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

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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

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Calgary, Alberta

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

--- OPENING COMMENTS

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

(LAUGHTER)

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

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

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

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

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

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

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

--- DRUMMING CEREMONY

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

(APPLAUSE)

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

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

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

MR. SPIKE EAGLE SPEAKER AND MS. ALVINE EAGLE SPEAKER: (Speaking in Native language).

--- OPENING PRAYER

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

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

(APPLAUSE)

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

(LAUGHTER)

UNIDENTIFIED SPEAKER: Welcome, (indiscernible).

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

UNIDENTIFIED SPEAKER: Yes, thank you.

MR. JASON GOODSTRIKER: Welcome to Calgary.

UNIDENTIFIED SPEAKER: We're going to take

a break, so...

CHIEF COMMISSIONER MARION BULLER: We'll take a short break and reconvene at 8:30.

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

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

MS. JENNIFER COX: Good morning, everybody. My name is Jennifer Cox, and I'm Commission counsel for the National Inquiry Missing and Murdered Indigenous Women and Girls.

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

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

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

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

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

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

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

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

UNIDENTIFIED SPEAKER: The witness would prefer an affirmation.

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

DR. VALERIE GIDEON: Thank you.

VALERIE GIDEON, Affirmed:

CHIEF COMMISSIONER MARION BULLER: Thank

you, Doctor.

MS. JENNIFER COX: Ms. Turley.

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

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

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

EXAMINATION-IN-CHIEF BY MS. TURLEY:

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

DR. VALERIE GIDEON: Morning.

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

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

DR. VALERIE GIDEON: That's correct.

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

DR. VALERIE GIDEON: That's correct.

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

DR. VALERIE GIDEON: That's correct.

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

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

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

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

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

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

DR. VALERIE GIDEON: That is correct.

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

DR. VALERIE GIDEON: That's correct.

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

DR. VALERIE GIDEON: Yes, it is.

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

DR. VALERIE GIDEON: Yes, it is.

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

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

--- EXHIBIT NO. 24(a):

Biography of Valérie Gideon (one page)

--- PIÈCE NO. 24(b):

Biographie de Valérie Gideon (une page)

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

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

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

DR. VALERIE GIDEON: I was.

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

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

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

DR. VALERIE GIDEON: Yes.

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

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

--- EXHIBIT NO. 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)

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

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

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

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

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

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

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

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

DR. VALERIE GIDEON: Okay.

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

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

course, First Nations and Inuit government.

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

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

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

--- EXHIBIT NO. 26:

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

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

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

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

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

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

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

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

be offered, or delivered by FNIHB?

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

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

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

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

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

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

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

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

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

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

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

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

So we've adapted the model to whatever

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

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

decision-making at tables.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Alberta to begin that process.

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

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

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

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

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

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

DR. VALERIE GIDEON: M'hm.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

--- EXHIBIT NO. 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)

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

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

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

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

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

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

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

You know, obviously provincial health

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

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

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

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

treatment and 90 percent having viral suppression.

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

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

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

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

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

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

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

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

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

DR. VALERIE GIDEON: M'hm.

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

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

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

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

--- EXHIBIT NO. 28:

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

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

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

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

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

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

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

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

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

DR. VALERIE GIDEON: That's correct.

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

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

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

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

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

--- EXHIBIT NO. 29:

Indian Residence Schools

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

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

CHIEF COMMISSIONER MARION BULLER: No kidding.

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

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

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

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

DR. VALERIE GIDEON: M'hm.

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

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

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

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

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

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

DR. VALERIE GIDEON: Correct.

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

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

--- EXHIBIT NO. 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)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Funding, of course, is always an issue, and

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

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

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

Infrastructure also will be a big priority

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

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

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

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

MS. ANNE TURLEY: Thank you. Chief

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

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

--- EXHIBIT NO. 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)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

--- EXHIBIT NO. 32:

First Nations and Inuit Component of

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

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

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

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

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

CHIEF COMMISSIONER MARION BULLER: Okay.

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

MS. JENNIFER COX: Sure. Thank you.

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

MS. JENNIFER COX: Just not --

MS. ANNE TURLEY: -- just not about her evidence.

MS. JENNIFER COX: Yes.

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

(LAUGHTER)

MS. ANNE TURLEY: Thank you.

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

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

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

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

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

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

CHIEF COMMISSIONER MARION BULLER: A-I --

MS. JENNIFER COX: A-I --

CHIEF COMMISSIONER MARION BULLER: N-E?

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

CHIEF COMMISSIONER MARION BULLER: Thank you.

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

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

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

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

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

anything.

JACKIE ANDERSON, Affirmed:

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

EXAMINATION-IN-CHIEF BY MS. COX:

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

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

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

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

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

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

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

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

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

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

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

also worked for the Province of Manitoba, correct?

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

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

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

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

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

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

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

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

people absolutely need.

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

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

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

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

--- EXHIBIT NO. 33:

Tracia’s Trust: Manitoba Sexual

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. JACKIE ANDERSON: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

huge challenge for her.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

work that they're doing?

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

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

MS. JENNIFER COX: So in terms of attracting

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

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

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

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

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

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

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

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

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

But Family Group Conferencing within the Ma

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

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

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

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

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

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

rebuild their families.

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

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

MS. JACKIE ANDERSON: M'hm.

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

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

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

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

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

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

for our families.

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

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

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

MS. JACKIE ANDERSON: Right.

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

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

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

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

So Family Group Conferencing, now that it has

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. JACKIE ANDERSON: Yeah.

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

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

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

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

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

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

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

I just want to really quickly share with

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

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

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

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

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

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

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

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

MS. CHRISTINE DUMAINE: Yes.

CHIEF COMMISSIONER MARION BULLER: Thank you.

CHRISTINE DUMAINE, Affirmed:

EXAMINATION-IN-CHIEF BY MS. COX:

MS. JENNIFER COX: Before we start with

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We continued to drive to Saskatoon, we were

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

UNIDENTIFIED SPEAKER: Experiential.

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

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

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

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

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

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

who was locked up.

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

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

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

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

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

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

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

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

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

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

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

MS. CHRISTINE DUMAINE: What do you mean?

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

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

MS. JENNIFER COX: From drugs and alcohol?

MS. CHRISTINE DUMAINE: Yes.

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

CHIEF COMMISSIONER MARION BULLER: I --

MS. JENNIFER COX: So --

CHIEF COMMISSIONER MARION BULLER: Go ahead.

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

CHIEF COMMISSIONER MARION BULLER: Okay, then

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

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

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

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

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

MS. JACKIE ANDERSON: Yes.

MS. JENNIFER COX: So --

CHIEF COMMISSIONER MARION BULLER: Could I

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

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

CHIEF COMMISSIONER MARION BULLER: March 2014?

MS. JENNIFER COX: Yes.

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

--- EXHIBIT NO. 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)

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

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

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

--- EXHIBIT NO. 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)

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

VALERIE GIDEON, Previously Affirmed:

CROSS-EXAMINATION BY MR. WUTTKE:

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

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

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

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

DR. VALERIE GIDEON: Yes, I am.

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

DR. VALERIE GIDEON: That's correct.

MR. STUART WUTTKE: And what would that entail?

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

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

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

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

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

DR. VALERIE GIDEON: No.

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

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

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

DR. VALERIE GIDEON: It does not.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

But that being said, sometimes proposals are

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

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

DR. VALERIE GIDEON: That's correct.

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

DR. VALERIE GIDEON: Wapakika.

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

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

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

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

to access supplementary funding from their funding agreement.

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

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

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

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

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

were speaking about MKO?

MR. STUART WUTTKE: Yes.

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

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

JACKIE ANDERSON, Previously Affirmed:

CROSS-EXAMINATION BY MR. WUTTKE:

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

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

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

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

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

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

the funding to receive the services.

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

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

JACKIE ANDERSON, Previously Affirmed:

CROSS-EXAMINATION BY MS. LOMAX:

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

strategies for prevention of childhood abuse?

MS. JACKIE ANDERSON: Absolutely.

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

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

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

MS. JACKIE ANDERSON: Yes.

MS. VIRGINIA LOMAX: Would you agree with the

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

MS. JACKIE ANDERSON: Absolutely.

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

MS. JACKIE ANDERSON: As priority.

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

MS. JACKIE ANDERSON: Absolutely.

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

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

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

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

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

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

MS. JACKIE ANDERSON: Yes.

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

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

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

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

MS. JACKIE ANDERSON: Yes.

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

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

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

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

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

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

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

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

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

MS. VIRGINIA LOMAX: Natural resource extraction.

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

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

MS. VIRGINIA LOMAX: Yes. Mining, pipelines.

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

MS. VIRGINIA LOMAX: Yes.

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

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

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

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

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

MS. JACKIE ANDERSON: Thank you.

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

VALERIE GIDEON, Previously Affirmed:

CROSS-EXAMINATION BY MS. LOMAX:

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

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

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

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

particular for sure.

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

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

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

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

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

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

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

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

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

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

MS. VIRGINIA LOMAX: M'hm.

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

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

DR. VALERIE GIDEON: (Speaking in Native language).

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

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

JACKIE ANDERSON, Previously Affirmed:

CROSS-EXAMINATION BY MS. WEBER:

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

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

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

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

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

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

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

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

MS. LISA WEBER: Okay. In -- at least in the province I'm from, which is Alberta, I would assume Manitoba is similar, often when children come into care, in order to receive services, parents must give up some or -- and often all of their parental rights as a guardian in order for their child to receive services. Did I understand you correctly that in order to receive -- to have a -- a child or a girl come into your facility, that that is not an issue? The parent does not need to give up their guardianship rights?

MS. JACKIE ANDERSON: No, they do.

MS. LISA WEBER: They do need to?

MS. JACKIE ANDERSON: They need to -- well, I mean, they would sign a voluntary placement with the agency, which they still, as I mentioned, remain the guardian of the child. However, they now have an open protection file with Child and Family Services where they have a social worker and funding coming through the province to cover their costs.

MS. LISA WEBER: So is that requirement rooted in the provincial legislation, then, that they give up those rights?

MS. JACKIE ANDERSON: Yes, I believe so.

MS. LISA WEBER: And do you know if parents and children, especially if they're youth, are explained the legal implications of giving up those rights?

MS. JACKIE ANDERSON: Not necessarily, and/or if it's being explained, the language that's being used is not understandable to a parent and/or English may not be their first language. So we often will hear those stories from families after the fact, that they didn't understand what it was they were signing or participating in.

MS. LISA WEBER: And in your opinion, in order to receive services through your program or your centre, would it necessarily be -- would they need to give

up those rights?

MS. JACKIE ANDERSON: Unfortunately --

MS. LISA WEBER: If the province didn't have that requirement?

MS. JACKIE ANDERSON: -- the -- yeah. Unfortunately, because we're funded through the province, that is the way that the -- the funding agreement is established. However, I think it's very important that there's not -- not situations like this where children are having to. There should be funding allowed to support those parents, to be able to have services for their children without having to put their child in the system and having a file open on CFIS.

MS. LISA WEBER: Okay. One of the previous parties asked about, or made mention to the First Nations Child and Family Caring Society, litigation and the resulting focus or -- or provisions to -- to provide funding for prevention. And I'm just wondering whether, in providing the services that you do, whether or not you have yet seen any effects of that change in program funding from the Federal government.

MS. JACKIE ANDERSON: Not nearly enough, I can say that. I think more is needed, and, as I also mentioned, it can't be in, like, piecemeal funding. This is -- this is going to be, you know, an awareness that

needs to be happening forever, not just for a year or two years or a three-year pilot project.

MS. LISA WEBER: M'hm. You made mention of family group conferencing, which I know is also a concept or a practice that's used in -- in child welfare proceedings generally. I'm just -- just for clarity, is the family group conferencing you mentioned, is that specific to your organization or is that the group conferencing that occurs as part of a conventional child welfare file?

MS. JACKIE ANDERSON: Family group conferencing is the gift that was given to us directly from the Maori of New Zealand. Part of that gift was done through ceremony, and with that ceremony came great honour that we ensured that an Indigenous organization that doesn't have mandated status are the ones that facilitate and work with the family. I mean, it's common knowledge. A lot of our families are -- are -- have fear, you know, of Child and Family Services. And it's difficult for them to let down those fears and be able to work with them in a way that we can -- and -- and our ability to be able to help repair those relationships, to be able to work with all the different partners that need to be a part of that circle, to support this family.

MS. LISA WEBER: Do you know or is it your

experience that your family group conferencing is accepted by the Province as that component of their provision of services to the family or to the child?

MS. JACKIE ANDERSON: Yes. We have a very active Minister that is supporting and funding our initiative because the -- again, the expansion is still very new. We are working very hard right now with creating those partnerships and relationships and creating awareness on the model within all of our authorities and agencies within our Province.

MS. LISA WEBER: As part of your recommendations, Jackie, you said clearly that one of them was if -- if the law were followed. And I was wondering, in your experience, and you have a wealth of experience, if you could describe any new laws, perhaps, that need to be contemplated in addition to what is existing.

MS. JACKIE ANDERSON: Again, I'm not no expert in -- in that area, but I think my recommendations would probably be very harsh and -- but right now, what we do have that needs to be used is Bill -- Bill C-36. And that's a new bill over the last couple of years, but within our province we have a very active police force that are using this. And although it's not nearly as enough as what I would like to see at the end of the day for these perpetrators, it is a start. And these discussions need to

continue to happen to continue to be able to have that as a tool for police to be able to use and to be able to strengthen and -- and create newer laws that are a lot harsher that focus on the demand.

MS. LISA WEBER: Thank you. One of the issues that I often hear about, again, in Alberta, and I would assume it might be similar in Manitoba, is issues around the fact that there is a publication ban on the identity of children if they're receiving services, and I'm just wondering, given the nature of the work and services that your organization provides, whether or not that's ever been a -- if it's negatively impacted the ability to provide needed services or finding individuals who may go missing, as an example?

MS. JACKIE ANDERSON: Are you talking about if a child has gone missing or -- is that what you're referring to?

MS. LISA WEBER: Yeah, I'm referring to any legislative prohibitions on publishing the identity of person -- individuals, children, under age, and whether that's negatively impacted your ability to provide services?

MS. JACKIE ANDERSON: Not necessarily. I mean, there's a couple of things that, you know, when missing persons reports are going out they're identifying

them as a vulnerable child and youth. And although it's important that there's a response to be able to safely locate and bring our young people home, it's -- it's socially -- or it's on, you know, social media where perpetrators are also watching. Is that what you're referring to or --

MS. LISA WEBER: Yeah, whether or not there -- there has been a negative impact of the inability, for example, to publish the name or the identity of youth who may be missing?

MS. JACKIE ANDERSON: I don't think so.

MS. LISA WEBER: Okay. I know the focus of the Commission's work and your work is women and girls, and I am just wondering if you could comment in my closing question if you have any observations or knowledge about the situation of boys and men perhaps in your province and what's being done to address issues that they may be also --

MS. JACKIE ANDERSON: M'hm.

MS. LISA WEBER: -- feeling the impact of?

MS. JENNIFER COX: Those are -- that's a question that's sort of beyond the scope of the mandate of the National Inquiry.

MS. LISA WEBER: Okay, so she's not going to answer that then?

CHIEF COMMISSIONER MARION BULLER: Is this an official objection?

MS. JENNIFER COX: I guess it is, yes.

CHIEF COMMISSIONER MARION BULLER: Stop the clock, please, and submissions.

MS. LISA WEBER: Thank you very much. Those are all my questions. Thank you.

CHIEF COMMISSIONER MARION BULLER: And for the record --

MS. LISA WEBER: I'm sorry, I forgot to tell you my name yesterday too. Lisa Weber, counsel for the --

CHIEF COMMISSIONER MARION BULLER: That's okay, you're consistent.

MS. LISA WEBER: Thank you.

COMMISSIONER QAJAQ ROBINSON: Can we have that explained a little bit more, why the objection?

MS. JENNIFER COX: Why did I object?

COMMISSIONER QAJAQ ROBINSON: Yes.

MS. JENNIFER COX: Because it's beyond the scope of the terms --

COMMISSIONER QAJAQ ROBINSON: No, I know how, but she asked how are -- because -- perhaps it was because I wasn't sure exactly the scope of the question. I'm just wondering, we've heard about the need to educate boys, we've heard the needs to include men, so I wasn't

sure if your question was about violence that the boys are experiencing or their role in the situation?

MS. JENNIFER COX: Yeah, is it a follow-up, I guess, would be -- yeah, and that would be a proper question. I wouldn't object to that.

MS. LISA WEBER: Fair enough. I just wondered in her experience because Jackie has a wealth of experience, clearly, and I was just wondering if she had any closing comments that she might be willing to make just in regards to boys and men in Manitoba and the experiences they are having?

MS. JACKIE ANDERSON: Could I answer?

MS. JENNIFER COX: Yes.

