate
8 services?

9 **MS. JACKIE ANDERSON:** It's -- it's priority.
10 Again, you know, what we learn is our young people are not
11 connected to their spirit, and when their spirit is
12 wandering, that's when the hurt and vulnerabilities comes
13 into their lives.

14 **MS. CATHERINE DUNN:** And if you have
15 culturally appropriate services to provide to your young
16 people, that also has a positive effect or decreases the
17 issues of addiction, trauma, and other mental health issues.
18 Is that fair?

19 **MS. JACKIE ANDERSON:** Yes, it does decrease
20 their risk.

21 **MS. CATHERINE DUNN:** So the very factor of
22 using culturally appropriate services such as those that
23 your Indigenous organization provides is one thing that hits
24 a number of serious issues. By that, I mean if you are able
25 to provide your services in a culturally appropriate way,

1 you can speak to addictions, trauma, and mental health at
2 the same time.

3 **MS. JACKIE ANDERSON:** Yes.

4 **MS. CATHERINE DUNN:** In terms of the funding
5 that you have, you've mentioned that it is difficult at
6 times to have appropriate funding mechanisms because of the
7 length of time that various programs, such as your own, are
8 -- are provided for. Is that fair?

9 **MS. JACKIE ANDERSON:** For our homes?

10 **MS. CATHERINE DUNN:** Yes.

11 **MS. JACKIE ANDERSON:** Well, again, we're
12 provincially funded for Hands of Mother Earth and Honouring
13 the Spirits of Our Little Sisters. What I was referring to
14 earlier are these pilot projects that we're, you know, where
15 organizations are getting short-term funding to do
16 programming and to mobilize communities, and then there's no
17 more funding.

18 **MS. CATHERINE DUNN:** Could you give us an
19 example of what type of short-term programs your
20 organization provides?

21 **MS. JACKIE ANDERSON:** Well, I mean, we look
22 at, as I mentioned earlier, I'm -- I'm thinking this would
23 probably be the top of my head that I can think of is within
24 -- we get short-term funding to be able to provide youth
25 leadership and engagement for community youth, and often

1 those are funding projects for six months or for a year. So
2 again, when you're working with your -- these young people,
3 working through, building their capacity, there needs to be
4 constant post-support to continue to help them with
5 opportunities to build their strengths and their gifts.

6 **MS. CATHERINE DUNN:** And self-esteem is not
7 necessarily built in a year or two, is that fair to say?

8 **MS. JACKIE ANDERSON:** Very fair.

9 **MS. CATHERINE DUNN:** And often, on their
10 journeys, you -- your organization tries to provide positive
11 life experiences such -- you mentioned going to Edmonton
12 mall, et cetera. Is that fair?

13 **MS. JACKIE ANDERSON:** Yes.

14 **MS. CATHERINE DUNN:** And that is comparable
15 to a family experience for these young people, and it
16 doesn't necessarily translate to a budget line on your
17 financing application.

18 **MS. JACKIE ANDERSON:** Right.

19 **MS. CATHERINE DUNN:** And what that means is
20 that you have a lot of off-the-table or out-of-pocket
21 expenses to provide life-empowering experiences for your
22 young people.

23 **MS. JACKIE ANDERSON:** Yes.

24 **MS. CATHERINE DUNN:** And who -- who provides
25 that out-of-pocket money or that off-the-table expense? Who

1 do you get that money from?

2 **MS. JACKIE ANDERSON:** Well, I guess it really
3 depends. Like, we do a lot of, like, internal fundraising.
4 You know, we might sometimes receive some support through
5 philanthropy. But again, we -- we do our -- our yearly
6 program planning to identify the needs and the wishes of our
7 young people and create what that looks like, and then start
8 doing our fundraising to be able to make that a reality.

9 **MS. CATHERINE DUNN:** And the -- -- the
10 problem, although Winnipeg and Manitoba is a very generous
11 in terms of providing funds, you can't always build a
12 budget on hoping what you're going to get from a
13 fundraising event; is that fair?

14 **MS. JACKIE ANDERSON:** Yes.

15 **MS. CATHERINE DUNN:** And as a result, your
16 young people may not get the programming that they ask you
17 for and that you encourage them to ask you for as part of
18 their journey to become independent young adults?

19 **MS. JACKIE ANDERSON:** Yes.

20 **MS. CATHERINE DUNN:** You mentioned that you
21 currently have two group homes, and there are ten
22 beds -- or is it 12 beds in total?

23 **MS. JACKIE ANDERSON:** Are you talking about
24 the -- that's specialized for sexually exploited children
25 and youth?

1 **MS. CATHERINE DUNN:** Yes, I am, sorry.

2 That's what I am --

3 **MS. JACKIE ANDERSON:** Homes, yes. Beds.

4 **MS. CATHERINE DUNN:**

5 (Indiscernible) -- exactly. Yeah. So how many beds is it?

6 **MS. JACKIE ANDERSON:** Twelve beds in total
7 between the two.

8 **MS. CATHERINE DUNN:** Twelve beds. How many
9 sexually exploited youth do you think there are in Manitoba
10 at the present time?

11 **MS. JACKIE ANDERSON:** I -- I couldn't even
12 give you a number. I mean, you're looking at, you know,
13 the visible and the non-visible exploitation, which is
14 always hard to track. But absolutely, a very high number
15 of -- of young people under the age of 18.

16 **MS. CATHERINE DUNN:** Would you put that
17 number in the hundreds or in the thousands or can you say?

18 **MS. JACKIE ANDERSON:** I would say in the
19 hundreds, for sure.

20 **MS. CATHERINE DUNN:** All right. And in
21 order to access -- and you would, I think -- and I think
22 you've made it clear this morning, but in your opinion,
23 your program is very successful?

24 **MS. JACKIE ANDERSON:** It's very successful.
25 And again, when I, you know, look at, you know, my little

1 sisters who once used to give me a hard time and push me
2 away and keep me out of their lives, and they're sitting
3 beside me, you know, and -- and working with me and
4 supporting their little sisters, that's something to
5 celebrate.

6 **MS. CATHERINE DUNN:** And what is sitting
7 beside you is your work and her work?

8 **MS. JACKIE ANDERSON:** Absolutely. She was a
9 very resilient young woman who knew what she wanted, and
10 once she let her walls down and allowed us to love her,
11 she -- she grew.

12 **MS. CATHERINE DUNN:** And can you tell me in
13 terms of allowing her to grow and to fulfill her own
14 dreams, how important was it that she experience her own
15 culture?

16 **MS. JACKIE ANDERSON:** Extremely important.
17 And I remember her when she first came in at the age of 13,
18 not even knowing where she was from, you know, not having
19 memories of her community, her First Nations community, not
20 ever attending a ceremony or sitting at a drum or using
21 medicines. And that was something that we immediately, you
22 know, provided her. And as she took her time to -- to
23 engage in that, that became part of her healing and her
24 strength.

25 **MS. CATHERINE DUNN:** You mentioned --

1 **MS. JENNIFER COX:** Counsel, sorry. Time's
2 up.

3 **MS. CATHERINE DUNN:** Thank you.

4 **MS. JENNIFER COX:** The next party is the
5 Aboriginal Women's Action Network with 13 minutes.

6 **JACKIE ANDERSON, Previously Affirmed:**

7 **CROSS-EXAMINATION BY MS. BLANEY:**

8 **MS. FAY BLANEY:** Thank you. Good afternoon.
9 My name is Fay Blaney, and I am with the Aboriginal Women's
10 Action Network. Thank you, Jackie, for your presentation.
11 I was very moved by it, and a lot of my questions will be
12 directed to you.

13 **MS. JACKIE ANDERSON:** Okay.

14 **MS. FAY BLANEY:** I listened with keen
15 interest as you spoke about how you used terminology. And
16 I know that some of the women from your organization that
17 came out to Vancouver when we were preparing for this
18 Inquiry also addressed this issue of the use of
19 terminology.

20 **MS. JACKIE ANDERSON:** M'hm.

21 **MS. FAY BLANEY:** And you were saying that
22 you prefer not to use the word "prostitution" because it is
23 so normalized as a form of violence, and that the use of
24 the term "prostitution" in some ways obscures sexual
25 exploitation. I'm just wondering if you can tell us more

1 about the use of that terminology.

2 **MS. JACKIE ANDERSON:** The -- the correct
3 terminology that -- or sorry, that we use within our
4 province as directed by our survivors? I guess just more
5 to elaborate that when you -- and this is what we hear from
6 your survivors and those young women that we were, you
7 know, facilitating to come into our homes or sharing with
8 us that when, you know, they're -- they're called, you
9 know, a prostitute or prostituting yourself or working in
10 the sex trade, that there was, like, an element of choice.
11 And -- and that is something that is imperative for their
12 healing to understand, that this was not a choice, it's
13 others taking advantage of them and the shame that's often,
14 you know, carried with using that terminology.

15 So in order for us to have started to help
16 our -- our young people heal, it was to take -- create that
17 education and awareness of -- of where they are and to help
18 them be able to let go of all that shame and blame that
19 they've been carrying over the years through their
20 victimization.

21 **MS. FAY BLANEY:** Okay. Thank you. And I
22 was really pleased to hear that there have been -- I think
23 you said 100 convictions?

24 **MS. JACKIE ANDERSON:** Yes, last year.

25 **MS. FAY BLANEY:** Last year. Of sexual

1 predators, pimps and johns.

2 **MS. JACKIE ANDERSON:** M'hm.

3 **MS. FAY BLANEY:** In Vancouver, the Vancouver
4 Police Department refuses to enforce Bill C-36, the
5 *Protection of Communities and Exploited Persons Act*. And
6 so -- so there have been no arrests. There's no
7 convictions because they refuse to enforce it.

8 **MS. JACKIE ANDERSON:** M'hm.

9 **MS. FAY BLANEY:** And so I'm just wondering,
10 how were you able to work with your criminal justice
11 system? How were you able to convince them to do their job
12 and to uphold the law and why is it important to enforce
13 this law?

14 **MS. JACKIE ANDERSON:** Again, when I talk
15 about the partnership and the collaboration and the
16 importance of relationships, with all sectors that are
17 involved in protecting and standing up for our young
18 people, our Sexually Exploited Youth Community Coalition
19 that we have started over the years includes our police
20 department and other different systems. So again, those
21 relationships are really key and important, especially when
22 you're operating a safe home for our young people because,
23 often, our young people are afraid to speak to the police.
24 However, they trust in us who we trust, and by having those
25 established relationships with specific people within the

1 police, it really provides more of a safe place for our
2 young people to be able to share what's going on in their
3 lives. I mean, our young people will take us for a drive,
4 and they'll show us where, you know, all the drug houses
5 are or where girls are being exploited, but they're not in
6 a place to be sitting on a stand and, you know, disclosing
7 what's happening to them. But by us having those
8 relationships with the police, coming into our home not
9 just to enforce the law but to come have tea and bannock,
10 you know, is very important for our -- for our young
11 people.

12 So our police department is very active
13 in -- in enacting this bill, and are partners are part of
14 our Winnipeg Outreach Network.