MS. JACKIE ANDERSON: Okay, I'm completely comfortable with answering that as well because often our little brothers are forgotten, you know, and unfortunately it is something that we come across every day, where young boys are also being exploited and being hurt and harmed, and I think that a lot more work needs to be done to also be able to address some of the special needs that our young -- our young men need to have as it relates to the violence and exploitation they are experiencing.

There was research that was done, and I can't say what year it is, but it's called Under the Radar, I believe it is, and it was done by Dr. Sue McIntyre who

travelled across Canada and held summits and spoke to boys and men who were also being affected through exploitation.

MS. LISA WEBER: Thank you very much. Those are all my questions. Thank you, Commissioners.

MS. JENNIFER COX: So the next party is Awo Tran Healing Lodge Society.

VALERIE GIDEON, Previously Affirmed:

CROSS-EXAMINATION BY MR. BLAIN:

MR. DARRIN BLAIN: Good afternoon, Chief Commissioner Buller, Commissioners, panelists, my friends in the legal profession and the people behind me who are representing parties. My name is Darrin Blain and I'm a lawyer in private practice here in Calgary. I've just finished my 800th Indian residential school hearing. And I don't tell you that to play my violin, I tell you that because I might be talking about some perspective that I've gotten from that process.

I'm also a proud member of the Peguis First Nation in Manitoba, which I'm sure a couple of you on the -- on the board have heard about, so thank you for having me.

To the representative from Health Canada, good afternoon. Would you agree with this statement: That the physical, emotional and spiritual health of the Aboriginal women and girls in this country, and how those

are not being met by your agency and other agencies that are responsible for delivering them, constitute a national emergency, or they are of national emergent concern?

DR. VALERIE GIDEON: So I just wanted to clarify that I'm not with Health Canada, just for the record, I'm with the Department of Indigenous Services Canada under the First Nations Inuit Health Branch.

I would say that it wouldn't be for me to define that, it would be for Aboriginal women and girls to define that from their own experience with respect to -- and from the leadership in the communities and First Nations Inuit and Métis organizations.

MR. DARRIN BLAIN: So your organization or who you work for, doesn't -- you wouldn't call that of national urgent concern?

DR. VALERIE GIDEON: It would not be for us to declare an emergency. For instance, in First Nations communities, First Nations communities have sometimes declared emergencies due to social crises, it would be up to them to do that. It wouldn't be something that we would feel that we would have the mandate to do.

MR. DARRIN BLAIN: Do you think that this issue of the health of First Nation women and girls in this country ought to receive principal discussion by these Commissioners in their report?

DR. VALERIE GIDEON: It isn't for me to say what the Commissioners should be focussing on in the report. My job is to provide evidence and advice, if asked, on specific issues, but I certainly would not pretend to tell the Commissioners what they should or should not be focussing on.

MR. DARRIN BLAIN: And do you agree with me that we ought to be hiring more First Nation nurses, doctors and psychologists in this country?

DR. VALERIE GIDEON: Absolutely. I would agree with that.

MR. DARRIN BLAIN: And can we make that a joint recommendation to the Commission?

DR. VALERIE GIDEON: I would certainly --

MR. DARRIN BLAIN: Because I agree with it.

DR. VALERIE GIDEON: -- support the recommendation that there needs to be more Indigenous health human resources. In fact, that's a recommendation that the Royal Commission on Aboriginal Peoples made in the '90s -- or, sorry, in 2006, and they actually called for, if I believe it, 10,000 Indigenous health human resources professions to be trained by that point in time. They had specified a target.

MR. DARRIN BLAIN: And do you agree with me that First Nations women and girls represent, in a lot of

cases, the most vulnerable segment of our society, and they really deserve the best care with the most talent? Would you agree with that?

DR. VALERIE GIDEON: The evidence definitely shows that First Nations women and girls are often at risk, at greater risk, of -- from health conditions to other social issues and factors, absolutely. There is a growing body of evidence that demonstrates that.

MR. DARRIN BLAIN: And to the next part of that question, would you agree that they deserve the best -- the best medical talent this country has to offer?

DR. VALERIE GIDEON: I would agree that First Nations women and girls absolutely deserve attention in this country and quality services to address their needs.

MR. DARRIN BLAIN: Bear with me, please. You mentioned a 24/7 help line for people contemplating suicide that's available in French, English and I think you mentioned three or four First Nation languages; is that right?

DR. VALERIE GIDEON: The same languages that is -- that are used in the 24/7 line of the Commission.

MR. DARRIN BLAIN: Could it be a recommendation to the Commissioners that any 24/7 help line that is established or continues in this country to help

Aboriginal women and children, particularly girls, that are contemplating suicide be made available in every First Nation language in this country?

DR. VALERIE GIDEON: Are you asking me a question or you're making a recommendation to the Commission?

MR. DARRIN BLAIN: I'm asking if you agree with my recommendation.

DR. VALERIE GIDEON: I honestly don't know how feasible it would be for that to happen. But I certainly believe that in community, it would be -- it is important for First Nation women and girls to have access to services in their language to the maximum extent possible.

MR. DARRIN BLAIN: All right. Very well. Time is of the essence this afternoon. I've got some more questions here. I need to move on to the other presenters. Thank you for your comments.

JACKIE ANDERSON, Previously Affirmed:

CROSS-EXAMINATION BY MR. BLAIN:

MR. DARRIN BLAIN: Ms. Anderson. Good afternoon.

MS. JACKIE ANDERSON: Hi.

MR. DARRIN BLAIN: I think you know where I'm from, do you not?

MS. JACKIE ANDERSON: Peguis.

MR. DARRIN BLAIN: Yeah. Nice to finally meet you.

MS. JACKIE ANDERSON: (Indiscernible).

MR. DARRIN BLAIN: Bear with me, please. Have you attended the funerals of any of your clients that have slipped through the cracks and not made it through your program?

MS. JACKIE ANDERSON: Yes.

MR. DARRIN BLAIN: Do you feel like better funding and better resources may have prevented that?

MS. JACKIE ANDERSON: Absolutely.

MR. DARRIN BLAIN: Is that one of the recommendations to this Commission, that your program and programs like it receive the maximum funding available, and that the programs be reviewed and receive principal consideration by this Commission?

MS. JACKIE ANDERSON: I -- I think it needs to be a priority. We're here today to, you know, honour -- honour our victims, those that are still being victimized and those that we have lost. And yes, sadly, today I -- I sit here, and I've had to, you know, bury three of our little sisters. And, in fact, behind me on this wall, some of them are -- are behind us.

MR. DARRIN BLAIN: M'hm.

MS. JACKIE ANDERSON: M'hm.

MR. DARRIN BLAIN: You mentioned the effectiveness of something called the National Survivor Summit?

MS. JACKIE ANDERSON: Yes.

MR. DARRIN BLAIN: And is it a recommendation to the Commission that the National Survivor Summits be funded by Health Canada or a health agency of the Government of Canada, and that they receive significant and fulsome review?

MS. JACKIE ANDERSON: I can't say who would be responsible, I guess, for the funding piece of it. But when you look at, you know, the life of a survivor, the ongoing, it's -- health is absolutely a number one priority for the ongoing healing that they need. And in regards to that summit, that is an absolute need. And not, again, something that happens once every ten years. I believe it needs to be happening every year.

MR. DARRIN BLAIN: Let's make that a recommendation to the Commission today. Is that all right?

MS. JACKIE ANDERSON: M'hm.

MR. DARRIN BLAIN: Okay.

MS. JENNIFER COX: So for the purposes of the record, it has to be yes or no.

MR. DARRIN BLAIN: Oh. Sorry.

MS. JACKIE ANDERSON: Yes.

MR. DARRIN BLAIN: I have one more question for you, then I'll move on to Ms. Dumaine. Are you involved in criminal law. Are you involved in criminal law reform or are you being asked by the criminal law experts in this country about criminal law reform, and specifically, sentencing for these people that are preying on -- on the women and girls that you see?

MS. JACKIE ANDERSON: Not directly involved at that level. However, my involvement is education and awareness. As I mentioned earlier, it's important that, in the work that we do, that there is collaboration with police and all the different systems that we're needing in order to share what we're seeing and what we're experiencing and what needs to happen for our young people.

MR. DARRIN BLAIN: Okay.

CHRISTINE DUMAINE, Previously Affirmed:

CROSS-EXAMINATION BY MR. BLAIN:

MR. DARRIN BLAIN: Okay. Christine, good afternoon.

MS. CHRISTINE DUMAINE: Good afternoon.

MR. DARRIN BLAIN: I was impressed by your testimony, and I'm not sure you noticed this, but when you were speaking, the room went very quiet. And I think that everyone that I talked to was remarkably impressed by your

testimony.

MS. CHRISTINE DUMAINE: Thank you.

MR. DARRIN BLAIN: Thank you for being here. Thank you for being a survivor. Thank you for being a role model to the woman who's watching this on the internet right now from a women's shelter with bruises and a lack of hope. Thank you for speaking to her today. I appreciate that, and I'm sure that everyone in this room does.

MS. CHRISTINE DUMAINE: Thank you.

MR. DARRIN BLAIN: I had a couple of questions for you. I think something you said today was just the most -- the -- I'm going to -- when I -- when I conclude this week, I'm going to take something that you said with me that was remarkable. I'm just going to repeat it. "We need Indigenous-led homes run by people with experience that are First Nation." Now listen, here's the important part. "As they are the true experts." I just love what you said there. And I thought that was really telling about your own healing, and in many respects, you're the most important person giving evidence or comments today.

So I take it, then, that if we were to ask the Commissioners for something out of your testimony, that we would be asking them for funding or to make it a principle or a really important part of their report that

for women and girls in crisis, like you were, that they make available or consideration of the availability of Indigenous-led homes, just like you mentioned, and that funding ought to come for that so people don't need to worry about how to pay to get in there and how to run the organization, and that we source out the best Aboriginal talent to help people just like you were in their road to recovery. Are we asking the Commission for that today?

MS. CHRISTINE DUMAINE: Yes.

MR. DARRIN BLAIN: Thank you again for being here. The Commission. Good afternoon. Those are my questions.

MS. JENNIFER COX: So the next party with 13 minutes is ITK.

JACKIE ANDERSON, Previously Affirmed:

CROSS-EXAMINATION BY MS. ZARPA:

MS. ELIZABETH ZARPA: Good afternoon. I want to start -- start off and say I want to thank Treaty 7 Nation for allowing us to be here on their territory again all throughout the week. The Blackfoot and the Métis, thank you. And I also want to say thank you, too, for the wonderful testimony today and the questions. So I'm going to start -- going to start with you, Ms. Jackie Anderson and Ms. Christine Duhaine?

MS. CHRISTINE DUMAINE: Dumaine.

MS. ELIZABETH ZARPA: Dumaine. Oh, sorry. Okay. I -- I want to highlight a little bit about the experience that was expressed by you, Ms. Anderson, around Indigenous people who come from sort of rural northern areas, and they go into urban settings, and there's predators there. I -- I wanted to question whether there was any programs or any sort of initiatives that you're aware of that seeks to address the predatorial behaviour of those individuals that prey on vulnerable and young Indigenous women.

MS. JACKIE ANDERSON: Programs for the perpetrators or programs for the -- the young people coming in from rural?

MS. ELIZABETH ZARPA: I would like to speak to the experience of the predatorial behaviour, like the predators somehow being targeted in this experience. Are they -- are they targeted for -- to change their behaviours?

MS. JACKIE ANDERSON: The predators? Sorry. I --

MS. ELIZABETH ZARPA: Yeah.

MS. JACKIE ANDERSON: As -- as far as I know, the only program that is for predators or perpetrators is john school, and that's based on their first arrest. They have an opportunity to go to john

school. But there's no actual program specifically targeting the demand on changing behaviours or -- or confronting their behaviours and what they're doing to our young people.

MS. ELIZABETH ZARPA: And upon entering into this john school, are -- is there a -- criminal charged, or that you're aware of, or if you're not aware of that?

MS. JACKIE ANDERSON: I'm not totally sure. But I do know that if it's your first charge, you have the opportunity to pay a fine or go to john school. You also do have to pay for the -- the john school yourself.

MS. ELIZABETH ZARPA: And it's mandatory?

MS. JACKIE ANDERSON: Yes.

MS. ELIZABETH ZARPA: And is that, sort of, experience of looking, seeking of johns, is that something that's used extensively, say, in Winnipeg, around the place that you mentioned? Like, the areas where young Indigenous people hangout?

MS. JACKIE ANDERSON: M'hm.

MS. ELIZABETH ZARPA: Are -- is that, sort of, monitored to make sure that johns are not praying on young Indigenous women?

MS. JACKIE ANDERSON: I'm sorry. I don't know what your -- understand your question.

MS. ELIZABETH ZARPA: So is -- how do you --

how -- how -- in your experience --

MS. JACKIE ANDERSON: M'hm.

MS. ELIZABETH ZARPA: -- are johns, sort of, sought out? Are they --

MS. JACKIE ANDERSON: Being identified?

MS. ELIZABETH ZARPA: -- policed? Yeah.

MS. JACKIE ANDERSON: Oh, okay. Again, we have some very, very strong community outreach teams working on the front lines and working on the streets. And it's a collaborative approach of multiple organizations that are going in different areas within our city that we know are identified stroll areas that perpetrators are out seeking. So there's that collaborated, coordinated approach where licence plates of -- of vehicles that are coming into our communities that we know have no other reason why they should be in that community. We're tracking, we're doing suspect trafficking forms, and they are meeting weekly, these teams, and -- and giving this information over to the police.

MS. ELIZABETH ZARPA: Okay. And are -- are those -- are those volunteer, or are they funded?

MS. JACKIE ANDERSON: The outreach teams?

MS. ELIZABETH ZARPA: Yes.

MS. JACKIE ANDERSON: They are -- they are funded within different organizations.

MS. ELIZABETH ZARPA: Okay. Great. And you mentioned that some of the most vulnerable people are the ones who come from the north.

MS. JACKIE ANDERSON: M'hm.

MS. ELIZABETH ZARPA: And would you classify Inuit who travel to Winnipeg, they -- they're from the north?

MS. JACKIE ANDERSON: Pardon me? Who?

MS. ELIZABETH ZARPA: Inuit.

MS. JACKIE ANDERSON: Inuit. Yes.

MS. ELIZABETH ZARPA: Okay. And do you know if there is any specific programming for young Inuit women who go to Winnipeg who, say, are vulnerable as well? Or getting caught up in the systems?

MS. JACKIE ANDERSON: I do know that they do have a community centre specifically for Inuit families that are coming in. Our programs are -- are open to all Indigenous peoples.

MS. ELIZABETH ZARPA: Okay. Thank you so much.

MS. JACKIE ANDERSON: Thank you.

VALERIE GIDEON, Previously Affirmed:

CROSS-EXAMINATION BY MS. ZARPA:

MS. ELIZABETH ZARPA: Okay. So my next questions are for Ms. Gideon. So you mentioned that First

Nations and Inuit Health Branch includes First Nations and Inuit. Could you please elaborate to me what -- what that means? Who -- who classifies as Inuit?

DR. VALERIE GIDEON: Well, our mandate does include providing a number of programs and services to Inuit. It does work differently in the Inuit context because of Inuit land claim agreements, and the role of territorial governments. However, we do provide funding specific to Inuit for a variety of community health programs in the area of mental health, and the area of a -- a healthy child development, home and community care, and as well, Inuit have coverage for non-insured benefits regardless of where they live in Canada.

We have an Inuit health approach specifically within the First Nations Inuit Health Branch that we developed with ITK and the National Inuit Committee on Health in 2014 that spells out how we work collaboratively with Inuit land claim organizations across the country. And when we receive new investments, we work with the National Inuit Committee on Health and each of the individual land claim organizations to discuss how those resources would be best invested.

In Nunavut, we have a tripartite partnership table, so that NTI, the Government of Nunavut, and ourselves, discuss very openly working together to address

needs of -- of Inuit. In Nunavut, specifically, there is a tripartite MOU that was signed to support a ten-year funding agreement --

MS. ELIZABETH ZARPA: Right.

DR. VALERIE GIDEON: -- for Nunavut.

MS. ELIZABETH ZARPA: M'hm.

DR. VALERIE GIDEON: Which includes a lot of these programs and initiatives that I mentioned.

MS. ELIZABETH ZARPA: Okay. Wonderful. So with all of these different agreements, and these different strategies, and these different guidelines, and these different meetings, are there Inuit doctors that you're aware of?

DR. VALERIE GIDEON: I believe that there are a few. We do not employ physicians specifically that work in Inuit Nunangat. It's done through either a provincial, territorial, or an Inuit government. So my knowledge is more superficial with respect to who is providing direct service delivery in Inuit communities. But, I think, health human resources is a significant priority --

MS. ELIZABETH ZARPA: And --

DR. VALERIE GIDEON: -- within the context of Inuit Nunangat.

MS. ELIZABETH ZARPA: And would you agree that having individuals who have lived experiences in

northern regions, such as Inuit communities, are best equipped to deal with in the health system -- the population in which they're serving?

DR. VALERIE GIDEON: Hundred percent.

MS. ELIZABETH ZARPA: Right.

DR. VALERIE GIDEON: Especially, even just from the perspective of language.

MS. ELIZABETH ZARPA: Great. And are you aware of -- are there hospitals in Nunatsiavut?

DR. VALERIE GIDEON: There's not a hospital in Nunatsiavut. They have health centres, primary healthcare clinics, and -- that are -- that are run in partnership between the Nunatsiavut Government and the provincial government.

MS. ELIZABETH ZARPA: Okay. I'm actually going to ask if I can have a CBC news article entitled, "Montreal Boarding Home for Nunavik Medical Patients Over Capacity Since Opening." It's a CBC News article that was posted in July 2000 [sic] -- 2017. Have you seen this?

DR. VALERIE GIDEON: I only saw it today when it was handed to me.

MS. ELIZABETH ZARPA: Okay. I'm going to ask the Commissioners and counsel whether I can enter this as an exhibit?

CHIEF COMMISSIONER MARION BULLER: Is this by

consent?

MS. ANNE TURLEY: It's by consent.

CHIEF COMMISSIONER MARION BULLER: It is. Okay. Then the CBC article, "Montreal Boarding Home for Nunavik Medical Patients Over Capacity Since Opening," post July 25th, 2017 will be the next exhibit, which is, sorry, number 36. And while I have the mic, counsel's name for the record, please?

MS. ELIZABETH ZARPA: My name is Elizabeth Zarpa. Thank you.

--- EXHIBIT NO. 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)

MS. ELIZABETH ZARPA: So I'm going to quote on the last part. I'm just going to quote a couple of things from the article. And it says, Nunavik director sees load is, "Not sustainable." "Would like to see hospital built in Nunavik."

The idea of having a regional hospital in Nunavik is a must - it's a necessity -- because unless certain specialties are repatriated back to

Nunavik in a regional hospital, the number of our clients arriving will only be increasing.

I'm not entirely sure whether if the First Nations and Inuit Health branch deals directly with this; does it?

DR. VALERIE GIDEON: So Nunavik is under a land claim agreement. The Nunavik Health and Social Services Board is part of the provincial health system. So it is not directly related to the First Nations and Inuit Health Branch. The only thing that I would say is that boarding home capacity is a national issue.

With respect to patients coming from Inuit Nunangat, particularly with the high birth rate and prenatal escorts also requiring a lot of accommodation in urban centres. So I would say that we're aware of the needs for more accommodation for Inuit patients coming south or in Iqualuit for services, but we're not directly related to -- we're not directly linked to the care system in Nunavik because it's governed under the land claim agreement.

MS. ELIZABETH ZARPA: So because it's governed under the land claim agreement in its provincial jurisdiction, in order for them to put a hospital in, say, Kuujjuaq?

DR. VALERIE GIDEON: That's right. But we do

meet with them regularly to talk about what we can do to help support their needs in a partnership model. So we meet with Minnie Grey, the Executive Director of the Nunavik Health and Social Services Board. And I'm sure that we would be open to speaking with her about what her thoughts are on this matter.

MS. ELIZABETH ZARPA: And would you -- would you provide any suggestion in terms of how to make this process a little less administratively challenging for Inuit who want to build a hospital in Nunavik?

DR. VALERIE GIDEON: I mean, they are -- they are governing the health services in their particular territory under the land claim agreement, so I -- I just don't feel like I could provide or impose my advice to them.

MS. ELIZABETH ZARPA: And is it common in your experience that Inuit travel from, say, Iqualuit or Inuvialuit to go down south to go to the hospitals?

DR. VALERIE GIDEON: Absolutely.

MS. ELIZABETH ZARPA: So this experience in the CBC news article is something that's very common?

DR. VALERIE GIDEON: It is common, yes.

MS. ELIZABETH ZARPA: And it's not the jurisdiction of the First Nations or First Nations Inuit Health Branch to deal with this?

DR. VALERIE GIDEON: That's right. Not

specifically, no.

MS. ELIZABETH ZARPA: Okay. Thank you so much. That's all the questions I have today.

MS. JENNIFER COX: The next party is Independent First Nations and they have 17 minutes.

VALERIE GIDEON, Previously Affirmed:

CROSS-EXAMINATION BY MS. BEAMISH:

MS. SARAH BEAMISH: Hello, my name is Sarah Beamish, I'm counsel for Independent First Nations, which is a group of 12 Anishinaabe, Haudenosaunee and Oji-Cree First Nations. Thank you all for your testimony today.

I'd like to start with a few questions for Dr. Gideon. So, firstly, the projects about digital health technology, I think there's a lot of promising stuff in there, but from an IFN perspective there's one -- at least one barrier to implementing them that I want to ask you about.

So in some of the IFN communities a major barrier would be electricity. Some of these communities' electricity grids are basically maxed out, such that they can't even be building new houses at this point, so any new programs or services that would put significant demand in terms of electricity would be a problem.

So my question for you is whether the plans and efforts regarding digital health technologies have

anticipated this problem and whether there are any plans to deal with it?

DR. VALERIE GIDEON: So absolutely when we look at community infrastructure requirements, it absolutely is a consideration, and it's not just with respect to digital technologies, it's also with respect to construction of new health facilities, right? You also have to make sure that they -- the water plant, the waste water system, all of those elements of community infrastructure can sustain a new health facility, particularly if the capacity is maximized.

So, you know, it's -- within the context of Ontario, however, we have been successful, as I noted earlier, in terms of being able to make investments to increase connectivity through the fiber optic network, and that has seemed to work well for a number of northern and isolated communities across Ontario. But, of course, I'm not familiar with each situation of each of the Independent First Nations, but I recognize that community infrastructure is part of the -- could be part of the barriers to access for greater health care services, not just digital, but also new health care infrastructure in general.

MS. SARAH BEAMISH: Okay. So my next question is about dental care. I notice that in the

Exhibit 25 about the Non-Insured Health Benefits Program, it talked about providing coverage for medically necessary dental care. And in the Independent First Nations there are women who have had their teeth damaged or lost because of violence, and it affects their self-esteem and dignity, it affects their sense of wellbeing, it sometimes affects their ability to get employment.

They experience it as a major impact of violence on them and one that potentially increases their vulnerability to future violence, but they experience -- their experience in trying to get dental care in these situations has sometimes been that they can't get coverage for it because it's deemed to be a cosmetic issue rather than a medically necessary issue. So my question is whether currently you know if the -- if this health benefits program would fund repair or replacement in a situation where it was only deemed to be cosmetic?

DR. VALERIE GIDEON: The program that we have with respect to orthodontics I think is what you're referring to specifically, it absolutely is based on severe and functionally handicapped malocclusion. With respect to general oral health care services though, there are a number of dental services that are available, as well as preventative services, such as fluoride varnishes and a lot of sort of very basic accesses to dental services. 97

percent of the dental benefit doesn't require any predetermination whatsoever, and so it would -- I think that what would probably be the barrier that you're referring to would be in the case of orthodontic coverage, so it is based on medically required services.

MS. SARAH BEAMISH: Okay. Would you agree that coverage for tooth repair or replacement in the kind of situation I'm talking about, where there is -- where it is maybe a cosmetic issue, is -- would still be beneficial for Indigenous women's overall health and wellbeing?

DR. VALERIE GIDEON: I mean, the mandate of the program is based on medical necessity. The mandate of the program dates back to 1997 and -- and we used clinical criteria based on evidenced best practices. We have a national oral health advisory committee made up of independent experts that advise us with respect to coverage within the context of the benefit, so it really isn't about sort of my opinion, it really is on the basis of research evidence, evidence-based practice and independent advice from oral health experts, of which I am not one.

MS. SARAH BEAMISH: Okay. All right, I hope you can answer this next question, it's about sort of cooperation between the health care agencies and other parts of government. So as some background of what I'm -- to my question, in some IFN communities they see

that what appear to be non-health related decisions by other parts of government have significant health impacts that the health system is not always sort of prepared to address. So as one example of where that has happened, there was one remote IFN community where there was a high rate of use of an addictive drug by the residents there, and there was a bust by the police that abruptly shut down the communities sources of that drug, and as a result in the following days and weeks there was a sudden unplanned widespread experience of going through withdrawal --

DR. VALERIE GIDEON: M'hm.

MS. SARAH BEAMISH: -- and there weren't appropriate detox or other support services for the people there. And so their experience with this was that this -- this police intervention had caused a health crisis and had actually increased safety risks in the community.

So in that kind of situation, if the police had contacted health care officials in your agency or another federal agency, do you think that it's possible that a plan could have been made to proactively address those foreseeable health risks?

DR. VALERIE GIDEON: Absolutely. And, in fact, my experience early in my days at what was Health Canada -- we were part of Health Canada at the time, I ran the Ontario region with respect to First Nations Inuit

Health Branch, and in that period of time prescription drug abuse was extremely common, the use of Oxycontin in communities illegally, and we worked together with Nishnawbe Aski Nation police services in order to be able to ensure that we were providing community safety plans and the use of harm reduction measures, such as Suboxone, which is an opioid agonist treatment, available to support individuals to manage through their symptoms of withdrawal and also to manage their addiction and provide a safer environment for communities. And we were able to do that in a number of communities, isolated communities in northern Ontario that were affected so that we would prevent these types of measures.

I would absolutely agree that collaboration between multiple Federal, or Federal and provincial, or Federal provincial First Nations agencies is extremely important to ensure that community safety planning and community wellness planning is -- is in place.

MS. SARAH BEAMISH: Okay. So you would recommend a more systemic approach to that kind of thing then?

DR. VALERIE GIDEON: Yeah, we actually set up community wellness development teams during that time that are still available and resourced federally and provincially in order to support communities to develop

this type of plan.

MS. SARAH BEAMISH: Okay.

DR. VALERIE GIDEON: And to invest in some targeted interventions and measures.

MS. SARAH BEAMISH: Okay, thank you. I may just ask you one or two more questions. My next one is about ID. In some of the -- in some of the Independent First Nations, girls and women have had difficulty accessing health care services when they don't have the proper ID for whatever reason, and sometimes, as a result, they don't seek out health care that they need because they anticipate having -- having issues with ID. Is it right that Indigenous people often need to present ID to receive the health services through the programs that you've discussed today and the ones that are discussed in your materials?

DR. VALERIE GIDEON: So within the context of the provincial health system, I'm not sure what the province would do if someone didn't have an OHIP card. I mean, I know that in the nursing station or health centre context people are not asked for their status card when they walk through the door, they are served by nurses. Regardless of whether or not the health facility is run by the Federal Government or operated by Federal Government employees or by First Nation employees, the services are

provided. Emergency health services in the province will be provided to people who need it.

Within the context of the Non-Insured Health Benefits Program, you know, I think that we've not seen that as a major barrier to access that I'm aware of in all of my years. But we have intervened in cases where we've had First Nation women that lost their ID or couldn't find their ID in order to contact the office of the Indian Registrar to do an emergency issuance of a letter that actually just validates that they do have status in that -- but that is for transportation purposes, in the sense of them being able to -- if they need air travel to return home or whichever, we've been able to do that. The Office of the Indian Registrar will work collaboratively with us to issue emergency validation of identification if it -- particularly if it's an urgent situation or if -- if it's a woman who's at risk or finds herself in a situation where she can't access service.

MS. SARAH BEAMISH: Okay. My next question is about childhood sexual abuse. Do any of the Federal programs -- health programs for Indigenous people directly address childhood sexual abuse as a health issue, as far as you know?

DR. VALERIE GIDEON: Well, our clinical practice guidelines include that aspect of it. In fact,

we're right now in the process of updating the pre-pubertal -- sorry, my French sometimes comes out -- child abuse guidelines specifically. We -- again, we offer a lot of flexibility with respect to the parameters of community-based programming so that they can identify their priorities. The Chiefs of Ontario recently contacted us because they are setting up a task force specific to child abuse and also Nishnawbe Aski Nation has done the same thing in order to be able to develop some more targeted interventions to address the issue in community. So we absolutely fund that and support those types of initiatives initiated by First Nations.

And I think, you know, the increase in amount of resources and services available within the context of mental wellness broadly, regardless of, you know, what is the need of the child, which is not for the Federal Government to -- to know about, but is just something that is supported. I mean, all those services are available to children that have experienced sexual abuse.

MS. SARAH BEAMISH: Okay. Are any of the -- the services you're talking about -- do any of them take a proactive prevention approach to childhood sexual abuse, or are they responding after the fact?

DR. VALERIE GIDEON: Our clinical practice guidelines for frontline nursing staff absolutely do talk

about detection and identifying, really, risk factors within that context. We also have the Maternal Child Health Program, as an example, which includes the supports for home visiting. Home visiting has actually been demonstrated as an effective practice for community health professionals to -- or health workers to come into communities and be able to build that trust relationship with families early on, from birth until early childhood. The Aboriginal Head Start program also is a program that's widely utilized in communities to help support preschool children.

And within the context of those guidelines, there's also, you know, identifying risk factors and also having provincial -- parental involvement and parental engagement in the child's development at an early age. So there are a number of healthy child development type of initiatives where proactivity is encouraged, absolutely.

MS. SARAH BEAMISH: Okay. I do have more questions, but I think I'd like to leave a few minutes for -- for the next witness, so thank you for your answers.

JACKIE ANDERSON, Previously Affirmed:

CROSS-EXAMINATION BY MS. BEAMISH:

MS. SARAH BEAMISH: All right. So, Ms. Anderson, first, I just want to say I was moved to hear of the Centre's relationship with Maori people in developing your services. I belong to the Ngāruahine Maori people, and

so I am sure they would support me in bringing special greetings to you and the Centre on their behalf.

I just -- I think I only have two questions for you.

MS. JACKIE ANDERSON: Yeah.

MS. SARAH BEAMISH: My first one is, in your experience, would you say that childhood sexual abuse at the community level, including by family members, is a common and significant risk factor related to Indigenous girls and women ending up in situations of sex trafficking and exploitation?

MS. JACKIE ANDERSON: Yes.

MS. SARAH BEAMISH: Yes?

MS. JACKIE ANDERSON: Absolutely. A very high number of our children have experienced that child -- that childhood -- child abuse, all forms of child abuse. That absolutely has an effect on their vulnerability.

MS. SARAH BEAMISH: Yeah. Okay. Well, I think -- I would just like to leave a few minutes, because I wanted to ask you your recommendations to the Commission on this issue specifically, on the issue of childhood sexual abuse at the community level, including by family members, and its connection to violence, other violence, later on in -- in -- in people's lives. If you want to take a few minutes to talk about any recommendations you have about

addressing this.

MS. JACKIE ANDERSON: About -- sorry?

MS. SARAH BEAMISH: About childhood sexual abuse.

MS. JACKIE ANDERSON: Well, again, I think it really has to -- to go with creating that awareness and education and supporting, you know, our young people with being able to deal with that trauma and being able to create safe environments for when children are disclosing or talking about, you know, experiences that they have experienced and not re-victimizing them by having to continuously tell their story of what's going on or what's happened to them. I think that's very important.

MS. SARAH BEAMISH: Okay. All right. Well, I think that's all -- those are all my questions for you, then. Thank you. So did we want to have a break?

CHIEF COMMISSIONER MARION BULLER: Yes. We will reconvene at three o'clock.

MS. SARAH BEAMISH: Three o'clock.

--- Upon recessing at 2:46 p.m.

--- Upon reconvening at 3:10 p.m.

MS. JENNIFER COX: The next party is Pauktuuitit for 13 minutes.

MS. BETH SYMES: Good afternoon. My name is Beth Symes, and I represent Pauktuutit, the Inuit women of

Canada, the Labrador Inuit women, Saturviit, the Ottawa Inuit Children's Centre and the Manitoba Inuit Association, and I'm going to try and focus on prevention, prevention of violence and death for Inuit women and girls.

I want to thank you, Jackie and Christine, for coming. One of the really memorable times was hearing the story in Rankin Inlet of the death of Jessica Michaels who was an Inuk girl from Chesterfield Inlet taken into care in Winnipeg, and she became trafficked and probably was killed. And so the services that you do has a range that is geographically probably even bigger than you think. But her story was told beautifully by her cousin's sister. So thank you.

VALERIE GIDEON, Previously Affirmed:

CROSS-EXAMINATION BY MS. BETH SYMES:

MS. BETH SYMES: Dr. Gideon, I'm going to be concentrating my questions on you and as it relates to Inuit, Inuit women.

The health care that -- would you agree with me that health care is an essential service for all Canadians?

DR. VALERIE GIDEON: I would.

MS. BETH SYMES: And that includes Inuit women?

DR. VALERIE GIDEON: Yes, I would agree.