15 **MS. FAY BLANEY:** M'hm. Well, I hope that
16 they will support the continuation of this -- this law. So
17 you were saying that the bill is somewhat inadequate, and I
18 was wondering, like, what do you mean by that? What more
19 can be added or included to make it more effective?

20 **MS. JACKIE ANDERSON:** It's -- it's something
21 that is very, very useful today. I -- I do absolutely
22 believe that there's still other aspects. I mean, again, I
23 would like to see perpetrators immediately be given jail
24 time, you know. And -- and I guess the other aspect is,
25 you know, for our women, our women are, you know -- don't

1 want to be in those situations. However, what needs to
2 happen is programs and services for our adult women. You
3 know, when you turn 18 or you age out of care, you know,
4 services shouldn't just be stopped. And -- you know, and
5 unfortunately, there's not a lot of services for adult
6 women, in particular in our province, a safe place where
7 they can go to, a safe place for resources to maybe get
8 them off the street and be able to take them somewhere
9 where they're going to be nurtured, loved, and taken care
10 of and get the services that they need.

11 **MS. FAY BLANEY:** Yeah, I think that's a
12 prevalent theme that the Commissioners have heard, that
13 there is inadequate programs and services for Indigenous
14 women and girls, and especially I think there's inadequate
15 attention being paid to us being able to have independent
16 women's groups and organizations so that we can bring our
17 voices forward. But we're not supposed to make
18 submissions, so I better stick to my questions.

19 **(LAUGHTER)**

20 **MS. FAY BLANEY:** So just getting back to the
21 topic of terminology. In BC we abolitionists, there's a
22 good group of us, use the language of prostitution to
23 underscore sexual exploitation of women and girls, and we
24 see prostitution as being on the continuum of male violence
25 against Indigenous women and girls -- well, against all

1 women and girls.

2 **MS. JACKIE ANDERSON:** M'hm.

3 **MS. FAY BLANEY:** And that the struggle that
4 we have is with the pro sex groups that see this as a
5 viable source of employment or work, sex work, and I just
6 wanted to get your thoughts on that language, the term "sex
7 work"?

8 **MS. JACKIE ANDERSON:** I mean, again, just
9 coming from my experience of, you know, being with our
10 young people and our experiential women. I've sat at
11 tables to support them, I've -- I've listened to how
12 language effects, you know, and interrupts even sometimes
13 their healing triggers, you know, the healing that they
14 have or where they're at, at that time, and it's just very
15 important that what our women with lived experience are
16 telling us, that, you know, that's something that we need
17 to stand strong.

18 So as an ally and support to those women,
19 it's important that, you know, if they're saying this is
20 something that I need to stand strong and educate and
21 correct when people within our province are, you know,
22 using that language, then it's something I'm committed to
23 do, to educate. And, again, I did share earlier that
24 language is different all across the province, and that was
25 a very common theme, you know, and when -- when they were

1 doing the visits across Canada with --

2 **MS. FAY BLANEY:** If I can pry just a little
3 bit deeper, do you see that as a viable source of
4 employment for Indigenous women and girls?

5 **MS. JACKIE ANDERSON:** No, I do not.

6 **MS. FAY BLANEY:** Okay. That's what I was
7 trying to get at. So you spoke about the importance of
8 autonomy for the young women that come into your
9 homes -- and my time is running out so quick I see
10 here -- and you -- I was going to give you examples of how
11 you said that, but I'll leave that for now.

12 You were talking about the importance of
13 them having some level of autonomy in their healing process
14 and in their wellness, and I have to say that I agree from
15 my feminist perspective that consciousness raising and
16 understanding the dynamics of power and the way power
17 works, oppression, exploitation. So I wanted to just get
18 on record your thoughts about the importance of women only
19 healing spaces, where, you know, there's a separate -- a
20 clear separate and distinct place for survivors of violence
21 and abuse and exploitation in doing their healing work, as
22 opposed to having co-ed treatment centres?

23 **MS. JACKIE ANDERSON:** That was one of the
24 direct recommendations when -- when we created the programs
25 underneath Tracia's Trust, and it was very -- it was very

1 important that -- that there was a space that was created
2 that would be safe for -- for our young women.

3 I mean, a very high number of exploiters,
4 traffickers that are harming our young people are men, and
5 it was important to them, especially in a children and care
6 facility, that their caregivers were -- were women, were
7 aunties, were kokums.

8 **MS. FAY BLANEY:** And do you think that that
9 concept of healing would apply to other areas, such as
10 addictions or addictions treatment or exiting services or
11 historic abuse groups?

12 **MS. JACKIE ANDERSON:** I would think so.
13 Again, depending on the nature of -- you know, so, for
14 example, I'll use domestic violence for example, we operate
15 a program for men and we operate a program for women.

16 **MS. FAY BLANEY:** M'hm.

17 **MS. JACKIE ANDERSON:** We also see the value
18 in, you know, relationships, so we do couples, you know, as
19 also a part of -- of couples retreat as part of that
20 healing. But our young women tell us if you put me in a
21 circle with a bunch of boys or, you know, a bunch of men,
22 I'm not going to be safe to be able to share my true
23 truths.

24 **MS. FAY BLANEY:** Yeah, I'm really alarmed at
25 that -- that way -- the way things are done where treatment

1 centres for addictions are co-ed, and often the offenders
2 are there talking about their exploits in front of me who
3 is a survivor.

4 **MS. JACKIE ANDERSON:** M'hm.

5 **VALERIE GIDEON, Previously Affirmed:**

6 **CROSS-EXAMINATION BY MS. BLANEY:**

7 **MS. FAY BLANEY:** And it definitely doesn't
8 feel safe. So I have a minute left and I wanted to address
9 some questions to you, Ms. Gideon. I have three questions,
10 but I'm going to go right to my last one, and I might ask
11 the other two if time permits. So I'm just wondering how
12 your department is responding to the needs of Indigenous
13 women and girls in large urban centres?

14 I'm wondering if -- I'm going to ask a bunch
15 of questions all at once here. Is there any consideration
16 of drawing on Jackie's expertise in developing women only
17 spaces, where women survivors feel safe, or alternatively,
18 to have the damaging effects of having both offenders and
19 survivors in the same healing setting, is one of my
20 questions? I have another one for you, but I'll --

21 **DR. VALERIE GIDEON:** I mean, we don't design
22 specifically the -- the organization service delivery mix
23 to the populations that they serve --

24 **MS. FAY BLANEY:** Okay.

25 **DR. VALERIE GIDEON:** -- with respect to our

1 funding parameters, so --

2 MS. FAY BLANEY: Okay.

3 DR. VALERIE GIDEON: -- that flexibility is
4 offered.

5 MS. FAY BLANEY: Okay, that's the same
6 answer I heard before. I'm going to ask you a different
7 question then.

8 MS. JENNIFER COX: Your --

9 MS. FAY BLANEY: From a governance
10 perspective -- pardon?

11 MS. JENNIFER COX: You're out of time.

12 MS. FAY BLANEY: It says 12 seconds over
13 there.

14 MS. JENNIFER COX: Minus.

15 MS. FAY BLANEY: What? 17 -- okay, it's
16 moving now, but it still had time over there. Okay.

17 UNIDENTIFIED SPEAKER: It's going in the
18 negative and it's confusing people.

19 UNIDENTIFIED SPEAKER: Because it's red.

20 UNIDENTIFIED SPEAKER: It's going backwards.

21 MS. JENNIFER COX: So the next party is
22 Eastern Door Indigenous Women's Association, and 13
23 minutes.

24 CHRISTINE DUMAINE, Previously Affirmed:

25 CROSS-EXAMINATION BY MS. CLIFFORD:

1 **MS. NATALIE CLIFFORD:** Good? All right.

2 I'm Natalie Clifford from the Eastern Door Indigenous
3 Women's Association. We represent the interests of
4 primarily Mi'kmaq and Maliseet women in the Atlantic
5 Region, and where those interests align with other
6 Indigenous women in that region as well.

7 I'm going to just start with one quick
8 question -- one quick question for Ms. Dumaine. Thank you
9 very much for being here and sharing your story with us. I
10 just wondered, what will you teach your kids to help them
11 avoid being targeted by human traffickers?

12 **MS. CHRISTINE DUMAINE:** Well, my son, he's
13 ten, and I just keep -- like, he knows what I -- where I
14 work and everything, and I just -- and my -- I have a
15 four-year-old daughter, so it scares me to even think about
16 that kind of stuff, like, what could happen to her, but I
17 would -- I would educate her what I all know and what
18 I -- like, what the girls at the HOME taught me as well.

19 **JACKIE ANDERSON, Previously Affirmed:**

20 **CROSS-EXAMINATION BY MS. CLIFFORD:**

21 **MS. NATALIE CLIFFORD:** Thank you.

22 Ms. Anderson, I have a few quick questions for you. I'm
23 curious about whether you're ever directly consulted by the
24 ISC and FNIHB for your position as you've shared today,
25 given your experience?

1 **MS. JACKIE ANDERSON:** Can you explain what
2 ISC is?

3 **MS. NATALIE CLIFFORD:** The --

4 **MS. JACKIE ANDERSON:** That probably answers
5 your question.

6 **(LAUGHTER)**

7 **MS. NATALIE CLIFFORD:** The new name -- the
8 new name for the Federal department overseeing health
9 services for Indigenous people.

10 **MS. JACKIE ANDERSON:** Okay. No, not -- not
11 directly, personally.

12 **MS. NATALIE CLIFFORD:** So do you rely on
13 your AFN rep -- and -- and I'm asking these questions
14 because I want to understand whether you do get consulted
15 on the gaps?

16 **MS. JACKIE ANDERSON:** We -- we are a very
17 active consultant as it relates to issues that are directly
18 affecting urban children and families, however, personally
19 that would not be my role, that would be the role of our
20 executive director, who is a very, very engaged,
21 intelligent woman that ensures that the voice of our
22 community is -- is represented.

23 **MS. NATALIE CLIFFORD:** So is that through
24 the regional AFN rep?

25 **MS. JACKIE ANDERSON:** I can't answer you

1 that, I'm sorry, I have no --

2 **MS. NATALIE CLIFFORD:** Based on your
3 evidence, is it fair to say that you credit the solid
4 support from a provincial Minister of your programming for
5 its success?

6 **MS. JACKIE ANDERSON:** Well, we've had
7 multiple Ministers over the years, and -- and I'm not, you
8 know, into the politics and all that stuff. At the end of
9 the day it's about our -- our young people, and -- and,
10 yes, today we have very, very strong community support at
11 all levels.

12 **MS. NATALIE CLIFFORD:** You mention you have
13 215 -- 250 employees?

14 **MS. JACKIE ANDERSON:** Yes.

15 **MS. NATALIE CLIFFORD:** So just looking
16 forward to next year, do they have jobs with their funding
17 in place to employees?

18 **MS. JACKIE ANDERSON:** Yes, within our
19 Children in Care programs they do.

20 **MS. NATALIE CLIFFORD:** Okay. Thank you.

21 **MS. JACKIE ANDERSON:** You're welcome.

22 **VALERIE GIDEON, Previously Affirmed:**

23 **CROSS-EXAMINATION BY MS. CLIFFORD:**

24 **MS. NATALIE CLIFFORD:** So, Dr. Gideon, the
25 rest of my questions are for you.

1 I'm going to focus in on the example of
2 mental health and contribution agreements because you've
3 indicated that they are developed from community plans,
4 correct?

5 **DR. VALERIE GIDEON:** That's right.

6 **MS. NATALIE CLIFFORD:** Can you define
7 community for me, please?

8 **DR. VALERIE GIDEON:** So for those programs
9 that are specific to First Nations communities, it's the
10 First Nation community reserve base in the --

11 **MS. NATALIE CLIFFORD:** Reserves?

12 **DR. VALERIE GIDEON:** -- province.

13 **MS. NATALIE CLIFFORD:** And councils?

14 **DR. VALERIE GIDEON:** Yes, but there's also
15 other organizations like political/territorial
16 organizations or the equivalent of what would be a tribal
17 council in regions also that provides services.

18 **MS. NATALIE CLIFFORD:** Okay. Can and
19 individual group say in a city administering services for
20 women and young people in that city, submit a community
21 plan for a contribution agreement on mental health?

22 **DR. VALERIE GIDEON:** We do fund, under the
23 Victims of Violence Initiative, or even under the Non-
24 Insured Health Benefits Program service delivery
25 organizations that are working in urban contexts.

1 Sometimes it's friendship centres or other organizations
2 that have service delivery. So for instance in Winnipeg we
3 do fund 24/7 youth shelter access. So there's -- there's
4 examples of those types of initiatives.

5 Each region, as I mentioned, we have
6 partnership committees, so for instance, in the Atlantic
7 Region we have the Atlantic First Nations health
8 partnership table that's existed since the '90s. It's a
9 co-management table. There are a number of representatives
10 from each of the First Nations regions that sit at that
11 table and they make decision with respect to where funding
12 should be targeted. So it's not always held at a community
13 level. Depending on what the needs are and depending on
14 what the most effective interventions are that are judged
15 by the First Nations in that -- in that region.

16 **MS. NATALIE CLIFFORD:** Okay. Thank you.
17 Can you speak to -- with that example of on the east coast,
18 the effectiveness, then, of using mental health and
19 contribution agreements as it currently plays out. Can you
20 speak to the effectiveness of that right now in Nova Scotia
21 and how that's playing out?

22 **DR. VALERIE GIDEON:** Sorry, I just lost the
23 last part of the -- effectiveness in? Sorry?

24 **MS. NATALIE CLIFFORD:** Nova Scotia.

25 **DR. VALERIE GIDEON:** In Nova Scotia. Well,

1 I can speak to at a National level an evaluation that was
2 done with respect to specific outcomes that I referenced
3 earlier around increasing healthy behaviours awareness.

4 **MS. NATALIE CLIFFORD:** Okay. So do you know
5 who sits at that table, then, the --

6 **DR. VALERIE GIDEON:** The Atlantic First
7 Nations health partnership table?

8 **MS. NATALIE CLIFFORD:** Or the parties
9 involved?

10 **DR. VALERIE GIDEON:** So there are First
11 Nations representatives that are assigned by each of the
12 sub-regions by leadership, so there are community Chiefs,
13 political territorial organizations that are represented at
14 that table, as well as, of course, some FHNIB regional
15 executives.

16 **MS. NATALIE CLIFFORD:** So does it go back,
17 then, to a reliance on a relationship with the regional
18 Chiefs, say the AFN representative that sits at the
19 national table?

20 **DR. VALERIE GIDEON:** The regional Chief is
21 invited to participate, but it's actually the First Nations
22 leaders Chiefs elected by communities. But then as an
23 assembly they identify who the regional reps will be as a
24 collective.

25 So, like, in -- in New Brunswick, the New

1 Brunswick Chiefs would get together and determine who their
2 representatives would be at the table. In Nova Scotia the
3 communities would get together and determine who their
4 representatives are at the table.

5 **MS. NATALIE CLIFFORD:** Okay. So do you know
6 who the representatives are that the chiefs and the AFN
7 representatives have chosen at the Nova Scotia table?

8 **DR. VALERIE GIDEON:** We have that
9 information in terms of -- I know some of them in terms of
10 names, but I can't tell you the full list of members.

11 **MS. NATALIE CLIFFORD:** So do you think,
12 then, it might be fair to say that it would be beneficial
13 for the Commission if they're interested in understanding
14 diversity of the way these agreements and funding is
15 implemented across the country that they may need to hear
16 from representatives from those jurisdictions?

17 **DR. VALERIE GIDEON:** I really can't presume
18 to tell the Commissioners who they should hear from. I --
19 I mean --

20 **MS. NATALIE CLIFFORD:** You can't speak to
21 the diversity of implementation across the country
22 yourself?

23 **DR. VALERIE GIDEON:** I can speak to each of
24 the regional committees and who makes up the membership
25 generally in terms of names. Like, Chief Candice Paul is

1 the co-chair, I know that.

2 **MS. NATALIE CLIFFORD:** Okay.

3 **DR. VALERIE GIDEON:** But in terms of all of
4 the individuals that are part of that, we're talking about
5 hundreds of people, so it would be difficult for me to know
6 all of the names.

7 **MS. NATALIE CLIFFORD:** So when we're talking
8 about service provision in cities, for example, and say
9 there is an organization wishing to be heard -- wishing for
10 you to hear their perspective on service provision and the
11 gaps, is there any way for you to monitor how the regional
12 tables or the provincial tables are actually selecting
13 members or is it possible that individual service providers
14 who may be interested in having input would fall through
15 the cracks and not be heard by -- by your department?

16 **DR. VALERIE GIDEON:** Well, I mean, anybody
17 can absolutely contact us and sit with us to talk about
18 what needs exist in context and what priorities, and we can
19 bring that information and -- and invite presentations at
20 the partnership committee tables. My experience with these
21 tables is that they're extremely open to hear from service
22 delivery organizations with respect to what the needs are.
23 And most First Nations leadership across the country are
24 very concerned about how to support their members that are
25 living in urban cities and urban contexts, and they want to

1 be able to provide them with service and reach them.

2 **MS. NATALIE CLIFFORD:** Okay. So the role of
3 FNIHB is, just to confirm, is -- is like proper
4 characterization to fill the gaps while respecting the role
5 of other jurisdictions, being First Nations governance and
6 provinces with respect to health?

7 **DR. VALERIE GIDEON:** That's a good way of
8 expressing it, for sure.

9 **MS. NATALIE CLIFFORD:** Okay. So would you
10 characterize that as in a positive responsibility on
11 government or on Canada?

12 **DR. VALERIE GIDEON:** I -- I would
13 characterize that as a positive responsibility.

14 **MS. NATALIE CLIFFORD:** Okay. Requiring
15 action and research?

16 **DR. VALERIE GIDEON:** Yes, and which is -- I
17 mean, the last three Federal budgets has made significant
18 investments with respect to mental wellness, I think the
19 government is recognizing its responsibility with respect
20 to supporting First Nations and mental illness.

21 **MS. NATALIE CLIFFORD:** Okay. So I just want
22 to go back to the idea of the round tables, and as you
23 mentioned the Chiefs and you mentioned the name of a Chief
24 who sits at the round table and chairs it. So is it
25 possible that a grassroots women's organization who does

1 not necessarily have standing to deal directly with your
2 department, and maybe whose interests don't align with
3 those of the chiefs, and say the example again is that
4 their -- that they would not be selected to sit at that
5 table; correct?

6 **DR. VALERIE GIDEON:** They wouldn't
7 necessarily -- they wouldn't sit at the table, but they
8 could come in and present what are their ideas and
9 solutions with respect to better servicing First Nations in
10 -- in their province or in the city.

11 **MS. NATALIE CLIFFORD:** Okay. Make or give a
12 presentation to that same round table that opted not to
13 incorporate them in the discussion in the first place?

14 **DR. VALERIE GIDEON:** Well, it's not really
15 about not agreeing to service delivery organizations
16 specifically being part of it, but these are tables that
17 represent First Nations leadership in terms of governments,
18 and so it is a measure to share decision making with
19 elected representatives --

20 **MS. NATALIE CLIFFORD:** Decide -- decide on
21 funding allocations?

22 **DR. VALERIE GIDEON:** Correct, but it doesn't
23 mean that there isn't collaboration with service delivery
24 organizations.

25 **MS. NATALIE CLIFFORD:** Just a moment. I

1 just wanted to look at -- Ms. Anderson identified a really
2 specific area of -- and I think it goes to the heart of the
3 issue of our women experiencing a disproportionate amount
4 of violence. This connection between women coming from
5 remote communities to city centers -- and young people.
6 It's not just women, but women, especially -- arriving in
7 city centers and being specifically targeted, and the very
8 disturbing evidence that traffickers and recruiters are
9 listening for their accents to determine their isolation
10 and vulnerability.

11 So I wondered, to me this sounds like a
12 significant gap where the provinces aren't necessarily
13 prepared to deal with this kind of specific vulnerability.
14 The communities themselves, due to the remoteness, are, you
15 know, not preparing these children. So is there a mandate
16 within the ISC or a plan for, you know, health promotion
17 and education specifically before children and women leave
18 remote communities in this respect?

19 **DR. VALERIE GIDEON:** It's a good question.
20 I think that we do have sources of funds that can help to
21 support strategies. For instance, in Thunder Bay, we have
22 initiatives with the high schools that First Nations youth
23 from remote communities --

24 **MS. NATALIE CLIFFORD:** After they've come to
25 the high school, though.

1 **DR. VALERIE GIDEON:** But knowing that they
2 are to come to the high school, to plan in advance services
3 to -- to help support them, so targeted mental health
4 counselling. We have a Suboxone program in the Thunder Bay
5 high school, for instance, that First Nations are governing
6 to help address at-risk behaviour. So there is planning in
7 advance that can be made to make sure that there are
8 support systems for individuals that have to come down for
9 education or other reasons.

10 **MS. NATALIE CLIFFORD:** Thank you. That's
11 all my questions.

12 **MS. JENNIFER COX:** So the next party is the
13 Assembly of Manitoba Chiefs, and they have 13 minutes.

14 **VALERIE GIDEON, Previously Affirmed:**

15 **CROSS-EXAMINATION BY MS PASTORA SALA:**

16 **MS. JOËLLE PASTORA SALA:** Good afternoon,
17 Commissioners, Elders, family members. My name is Joëlle
18 Pastora Sala. I am counsel to the Assembly of Manitoba
19 Chiefs. Good afternoon, panel members. Thank you all for
20 your presentations today.

21 I'll be focussing my questions to
22 Dr. Gideon. I hope to have time to ask you some questions,
23 Ms. Anderson. Ms. Dumaine, out of respect for -- for you,
24 I will not be asking you questions today, but on behalf of
25 the Assembly of Manitoba Chiefs, I'd like to thank you for

1 sharing your voice and experience with us.