MS. BETH SYMES: And that the failure to provide health care is actually a breach of right to life, lint, and the security of the person?

DR. VALERIE GIDEON: So -- so that's a legal -- more a legal question. And I -- what I would say is that the provision of health care services for Inuit women is extremely important for their ability to thrive.

MS. BETH SYMES: Thank you. The standards of health care, I'm a bit confused about what you have written in the overview. So the standard of health care on page 1 says to attain health levels comparable to other Canadians living in similar locations. Now, is that for Inuit, the standard as compared to non-Inuit living in, say, a remote community such as, I don't know -- let's pick Hall Beach. Is that the standard that you say Inuit women can achieve? That's all?

DR. VALERIE GIDEON: So comparability is -- definitely has its pitfalls because in many circumstances across Canada, there are no comparable circumstances with respect to where Indigenous people live. So, really, it's about achieving -- and closing the gap is often language that people use whereby there should be a comparable state of health outcomes at minimum with respect to Indigenous peoples and non-Indigenous peoples in Canada,

and that is something that I think most people would agree with, and certainly there are many political commitments that have been made. And it's written over and over with respect to policy documents.

But when we were developing the strategic plan for First Nations Inuit health, the National Inuit Committee on Health really advised that it is about healthy community members, families, healthy communities, healthy nations, and that -- however those communities are defining health, really, that is what we should be supporting and what we should be aspiring to.

MS. BETH SYMES: It's not a race to the bottom.

DR. VALERIE GIDEON: Pardon me?

MS. BETH SYMES: It is not a race to the bottom for Inuit women in terms of health care.

DR. VALERIE GIDEON: No. So --

MS. BETH SYMES: (Indiscernible).

DR. VALERIE GIDEON: -- the goal is to continue to improve health outcomes for Inuit women and Inuit across Ananaakatiget -- or regardless of where they live in Canada.

MS. BETH SYMES: Dr. Gideon, isn't the only appropriate standard for health care for Inuit women to be the standard of health care for all Canadians? Isn't that

the aspiration?

DR. VALERIE GIDEON: So the issue is what would you define as a standard of health care for all Canadians? I would just say that that's, again, the pitfalls of comparability. So what would be an acceptable basket of services for an urban-based non-Indigenous population may be very different to what an Inuit community needs. An Inuit community may need higher degrees of services for mental wellness, as an example. They may need more family-centered care.

So I would just say that I don't think that -- I've never heard from the National Inuit Committee on Health a desire to define a national standard of care. What I have heard is we are developing our strategies. We are developing the needs and -- or we are identifying our needs and the strategies required to meet them, and we would like federal, provincial, and territorial governments to respond effectively to support us in addressing those needs.

MS. BETH SYMES: Well, Dr. Gideon, we've heard over the last year stories from Inuit families, talking about the very poor quality of physical health and the abysmal quality of mental health services in Inuit Ananaakatiget. And you've -- you've read those stories, haven't you?

DR. VALERIE GIDEON: I've certainly --

MS. BETH SYMES: (Indiscernible).

DR. VALERIE GIDEON: Yes, absolutely.

MS. BETH SYMES: And let's just look objectively at some numbers because qualitative things are always tricky. You'd agree with me that the life expectancy of an Inuit woman in Canada is 11 years less than a non-Inuit woman in Canada?

DR. VALERIE GIDEON: So I haven't studied those statistics specifically or have the source validated before me, but I -- I certainly wouldn't argue that there is a gap in life expectancy between Inuit women and other Canadian women in the country.

MS. BETH SYMES: And you'd agree with me that the birthrate for Inuit women in Nunavut is almost twice the birthrate of Canadian women not in Nunavut?

DR. VALERIE GIDEON: I am aware that the birthrate among Inuit women is higher than other Canadian women.

MS. BETH SYMES: And that the infant mortality rate for Inuit children is three times the Canadian average?

DR. VALERIE GIDEON: Again, I am aware that there are higher infant mortality rates among Inuit compared to the mainstream Canadian population.

MS. BETH SYMES: And I think that Census Canada but -- or Statistics Canada must be looking over your shoulders, Commissioners, because today, they released the violence rates for women in the three territories, as well as each province in Canada. And that the rate for Inuit women in Ananaakatiget -- pardon me, in Nunavut -- apologies -- is ten times the national average for all of Canada. Now, does that surprise you, Dr. Gideon, in terms of the rates of violence for Inuit women being many times the rates for Canadian women?

DR. VALERIE GIDEON: It does not surprise me that Inuit women are at greater risks of violence.

MS. BETH SYMES: Now, maybe because it's 2018, you said that in developing health initiatives, NFIHB uses a gender-based analysis. You wrote that, didn't you? In your report?

DR. VALERIE GIDEON: I spoke about how all federal departments are implementing gender-based plus analysis in the development of policies or programs and services.

MS. BETH SYMES: And do you also --

DR. VALERIE GIDEON: It's a mandatory element. Sorry.

MS. BETH SYMES: Sorry. It's mandatory?

DR. VALERIE GIDEON: Yeah.

MS. BETH SYMES: And you said that your department looks at issues and solutions through a gendered lens? Is that right?

DR. VALERIE GIDEON: It is part of the mandatory GBA plus assessment.

MS. BETH SYMES: I was really taken by your description of these partnership tables where having Indigenous people at the decision-making table, not just to give their input, not just to advise, but also to be part of or be a decision-maker. That's what you described, right?

DR. VALERIE GIDEON: That's correct. It's variable with respect to the mandate that are provided through leadership for these tables, but absolutely. Where possible, we have been including them with respect to the decision-making process at the branch level.

MS. BETH SYMES: And that's the decision where and how health dollars will be spent?

DR. VALERIE GIDEON: That's correct. There are decisions made, for instance, with the National Inuit Committee on Health with respect to where health dollars would be allocated. Now, the ITK board also plays a role in that. We're not at that table, but we understand that they are part of the decisions, as well.

MS. BETH SYMES: Now, I understand from what

you said today that the two representatives of Indigenous people at the table are the AFN and ITK?

DR. VALERIE GIDEON: So they are members of the committee, but they do go back and seek advice and also decisions of their regional organizations. So in the Inuit context, the National Inuit Committee on Health provides advice, as well, to the ITK board, and decisions are relayed back. So ITK at that table does not make the decision. ITK brings the information back and consults within the Inuit governance structure, and then comes back to us with the decision that has been agreed to at those tables.

MS. BETH SYMES: And Pauktuutit, the voice of Inuit women in Canada, is not at that partnership table.

DR. VALERIE GIDEON: The Pauktuutit is invited to the National Inuit Committee on Health. They are definitely in the room. I don't know the -- all of the interplays between Pauktuutit, specifically, and the National Inuit Committee on Health members or governance. Obviously within the First Nations Inuit health branch, we do not specify to First Nations or Inuit how to organize their decision-making process or their government structures. We rest back and recognize those government structures.

MS. BETH SYMES: Dr. Gideon, I'm having

difficulty understanding how you're going to carry out your mandate to do a gender base analysis plus, or to look at this issue through a gendered lens, if you don't have Inuit women at the table with the right to vote, to say how the money is spent with respect to health.

DR. VALERIE GIDEON: So Inuit governments are represented on the National Inuit Committee on Health, and we respect and recognize their authority as Inuit governments to provide that decision-making to us.

MS. BETH SYMES: Well, Dr. Gideon, you told us that you use Pauktuutit's health care materials, in terms of provisions of services.

DR. VALERIE GIDEON: We have funded Pauktuutit to undertake various initiatives over the years that they have identified as priorities through their board of directors.

MS. BETH SYMES: Now, you know that Pauktuutit was without a contribution agreement from FNIHB from 2012 to 2017 under a previous government?

DR. VALERIE GIDEON: I -- I was not directly involved during that period, but I -- I am aware through their Executive Director, who communicated that to me in 2017.

MS. BETH SYMES: And so now there is just one project that FNIHB has with Pauktuutit for $150,000 on

sexual health?

DR. VALERIE GIDEON: I wouldn't be able to verify the number, but I -- I'm sure that's likely correct. The Minister -- our Minister has met with the Pauktuutit president, and I believe attended or is attending a board of director's meeting to discuss future partnership with Pauktuutit, and so it -- it continues to be something that we are open to discussing.

MS. JENNIFER COX: Excuse -- time's up.

MS. BETH SYMES: I still -- I'm sorry, thank you.

MS. JENNIFER COX: Thank you. So the next party is the Families for Justice. And 13 minutes as well, Mr. Registrar.

MS. SUSAN FRASER: Good afternoon, Commissioners. Good afternoon, witnesses. My name is Susan Fraser. I am here on behalf of 20 families, many of Canada's provinces, and from different territories across this land, and I have some questions for all of you. Quite grateful for you being here, and I'm -- so I'm going to be asking both from the families' perspective, and also on some broader issues.

Just starting with Jackie, Ms. Anderson. Thank you for your very beautiful description of the HOME, and for making it a home.

JACKIE ANDERSON, Previously Affirmed:

CROSS-EXAMINATION BY MS. FRASER:

MS. JACKIE ANDERSON: M'hm.

MS. SUSAN FRASER: And wanted to ask you to follow up on the question on the voluntary, so called voluntary service agreement, where children are given-up into care in order for them to have access to health services that they would not be able to access without being put into care, okay? In Ontario, that practice was outlawed because children were thought to be entitled to services. Would you support a recommendation outlying the practice of children being put into -- into voluntary care for the purposes of accessing health services?

MS. JACKIE ANDERSON: Yes, I would agree.

MS. SUSAN FRASER: Okay, thank you. And members of our group -- one member of the group of families described to the Inquiry her experience of coming into care.

MS. JACKIE ANDERSON: M'hm.

MS. SUSAN FRASER: Having a breakdown of the foster care placement and being sent from her First Nation to the city of Winnipeg on a bus, at the age of 12, where she came into contact with people who would come to exploit her.

MS. JACKIE ANDERSON: M'hm.

MS. SUSAN FRASER: Are you aware of this

practice continuing?

MS. JACKIE ANDERSON: I -- I would say so, yes. Again, we are seeing that recruiters are associating around places where the most vulnerable children and youth are, it is known. And I've heard a number of instances where bus depots, airports are also places of recruitment.

MS. SUSAN FRASER: Okay. So it would be recommendation for you that First Nations and Indigenous children be protected around places where they are vulnerable, which is backing it up a step that -- that child welfare not put them in situations like that.

MS. JACKIE ANDERSON: Absolutely.

MS. SUSAN FRASER: Okay. Are you aware of other children being put unescorted on public transportation?

MS. JACKIE ANDERSON: I -- I'm aware of one situation that an adult woman actually experienced that situation when she was very young.

MS. SUSAN FRASER: It's possible that we're talking about the same person because she is from the Winnipeg -- she did end up in Winnipeg. Also have heard in through the media, the practice of young girls being placed while in the care of the Children's Aid Society or the -- I can't remember the Manitoba name, Child and Family Services.

MS. JACKIE ANDERSON: M'hm.

MS. SUSAN FRASER: Being placed as a residential placement in a hotel, when there are no foster care or group home placements available. Is this something that you have heard about?

MS. SUSAN FRASER: In the past, yes, but it's not a practice they currently use today.

MS. SUSAN FRASER: Okay. Is it -- is it a practice that is prohibited in -- to your knowledge?

MS. JACKIE ANDERSON: Yes, I believe so.

VALERIE GIDEON, Previously Affirmed:

CROSS-EXAMINATION BY MS. FRASER:

MS. SUSAN FRASER: Okay, Thank you. I want to just turn then to Dr. Gideon. Dr. Gideon, you have described this morning a myriad of promising sounding strategies and initiative and practices that are emerging from Indigenous Services Canada. And you also mentioned in your evidence this morning, and this is how I'd understood, that it's not clear that -- of how the funding is making a difference.

DR. VALERIE GIDEON: We have evidence with respect to a series of evaluations, even that I referred to this morning, such as the July 2016 evaluation of the mental wellness suite of programs. I talked about a number of outcomes that have resulted from those investments. I also spoke about an evaluation that will be released publicly,

shortly with respect to clinical and client care, and that we've seen some demonstrated progress and outcomes from that. So I would not say that we do not have outcomes data, in fact we do in a number of areas.

I think health data is a -- the challenge with respect to a comprehensive picture of Indigenous health information, is that multiple government are involved in the delivery of services, and that there isn't a connection between all of those data collection systems. It is a -- something that all governments are aware of. There isn't, also, an ability to disaggregate the information that's captured, for instance, in a lot of provincial or territorial health systems to specifically identify who is First Nation, who is Inuit, who is Métis, that also makes it a challenge. But wherever possible we are supporting partnerships to improve access to data that are driven by First Nations and Inuit, specifically, and Métis as well, who've just recently received funding in budget 2018 for Métis health data and surveillance.

Budget 2018 also committed to an Inuit health survey with ongoing resources in order to support Inuit to develop their own source of health information, and we also fund directly the First Nations information government centre to issue the Longitudinal Regional Health Survey. They have done that for a number of years. They've

just recently released their latest national report at conference a few months ago, and they're planning the next wave, so we are making investments for First Nations, Inuit, and Métis to collect their own data to -- under the OCAP principles: ownership control, access, and possession of information. So there is growing data with respect to health outcome measures.

MS. SUSAN FRASER: Okay. So that -- and that -- agree that it is a critic -- the health, in understanding health, is a critical part of understanding a person's well-being?

DR. VALERIE GIDEON: Absolutely.

MS. SUSAN FRASER: Okay. And it's also -- health is -- also in how people are doing is also a critical part of understanding a community's well-being?

DR. VALERIE GIDEON: Yes, I would agree.

MS. SUSAN FRASER: Okay. And I understand that Indigenous Services Canada has a measure of social and economic well-being on reserves, called the Community Well-Being Index.

DR. VALERIE GIDEON: So the former --

MS. SUSAN FRASER: Have you heard of that?

DR. VALERIE GIDEON: Yes, I've heard of that. It -- it was developed through what was Indigenous and Northern Affairs Canada, to mirror the United Nations

Development Index and their methodology, in order to offer a comparability between international nations and First Nations with in the context of Canada. So it was one specific measure to offer some comparability within the United Nations Development Index. It's not, of course, the only measure that the federal government would take with respect to measuring health or socio-economic measures or statistics with respect to First Nations, Inuit, and Métis.

MS. SUSAN FRASER: Right. The -- the measurements of outcomes are important, and the Community Well-Being Index is something that Indigenous Service Canada uses in order to measure how communities are doing, fair?

DR. VALERIE GIDEON: It was actually developed with First Nations at that time. Because First Nations --

MS. SUSAN FRASER: I'm -- I'm sorry to cut you off, but I'm -- I'm not interested in the history of it, I'm just wondering, the question really was -- was whether -- Dr. Gideon, was whether this is something that Indigenous Services Canada uses to measure the socio-economic health of First Nations Communities?

DR. VALERIE GIDEON: The information has been provided in analysis, but I can't tell you, even most recently, when that would have been. So I -- I have not -- my -- my knowledge of the Community Well-Being Index and the

use of it, is dated. It was when I was at the Assembly of First Nations.

MS. SUSAN FRASER: Okay. Because yesterday, and, Commissioners, I think I'm going to be -- you're going to be hearing more from me on this topic this week, so this is why I'm -- I'm leading this way. I expect to be able to tender, later in the week, the Auditor General's Report. And the Auditor General, I expect, we're going to hear through that report, if it's received by this Inquiry, that --

DR. VALERIE GIDEON: Excuse me.

MS. SUSAN FRASER: -- that there -- there is an incomprehensible failure in Canada to address the gaps in First Nations community as against Indigenous -- not -- Indigenous people as against non-Indigenous people, all right? And so -- and the Auditor General goes directly in looking at the economic -- the social economic Well-Being Index as -- and is critical of it not including health. So are you -- do you have any knowledge as to why the Community Well-Being Index does not include health?

DR. VALERIE GIDEON: At the time, and the knowledge that I have, which again, dates back to when I was at the Assembly of First Nations, they were developing a methodology that mirrored what the United Nations was using in terms of the Human Development Index. So it was not a

deliberate exclusion of health, it was trying to achieve comparability with respect to a global measurement tool.

MS. SUSAN FRASER: All right. And I also understand that -- that the -- and I ask you to consider this -- this point, the Auditor General says that, Indigenous Services Canada is not using the data that is readily available in order to provide a comprehensive picture of the health of First Nations Communities. I'm paraphrasing. I can give you the exact --

DR. VALERIE GIDEON: So I haven't read the report. It was released yesterday, and I was travelling. These reports are embargoed and only shared with certain officials prior to them being released. So I'm afraid I can't comment. I have not had the opportunity to read the report.