2 **MS. CHRISTINE DUMAINE:** Thank you.

3 **MS. JOËLLE PASTORA SALA:** Dr. Gideon. You
4 stated that FNIHB derives its authority from the *Indian*
5 *Health Policy* of 1979 and the Department of Health -- of
6 *Health Act*, correct?

7 **DR. VALERIE GIDEON:** So it was the
8 *Department of Health Act*. Of course, now we are within the
9 context of the Department of Indigenous Services Canada,
10 and enabling legislation for the creation of that
11 department has not yet been introduced.

12 **MS. JOËLLE PASTORA SALA:** And it's the three
13 pillars in the policy from 1979 that continue to guide the
14 work of FNHIB?

15 **DR. VALERIE GIDEON:** Yes. But as I
16 mentioned in 2012, we published a more comprehensive
17 strategic plan in order to increase our commitments and
18 also updating in the relevancy of the context.

19 **MS. JOËLLE PASTORA SALA:** But these three
20 pillars continue to be at the root of your department's
21 work?

22 **DR. VALERIE GIDEON:** It's still part of the
23 mandate, absolutely.

24 **MS. JOËLLE PASTORA SALA:** Would it be
25 correct to say that First Nations health services are

1 delivered as a matter of policy and are not entrenched in
2 legislation?

3 DR. VALERIE GIDEON: That is correct.

4 MS. JOËLLE PASTORA SALA: And because of
5 this, policies may change frequently, based on political
6 mandates?

7 DR. VALERIE GIDEON: I have not seen in my
8 20-some years in my career policy changes that have been
9 significant within the context of the First Nations health
10 branch mandate.

11 MS. JOËLLE PASTORA SALA: But it would be
12 conceivable?

13 DR. VALERIE GIDEON: I think that it
14 would -- conceivable.

15 MS. JOËLLE PASTORA SALA: Would it be
16 possible?

17 DR. VALERIE GIDEON: It would be possible.

18 MS. JOËLLE PASTORA SALA: Are you
19 generally -- generally familiar with the *Canada Health Act*?

20 DR. VALERIE GIDEON: I am familiar with the
21 *Canada Health Act*.

22 MS. JOËLLE PASTORA SALA: If I describe this
23 Act to you as the federal legislation which establishes
24 criteria and conditions for insured health services and
25 extended health care services under provincial law to

1 access cash contributions by the Federal government, that
2 would be consistent with your understanding?

3 **DR. VALERIE GIDEON:** That would be
4 consistent.

5 **MS. JOËLLE PASTORA SALA:** I'd like to just
6 quickly read to you the five pillars of the *Canada Health*
7 *Act*. Public administration, comprehensiveness,
8 universality, portability, accessibility. Subject to
9 check, is this familiar to you?

10 **DR. VALERIE GIDEON:** Yes.

11 **MS. JOËLLE PASTORA SALA:** In thinking of
12 the mandate of NHI -- FNHI -- I'm -- I have trouble with
13 acronyms, I apologize. Of your department, are you able to
14 describe for me the relationship between the 1979 Indian
15 Health Policy and the Canadian *Health Act*? Specifically,
16 does the Canadian *Health Act* apply to First Nations living
17 on reserve?

18 **DR. VALERIE GIDEON:** Yes, because First
19 Nations populations on reserve, their population numbers
20 are included within the overall per capita calculations
21 on -- on the basis of which fiscal transfers are negotiated
22 with provincial governments and territorial
23 governments -- or provincial governments.

24 **MS. JOËLLE PASTORA SALA:** And so the
25 principles that I read to you earlier would apply to First

1 Nations living on reserve?

2 **DR. VALERIE GIDEON:** There is no reason why
3 it would exclude them, considering that their population
4 numbers are included within the fiscal transfer
5 calculations.

6 **MS. JOËLLE PASTORA SALA:** The mandate of
7 your department is to ensure the availability of or access
8 to health services for First Nations and Inuit communities,
9 correct?

10 **DR. VALERIE GIDEON:** We provide services
11 that are not offered through provincial/territorial health
12 systems, yes.

13 **MS. JOËLLE PASTORA SALA:** And you would
14 agree generally that there continues to be a gap for public
15 and primary health care between on-reserve and off-reserve,
16 including with respect to infrastructure, training, medical
17 equipment, laboratory services, medical office assistants,
18 pharmacy, et cetera?

19 **DR. VALERIE GIDEON:** Well, it is -- those
20 responsibilities are often exercised through the First
21 Nations Inuit Health Branch directly or through funding
22 provided by the First Nations Inuit Health Branch.

23 **MS. JOËLLE PASTORA SALA:** My question was
24 specifically whether you would agree that there continues
25 to be a gap on -- between off and on reserve for those

1 services.

2 **DR. VALERIE GIDEON:** It's too general a
3 question for me to answer definitively. There are areas
4 where actually there are a higher per capita level of
5 investment in First Nations communities than in an
6 off-reserve context, so it's a very complicated question to
7 answer.

8 **MS. JOËLLE PASTORA SALA:** What about with
9 respect to infrastructure?

10 **DR. VALERIE GIDEON:** So, again, comparing
11 the building of a hospital in Winnipeg to a building, you
12 know, a primary health care facility in an isolated
13 context, it's a difficult comparison to make. What I would
14 say is that the level of health care infrastructure that's
15 needed across First Nations communities is not yet
16 adequate.

17 **MS. JOËLLE PASTORA SALA:** Okay. I'm going
18 to come back to this theme a little bit later. Some of my
19 colleagues have already mentioned or have asked you
20 questions about Jordan's Principle. And Jordan's Principle
21 relates to the provision of services for First Nations
22 children, correct?

23 **DR. VALERIE GIDEON:** Yes.

24 **MS. JOËLLE PASTORA SALA:** I'm wondering if
25 you could confirm whether or not Jordan's Principle applies

1 to jurisdictional disputes or gaps of services to First
2 Nations adults.

3 **DR. VALERIE GIDEON:** Jordan's Principle
4 currently applies to children.

5 **MS. JOËLLE PASTORA SALA:** To your knowledge,
6 does your department or Indigenous Services Canada, are
7 they considering the creation of a principle akin to
8 Jordan's Principle which would prevent jurisdictional
9 disputes or hot potato games for First Nation adults living
10 on and off-reserve?

11 **DR. VALERIE GIDEON:** I don't have any
12 knowledge of those discussions occurring.

13 **MS. JOËLLE PASTORA SALA:** You spoke briefly
14 about the funding agreements or models for the provisions
15 of health services. Can you confirm how the funding is
16 identified, and specifically I'm wondering if you could
17 clarify whether funding is established based on population
18 or based on needs?

19 **DR. VALERIE GIDEON:** It's a combination of
20 both. So it is -- as I mentioned, there are 114 programs
21 that are funded through the First Nations Inuit Health
22 Branch, and they vary with respect to how funding was
23 initially provided. I mean, these are through decade-long
24 processes. So while many programs were initially per
25 capita-based, there were changes made in the '80s where it

1 included factors of isolation, for instance, or remoteness
2 through the Berger formula. We also now include factors
3 such as an aging population, for instance, through the home
4 and community care program. So there are a variety of
5 mechanisms through which funding has been allocated. Most
6 recently, in Budget 2017, for instance, four initiatives
7 relating to infectious diseases, we did look at disease
8 incidents. So, for instance, around tuberculosis, the
9 incidents of tuberculosis would drive the extent of
10 investment in certain regions. So it is more complicated
11 than just a per capita allocation.

12 **MS. JOELLE PASTORA SALA:** And where would one
13 go to to find out whether or not the allocation of services
14 is based or funding is based on funding or needs? Where
15 does one look?

16 **DR. VALERIE GIDEON:** Well, we would certainly
17 be able to provide that information. We do it through our
18 senior management table. But because there's been
19 information over many years of periods, the individuals that
20 would have had that information at the Assembly of Manitoba
21 Chiefs, for instance, may have moved on, and it's hard to
22 find that particular source. So it's something that we
23 could -- that we would provide based on requests from First
24 Nations.

25 **MS. JOELLE PASTORA SALA:** Is it written?

1 Like, in a policy anywhere?

2 **DR. VALERIE GIDEON:** It -- we don't have one
3 consolidated document.

4 **MS. JOELLE PASTORA SALA:** I'd like to ask you
5 a couple questions on non-insured health benefits. Is it
6 correct to say that this is a program that exists as a last
7 resort to capture those things that are not covered by other
8 programs?

9 **DR. VALERIE GIDEON:** I would say that I would
10 use the term "supplementary health benefits," so absolutely
11 there are benefits that are not covered through provincial,
12 territorial, or private insurance or employers' programs.

13 **MS. JOELLE PASTORA SALA:** My client is being
14 told by First Nations in Manitoba who are members -- or
15 citizens of their member nations that the province and
16 private insurance companies are also stating that their
17 programs are of last resort. Is this something you could
18 comment on or are familiar with?

19 **DR. VALERIE GIDEON:** I am familiar with
20 certain jurisdictions doing that. There is -- we don't have
21 a -- a -- we coordinate with other insurance plans where
22 that is possible, and where it is not possible, we will
23 provide the benefit.

24 **MS. JOELLE PASTORA SALA:** I'm just -- I do
25 have a lot more questions for you. I'm just going to ask

1 you one more. You mentioned some examples of increased
2 First Nation and Inuit control over the design, planning,
3 delivery, and evaluation of community programs and services.
4 I'm wondering if your department has established benchmarks
5 or targets to ensure equity in all of the regions in terms
6 of co-management or governance approaches to ensure
7 consistency.

8 **DR. VALERIE GIDEON:** We have not. We would
9 have to do that, obviously, with First Nations. In fact,
10 they would -- we would look to them to be able to do that,
11 because it would not be appropriate for us to tell them how
12 to govern within their own voices and their own leadership
13 models. I think we have been receptive to whatever model
14 works for them in terms of governance.

15 **MS. JOELLE PASTORA SALA:** Thank you.

16 **DR. VALERIE GIDEON:** Thank you.

17 **JACKIE ANDERSON, Previously Affirmed:**

18 **CROSS-EXAMINATION BY MS. PASTORA SALA:**

19 **MS. JOELLE PASTORA SALA:** Ms. Anderson, you
20 spoke briefly about the large proportion of your sisters who
21 have had the -- that you've had the opportunity to work with
22 who are former or current children in care, correct?

23 **MS. JACKIE ANDERSON:** Yes.

24 **MS. JOELLE PASTORA SALA:** And you spoke --
25 and you gave us one example of the 14-year-old girl who had

1 been in 103 placements.

2 **MS. JACKIE ANDERSON:** M'hm.

3 **MS. JOELLE PASTORA SALA:** I'm wondering
4 whether you could provide additional information on the link
5 that you have observed between child welfare and missing and
6 murdered Indigenous women and girls.