MS. SUSAN FRASER: All right. It -- what the Auditor General said, and I don't expect you to know it, but I want to know, what he's critical about is that the department could have used the volumes of available data from multiple sources, I think you've given us information about some of those sources, to more comprehensively compare well-being relative to other Canadians and First Nations communities but did not. So
in -- in terms of using data, do you have any knowledge as to why the department would not use this available data,

which you've told us is quite rich in comparing Indigenous Canadians to non-Indigenous Canadians?

DR. VALERIE GIDEON: The data that I was referring to was specific to health. So my knowledge is limited, and I don't have the expertise to answer that question with respect to other areas of the department. Acknowledging that we have just been transferred into the creation of a new department of Indigenous Services Canada, so my knowledge has been grounded and my long-standing experience in working in First Nations and Inuit Health specifically, I'm more familiar with health data than other sources of information.

MS. SUSAN FRASER: All right. You -- you said in your evidence that there's much more to be done, or words to that effect, that you recognize that there's a -- a lot of work to be done. But I -- I don't have time to go into that. I want to ask you this last question as to whether you're -- you're familiar with the Child's Rights Impact Assessment, and whether that's something that your department uses to assess the impact of its programs?

DR. VALERIE GIDEON: I'm not familiar with it. What is the source of it?

MS. SUSAN FRASER: Child's Rights Impact is a tool that is available. It's promoted by the -- through UNICEF Canada, other organizations. It's a way of assessing

a government's compliance with child -- children's rights and convention rights.

DR. VALERIE GIDEON: So I'm not familiar with it, but I think it's something we should -- we would bring to the senior management table.

MS. SUSAN FRASER: You would support a recommendation, that in addition to using a gender-based analysis, that -- that the programs be evaluated with a view to child's rights? And in -- impact on child's rights?

DR. VALERIE GIDEON: We make decisions with First Nations and Inuit representatives at the table. And so what I would say is that, if it's of an interest to them, we would certainly look at it within the context of the senior management table with First Nations and Inuit.

MS. SUSAN FRASER: Right. And I appreciate --

MS. JENNIFER COX: Counsel, time is up.

MS. SUSAN FRASER: Oh, thank you. My -- the clock still shows seconds, so I just -- if -- if that's -- thank you.

MS. JENNIFER COX: It's negative. The next party is the Regina Treaty Status Indian Services. And they have 21 minutes.

VALERIE GIDEON, Previously Affirmed:

CROSS-EXAMINATION BY MS. BEAUDIN:

MS. ERICA BEAUDIN: Are we -- same issue as yesterday. Good afternoon. Thank you to the Elders, drummers, and singers for their prayers and songs we've all been privilege of. Is what -- as well, once again, as a citizen of Treaty 4, I acknowledge the continued welcome to Treaty 7 and bring well wishes from our Treaty area. I will walk softly on your lands. My name is Erica Beaudin. I'm the Executive Director of the Regina Treaty Status Indian Services. I have several questions; therefore, I'm going to speak faster than I normally do. And please feel free to answer yes or no if it's an easy answer. So question one is, Dr. Gideon, *wela'lin* for your presentation this morning. It was very educational, and I appreciate the information. I would like to provide a bit of background, oh, as I'm talking about, I'm wasting my own time. I would like to provide a bit of background before I get to my questions. The tribal councils who own my organization, own and operate two adult domestic violence safe shelters; a hospital, the All Nations Healing Hospital that you talked about this morning; a social housing corporation; an economic development corp.; a youth treatment facility; and as well as a casino. As their urban services delivery agency, we provide womb to tomb services including accredited adult education, training and an employment agency, various restitution programs, a family support centre, and programs

prioritizing various priorities. Two of these programs that we have contribution agreements with is for the Indian residential school and missing and murdered Indigenous women and girls programming to family members, survivors, and loved ones.

At our tribal council, that being the File Hills Qu'Appelle Tribal Council, we're committed to wrap-around care for all people who access our services. In working with FNIHB, it is often difficult to provide comprehensive case management to our people when we're bound by CAs, and I'll use the term CAs, if you don't mind, that are very specific in their deliverables. Do you believe that CAs, that Tribal Councils, or organizations assigned to deliver services, should have CAs that allow for more flexibility so that the agreements can meet the needs of the clients for better outcomes?

DR. VALERIE GIDEON: Yes, I do.

MS. ERICA BEAUDIN: If so, how could this be accomplished, or are there current opportunities that haven't been mentioned?

DR. VALERIE GIDEON: So we are very open to looking at more block funding agreements for Tribal Councils. In the past those were offered more to communities, but a few years ago we opened it up to PTOs -- or political territorial organizations -- for the

French translators, and also offering that to Tribal Councils.

So I think with the richness of the degree of capacity and governance of the organization that you've described, it seems to fit very well with that opportunity. So you would be able to do a comprehensive plan of the priorities of the community members that you're serving and be able to direct funds to those priorities without being tied to any cluster or program silos.

MS. ERICA BEAUDIN: Thank you. My organization has had a CA with FNIHB for the Indian residential school program for several years. I'd like to commend FNIHB for the ability to meet the needs of our clients in a more wholistic way. In my mind all other CAs should have the types of ability for eligible expenditures for the sake of survivors and families of survivors.

Saying all of this, one trend that emerged in our time working with IRS survivors, that many have experienced loved ones who are, were missing and/or murdered. Conversely, every single family we've worked with in the area of missing and murdered Indigenous women and girls are survivors or intergenerational survivors of Indian residential school, that's 100 percent.

Do you believe that FNIHB should utilize the Indian residential school program and expand it so that it

includes MMIWG, and if it is included, increase resources, including program training and human resources to agencies who are meeting these specific needs of survivors?

DR. VALERIE GIDEON: I believe that that's a recommendation of the interim report of the commission, which the government is currently in development of its response, and that will be considered as part of the response.

MS. ERICA BEAUDIN: Okay. You mentioned the IRS program has been extended for another three years. Does FNIHB understand and are you moving towards healing programs for -- whether it's IRS, maybe MMIWG, that could be decades long in length, and acknowledge the types of long-term healing that survivors require to move beyond survival?

DR. VALERIE GIDEON: So recent federal budget investments have provided some ongoing -- most of them, ongoing funding, so that it actually is part of our base. The Indian residential school health support program, because it was tied specifically to a court order, is associated with that, but a lot of the mental wellness investments that I described earlier are part of our core permanent funding, so they can be utilized for decades long planning for Tribal Councils or communities.

MS. ERICA BEAUDIN: Thank you. Often times

we hear that ISC or FNIHB fund mainly on-reserves programs. Many Indigenous people live in urban areas. Is FNIHB studying the unique needs of urban Indigenous people and creating, supporting or adjusting programs that would best serve their needs?

DR. VALERIE GIDEON: So this is a huge priority of our Minister, she's spoken about it several times, how do we provide better reach to community members that are living outside their communities, sometimes for shorter or longer term durations. So, for instance, as part of the budget 2018 investments with respect to addressing addictions issues for high risk communities, one of the areas that we're specifically looking at is how do we ensure that there is that outreach to community members that are living outside their communities.

MS. ERICA BEAUDIN: Thank you. I understand that health districts receive monies to serve the needs of Indigenous people in cities. Overall, do you believe the health districts are meeting the needs of urban Indigenous clients?

DR. VALERIE GIDEON: You mean within the context of the provincial context?

MS. ERICA BEAUDIN: Yes.

DR. VALERIE GIDEON: You know, I just -- all I could say is that I think that, you know, in speaking

with First Nations representatives across Saskatchewan at the health director and at the leadership level, they have expressed concerns that they are not receiving a sufficient amount of services that are adapted to their needs within the provincial health services context.

MS. ERICA BEAUDIN: How could FNIHB work with Indigenous organizations, Tribal Councils, leadership, to better meet the needs of the people who require healthcare services in urban areas?

DR. VALERIE GIDEON: Well, we actually have a 2008 memorandum of understanding that was signed with the Provincial Government with First Nations leadership and ourselves, specifically to develop a First Nations health and wellbeing plan, which was endorsed by all Chiefs and Assembly and Federal and Provincial Ministers. So we have a tripartite table in Saskatchewan specifically to support -- to do our part, but also to support First Nations to advance their interests with respect to provincial health services.

MS. ERICA BEAUDIN: Thank you. You spoke of increased mental health teams that are being supported by FNIHB, are any of these in urban areas?

DR. VALERIE GIDEON: So, yes, but I -- in Saskatchewan I know that communities have access to the mental wellness teams, but I'm sorry, I just off the top of

my head cannot confirm for you if in Saskatchewan we have one that is close to an urban centre or run by a Tribal Council in an urban centre. I believe that we do, I believe that the Saskatoon Tribal Council, as an example, but I would have to verify that information just off of the top of my head.

MS. ERICA BEAUDIN: Are there any plans, or do you believe that the department should have more in the urban areas?

DR. VALERIE GIDEON: I think that what we need to think about is a continuum of service for First Nations that -- so that it isn't -- it doesn't create a barrier, which government is responsible for funding what, and that essentially funding available by the two arms of government are brought together and provided to First Nations so that they can serve their community members regardless of where they live.

So an example is the British Columbia First Nations Health Authority, where because of their incredible partnership with regional health authorities across the province and provincial ministries, and also with the Federal Government, they are able to leverage that funding to offer those types of flexible interventions and strategies so that they can reach their community members living outside their communities.

MS. ERICA BEAUDIN: Thank you. You discussed addiction services this morning. What is the priority of FNIHB to fund agencies to have dedicated NNADAP workers to meet the addictions services needs of urban, in particular, the MMIWG families?

DR. VALERIE GIDEON: I'm sorry, do you mean First Nation service discovery agencies or child and family service agencies?

MS. ERICA BEAUDIN: Whatever it would look like.

DR. VALERIE GIDEON: Just First Nations agencies. I think what we would be doing with the new investments, for instance, is bringing that to the regional partnership committee that we have in Saskatchewan where all Tribal Councils have the opportunity to participate and bring -- as well as the Federation of Saskatchewan Indian Nations, Indigenous Nations and so forth, and actually come together to talk about what are the best areas of investment, right? So that there is that flexibility and First Nations can derive where there's those investments should be.

MS. ERICA BEAUDIN: Okay, thank you. So you're talking about STAG, the STAG table of the --

DR. VALERIE GIDEON: No, we actually had --

MS. ERICA BEAUDIN: -- FSIN?

DR. VALERIE GIDEON: So STAG is absolutely a critical partner, but we actually have a regional partnership committee that the Saskatchewan regional office has invited folks to participate in so that they can transparently share information about funding, operational plans and so forth, and where they can invite feedback and hopefully share decision making with respect to where funds are invested.

MS. ERICA BEAUDIN: Thank you. Speaking specifically of MMIWG, our organization has worked with some families for up to 14 years and we have now just started to work with fourth generation survivors. Wraparound agencies like ours walk with families from sometimes the day a person has gone missing, right to assisting families to learn how to live and be independent again.

What -- what possibilities are there for FNIHB to create opportunities for agencies and organizations working in this comprehensive and years long process with families to know that families won't fall through the crack on their healing journey, due to either, A, lack of funding or underfunding by government agencies such as FNIHB?

DR. VALERIE GIDEON: Oh, that's an -- it's an excellent question. One of the ways in which this could

happen is by having comprehensive funding agreements that brings together multiple sectors of education, social, health, so that you have more global agreements where you have that flexibility to design services that are wraparound for families.

I think that is the goal of the new department of Indigenous Services Canada, is to be able to offer those types of opportunities where before we had silos, where we were separated by two different departments and also even within departments by sectors. So I think the -- the reason for establishing the new department, or one of them, is to bring together all of the needs and support systems for families so that First Nation service delivery agencies can support them and provide that wholistic approach to service delivery.

MS. ERICA BEAUDIN: Thank you. This is a bit off the path of the questions I've been asking. Our young women become vulnerable when they leave home, there are many reasons for this, but acceptance and confidence in our place -- of our place in community can be one of the reasons. When a young woman enters womanhood, this is very difficult for her, especially if she doesn't live with a trusted woman. Simple items such as birth control and feminine hygiene supplies are not accessible. Or even the self-care measures that can promote healing and strong

identity. How can FNIHB play a role in supporting the confidence of young woman through programing or eligible expenditures and current programming, so that young women receive these items without embarrassment, so that in -- in essence, their vulnerabilities will lessen?

DR. VALERIE GIDEON: So that's an interesting question, because within Saskatchewan in particular, First Nations communities do manage their own health services, and they have flexibility with respect to supplies, equipment or whatever it is that they wish to purchase with respect to supporting families. So I think I would need to speak with the Tribal Council in more detail with respect to what are the gaps that they're seeing and -- and why that can't be offered within the context of their agreements, because they do have the highest degree of flexibility that's offered outside of a self-government agreement to be able to design health services and benefits to -- that matches the needs of the population.

MS. ERICA BEAUDIN: Okay. Thank you. The reason why I ask that question is that we have several, especially in the north, many communities where this is an issue for our young women. And in the south, we actually have drives in order to get those -- those types of things that young women need, and then we send them to the north.

DR. VALERIE GIDEON: Okay.

MS. ERICA BEAUDIN: So there is that need in Saskatchewan, in the north for sure.

DR. VALERIE GIDEON: Okay.

MS. ERICA BEAUDIN: So our organization works directly with families of MMIWG. I've been told by -- I've been told one of their wishes for resources is a family treatment facility where families could stay up to six months that concentrates on PTSD, intergenerational traumas, addictions, life skills, et cetera. All being delivered on the land, and grounded in traditional ceremony, language and arts. Do you believe this dream could be a reality for these families? And if so, what would be the process?

DR. VALERIE GIDEON: Family treatment is absolutely needed and where we've had family treatment centre's that have been developed, including one in isolated community, it has been very successful with respect to outcomes. So you know, I mean, it's -- it's -- do I believe that it's a possibility? I like to believe that everything is a possibility. We have to start from that perspective to provide hope. It is very important to do that. I think we would need a partnership model, and I think it is something that we would be very open to meeting with the Tribal Council about to discuss how we would get started in terms of a planning effort.

MS. ERICA BEAUDIN: Thank you so much, Dr. Gideon.

JACKIE ANDERSON, Previously Affirmed:

CROSS-EXAMINATION BY MS. BEAUDIN:

MS. ERICA BEAUDIN: Ms. Anderson, *Mashi Cho* for your presentation this morning. It was in the early 2000s that I toured your facilities, and I was very impressed and inspired by both the youth and the staff. It's often difficult to create long-term programming for the youth when CBO's, community-based organizations, we are often juggling several grants and contribution agreements. Many of them only for months long initiatives, and definitely not many past a year. Is this -- do you find this to be true?

MS. JACKIE ANDERSON: It was important that with our HOME's is that there's not a timeframe for how long our young people can actually reside in our HOME's. Again, recognizing the fact that healing doesn't happen overnight. Christine, for example, resided with us at Little Sisters for almost four years.

MS. ERICA BEAUDIN: M'hm. I'm speaking specifically about contribution agreement as opposed to length of stay for -- for youth.

MS. JACKIE ANDERSON: Okay. In -- within --

MS. ERICA BEAUDIN: Full grants, contribution

agreements, those types of things. Like, for example, if you bring in a beading project.

MS. JACKIE ANDERSON: M'hm.

MS. ERICA BEAUDIN: And it usually comes from a small grant that has a lot of reporting requirements attached to it.

MS. JACKIE ANDERSON: Okay. We do -- we do have within our organization some of those small grants. And as I mentioned earlier, these are not things that we can bring to our people and to our young people and run it for a short period of time and say it's done, it's over. If we want to engage and bring our young people back to their identity and to their culture, and if that means teaching them how to make their skirt or teaching them how to do beading or make their moccasins, it's not something that is a very short-term, you know, project. One off of one program. It needs to be an ongoing.

MS. ERICA BEAUDIN: Right. As well, have you noticed the amount allowed for administration? Staffing is decreasing, and we are expected to do more with less. The only more we have experienced is more reporting for those -- those types of grants. Would you say this has been your experience?

MS. JACKIE ANDERSON: Well, Child and Youth Care Workers in itself are not -- are not paid a lot for the

work that we do, and the extra work that we do. I'm not sure what you're asking in regards to administrative grants.

MS. ERICA BEAUDIN: Several times when we have these contribution and grants, and it has been my experience, and I was seeing if it was your experience, that we are expected to do more with less. So we can't bring on extra staffing. We have more administration with less dollars towards the administration. And we're expected to do more, basically five cents on the dollar.

MS. JACKIE ANDERSON: Yes, absolutely. We run into those situations, and again it's not always having the capacity to respond to the needs of our families and our young people.

CHRISTINE DUMAINE, Previously Affirmed:

CROSS-EXAMINATION BY MS. BEAUDIN:

MS. ERICA BEAUDIN: Okay. Thank you. Ms. Dumaine, I'm not quite sure if your community is Ojibwe or Cree?

MS. CHRISTINE DUMAINE: Ojibwe.