7 **MS. JACKIE ANDERSON:** Oh. That'd be a --
8 well, again, I guess when you're looking at, you know,
9 specialized services, that was one of the indicating factors
10 from our advisory council that were young women or adults at
11 the time when we were developing our two homes, is that
12 their -- their risks, they felt, were extremely high when
13 they were young and in care of Child and Family Services,
14 being taken care of by caregivers that had no ability to be
15 able to help them get away from the perpetrators or to start
16 their healing or to have any understanding of what their
17 needs were.

18 So when I -- when I think about that and I
19 hear the stories, you know, that they have shared about, you
20 know, running from placements, as Christine mentioned
21 earlier, you know, being threatened and told she was going
22 to be locked up in secure care, how that increased her risk
23 of going underground, which increased her vulnerability to
24 be trafficked. You know, whether provincially or
25 nationally. There's -- there's huge impacts to that, and at

1 the end of the day, it's about delivering strength-based,
2 relationship-based care through an Indigenous lens of -- of
3 survival for our young people, what they need.

4 **MS. JOELLE PASTORA SALA:** That's great. I
5 was going to ask you about recommendations, and I'll ask you
6 if you wanted to add to that, but before, because my time is
7 almost up, I just wanted to thank you for mentioning the
8 work of the AMC and Our Circle to Protect.

9 **MS. JACKIE ANDERSON:** Yes, it was wonderful
10 work.

11 **MS. JOELLE PASTORA SALA:** And I wanted to ask
12 you about whether you had any recommendations for the
13 Commission, whether flowing from that work or from what
14 you've just spoken about on child welfare, just to provide
15 you that opportunity.

16 **MS. JACKIE ANDERSON:** I -- I just think
17 again, like, I'm -- I haven't touched base with AMC over the
18 last little while since they've done their Phase 3, but
19 again, one of the things that I had recognized when I was
20 going into the community is that our communities have such
21 beautiful strengths, but they need a lot more awareness and
22 they need to be mobilized and they need to be within their
23 communities, in control of those community action plans.
24 And I know that there was recommendations that were made in
25 Phase 1, but I'm not sure if those were supported, because

1 of lack of funding. You know, such as developing tools in
2 the language of that community. You know, again, awareness
3 training on internet. All of those, again, all of those --
4 if we're going to go to a community and ask them what their
5 needs are, we need to be able to provide the resource to do
6 so, to empower them to be able to sustain that protection
7 within their community of their children.

8 **MS. JOELLE PASTORA SALA:** Thank you all.

9 **MS. JENNIFER COX:** Commissioners, it's nearly
10 five o'clock. We have four parties, including Commission
11 counsel, left to do cross-examination, we have closing
12 ceremonies ...

13 **(SHORT PAUSE)**

14 **CHIEF COMMISSIONER MARION BULLER:** We've
15 decided to continue. We'd like to hear from at least two
16 more parties. That will take us to approximately 5:30.

17 **MS. JENNIFER COX:** The next party has 17
18 minutes and then they're in. So it'll probably be closer to
19 quarter to six or so. The next party is Nishnawbe Aski
20 Nation, Grand Council Treaty 3, Treaty Alliance Northern
21 Ontario, with 17 minutes.

22 **MS. KRISTYN ORDYNIEC:** Good afternoon to the
23 Commissioners, Chief Commissioner, Commissioners. I'd like
24 to once again acknowledge on behalf of our clients, Grand
25 Council Treaty 3 and Nishnawbe Aski Nation, the Treaty 7

1 territory as well as the Métis Nation Region 3. I'd also
2 like to acknowledge that with me to this point was Nishnawbe
3 Aski Nation Deputy Grand Chief Anna Betty Achneepineskum,
4 who unfortunately had to leave to get back home.

5 I'd like to echo what my fellow parties
6 withstanding had to say about Ms. Anderson and Ms. Dumaine's
7 testimony today. Thank you on behalf of myself and my
8 clients for your strength and transparency today.

9 **JACKIE ANDERSON, Previously Affirmed:**

10 **CROSS-EXAMINATION BY MS. ORDYNIEC:**

11 **MS. KRISTYN ORDYNIEC:** I just have one
12 question for Ms. Anderson. When you have been working on
13 the development of your -- the safe house, did you work with
14 government partners as you were working towards your goals?

15 **MS. JACKIE ANDERSON:** Yes, to a degree
16 because, again, we're -- we're funded through the province,
17 so we were assigned a residential care licensing specialist.
18 So when we were out looking and seeking for a potential
19 property, we needed to have them with us to be able to
20 identify risk, and what would need to happen to that
21 environment in order to fit to residential care licensing
22 standards.

23 **MS. KRISTYN ORDYNIEC:** Right. And are there
24 any challenges you would identify from working with
25 -- within government agencies you might be able to provide

1 best practices for for other organizations that may be --
2 that may have similar goals?

3 **MS. JACKIE ANDERSON:** I think, again, it's
4 -- it's important that you know, because we -- we have such
5 a strong strategy within our province that there's, you
6 know, a relationship between the community and through our
7 -- our partners within the province, but I think what
8 -- what we always need to keep in mind is that if -- if
9 things need to be discussed for potential change that needs
10 to be discussed at the community level.

11 **VALERIE GIDEON, Previously Affirmed:**

12 **CROSS-EXAMINATION BY MS. ORDYNIEC:**

13 **MS. KRISTYN ORDYNIEC:** Thank you, thank you
14 again. The remainder of my time, I'm going to ask
15 Dr. Gideon some questions, and given your testimony, so far,
16 I probably already know the answer to this, but are you
17 familiar with Nishnawbe Aski Nation and Grand Council Treaty
18 3 Territory, and the historical and current challenges faced
19 there, with respect to health services?

20 **DR. VALERIE GIDEON:** I certainly have had the
21 privilege of working with many communities and leadership
22 within both Treaty 3 and NAN, but I would never presume to
23 fully know the challenges that they're experiencing.

24 **MS. KRISTYN ORDYNIEC:** Thank you. And -- and
25 I just wanted to make sure that -- that you were aware of

1 the location that I am speaking of.

2 DR. VALERIE GIDEON: Yes.

3 MS. KRISTYN ORDYNIEC: Thank you. And you're
4 aware over the last number of decades that there'd been
5 suicide crises declared in NAN territory and Grand Council
6 Treaty 3 territory, but also across the country?

7 DR. VALERIE GIDEON: Yes, I am aware.

8 MS. KRISTYN ORDYNIEC: Okay. And I -- I
9 think that your early -- your earlier testimony referred to
10 recent suicide crises as one of the catalysts for the NAN
11 Charter of Relationship Principles that was executed.

12 DR. VALERIE GIDEON: That's what was
13 communicated to me by Nishnawbe Aski Nation leadership.

14 MS. KRISTYN ORDYNIEC: Sure, thank you.
15 Earlier, we heard from AFN council regarding the Wapekeka
16 tragedy, which Wapekeka is a NAN community. So I'd just
17 like to clarify for the record, that in the summer of 2016
18 the survivors of suicide proposal was submitted to the
19 government, and in the summer of 2017 the tragedy struck in
20 Wapekeka. Thereafter, Wapekeka was provided funding.
21 Previously, in response to a question Mr. -- Mr. Blain
22 posed, you said, "It would not be for us, meaning the
23 government, to declare an emergency in First Nation
24 communities. It's up to them to do that." Is that correct?

25 DR. VALERIE GIDEON: That's correct. And

1 there is several Nishnawbe Aski Nation communities that have
2 declared states of emergency specifically related to
3 suicide.

4 **MS. KRISTYN ORDYNIEC:** Correct. So I -- I
5 say all that to ask you to explain a government response
6 that seems to wait for a First Nation to declare a state of
7 emergency before it acts.

8 **DR. VALERIE GIDEON:** That's to declare the
9 state of emergency. It doesn't mean that the government
10 wouldn't proactively support communities if they identified
11 risk factors and -- and brought those forward. I think we
12 do try and collaborate with communities as much as possible
13 with respect to supporting them, to address needs.

14 **MS. KRISTYN ORDYNIEC:** Sure. Just unpacking
15 that a little bit, there have been suicide crises over the
16 past number of decades, and there are risk factors that are
17 known, so I -- I wonder if in response a community -- how it
18 sees that it continues to have to declare a state of
19 emergency before it's provided funding, and specifically I
20 refer to Wapekeka.

21 **DR. VALERIE GIDEON:** So Wapekeka did have
22 funding for mental wellness services through a block
23 agreement, which is the highest level of flexible agreement
24 we have outside of a grant process. Prior to the crisis,
25 they had a multi-year funding agreement that enabled them to

1 allocate resources based on their targeted priorities and to
2 carry over funds from year to year. They did have funding
3 as part of that agreement for the survivors of suicide,
4 annual gathering that they organized, but the proposal that
5 they had sent in was for supplementary youth mental health
6 counsellors. I think we have now a tracking system within
7 the regional office to make sure that these proposals are
8 addressed through Jordan's Principle, and specifically the
9 Choose Life initiative, which Nishnawbe Aski Nation designed
10 in collaboration with us, but it was through their
11 initiative. And that was submitted to the Tribunal as a
12 consent order --

13 **MS. KRISTYN ORDYNIEC:** Right.

14 **DR. VALERIE GIDEON:** -- and a response to
15 Jordan's Principle on the decision.

16 **MS. KRISTYN ORDYNIEC:** And that was because
17 there was a court order that orders that -- that sort of
18 funding; that's correct?

19 **DR. VALERIE GIDEON:** Choose Life, actually,
20 was initiated outside of a specific order. We developed it,
21 well, based on NAN coming forward and requesting us to
22 participate in that process, and NAN submitted it or asked
23 us to participate in the consent being submitted to the
24 Tribunal.

25 **MS. KRISTYN ORDYNIEC:** I'd like to move on to

1 -- to another segment, in respect of suicides have led to a
2 number of inquests into deaths of -- of Indigenous youth;
3 are you aware?

4 **DR. VALERIE GIDEON:** Yes. In Pikangikum, and
5 I believe also -- I'm aware of the one in Pikangikum in
6 particular, and also in Thunder Bay there was also a
7 Coroner's Inquest with respect to youth.

8 **MS. KRISTYN ORDYNIEC:** That's right, and I'm
9 just going to ask on a general basis --

10 **DR. VALERIE GIDEON:** Okay, sorry.

11 **MS. KRISTYN ORDYNIEC:** -- not in particular
12 to any -- any inquest. And you're aware that as part of the
13 inquest process, like this Inquiry, recommendations are made
14 and come out of the inquest?

15 **DR. VALERIE GIDEON:** Yes.

16 **MS. KRISTYN ORDYNIEC:** What is the government
17 policy on implementation of those recommendations, even
18 though they are not legally binding?

19 **DR. VALERIE GIDEON:** We have always, in my
20 experience in the ten years that I've been involved with
21 respect to Ontario and First Nation Inuit Health Branch,
22 proactively sought to address those recommendations.

23 **MS. KRISTYN ORDYNIEC:** And -- it -- would it
24 be then your position that Indigenous Services Canada if
25 there are recommendations that are directed to your branch

1 that come out of this Inquiry that you will also implement
2 those?

3 **DR. VALERIE GIDEON:** I can't speak on behalf
4 of the Minister, but I would say that we value the advice
5 and the recommendations that will be provided by
6 Commissioners, as we have done with the interim report, and
7 it is informing the consideration of the government
8 response.

9 **MS. KRISTYN ORDYNIEC:** Thank you. I -- I'd
10 like to move to -- and it still has to do with suicide. Are
11 you aware of how many youth healing centres there are in
12 northern communities, so communities that serve -- NAN and
13 Grand Council Treaty 3 communities?

14 **DR. VALERIE GIDEON:** I am aware of some of
15 the centres. I don't have a specific number in my head, but
16 we have been working with Treaty 3 leadership in particular
17 because there is a gap with respect to a specific child or
18 youth centre in that territory. And we are -- we have been
19 working with Nishnawbe Aski Nation and both Treaty 3 to look
20 at youth at risk and specific strategies, such as through
21 the Choose Life initiative as an example where there are a
22 lot of on the land initiatives that are being driven by
23 communities.

24 **MS. KRISTYN ORDYNIEC:** Right. So -- so it's
25 your position that going forward there are -- there are

1 certainly the intent that there would be youth healing
2 centres in -- in that -- those communities?

3 **DR. VALERIE GIDEON:** Yeah, so we -- through
4 the provincial government, they've recently gone through a
5 process of sending out a call for proposals for youth
6 treatment centres. They were able to fund a certain number,
7 but not all the requests. They have shared those with us to
8 see if we can provide resources for those centres that have
9 not been able to be funded, and we're in the process of
10 assessing those against the \$200 million that was just
11 recently announced in budget 2018.

12 **MS. KRISTYN ORDYNIEC:** Thank you. With
13 respect to collecting statistics on the tragedies of youth
14 suicide, is there a database with respect to those
15 statistics?

16 **DR. VALERIE GIDEON:** It's interesting. So
17 there isn't currently one database, but Grand Chief Fiddler
18 raised this when several NAN communities were going through
19 a crisis state in 2016 and '17, and we developed a specific
20 working group with Nishnawbe Aski Nation, the public health
21 agency and ourselves, and other provincial partners. In
22 order to explore a suicide surveillance system, the Public
23 Health Agency of Canada has developed a suicide surveillance
24 framework, and so we have been working in a tripartite way
25 to be able to look at the adaptation of that suicide

1 surveillance framework, specifically for NAN communities.
2 The Weeneebayko area health authority had a particular
3 interest. They had already launched a population health
4 data surveillance initiative, and so the public health
5 agency has visited them and is working with them initially
6 as -- as one of the areas of focus, so we've never forgotten
7 in our working to address that particular need that has been
8 highlighted several times by Grand Chief Fiddler.

9 **MS. KRISTYN ORDYNIEC:** Sure. And not only
10 in NAN and Grand Council Treaty 3 communities, but is that
11 an important aspect of the work that you're doing across
12 Canada?

13 **DR. VALERIE GIDEON:** We would absolutely
14 take the results of that particular initiative and broaden
15 it to look at how we could apply it nationally.

16 **MS. KRISTYN ORDYNIEC:** Thank you. We talk a
17 lot about what is culturally appropriate, and I -- and I
18 know that there are a lot of new policies, new government
19 initiatives that are coming out as we respond and as we
20 deal with -- with health initiatives going forward. Is
21 there any sort of definition in your policies that define
22 what is culturally appropriate?

23 **DR. VALERIE GIDEON:** I think the best
24 resource document would be the First Nations Mental
25 Wellness Continuum Framework From a First Nations

1 Perspective, and that was developed as a partnership
2 between First Nations representatives, First Nations mental
3 health experts and also departmental representatives. So
4 while it's not a policy, we refer to it a lot in our policy
5 documents.

6 **MS. KRYSYTN ORDYNIEC:** And I ask, would
7 "culturally appropriate" extend to include infrastructure
8 and not just the way a program may be delivered?

9 **DR. VALERIE GIDEON:** Yes, I would agree with
10 that, absolutely.

11 **MS. KRYSYTN ORDYNIEC:** My last set of
12 questions would focus around a situation that occurred
13 where an individual in a community required access to
14 mental health supports that were specialized, so that those
15 mental health supports were not available in the community.
16 And we've heard testimony throughout the community hearings
17 and throughout these expert hearings on how difficult it is
18 for some community members to travel to urban centres to
19 get those services, so the community decided to request
20 that the mental health professional come into the
21 community. And one of the responses received was that it
22 takes too long for me to be reimbursed, so I am not able to
23 come.

24 So I would ask if there is a certain -- a
25 government policy around reimbursement and specifically

1 providing services to the communities when they don't have
2 them?

3 **DR. VALERIE GIDEON:** Well, I'm surprised by
4 that situation because with registered mental health
5 providers we have regular ability to reimburse them for
6 expenses. However, we don't -- the majority of service
7 providers that are delivering mental health services are
8 not directly paid for by us, they are paid for through
9 First Nations organizations, Tribal Councils, Nishnawbe
10 Aski Nation, (indiscernible) through the Sioux Lookout
11 First Nations Health Authority, Kenora Chief's Advisory, so
12 it would depend on that particular situation.

13 I certainly can say to you that we are
14 always actively cognizant of the fact that we need to
15 promptly pay service providers in order to ensure that they
16 continue to be registered with the program and are
17 participating in the delivery of services to clients, and
18 that would include the Indian residential school health
19 support program.

20 But, for instance, Treaty 3 delivers that
21 program specifically to its members and there are health
22 authorities also in NAN and Treaty 3 communities that are
23 receiving those dollars directly so that they are able to
24 contract service providers that they choose and that they
25 feel are going to provide culturally competent services.

1 **MS. KRISTYN ORDYNIEC:** Right. And I would
2 suggest that this was not one of those situations where the
3 First Nation was able to provide their own services, but
4 thank you for your answer.

5 And just lastly, with respect to
6 specifically women's health and sexual assaults that may
7 occur in communities, and the necessity of gathering
8 evidence and information right away in those communities,
9 are -- are communities provided with necessary supports to
10 administer something like a rape kit?

11 **DR. VALERIE GIDEON:** The sexual assault
12 kits, so they are -- in some jurisdictions the RCMP
13 detachment has those kits and they were brought to the
14 primary health care facility. So, you know, depending on
15 how it's actuality regulated in the provinces, but in most
16 provinces those kits are actually housed in the primary
17 health care facility in the community.

18 **MS. KRISTYN ORDYNIEC:** And do you have any
19 information as to whether the nurses that are in those
20 communities are able to administer those kits, because I
21 understand that there's special training that is required
22 to do that?

23 **DR. VALERIE GIDEON:** Yes, so we have ensured
24 even as recently as last year again, we do monitor that to
25 ensure there is capacity in communities for sexual assault

1 kits to be utilized.

2 Now, that being said, there are many
3 community members who prefer to be flown out when they're
4 in that situation and they don't necessarily want to remain
5 in the community, so that is also a consideration. So if
6 the client consents and wishes to have those kits
7 administered in the community, we are -- we would be able
8 to do it in most cases, unless it's within the context of
9 the RCMP detachment having the kit or whichever, but it is
10 still -- we still run into the issue where clients don't
11 necessarily want that to be administered in the community.

12 **MS. KRISTYN ORDYNIEC:** Thank you. And I'll
13 just take my last few seconds to thank you very much for
14 the work that you do, and to everybody on the panel and the
15 Commission. Thank you.

16 **MS. JENNIFER COX:** The next party is
17 *Directeur des poursuites criminelles et pénales* in French.

18 **MS. ANNY BERNIER:** *Je vais d'ailleurs vous*
19 *laisser un peu de temps pour prendre le temps de mettre vos*
20 *écoutateurs, parce que je vais effectivement parler en*
21 *français.*

22 **MS. JENNIFER COX:** And 13 minutes,
23 Mr. Registrar.

24 **MS. ANNY BERNIER:** *Alors, bonjour. Anny*
25 *Bernier, Directeur des poursuites criminelles et pénales*

1 *pour le Québec, communément appelé DPCP.*

2 *Alors, d'abord un très grand merci à tous*
3 *les panelistes. Vous étiez extrêmement intéressantes.*
4 *J'aimerais d'abord préciser que le DPCP n'a pas de témoins*
5 *présents cette semaine. Par contre, nous avons... et*
6 *quand je dis nous, je parle au nom de l'organisation, bien*
7 *sûr... nous avons transmis une lettre aux avocats de la*
8 *Commission le 2 mai dernier. Si vous me permettez, je vais*
9 *vous lire les passages de cette... les deux premiers*
10 *paragraphes de cette lettre simplement pour vous mettre en*
11 *contexte. C'est une lettre qui a été envoyée dans le cadre*
12 *d'une demande de témoins potentiels pour les audiences de*
13 *cette semaine. Alors la lettre se lit comme suit :*

14 *« Au cours des dernières années, le DPCP a*
15 *mis sur pied et participé à différents*
16 *programmes visant l'accessibilité et*
17 *l'accompagnement de clientèles fragiles et*
18 *vulnérables à travers le processus*
19 *judiciaire notamment avec les victimes et*
20 *les personnes souffrant de problèmes en*
21 *santé mentale. Il va sans dire que ces*
22 *initiatives impliquent la collaboration de*
23 *plusieurs procureurs chez nous, mais*
24 *également de différents intervenants issus*
25 *du système judiciaire et du réseau de santé*

1 des services sociaux. Ainsi bien que le
2 DPCP souhaite collaborer activement aux
3 travaux de la Commission, sans obtenir
4 davantage de précisions quant aux programmes
5 sur lequel ou lesquels les commissaires
6 souhaitent traiter lors de cette audition,
7 nous ne sommes malheureusement pas en mesure
8 d'identifier le témoin approprié. Nous vous
9 soumettons néanmoins la liste des différents
10 programmes et directives pertinents du DPCP
11 en Annexe 1 afin de faciliter le travail des
12 commissaires en prévision de ces audiences
13 et de la rédaction du rapport final. »
14 Donc, cette lettre est malheureusement
15 demeurée sans réponse. Nous n'avons donc personne cette
16 semaine ici à faire entendre.

17 Alors, j'aimerais avoir votre autorisation
18 afin de pouvoir déposer en preuve la lettre et son annexe
19 puisque leur contenu contient une mine d'informations
20 pertinentes aux audiences de cette semaine.