MS. ERICA BEAUDIN: So *Miigwetch* for your courage and telling your story this morning. The first time I stood here, I disclosed some very personal information about my journey from young adulthood. And not only did my voice shake, but I almost broke down. So thank you for adding your voice to legitimize and support the lived

experiences many of us Indigenous women live.

In the discussion this morning, you spoke of your -- your agency, your HOME, and I'm not Ojibwe so I'm -- I don't want to butcher how the HOME is called, provided and how the HOME had provided years' long and supportive services for you and because of this, you are able to create a life you are comfortable and safe in. You now work at the HOME and you are giving back. Would you state that the best opportunity for other youth women or families who are struggling would be long-term uninterrupted services?

MS. CHRISTINE DUMAINE: Yes.

MS. ERICA BEAUDIN: Ms. Dumaine, how important on the scale of one to ten is the accessibility to Indigenous traditions, languages, and customs to create a strong identity for our youth and women?

MS. CHRISTINE DUMAINE: Okay. Can you say that again?

MS. ERICA BEAUDIN: How important on a scale of one to ten is the ability to access Indigenous traditions, languages and customs to create a strong identity for our young people and our women?

MS. CHRISTINE DUMAINE: It's -- I would say ten, 'cause it's very important.

MS. ERICA BEAUDIN: Okay. Ms. Dumaine, you also spoke of legitimacy of helpers and helping agencies

even though you didn't frame it that way. I've heard this many times from many other individuals and families. Many agencies have had generations of people who have paid mortgages, schooling and vehicles off the misery industry of our people. That is basically off the suffering of where we're going when we go seek help. Many of them are non-Indigenous, or the wily agencies often put one brown face on their board to state they're Indigenous. Do you believe funding agencies should add to their eligibility requirements, and that there should be some sort of requirement by agencies to prove they are legitimate helpers of vulnerable children, youth and families? So in other words, how should the voice of the people who are accessing services be heard and listened to right down to the legal agreements that agencies sign?

MS. CHRISTINE DUMAINE: I don't -- I'm not too sure on -- like, can you give me an example?

MS. ERICA BEAUDIN: So do you -- how do you believe that voice like, your voice as a young -- when you went to the HOME, your voice even now as a person of lived experience and has gone back to the HOME, how do you believe that that voice should be heard even with the funding agencies to make it part of that legal obligation that agencies provide these services?

MS. CHRISTINE DUMAINE: I'm not sure. Like,

I'm not too sure. I -- like, I can't -- I don't know what you're saying. Like --

MS. ERICA BEAUDIN: Okay.

MS. JENNIFER COX: So are you asking how would she be reported? The staff -- the staff --

MS. ERICA BEAUDIN: Like, how do you -- how would you like to be heard to make sure that agencies do what they say that they are going to do for youth?

MS. CHRISTINE DUMAINE: Maybe tell my story to them and let them know how I felt when I was little.

MS. ERICA BEAUDIN: Okay. Thank you very much. I'm actually ten seconds left, so thank you to everyone on the panel today. May you journey home safely and find your home's fires burning strong and bright when you get home. Thank you very much.

MS. JENNIFER COX: So the next party is the Manitoba Murdered and Missing Indigenous Women and Girls Manitoba Coalition and 13 minutes.

MS. CATHERINE DUNN: Good afternoon, Commissioners. My name is Catherine Dunn and my questions this afternoon are going to be restricted to Ms. Anderson and Ms. Dumaine.

CHRISTINE DUMAINE, Previously Affirmed:

CROSS-EXAMINATION BY MS. DUNN:

MS. CATHERINE DUNN: Firstly, Ms. Dumaine,

you stated this morning that, if you had a recommendation, and you did have a recommendation for the Inquiry, that you would like to see rehabilitative residential centres for youth under age 18. Is that correct?

MS. CHRISTINE DUMAINE: Correct.

MS. CATHERINE DUNN: Why did you make that recommendation?

MS. CHRISTINE DUMAINE: I know we have AFM in Winnipeg, but we just need something, like, on sacred land with teaching, ceremony. Something where a family can go in right away, not wait 60 days.

MS. CATHERINE DUNN: And in your view, waiting lists for addiction treatment -- why is that a bad thing?

MS. CHRISTINE DUMAINE: Please, can you say that again?

MS. CATHERINE DUNN: Why is having to wait to get addiction treatment not a good thing?

MS. CHRISTINE DUMAINE: Because they can -- they can get worse.

MS. CATHERINE DUNN: And it -- would it be fair to say that, when you have reached a decision to turn away from alcohol and drugs, that it is important to have people respond to that decision immediately?

MS. CHRISTINE DUMAINE: Yes.

MS. CATHERINE DUNN: All right. Because if you don't respond immediately, it may be that you won't make that decision again in 60 days? Is that fair?

MS. CHRISTINE DUMAINE: Correct.

MS. CATHERINE DUNN: Thank you.

JACKIE ANDERSON, Previously Affirmed:

CROSS-EXAMINATION BY MS. DUNN:

MS. CATHERINE DUNN: My questions now are for Ms. Anderson. Ms. Anderson, you have a great deal of knowledge in the area of sexual exploitation, and in particular, as part of your background, you were part of the development of Tracia's Trust, Manitoba's sexual exploitation strategy. Is that correct?

MS. JACKIE ANDERSON: Yes.

MS. CATHERINE DUNN: Do you know who Tracia was?

MS. JACKIE ANDERSON: Yes. She was a young Indigenous woman who, unfortunately, was taken from her community and put into care of Child Family Services in programs that didn't understand who she was and what she was experiencing. And unfortunately, she's no longer here with us.

MS. CATHERINE DUNN: And this young girl committed suicide, did she not?

MS. JACKIE ANDERSON: Yes.

MS. CATHERINE DUNN: And if I recall correctly, she was 15.

MS. JACKIE ANDERSON: Yes.

MS. CATHERINE DUNN: Thank you. And Tracia's Trust came about as a result of the -- the inquest into the death of that young person. Is that fair to say?

MS. JACKIE ANDERSON: It actually started prior.

MS. CATHERINE DUNN: Okay.

MS. JACKIE ANDERSON: But it was formalized in 2008, where, again, summits were held in the north and the south to provide recommendations of what else was needed within our province to address the issue.

MS. CATHERINE DUNN: And in terms of the young people that come to your programs, would it be fair to say that -- is there a -- I know you -- what -- what is the common age of young people coming to your programs?

MS. JACKIE ANDERSON: The common age of referrals that are coming into -- in our home is between 14 and 16. However, when you're looking at the average age of -- of exploitation, we're looking at anywhere from 12 to 13 years old.

MS. CATHERINE DUNN: All right. And can you speak about the issue of addiction for the young people who come to your program? Is that a common symptom that they

come into the program with?

MS. JACKIE ANDERSON: Unfortunately, it is a very common -- because it's part of that luring and -- and recruitment of those that are taking advantage of our kids, and unfortunately, those drugs are being provided to our young people, and that's when the addiction and the masking happens for them. So yes, it is very common that we are dealing with young people that are very hurting through addictions.

MS. CATHERINE DUNN: Are you able to say that addictions affects these young people in the 90 to 100 percent range or something less than that, or can you say?

MS. JACKIE ANDERSON: Affecting them or …

MS. CATHERINE DUNN: Well, the young people who come into your programs, would you say that 90 percent of them are suffering from addiction issues or 50 percent or is that not a fair question?

MS. JACKIE ANDERSON: It's a very high number, absolutely.

MS. CATHERINE DUNN: Okay.

MS. JACKIE ANDERSON: Higher than 80.

MS. CATHERINE DUNN: And would it be fair to say that the young people who come into your program all have a very high degree of trauma?

MS. JACKIE ANDERSON: Absolutely.

MS. CATHERINE DUNN: And would it be fair to say that the young people who come into your program have high degrees of mental health issues other than trauma?

MS. JACKIE ANDERSON: Absolutely, because, I mean, just with the trauma they're experiencing, the mental health issues that are attached to that as well as the addictions, the drugs, there's the drug-induced -- that's also affecting them.

MS. CATHERINE DUNN: And would you say that these issues that you have described in your evidence now and this morning, that is, addictions, trauma, mental health issues, are issues that are not easily addressed in short periods of time?

MS. JACKIE ANDERSON: Correct, and again, as I spoke earlier, you're looking at, you know, anywhere up to 90 days to access an adult treatment centre. You know, we have different tools for our young people, but when our young people are saying, I want help, I want it now, you need to be able to provide it now.

MS. CATHERINE DUNN: And with the young people who come into your program, are you the only organization that is able to provide culturally appropriate services for sexually exploited Indigenous youth?

MS. JACKIE ANDERSON: Well, we are an Indigenous organization, as I mentioned.

MS. CATHERINE DUNN: Right.

MS. JACKIE ANDERSON: Hands of Mother Earth is the only rural traditional healing lodge that we know across Canada that is providing culture and ceremony and healing on sacred land.

MS. CATHERINE DUNN: How important, in your view, is the issue of culture and culturally appropriate services?

MS. JACKIE ANDERSON: It's -- it's priority. Again, you know, what we learn is our young people are not connected to their spirit, and when their spirit is wandering, that's when the hurt and vulnerabilities comes into their lives.

MS. CATHERINE DUNN: And if you have culturally appropriate services to provide to your young people, that also has a positive effect or decreases the issues of addiction, trauma, and other mental health issues. Is that fair?

MS. JACKIE ANDERSON: Yes, it does decrease their risk.

MS. CATHERINE DUNN: So the very factor of using culturally appropriate services such as those that your Indigenous organization provides is one thing that hits a number of serious issues. By that, I mean if you are able to provide your services in a culturally appropriate way,

you can speak to addictions, trauma, and mental health at the same time.

MS. JACKIE ANDERSON: Yes.

MS. CATHERINE DUNN: In terms of the funding that you have, you've mentioned that it is difficult at times to have appropriate funding mechanisms because of the length of time that various programs, such as your own, are -- are provided for. Is that fair?

MS. JACKIE ANDERSON: For our homes?

MS. CATHERINE DUNN: Yes.

MS. JACKIE ANDERSON: Well, again, we're provincially funded for Hands of Mother Earth and Honouring the Spirits of Our Little Sisters. What I was referring to earlier are these pilot projects that we're, you know, where organizations are getting short-term funding to do programming and to mobilize communities, and then there's no more funding.

MS. CATHERINE DUNN: Could you give us an example of what type of short-term programs your organization provides?

MS. JACKIE ANDERSON: Well, I mean, we look at, as I mentioned earlier, I'm -- I'm thinking this would probably be the top of my head that I can think of is within -- we get short-term funding to be able to provide youth leadership and engagement for community youth, and often

those are funding projects for six months or for a year. So again, when you're working with your -- these young people, working through, building their capacity, there needs to be constant post-support to continue to help them with opportunities to build their strengths and their gifts.

MS. CATHERINE DUNN: And self-esteem is not necessarily built in a year or two, is that fair to say?

MS. JACKIE ANDERSON: Very fair.

MS. CATHERINE DUNN: And often, on their journeys, you -- your organization tries to provide positive life experiences such -- you mentioned going to Edmonton mall, et cetera. Is that fair?

MS. JACKIE ANDERSON: Yes.

MS. CATHERINE DUNN: And that is comparable to a family experience for these young people, and it doesn't necessarily translate to a budget line on your financing application.

MS. JACKIE ANDERSON: Right.

MS. CATHERINE DUNN: And what that means is that you have a lot of off-the-table or out-of-pocket expenses to provide life-empowering experiences for your young people.

MS. JACKIE ANDERSON: Yes.

MS. CATHERINE DUNN: And who -- who provides that out-of-pocket money or that off-the-table expense? Who

do you get that money from?

MS. JACKIE ANDERSON: Well, I guess it really depends. Like, we do a lot of, like, internal fundraising. You know, we might sometimes receive some support through philanthropy. But again, we -- we do our -- our yearly program planning to identify the needs and the wishes of our young people and create what that looks like, and then start doing our fundraising to be able to make that a reality.

MS. CATHERINE DUNN: And the -- -- the problem, although Winnipeg and Manitoba is a very generous in terms of providing funds, you can't always build a budget on hoping what you're going to get from a fundraising event; is that fair?

MS. JACKIE ANDERSON: Yes.

MS. CATHERINE DUNN: And as a result, your young people may not get the programming that they ask you for and that you encourage them to ask you for as part of their journey to become independent young adults?

MS. JACKIE ANDERSON: Yes.

MS. CATHERINE DUNN: You mentioned that you currently have two group homes, and there are ten beds -- or is it 12 beds in total?

MS. JACKIE ANDERSON: Are you talking about the -- that's specialized for sexually exploited children and youth?

MS. CATHERINE DUNN: Yes, I am, sorry. That's what I am --

MS. JACKIE ANDERSON: Homes, yes. Beds.

MS. CATHERINE DUNN: (Indiscernible) -- exactly. Yeah. So how many beds is it?

MS. JACKIE ANDERSON: Twelve beds in total between the two.

MS. CATHERINE DUNN: Twelve beds. How many sexually exploited youth do you think there are in Manitoba at the present time?

MS. JACKIE ANDERSON: I -- I couldn't even give you a number. I mean, you're looking at, you know, the visible and the non-visible exploitation, which is always hard to track. But absolutely, a very high number of -- of young people under the age of 18.

MS. CATHERINE DUNN: Would you put that number in the hundreds or in the thousands or can you say?

MS. JACKIE ANDERSON: I would say in the hundreds, for sure.

MS. CATHERINE DUNN: All right. And in order to access -- and you would, I think -- and I think you've made it clear this morning, but in your opinion, your program is very successful?

MS. JACKIE ANDERSON: It's very successful. And again, when I, you know, look at, you know, my little

sisters who once used to give me a hard time and push me away and keep me out of their lives, and they're sitting beside me, you know, and -- and working with me and supporting their little sisters, that's something to celebrate.

MS. CATHERINE DUNN: And what is sitting beside you is your work and her work?

MS. JACKIE ANDERSON: Absolutely. She was a very resilient young woman who knew what she wanted, and once she let her walls down and allowed us to love her, she -- she grew.

MS. CATHERINE DUNN: And can you tell me in terms of allowing her to grow and to fulfill her own dreams, how important was it that she experience her own culture?

MS. JACKIE ANDERSON: Extremely important. And I remember her when she first came in at the age of 13, not even knowing where she was from, you know, not having memories of her community, her First Nations community, not ever attending a ceremony or sitting at a drum or using medicines. And that was something that we immediately, you know, provided her. And as she took her time to -- to engage in that, that became part of her healing and her strength.

MS. CATHERINE DUNN: You mentioned --

MS. JENNIFER COX: Counsel, sorry. Time's up.

MS. CATHERINE DUNN: Thank you.

MS. JENNIFER COX: The next party is the Aboriginal Women's Action Network with 13 minutes.

JACKIE ANDERSON, Previously Affirmed:

CROSS-EXAMINATION BY MS. BLANEY:

MS. FAY BLANEY: Thank you. Good afternoon. My name is Fay Blaney, and I am with the Aboriginal Women's Action Network. Thank you, Jackie, for your presentation. I was very moved by it, and a lot of my questions will be directed to you.

MS. JACKIE ANDERSON: Okay.

MS. FAY BLANEY: I listened with keen interest as you spoke about how you used terminology. And I know that some of the women from your organization that came out to Vancouver when we were preparing for this Inquiry also addressed this issue of the use of terminology.

MS. JACKIE ANDERSON: M'hm.

MS. FAY BLANEY: And you were saying that you prefer not to use the word "prostitution" because it is so normalized as a form of violence, and that the use of the term "prostitution" in some ways obscures sexual exploitation. I'm just wondering if you can tell us more

about the use of that terminology.

MS. JACKIE ANDERSON: The -- the correct terminology that -- or sorry, that we use within our province as directed by our survivors? I guess just more to elaborate that when you -- and this is what we hear from your survivors and those young women that we were, you know, facilitating to come into our homes or sharing with us that when, you know, they're -- they're called, you know, a prostitute or prostituting yourself or working in the sex trade, that there was, like, an element of choice. And -- and that is something that is imperative for their healing to understand, that this was not a choice, it's others taking advantage of them and the shame that's often, you know, carried with using that terminology.

So in order for us to have started to help our -- our young people heal, it was to take -- create that education and awareness of -- of where they are and to help them be able to let go of all that shame and blame that they've been carrying over the years through their victimization.

MS. FAY BLANEY: Okay. Thank you. And I was really pleased to hear that there have been -- I think you said 100 convictions?

MS. JACKIE ANDERSON: Yes, last year.

MS. FAY BLANEY: Last year. Of sexual

predators, pimps and johns.

MS. JACKIE ANDERSON: M'hm.

MS. FAY BLANEY: In Vancouver, the Vancouver Police Department refuses to enforce Bill C-36, the *Protection of Communities and Exploited Persons Act*. And so -- so there have been no arrests. There's no convictions because they refuse to enforce it.

MS. JACKIE ANDERSON: M'hm.

MS. FAY BLANEY: And so I'm just wondering, how were you able to work with your criminal justice system? How were you able to convince them to do their job and to uphold the law and why is it important to enforce this law?

MS. JACKIE ANDERSON: Again, when I talk about the partnership and the collaboration and the importance of relationships, with all sectors that are involved in protecting and standing up for our young people, our Sexually Exploited Youth Community Coalition that we have started over the years includes our police department and other different systems. So again, those relationships are really key and important, especially when you're operating a safe home for our young people because, often, our young people are afraid to speak to the police. However, they trust in us who we trust, and by having those established relationships with specific people within the

police, it really provides more of a safe place for our young people to be able to share what's going on in their lives. I mean, our young people will take us for a drive, and they'll show us where, you know, all the drug houses are or where girls are being exploited, but they're not in a place to be sitting on a stand and, you know, disclosing what's happening to them. But by us having those relationships with the police, coming into our home not just to enforce the law but to come have tea and bannock, you know, is very important for our -- for our young people.

So our police department is very active in -- in enacting this bill, and are partners are part of our Winnipeg Outreach Network.

MS. FAY BLANEY: M'hm. Well, I hope that they will support the continuation of this -- this law. So you were saying that the bill is somewhat inadequate, and I was wondering, like, what do you mean by that? What more can be added or included to make it more effective?

MS. JACKIE ANDERSON: It's -- it's something that is very, very useful today. I -- I do absolutely believe that there's still other aspects. I mean, again, I would like to see perpetrators immediately be given jail time, you know. And -- and I guess the other aspect is, you know, for our women, our women are, you know -- don't

want to be in those situations. However, what needs to happen is programs and services for our adult women. You know, when you turn 18 or you age out of care, you know, services shouldn't just be stopped. And -- you know, and unfortunately, there's not a lot of services for adult women, in particular in our province, a safe place where they can go to, a safe place for resources to maybe get them off the street and be able to take them somewhere where they're going to be nurtured, loved, and taken care of and get the services that they need.

MS. FAY BLANEY: Yeah, I think that's a prevalent theme that the Commissioners have heard, that there is inadequate programs and services for Indigenous women and girls, and especially I think there's inadequate attention being paid to us being able to have independent women's groups and organizations so that we can bring our voices forward. But we're not supposed to make submissions, so I better stick to my questions.

(LAUGHTER)

MS. FAY BLANEY: So just getting back to the topic of terminology. In BC we abolitionists, there's a good group of us, use the language of prostitution to underscore sexual exploitation of women and girls, and we see prostitution as being on the continuum of male violence against Indigenous women and girls -- well, against all

women and girls.

MS. JACKIE ANDERSON: M'hm.

MS. FAY BLANEY: And that the struggle that we have is with the pro sex groups that see this as a viable source of employment or work, sex work, and I just wanted to get your thoughts on that language, the term "sex work"?

MS. JACKIE ANDERSON: I mean, again, just coming from my experience of, you know, being with our young people and our experiential women. I've sat at tables to support them, I've -- I've listened to how language effects, you know, and interrupts even sometimes their healing triggers, you know, the healing that they have or where they're at, at that time, and it's just very important that what our women with lived experience are telling us, that, you know, that's something that we need to stand strong.

So as an ally and support to those women, it's important that, you know, if they're saying this is something that I need to stand strong and educate and correct when people within our province are, you know, using that language, then it's something I'm committed to do, to educate. And, again, I did share earlier that language is different all across the province, and that was a very common theme, you know, and when -- when they were

doing the visits across Canada with --

MS. FAY BLANEY: If I can pry just a little bit deeper, do you see that as a viable source of employment for Indigenous women and girls?

MS. JACKIE ANDERSON: No, I do not.

MS. FAY BLANEY: Okay. That's what I was trying to get at. So you spoke about the importance of autonomy for the young women that come into your homes -- and my time is running out so quick I see here -- and you -- I was going to give you examples of how you said that, but I'll leave that for now.

You were talking about the importance of them having some level of autonomy in their healing process and in their wellness, and I have to say that I agree from my feminist perspective that consciousness raising and understanding the dynamics of power and the way power works, oppression, exploitation. So I wanted to just get on record your thoughts about the importance of women only healing spaces, where, you know, there's a separate -- a clear separate and distinct place for survivors of violence and abuse and exploitation in doing their healing work, as opposed to having co-ed treatment centres?

MS. JACKIE ANDERSON: That was one of the direct recommendations when -- when we created the programs underneath Tracia's Trust, and it was very -- it was very

important that -- that there was a space that was created that would be safe for -- for our young women.

I mean, a very high number of exploiters, traffickers that are harming our young people are men, and it was important to them, especially in a children and care facility, that their caregivers were -- were women, were aunties, were kokums.

MS. FAY BLANEY: And do you think that that concept of healing would apply to other areas, such as addictions or addictions treatment or exiting services or historic abuse groups?

MS. JACKIE ANDERSON: I would think so. Again, depending on the nature of -- you know, so, for example, I'll use domestic violence for example, we operate a program for men and we operate a program for women.

MS. FAY BLANEY: M'hm.

MS. JACKIE ANDERSON: We also see the value in, you know, relationships, so we do couples, you know, as also a part of -- of couples retreat as part of that healing. But our young women tell us if you put me in a circle with a bunch of boys or, you know, a bunch of men, I'm not going to be safe to be able to share my true truths.

MS. FAY BLANEY: Yeah, I'm really alarmed at that -- that way -- the way things are done where treatment

centres for addictions are co-ed, and often the offenders are there talking about their exploits in front of me who is a survivor.

MS. JACKIE ANDERSON: M'hm.

VALERIE GIDEON, Previously Affirmed:

CROSS-EXAMINATION BY MS. BLANEY:

MS. FAY BLANEY: And it definitely doesn't feel safe. So I have a minute left and I wanted to address some questions to you, Ms. Gideon. I have three questions, but I'm going to go right to my last one, and I might ask the other two if time permits. So I'm just wondering how your department is responding to the needs of Indigenous women and girls in large urban centres?

I'm wondering if -- I'm going to ask a bunch of questions all at once here. Is there any consideration of drawing on Jackie's expertise in developing women only spaces, where women survivors feel safe, or alternatively, to have the damaging effects of having both offenders and survivors in the same healing setting, is one of my questions? I have another one for you, but I'll --

DR. VALERIE GIDEON: I mean, we don't design specifically the -- the organization service delivery mix to the populations that they serve --

MS. FAY BLANEY: Okay.

DR. VALERIE GIDEON: -- with respect to our

funding parameters, so --

MS. FAY BLANEY: Okay.

DR. VALERIE GIDEON: -- that flexibility is offered.

MS. FAY BLANEY: Okay, that's the same answer I heard before. I'm going to ask you a different question then.

MS. JENNIFER COX: Your --

MS. FAY BLANEY: From a governance perspective -- pardon?

MS. JENNIFER COX: You're out of time.

MS. FAY BLANEY: It says 12 seconds over there.

MS. JENNIFER COX: Minus.

MS. FAY BLANEY: What? 17 -- okay, it's moving now, but it still had time over there. Okay.

UNIDENTIFIED SPEAKER: It's going in the negative and it's confusing people.

UNIDENTIFIED SPEAKER: Because it's red.

UNIDENTIFIED SPEAKER: It's going backwards.

MS. JENNIFER COX: So the next party is Eastern Door Indigenous Women's Association, and 13 minutes.

CHRISTINE DUMAINE, Previously Affirmed:

CROSS-EXAMINATION BY MS. CLIFFORD:

MS. NATALIE CLIFFORD: Good? All right. I'm Natalie Clifford from the Eastern Door Indigenous Women's Association. We represent the interests of primarily Mi'kmaq and Maliseet women in the Atlantic Region, and where those interests align with other Indigenous women in that region as well.

I'm going to just start with one quick question -- one quick question for Ms. Dumaine. Thank you very much for being here and sharing your story with us. I just wondered, what will you teach your kids to help them avoid being targeted by human traffickers?

MS. CHRISTINE DUMAINE: Well, my son, he's ten, and I just keep -- like, he knows what I -- where I work and everything, and I just -- and my -- I have a four-year-old daughter, so it scares me to even think about that kind of stuff, like, what could happen to her, but I would -- I would educate her what I all know and what I -- like, what the girls at the HOME taught me as well.

JACKIE ANDERSON, Previously Affirmed:

CROSS-EXAMINATION BY MS. CLIFFORD:

MS. NATALIE CLIFFORD: Thank you. Ms. Anderson, I have a few quick questions for you. I'm curious about whether you're ever directly consulted by the ISC and FNIHB for your position as you've shared today, given your experience?

MS. JACKIE ANDERSON: Can you explain what ISC is?

MS. NATALIE CLIFFORD: The --

MS. JACKIE ANDERSON: That probably answers your question.

(LAUGHTER)

MS. NATALIE CLIFFORD: The new name -- the new name for the Federal department overseeing health services for Indigenous people.

MS. JACKIE ANDERSON: Okay. No, not -- not directly, personally.

MS. NATALIE CLIFFORD: So do you rely on your AFN rep -- and -- and I'm asking these questions because I want to understand whether you do get consulted on the gaps?

MS. JACKIE ANDERSON: We -- we are a very active consultant as it relates to issues that are directly affecting urban children and families, however, personally that would not be my role, that would be the role of our executive director, who is a very, very engaged, intelligent woman that ensures that the voice of our community is -- is represented.

MS. NATALIE CLIFFORD: So is that through the regional AFN rep?

MS. JACKIE ANDERSON: I can't answer you

that, I'm sorry, I have no --

MS. NATALIE CLIFFORD: Based on your evidence, is it fair to say that you credit the solid support from a provincial Minister of your programming for its success?

MS. JACKIE ANDERSON: Well, we've had multiple Ministers over the years, and -- and I'm not, you know, into the politics and all that stuff. At the end of the day it's about our -- our young people, and -- and, yes, today we have very, very strong community support at all levels.

MS. NATALIE CLIFFORD: You mention you have 215 -- 250 employees?

MS. JACKIE ANDERSON: Yes.

MS. NATALIE CLIFFORD: So just looking forward to next year, do they have jobs with their funding in place to employees?

MS. JACKIE ANDERSON: Yes, within our Children in Care programs they do.

MS. NATALIE CLIFFORD: Okay. Thank you.

MS. JACKIE ANDERSON: You're welcome.

VALERIE GIDEON, Previously Affirmed:

CROSS-EXAMINATION BY MS. CLIFFORD:

MS. NATALIE CLIFFORD: So, Dr. Gideon, the rest of my questions are for you.

I'm going to focus in on the example of mental health and contribution agreements because you've indicated that they are developed from community plans, correct?

DR. VALERIE GIDEON: That's right.

MS. NATALIE CLIFFORD: Can you define community for me, please?

DR. VALERIE GIDEON: So for those programs that are specific to First Nations communities, it's the First Nation community reserve base in the --

MS. NATALIE CLIFFORD: Reserves?

DR. VALERIE GIDEON: -- province.

MS. NATALIE CLIFFORD: And councils?

DR. VALERIE GIDEON: Yes, but there's also other organizations like political/territorial organizations or the equivalent of what would be a tribal council in regions also that provides services.

MS. NATALIE CLIFFORD: Okay. Can and individual group say in a city administering services for women and young people in that city, submit a community plan for a contribution agreement on mental health?

DR. VALERIE GIDEON: We do fund, under the Victims of Violence Initiative, or even under the Non-Insured Health Benefits Program service delivery organizations that are working in urban contexts.

Sometimes it's friendship centres or other organizations that have service delivery. So for instance in Winnipeg we do fund 24/7 youth shelter access. So there's -- there's examples of those types of initiatives.

Each region, as I mentioned, we have partnership committees, so for instance, in the Atlantic Region we have the Atlantic First Nations health partnership table that's existed since the '90s. It's a co-management table. There are a number of representatives from each of the First Nations regions that sit at that table and they make decision with respect to where funding should be targeted. So it's not always held at a community level. Depending on what the needs are and depending on what the most effective interventions are that are judged by the First Nations in that -- in that region.

MS. NATALIE CLIFFORD: Okay. Thank you. Can you speak to -- with that example of on the east coast, the effectiveness, then, of using mental health and contribution agreements as it currently plays out. Can you speak to the effectiveness of that right now in Nova Scotia and how that's playing out?

DR. VALERIE GIDEON: Sorry, I just lost the last part of the -- effectiveness in? Sorry?

MS. NATALIE CLIFFORD: Nova Scotia.

DR. VALERIE GIDEON: In Nova Scotia. Well,

I can speak to at a National level an evaluation that was done with respect to specific outcomes that I referenced earlier around increasing healthy behaviours awareness.

MS. NATALIE CLIFFORD: Okay. So do you know who sits at that table, then, the --

DR. VALERIE GIDEON: The Atlantic First Nations health partnership table?

MS. NATALIE CLIFFORD: Or the parties involved?

DR. VALERIE GIDEON: So there are First Nations representatives that are assigned by each of the sub-regions by leadership, so there are community Chiefs, political territorial organizations that are represented at that table, as well as, of course, some FHNIB regional executives.

MS. NATALIE CLIFFORD: So does it go back, then, to a reliance on a relationship with the regional Chiefs, say the AFN representative that sits at the national table?

DR. VALERIE GIDEON: The regional Chief is invited to participate, but it's actually the First Nations leaders Chiefs elected by communities. But then as an assembly they identify who the regional reps will be as a collective.

So, like, in -- in New Brunswick, the New

Brunswick Chiefs would get together and determine who their representatives would be at the table. In Nova Scotia the communities would get together and determine who their representatives are at the table.

MS. NATALIE CLIFFORD: Okay. So do you know who the representatives are that the chiefs and the AFN representatives have chosen at the Nova Scotia table?

DR. VALERIE GIDEON: We have that information in terms of -- I know some of them in terms of names, but I can't tell you the full list of members.

MS. NATALIE CLIFFORD: So do you think, then, it might be fair to say that it would be beneficial for the Commission if they're interested in understanding diversity of the way these agreements and funding is implemented across the country that they may need to hear from representatives from those jurisdictions?

DR. VALERIE GIDEON: I really can't presume to tell the Commissioners who they should hear from. I -- I mean --

MS. NATALIE CLIFFORD: You can't speak to the diversity of implementation across the country yourself?

DR. VALERIE GIDEON: I can speak to each of the regional committees and who makes up the membership generally in terms of names. Like, Chief Candice Paul is

the co-chair, I know that.

MS. NATALIE CLIFFORD: Okay.

DR. VALERIE GIDEON: But in terms of all of the individuals that are part of that, we're talking about hundreds of people, so it would be difficult for me to know all of the names.

MS. NATALIE CLIFFORD: So when we're talking about service provision in cities, for example, and say there is an organization wishing to be heard -- wishing for you to hear their perspective on service provision and the gaps, is there any way for you to monitor how the regional tables or the provincial tables are actually selecting members or is it possible that individual service providers who may be interested in having input would fall through the cracks and not be heard by -- by your department?

DR. VALERIE GIDEON: Well, I mean, anybody can absolutely contact us and sit with us to talk about what needs exist in context and what priorities, and we can bring that information and -- and invite presentations at the partnership committee tables. My experience with these tables is that they're extremely open to hear from service delivery organizations with respect to what the needs are. And most First Nations leadership across the country are very concerned about how to support their members that are living in urban cities and urban contexts, and they want to

be able to provide them with service and reach them.

MS. NATALIE CLIFFORD: Okay. So the role of FNIHB is, just to confirm, is -- is like proper characterization to fill the gaps while respecting the role of other jurisdictions, being First Nations governance and provinces with respect to health?

DR. VALERIE GIDEON: That's a good way of expressing it, for sure.

MS. NATALIE CLIFFORD: Okay. So would you characterize that as in a positive responsibility on government or on Canada?

DR. VALERIE GIDEON: I -- I would characterize that as a positive responsibility.

MS. NATALIE CLIFFORD: Okay. Requiring action and research?

DR. VALERIE GIDEON: Yes, and which is -- I mean, the last three Federal budgets has made significant investments with respect to mental wellness, I think the government is recognizing its responsibility with respect to supporting First Nations and mental illness.

MS. NATALIE CLIFFORD: Okay. So I just want to go back to the idea of the round tables, and as you mentioned the Chiefs and you mentioned the name of a Chief who sits at the round table and chairs it. So is it possible that a grassroots women's organization who does

not necessarily have standing to deal directly with your department, and maybe whose interests don't align with those of the chiefs, and say the example again is that their -- that they would not be selected to sit at that table; correct?

DR. VALERIE GIDEON: They wouldn't necessarily -- they wouldn't sit at the table, but they could come in and present what are their ideas and solutions with respect to better servicing First Nations in -- in their province or in the city.