21 Je crois humblement que, tel que le
22 mentionnait d'ailleurs Monsieur Phelps hier, les
23 commissaires devraient pouvoir avoir le plus d'information
24 pertinente possible pour dresser un portrait complet des
25 services gouvernementaux offerts pas l'ensemble des

1 *au provinces et territoires.*

2 *Je vous soumets le tout respectueusement,*
3 *conformément aux règles de pratique de la Commission, soit*
4 *le Legal Path. Je vous soulève les Règles 8 et 30 dans la*
5 *version anglaise et les Règles 11 et 31 dans la version*
6 *française. Il y a une petite incohérence au niveau de la*
7 *numérotation et aussi au niveau de la traduction, mais on*
8 *va rester avec les Règles 8 et 30 de la version anglaise,*
9 *si vous le souhaitez.*

10 *Les Règles, ce qu'elles disent, en fait,*
11 *c'est que Règles de pratique sont flexibles et que les*
12 *commissaires doivent pouvoir admettre tout élément de preuve*
13 *pertinent, et ce même si ces éléments de preuve ne seraient*
14 *pas admissibles devant un tribunal.*

15 *Également, que les Règles de preuve ne*
16 *doivent pas être appliquées selon leur sens stricte pour*
17 *déterminer leur admissibilité.*

18 *Par ailleurs, j'aimerais préciser que bien*
19 *qu'un document pour préciser les Règles de pratique,*
20 *notamment les Règles 56 et 66, a été transmis par les*
21 *avocats de la Commission vendredi dernier, soit après des*
22 *échanges qui ont eu lieu avec moi et les avocats. Ces*
23 *règles visaient notamment les ajouts suivants. Je fais*
24 *référence à l'article 56. La partie ajoutée était :*

25 *« La partie ayant qualité pour agir*

1 *doit présenter un document en preuve*
2 *pendant le contre-interrogatoire d'un*
3 *témoin ou d'un expert. »*

4 *Et la partie ajoutée à l'article 66 était...*
5 *cette partie est présente. Je lis le début de la phrase :*

6 *« Les parties ayant qualité pour agir*
7 *qui entendent déposer des documents à titre*
8 *de pièces pendant... »*

9 *Ici on a changé « les audiences » pour « le*
10 *contre-interrogatoire » :*

11 *« ...le contre-interrogatoire doivent*
12 *en remettre copie... »*

13 *Et cetera. Donc, deux portions ont été*
14 *ajoutées et modifiées. J'aimerais préciser qu'il s'agit de*
15 *droit nouveau qui est entré en vigueur vendredi, le 25 mai,*
16 *suivant des précisions des avocats de la Commission et que*
17 *cela ne figure pas dans les Règles de pratique de la*
18 *Commission.*

19 *En conclusion, en tout respect pour*
20 *opinion contraire, dans l'esprit de collaboration qui*
21 *caractérise cette Commission, je vous demande de permettre à*
22 *mon organisation, le Directeur des poursuites criminelles et*
23 *pénales du Québec, de pouvoir déposer en preuve la lettre et*
24 *l'annexe préparées pour éclairer les commissaires quant aux*
25 *services en santé mentale et aux victimes offerts par le*

1 *DPCP afin de permettre d'avoir le plus d'information*
2 *pertinente possible pour vous permettre de soumettre les*
3 *meilleures recommandations possibles.*

4 *Merci. Et, pardon, je voudrais*
5 *simplement souligner que j'ai naturellement respecté la*
6 *Règle 66 et j'ai communiqué mon avis d'intention de déposer*
7 *le tout comme preuve vendredi dernier.*

8 *Merci.*

9 **MS. CHRISTA BIG CANOE:** I would like to make
10 an objection, so I'm going to suggest we stop the time at
11 this point. And -- sorry. Commission Counsel would like to
12 make -- actually, I'll have two objections. The first
13 objection is a little more procedural. The intention of
14 cross-examination was to cross-examine. There was not a
15 motion properly put before you, but I believe that we should
16 just deal with the issue. So I don't want it to be on a
17 technical latch that this was not the proper form, nor was
18 there notice of the motion, nor was it presented as a motion
19 prior.

20 So I'm going to suggest that I make the
21 second objection, which is the objection to putting the
22 material in, and I would like to provide the reasons why.
23 Because they're not just unilateral, and I do respect -- and
24 I will stop just 'cause I noticed Commissioner Audette, do
25 you need your --

1 **COMMISSIONER MICHÈLE AUDETTE:** Yeah. Yeah.
2 No. I'm answering your questions.

3 **MS. CHRISTA BIG CANOE:** Okay. Perfect.
4 Thanks. So I would appreciate the opportunity to respond,
5 so the -- my objection on behalf of Commission Counsel is
6 the manner in which the exhibits being presented in this
7 form. And we understand and respect the cooperation that
8 the party is actually speaking to. And we don't believe
9 that -- that the documents are not important. They are
10 important, but there's other manners and means to put the
11 documents before the Commission.

12 So we did re-apply and I feel at a loss
13 because I just learned of this motion this afternoon. And I
14 feel unprepared in that I could have actual exhibits to
15 respond to it, but my -- my friend here has presented the
16 letter and she read the letter in, which you have received a
17 copy is because a reply to putting these exhibits in on
18 Friday was that there were other means and that there were
19 no witnesses that could answer specifically the questions
20 that this document arises, and therefore we recommended that
21 there were a number of other means to get the documents
22 before the Commissioners. And I undertook and did actually
23 provide the documents to the Commissioners via e-mail in
24 response first to my friend, and then forwarding a copy to
25 Commissioners.

1 whether national or international.

2 And then it lists particular reports. And
3 rule -- rule 33 actually gives you -- and I don't know if
4 you want the opportunity to turn up the rules. Gives you the
5 authority to rely on: (as read)

6 Pre-existing reports, studies and other
7 substantive materials as evidence to
8 make findings of fact as Commissioners
9 consider relevant to the discharge of
10 their mandate.

11 The documents that are being proposed is
12 essentially a document created by the party that lists the
13 programs they have. The ability to source it pursuant to
14 rule 66 will be difficult as these witnesses will not have
15 knowledge of those particular programs, nor would any other
16 prior or future witnesses being hauled here.

17 Having said that, you guys have the authority
18 and ability to receive report and give it weight. Rule 4 of
19 the Legal Path also -- and my friend had listed rule 8 --
20 and can you help me? I -- rule 8 and rule --

21 **MS. ANNY BERNIER:** 30.

22 **MS. CHRISTA BIG CANOE:** 30, thank you -- in
23 the French version which is 31 in the English. That in an
24 ordinary course -- so rule 31: (as read)

25 In the ordinary course, Commission

1 Counsel will call and question witnesses
2 to testify at the Inquiry. Counsel for
3 a witness may apply to the Commissioners
4 to lead witness' evidence in-Chief if
5 counsel is granted.

6 Is that the same rule that you intended?

7 **MS. ANNY BERNIER:** Pardon me?

8 **MS. CHRISTA BIG CANOE:** I don't know if
9 that's the same rule you intended to cite.

10 **MS. CHRISTA BIG CANOE:** (as read)

11 can accept any information as evidence
12 they decide will further object as of
13 National Inquiry, including where that
14 evidence might not be admissible in the
15 court of law. The strict rule of
16 evidence will not apply to determine
17 admissibility of evidence, except with
18 respect to the law of privilege
19 immunity and respect to the cabinet
20 confidences and statutory bars.

21 I do want to also bring up though two
22 important rules that have to be considered. The first one
23 is that rule 4: (as read)

24 All parties and their counsel agree to
25 follow the rules as a condition of their

1 standing.

2 That first part, but in rule 4: (as read)
3 Subject to the various governing laws,
4 the conducts and procedures to be
5 followed at the National Inquiry is
6 under the complete control and
7 discretion of the Commissioners.

8 Rule 8 states: (as read)

9 The Commissioners may receive any and
10 all relevant inference.

11 This is a permissive clause. This does not
12 say they shall receive. And so there -- although that the
13 rules speak to the fact that you don't have to accept it in
14 the same manner as a court of law would, there should be a
15 principle approach taken to evidence in terms of when we're
16 putting it to witnesses. So it's permissive, it's not
17 shall. And if we look at a broader principle of evidentiary
18 law and evidence, is there's -- and I'm talking broad
19 principles. I would like to have cases before you, or some
20 more authority, but on the short notice of the motion, I
21 have been unable to do so.

22 Essentially, the -- one of the broader
23 principles is that the material or evidence that goes before
24 a witness, they should be able to answer, or have knowledge
25 to speak to. So if she was to source the document to my

1 friends, and have them identify it, they would not be able
2 to identify it because the creation of her parties.

3 And then they may be able to review it, but
4 they wouldn't be able to speak to the intimate details of
5 those programs, because as my friend has shared, there's not
6 a member from her party that's actually on the panel of
7 witnesses.

8 One of my concerns is that they have ability
9 and opportunity to put this evidence to you in other manners
10 and means, and by putting it to the witnesses before us
11 today, it's not testable, so they won't be able to answer
12 questions. We won't be able to explore the documents in any
13 great detail. So in your weighing and balancing of the
14 credibility of the evidence before these witnesses no
15 different than if you were receiving them by virtue and
16 using your authority under 33 or by provision H, because
17 these witnesses will not be able to speak to that document.
18 It's no different than if they submitted to you through
19 another mechanism.

20 So putting it on the record -- and I'm not
21 saying the sky is falling here, but by submitting this
22 document in this particular process sets a precedent to
23 allow any party -- because every party, all 101 of them,
24 would have the ability -- and I believe in this part 2
25 portion, there's 82 parties of which we have 32

1 here -- would then be able to create a document that talks
2 to their programs and policies and submit it before any
3 witness that may or may not be able to answer questions,
4 and in this case would not be able to answer questions
5 about their programs.

6 I would suggest the better result is to
7 receive, absolutely receive it, but not in the context of
8 evidence that's going before you in this format, which is
9 to put evidence to witnesses and then have them answer
10 questions, because the proper way to do it on a principled
11 evidentiary basis is to make sure that questions can
12 actually be answered about the evidence that's going in in
13 this part of the process.

14 I do feel at a bit of a loss because I
15 would like to give you some more citation on authority on
16 this. Unfortunately, in the short duration and notice of
17 when the motion would come up, I have been unable to. So
18 for now, those are my submissions, and I thank you.

19 **Me ANNY BERNIER:** *Si vous me permettez,*
20 *simplement pour répondre à ma consœur, en fait, c'est un*
21 *peu... l'idée derrière tout ça c'est vraiment que nous*
22 *voulions collaborer. Personne ne nous a donné d'indication*
23 *pour pouvoir préciser quels témoins seraient pertinents.*

24 *Bien sûr nous aurions pu amener plusieurs*
25 *témoins, mais une semaine n'aurait pas été suffisante pour*

1 *les entendre et le Québec et l'ensemble des 10 autres*
2 *provinces et trois territoires, ainsi que toutes les*
3 *parties ayant statut qui voulaient se faire entendre.*

4 *Nous sommes dans une audience*
5 *institutionnelle pour les services gouvernementaux. Je*
6 *pense que l'objectif de la Commission comme telle c'est*
7 *vraiment de connaître les détails les plus pertinents pour*
8 *pouvoir vous guider.*

9 *Ma consoeur nous rappelle que les règles de*
10 *la preuve déposée devraient passer par un témoin. Ça ne*
11 *fait pas partie des règles de procédure de la Commission.*
12 *Elle nous réfère aux Termes de Référence, au cadre de*
13 *référence de la Commission comme tel. La lettre (h), je*
14 *m'excuse, je l'ai regardée rapidement tout à l'heure, je ne*
15 *trouve pas qu'il y a une grande pertinence au point que*
16 *j'apporte aujourd'hui.*

17 *Par ailleurs, la différence de pouvoir vous*
18 *soumettre un document pour considération suivant*
19 *l'article... la Règle 33, telle que mentionnée par ma*
20 *consoeur, oui, c'est certainement une façon de faire. Par*
21 *contre, ce n'est pas un document qui devient déposé en*
22 *preuve.*

23 *Et puisque nous sommes toujours dans*
24 *l'attente des règles qui entoureront le dépôt de mémoires,*
25 *s'il y a dépôt de mémoire, vous me permettrez de vous*

1 *suggérer à quel point ceci a de l'importance pour mon*
2 *organisation, que les éléments pertinents du DPCP puissent*
3 *faire partie de la preuve lors des audiences sur les*
4 *services gouvernementaux entendus cette semaine.*

5 *Merci.*

6 **MS. CHRISTA BIG CANOE:** So, sorry. I -- it
7 was my objection. She had the right to respond, but I have
8 a right to reply in relation to what she said, if I may
9 actually exercise that right? So I agree. And I'm not
10 sure if the translation was completely accurate. My
11 friend's reference to the rules. Do you mean, like, the
12 process for the next steps?

13 **MS. ANNY BERNIER:** À propos des closing
14 submission?

15 **MS. CHRISTA BIG CANOE:** Gentlemen. Yes. So
16 the rules -- the only reference to the rules in the -- in
17 the legal path in relation to a party's right as it relates
18 to closing submissions is in Section 25, which clearly
19 states there is a right. We have not yet actually provided
20 the procedure that will apply to parties with standing in
21 their closing submissions, but the closing submissions and
22 that process will be forthcoming.

23 Also, just -- just in reply to my -- my
24 friend's comments, there clearly is a Rule 66. So she did
25 meet it in terms of the duration, like the 48 hours'

1 advance notice, but we also did -- Commission counsel did
2 reply to that response, and we stated our position at that
3 time. We did not get notice of a motion until today.

4 And I don't disagree. We do want this to
5 be a cooperative process. So the objection I'm making is
6 not because I don't value that -- the contents may, indeed,
7 be very helpful for the party in their closing submissions
8 or to point to resources. But I still would suggest that
9 in this particular process where we're having witnesses
10 provide oral testimony and evidence on their knowledge,
11 it's not the appropriate forum. Thank you.

12 **CHIEF COMMISSIONER MARION BULLER:** Is the
13 expectation that this document will be identified or spoken
14 to by any of the witnesses? No? Okay. On that basis,
15 then, for today's purposes, anyway, I appreciate it's been
16 a very long day, and all of the witnesses are free to go
17 for the day. And we look forward to seeing all of you
18 again tomorrow morning at 8:30. So thank you very much
19 for --

20 **UNIDENTIFIED SPEAKER:** We'll sort this out
21 without you.

22 **CHIEF COMMISSIONER MARION BULLER:** Yeah.

23 **(LAUGHTER)**

24 **UNIDENTIFIED SPEAKER:** I have the answer.

25 **CHIEF COMMISSIONER MARION BULLER:** And we

1 need to caucus about this. We'll take about a ten-minute
2 break. Thank you.

3 --- Upon recessing 5:37 p.m.

4 --- Upon reconvening at 5:54 p.m.

5 **CHIEF COMMISSIONER MARION BULLER:**

6 Ms. Bernier, Ms. Big Canoe, thank you for your submissions.
7 We're not going rule on the motion today, of course. If
8 parties wish to provide submissions, if they have anything
9 to add to submission that have been made, we will accept
10 those submissions in writing through Commission Counsel,
11 and the deadline is 12 noon tomorrow for any written
12 submissions from parties on the motion.

13 And can I emphasize that's only if you have
14 anything to add to the submissions that have already been
15 made. There will be no further submissions by Commission
16 Counsel or Ms. Bernier. We will give our oral ruling by
17 the end of the -- by the end of this hearing, so by the end
18 of this week.

19 **MS. CHRISTA BIG CANOE:** May I just ask a
20 procedural question in relation to Ms. Bernier's seven
21 remaining minutes on cross-examination?

22 Am I to understand that she will be allowed
23 to use those to proceed with the witnesses before us
24 because she will now not be able to put these documents to
25 these witnesses, but will be putting them potentially,

1 based on your ruling, to other witnesses, so I just want to
2 ensure because her request was to put them before these
3 witnesses. These witnesses will be completed their chief
4 and cross-examination prior to your ruling.

5 **CHIEF COMMISSIONER MARION BULLER:** Okay.
6 Ms. Bernier, if you have further cross-examination -- or
7 any cross-examination, rather, of the witnesses that we
8 heard from today, you may use your seven minutes tomorrow
9 morning starting at 8:30.

10 **MS. CHRISTA BIG CANOE:** Thank you.

11 **CHIEF COMMISSIONER MARION BULLER:** Okay.

12 **MS. BETH SYMES:** May I address -- in your
13 absence there was a lot of discussion amongst the other
14 parties withstanding. I am not certain what is the nature
15 or scope of what is being requested or of what you are
16 considering. One of the questions is, what is the nature
17 and scope of Rule 33, which is other documents that have
18 not been identified by -- by a party.

19 **CHIEF COMMISSIONER MARION BULLER:**

20 Ms. Symes, I'm going to interrupt you because I want to
21 make it very clear that if there are further submissions
22 from parties we will accept those submissions, however they
23 must be in writing and we must receive them by 12 noon
24 tomorrow.

25 **MS. BETH SYMES:** Sorry, I'm not asking to

1 make submissions. What I'm simply asking is what is in
2 dispute because, depending upon what the issues are, we may
3 or may not want to make submissions. That's my question.

4 **CHIEF COMMISSIONER MARION BULLER:** Okay.
5 The -- as I understand them, the specifics of the motion
6 are -- or the --

7 **UNIDENTIFIED SPEAKER:** Objection.

8 **CHIEF COMMISSIONER MARION BULLER:** -- the
9 decision sought by counsel is that the documents in
10 question be admitted into evidence not through a witness at
11 a hearing. Is that correct?

12 **MS. ANNY BERNIER:** It is correct.

13 **CHIEF COMMISSIONER MARION BULLER:** Okay.
14 Thank you. And we will close for the day. We will
15 reconvene tomorrow morning at eight o'clock for our
16 wonderful opening. Thank you.

17 **MR. JASON GOODSTRIKER:** Thank you and
18 congratulations to a very successful day to all of the
19 Commission -- Commissioners. And I was -- I was just kind
20 of excited about this afternoon, sorry I had to step out
21 for a few moments, I had some work stuff to worry about,
22 but my two girls that came in here, they're teenagers,
23 they're 15 and -- one is older 15, the other one is
24 younger, but they're very special to me, like each and
25 every one of our children are special to us. But something

1 that nobody knows about is that I have six daughters and
2 adopted children I have 20 all together, so these
3 are -- you know, they're young people, they're very excited
4 and they were happy to come down and to sit and to listen,
5 even though it was a few moments. And hopefully if they
6 skip school tomorrow I'm going to ask them to come back.

7 **(LAUGHTER)**

8 **UNIDENTIFIED SPEAKER:** No good.

9 **MR. JASON GOODSTRIKER:** But it's very
10 pressing and thank you very much to all of the
11 participants, all of the staff members for a successful
12 day.

13 We will try our best again for tomorrow and
14 for Friday coming in the -- so what I would just like to
15 leave you all with, as many of you -- as it happens in all
16 of the gatherings where we go to, I always encourage people
17 to meet new people, meet new people that are important to
18 not only this process, but down the road.

19 A lot of you don't know that Valerie Gideon
20 and I, (indiscernible), we've been friends for nearly 20
21 years now, and this is a very, very important undertaking.
22 And you don't want to leave an event like this thinking,
23 gee, I wish I would have said something, I wish I would
24 have questioned this, I wish I would have (indiscernible)
25 conversation.

1 Anyway, in our closing I'm going to ask
2 these boys, this is -- these are -- we say Siksika
3 (indiscernible) they're the singers from Siksika, and one
4 thing that's very interesting about Blackfoot singing is
5 that many of our songs follow the contours of the land,
6 river ways, hills, mountains, and we have a unique melody
7 about our singing from -- that comes from (indiscernible).
8 We're very proud of it, so I'm going to ask the boys to --
9 just a good time song. (Indiscernible) that song. But
10 first off, I'm going to ask the Elders just to stand right
11 where you're at, and if you could say a closing prayer for
12 us. Again, I'm going to introduce Spike and Alvine Eagle
13 Speaker, Métis Elder, Henry (indiscernible), our Stony
14 Elder, my big brother there with the hat, that's, of
15 course, John Wesley, and he's an uncle of mine at the end,
16 the Elder from Tsuu T'ina. He's also the richest of those
17 Elder, Gerald Meguinis. He's got the most heart. Anyways,
18 come to Brave Eagle tonight, if you have time, or I'll ask
19 if you could just join with us and we're going to have a
20 word of prayer on behalf of our Elders. Okay.

21 **MR. SPIKE EAGLE SPEAKER, MS. ALVINE EAGLE**
22 **SPEAKER, HENRY, JOHN WESLEY AND GERALD MEGUINIS:** (Speaking
23 in Native language).

24 **MR. JASON GOODSTRIKER:** Louise, I'm sorry, I
25 don't want to leave out our Inuit Elders and our special

1 people that travelled here from such a far away away. I'll
2 you if you would help us to put out the -- the --

3 **COMMISSIONER MICHÈLE AUDETTE:** Qulliq.

4 **MR. JASON GOODSTRIKER:** Qulliq. Qulliq.

5 (Indiscernible).

6 **UNIDENTIFIED SPEAKER:** Getting there.

7 **MR. JASON GOODSTRIKER:** Okay. I'm getting
8 close. I'm -- I'm a bit better tomorrow.

9 **(LAUGHTER)**

10 **MR. JASON GOODSTRIKER:** So our Inuit Elder
11 Louise Haulli to help us (indiscernible).

12 **MS. LOUISE HAULLI:** Blow it.

13 **MR. JASON GOODSTRIKER:** Oh, okay.

14 **(LAUGHTER)**

15 **MR. JASON GOODSTRIKER:** I don't make
16 (indiscernible) grandmother, so. All right. Thank you.
17 Thank you to Louise. Thank you. Give her a round of
18 applause and to --

19 **(APPLAUSE)**

20 **MR. JASON GOODSTRIKER:** -- to the young Ms.
21 Gladue (phonetic) back there, thank you again. Okay. So
22 enjoy yourselves. We're going to sing a happy song. You
23 could open the doors, you could start packing up, whatever.
24 So have fun tonight, and enjoy Calgary.

25 --- Upon adjourning at 6:06 p.m.

LEGAL DICTA-TYPIST'S CERTIFICATE

1
2
3
4
5
6
7
8
9
10
11

I, Krystle Palynchuk, Court Transcriber, hereby certify that I have transcribed the foregoing and it is a true and accurate transcript of the digital audio provided in this matter.



Krystle Palynchuk

May 29, 2018