MS. NATALIE CLIFFORD: Okay. Make or give a presentation to that same round table that opted not to incorporate them in the discussion in the first place?

DR. VALERIE GIDEON: Well, it's not really about not agreeing to service delivery organizations specifically being part of it, but these are tables that represent First Nations leadership in terms of governments, and so it is a measure to share decision making with elected representatives --

MS. NATALIE CLIFFORD: Decide -- decide on funding allocations?

DR. VALERIE GIDEON: Correct, but it doesn't mean that there isn't collaboration with service delivery organizations.

MS. NATALIE CLIFFORD: Just a moment. I

just wanted to look at -- Ms. Anderson identified a really specific area of -- and I think it goes to the heart of the issue of our women experiencing a disproportionate amount of violence. This connection between women coming from remote communities to city centers -- and young people. It's not just women, but women, especially -- arriving in city centers and being specifically targeted, and the very disturbing evidence that traffickers and recruiters are listening for their accents to determine their isolation and vulnerability.

So I wondered, to me this sounds like a significant gap where the provinces aren't necessarily prepared to deal with this kind of specific vulnerability. The communities themselves, due to the remoteness, are, you know, not preparing these children. So is there a mandate within the ISC or a plan for, you know, health promotion and education specifically before children and women leave remote communities in this respect?

DR. VALERIE GIDEON: It's a good question. I think that we do have sources of funds that can help to support strategies. For instance, in Thunder Bay, we have initiatives with the high schools that First Nations youth from remote communities --

MS. NATALIE CLIFFORD: After they've come to the high school, though.

DR. VALERIE GIDEON: But knowing that they are to come to the high school, to plan in advance services to -- to help support them, so targeted mental health counselling. We have a Suboxone program in the Thunder Bay high school, for instance, that First Nations are governing to help address at-risk behaviour. So there is planning in advance that can be made to make sure that there are support systems for individuals that have to come down for education or other reasons.

MS. NATALIE CLIFFORD: Thank you. That's all my questions.

MS. JENNIFER COX: So the next party is the Assembly of Manitoba Chiefs, and they have 13 minutes.

VALERIE GIDEON, Previously Affirmed:

CROSS-EXAMINATION BY MS PASTORA SALA:

MS. JOËLLE PASTORA SALA: Good afternoon, Commissioners, Elders, family members. My name is Joëlle Pastora Sala. I am counsel to the Assembly of Manitoba Chiefs. Good afternoon, panel members. Thank you all for your presentations today.

I'll be focussing my questions to Dr. Gideon. I hope to have time to ask you some questions, Ms. Anderson. Ms. Dumaine, out of respect for -- for you, I will not be asking you questions today, but on behalf of the Assembly of Manitoba Chiefs, I'd like to thank you for

sharing your voice and experience with us.

MS. CHRISTINE DUMAINE: Thank you.

MS. JOËLLE PASTORA SALA: Dr. Gideon. You stated that FNIHB derives its authority from the *Indian Health Policy* of 1979 and the Department of Health -- of *Health Act*, correct?

DR. VALERIE GIDEON: So it was the *Department of Health Act*. Of course, now we are within the context of the Department of Indigenous Services Canada, and enabling legislation for the creation of that department has not yet been introduced.

MS. JOËLLE PASTORA SALA: And it's the three pillars in the policy from 1979 that continue to guide the work of FNHIB?

DR. VALERIE GIDEON: Yes. But as I mentioned in 2012, we published a more comprehensive strategic plan in order to increase our commitments and also updating in the relevancy of the context.

MS. JOËLLE PASTORA SALA: But these three pillars continue to be at the root of your department's work?

DR. VALERIE GIDEON: It's still part of the mandate, absolutely.

MS. JOËLLE PASTORA SALA: Would it be correct to say that First Nations health services are

delivered as a matter of policy and are not entrenched in legislation?

DR. VALERIE GIDEON: That is correct.

MS. JOËLLE PASTORA SALA: And because of this, policies may change frequently, based on political mandates?

DR. VALERIE GIDEON: I have not seen in my 20-some years in my career policy changes that have been significant within the context of the First Nations health branch mandate.

MS. JOËLLE PASTORA SALA: But it would be conceivable?

DR. VALERIE GIDEON: I think that it would -- conceivable.

MS. JOËLLE PASTORA SALA: Would it be possible?

DR. VALERIE GIDEON: It would be possible.

MS. JOËLLE PASTORA SALA: Are you generally -- generally familiar with the *Canada Health Act*?

DR. VALERIE GIDEON: I am familiar with the *Canada Health Act*.

MS. JOËLLE PASTORA SALA: If I describe this Act to you as the federal legislation which establishes criteria and conditions for insured health services and extended health care services under provincial law to

access cash contributions by the Federal government, that would be consistent with your understanding?

DR. VALERIE GIDEON: That would be consistent.

MS. JOËLLE PASTORA SALA: I'd like to just quickly read to you the five pillars of the *Canada Health Act*. Public administration, comprehensiveness, universality, portability, accessibility. Subject to check, is this familiar to you?

DR. VALERIE GIDEON: Yes.

MS. JOËLLE PASTORA SALA: In thinking of the mandate of NHI -- FNHI -- I'm -- I have trouble with acronyms, I apologize. Of your department, are you able to describe for me the relationship between the 1979 Indian Health Policy and the Canadian *Health Act*? Specifically, does the Canadian *Health Act* apply to First Nations living on reserve?

DR. VALERIE GIDEON: Yes, because First Nations populations on reserve, their population numbers are included within the overall per capita calculations on -- on the basis of which fiscal transfers are negotiated with provincial governments and territorial governments -- or provincial governments.

MS. JOËLLE PASTORA SALA: And so the principles that I read to you earlier would apply to First

Nations living on reserve?

DR. VALERIE GIDEON: There is no reason why it would exclude them, considering that their population numbers are included within the fiscal transfer calculations.

MS. JOËLLE PASTORA SALA: The mandate of your department is to ensure the availability of or access to health services for First Nations and Inuit communities, correct?

DR. VALERIE GIDEON: We provide services that are not offered through provincial/territorial health systems, yes.

MS. JOËLLE PASTORA SALA: And you would agree generally that there continues to be a gap for public and primary health care between on-reserve and off-reserve, including with respect to infrastructure, training, medical equipment, laboratory services, medical office assistants, pharmacy, et cetera?

DR. VALERIE GIDEON: Well, it is -- those responsibilities are often exercised through the First Nations Inuit Health Branch directly or through funding provided by the First Nations Inuit Health Branch.

MS. JOËLLE PASTORA SALA: My question was specifically whether you would agree that there continues to be a gap on -- between off and on reserve for those

services.

DR. VALERIE GIDEON: It's too general a question for me to answer definitively. There are areas where actually there are a higher per capita level of investment in First Nations communities than in an off-reserve context, so it's a very complicated question to answer.

MS. JOËLLE PASTORA SALA: What about with respect to infrastructure?

DR. VALERIE GIDEON: So, again, comparing the building of a hospital in Winnipeg to a building, you know, a primary health care facility in an isolated context, it's a difficult comparison to make. What I would say is that the level of health care infrastructure that's needed across First Nations communities is not yet adequate.

MS. JOËLLE PASTORA SALA: Okay. I'm going to come back to this theme a little bit later. Some of my colleagues have already mentioned or have asked you questions about Jordan's Principle. And Jordan's Principle relates to the provision of services for First Nations children, correct?

DR. VALERIE GIDEON: Yes.

MS. JOËLLE PASTORA SALA: I'm wondering if you could confirm whether or not Jordan's Principle applies

to jurisdictional disputes or gaps of services to First Nations adults.

DR. VALERIE GIDEON: Jordan's Principle currently applies to children.

MS. JOËLLE PASTORA SALA: To your knowledge, does your department or Indigenous Services Canada, are they considering the creation of a principle akin to Jordan's Principle which would prevent jurisdictional disputes or hot potato games for First Nation adults living on and off-reserve?

DR. VALERIE GIDEON: I don't have any knowledge of those discussions occurring.

MS. JOËLLE PASTORA SALA: You spoke briefly about the funding agreements or models for the provisions of health services. Can you confirm how the funding is identified, and specifically I'm wondering if you could clarify whether funding is established based on population or based on needs?

DR. VALERIE GIDEON: It's a combination of both. So it is -- as I mentioned, there are 114 programs that are funded through the First Nations Inuit Health Branch, and they vary with respect to how funding was initially provided. I mean, these are through decade-long processes. So while many programs were initially per capita-based, there were changes made in the '80s where it

included factors of isolation, for instance, or remoteness through the Berger formula. We also now include factors such as an aging population, for instance, through the home and community care program. So there are a variety of mechanisms through which funding has been allocated. Most recently, in Budget 2017, for instance, four initiatives relating to infectious diseases, we did look at disease incidents. So, for instance, around tuberculosis, the incidents of tuberculosis would drive the extent of investment in certain regions. So it is more complicated than just a per capita allocation.

MS. JOELLE PASTORA SALA: And where would one go to to find out whether or not the allocation of services is based or funding is based on funding or needs? Where does one look?

DR. VALERIE GIDEON: Well, we would certainly be able to provide that information. We do it through our senior management table. But because there's been information over many years of periods, the individuals that would have had that information at the Assembly of Manitoba Chiefs, for instance, may have moved on, and it's hard to find that particular source. So it's something that we could -- that we would provide based on requests from First Nations.

MS. JOELLE PASTORA SALA: Is it written?

Like, in a policy anywhere?

DR. VALERIE GIDEON: It -- we don't have one consolidated document.

MS. JOELLE PASTORA SALA: I'd like to ask you a couple questions on non-insured health benefits. Is it correct to say that this is a program that exists as a last resort to capture those things that are not covered by other programs?

DR. VALERIE GIDEON: I would say that I would use the term "supplementary health benefits," so absolutely there are benefits that are not covered through provincial, territorial, or private insurance or employers' programs.

MS. JOELLE PASTORA SALA: My client is being told by First Nations in Manitoba who are members -- or citizens of their member nations that the province and private insurance companies are also stating that their programs are of last resort. Is this something you could comment on or are familiar with?

DR. VALERIE GIDEON: I am familiar with certain jurisdictions doing that. There is -- we don't have a -- a -- we coordinate with other insurance plans where that is possible, and where it is not possible, we will provide the benefit.

MS. JOELLE PASTORA SALA: I'm just -- I do have a lot more questions for you. I'm just going to ask

you one more. You mentioned some examples of increased First Nation and Inuit control over the design, planning, delivery, and evaluation of community programs and services. I'm wondering if your department has established benchmarks or targets to ensure equity in all of the regions in terms of co-management or governance approaches to ensure consistency.

DR. VALERIE GIDEON: We have not. We would have to do that, obviously, with First Nations. In fact, they would -- we would look to them to be able to do that, because it would not be appropriate for us to tell them how to govern within their own voices and their own leadership models. I think we have been receptive to whatever model works for them in terms of governance.

MS. JOELLE PASTORA SALA: Thank you.

DR. VALERIE GIDEON: Thank you.

JACKIE ANDERSON, Previously Affirmed:

CROSS-EXAMINATION BY MS. PASTORA SALA:

MS. JOELLE PASTORA SALA: Ms. Anderson, you spoke briefly about the large proportion of your sisters who have had the -- that you've had the opportunity to work with who are former or current children in care, correct?

MS. JACKIE ANDERSON: Yes.

MS. JOELLE PASTORA SALA: And you spoke -- and you gave us one example of the 14-year-old girl who had

been in 103 placements.

MS. JACKIE ANDERSON: M'hm.

MS. JOELLE PASTORA SALA: I'm wondering whether you could provide additional information on the link that you have observed between child welfare and missing and murdered Indigenous women and girls.

MS. JACKIE ANDERSON: Oh. That'd be a -- well, again, I guess when you're looking at, you know, specialized services, that was one of the indicating factors from our advisory council that were young women or adults at the time when we were developing our two homes, is that their -- their risks, they felt, were extremely high when they were young and in care of Child and Family Services, being taken care of by caregivers that had no ability to be able to help them get away from the perpetrators or to start their healing or to have any understanding of what their needs were.

So when I -- when I think about that and I hear the stories, you know, that they have shared about, you know, running from placements, as Christine mentioned earlier, you know, being threatened and told she was going to be locked up in secure care, how that increased her risk of going underground, which increased her vulnerability to be trafficked. You know, whether provincially or nationally. There's -- there's huge impacts to that, and at

the end of the day, it's about delivering strength-based, relationship-based care through an Indigenous lens of -- of survival for our young people, what they need.

MS. JOELLE PASTORA SALA: That's great. I was going to ask you about recommendations, and I'll ask you if you wanted to add to that, but before, because my time is almost up, I just wanted to thank you for mentioning the work of the AMC and Our Circle to Protect.

MS. JACKIE ANDERSON: Yes, it was wonderful work.

MS. JOELLE PASTORA SALA: And I wanted to ask you about whether you had any recommendations for the Commission, whether flowing from that work or from what you've just spoken about on child welfare, just to provide you that opportunity.

MS. JACKIE ANDERSON: I -- I just think again, like, I'm -- I haven't touched base with AMC over the last little while since they've done their Phase 3, but again, one of the things that I had recognized when I was going into the community is that our communities have such beautiful strengths, but they need a lot more awareness and they need to be mobilized and they need to be within their communities, in control of those community action plans. And I know that there was recommendations that were made in Phase 1, but I'm not sure if those were supported, because

of lack of funding. You know, such as developing tools in the language of that community. You know, again, awareness training on internet. All of those, again, all of those -- if we're going to go to a community and ask them what their needs are, we need to be able to provide the resource to do so, to empower them to be able to sustain that protection within their community of their children.

MS. JOELLE PASTORA SALA: Thank you all.

MS. JENNIFER COX: Commissioners, it's nearly five o'clock. We have four parties, including Commission counsel, left to do cross-examination, we have closing ceremonies ...

(SHORT PAUSE)

CHIEF COMMISSIONER MARION BULLER: We've decided to continue. We'd like to hear from at least two more parties. That will take us to approximately 5:30.

MS. JENNIFER COX: The next party has 17 minutes and then they're in. So it'll probably be closer to quarter to six or so. The next party is Nishnawbe Aski Nation, Grand Council Treaty 3, Treaty Alliance Northern Ontario, with 17 minutes.

MS. KRYSTYN ORDYNIEC: Good afternoon to the Commissioners, Chief Commissioner, Commissioners. I'd like to once again acknowledge on behalf of our clients, Grand Council Treaty 3 and Nishnawbe Aski Nation, the Treaty 7

territory as well as the Métis Nation Region 3. I'd also like to acknowledge that with me to this point was Nishnawbe Aski Nation Deputy Grand Chief Anna Betty Achneepineskum, who unfortunately had to leave to get back home.

I'd like to echo what my fellow parties withstanding had to say about Ms. Anderson and Ms. Dumaine's testimony today. Thank you on behalf of myself and my clients for your strength and transparency today.

JACKIE ANDERSON, Previously Affirmed:

CROSS-EXAMINATION BY MS. ORDYNIEC:

MS. KRYSTYN ORDYNIEC: I just have one question for Ms. Anderson. When you have been working on the development of your -- the safe house, did you work with government partners as you were working towards your goals?

MS. JACKIE ANDERSON: Yes, to a degree because, again, we're -- we're funded through the province, so we were assigned a residential care licensing specialist. So when we were out looking and seeking for a potential property, we needed to have them with us to be able to identify risk, and what would need to happen to that environment in order to fit to residential care licensing standards.

MS. KRYSTYN ORDYNIEC: Right. And are there any challenges you would identify from working with -- within government agencies you might be able to provide

best practices for for other organizations that may be -- that may have similar goals?

MS. JACKIE ANDERSON: I think, again, it's -- it's important that you know, because we -- we have such a strong strategy within our province that there's, you know, a relationship between the community and through our -- our partners within the province, but I think what -- what we always need to keep in mind is that if -- if things need to be discussed for potential change that needs to be discussed at the community level.

VALERIE GIDEON, Previously Affirmed:

CROSS-EXAMINATION BY MS. ORDYNIEC:

MS. KRYSTYN ORDYNIEC: Thank you, thank you again. The remainder of my time, I'm going to ask Dr. Gideon some questions, and given your testimony, so far, I probably already know the answer to this, but are you familiar with Nishnawbe Aski Nation and Grand Council Treaty 3 Territory, and the historical and current challenges faced there, with respect to health services?

DR. VALERIE GIDEON: I certainly have had the privilege of working with many communities and leadership within both Treaty 3 and NAN, but I would never presume to fully know the challenges that they're experiencing.

MS. KRYSTYN ORDYNIEC: Thank you. And -- and I just wanted to make sure that -- that you were aware of

the location that I am speaking of.

DR. VALERIE GIDEON: Yes.

MS. KRYSTYN ORDYNIEC: Thank you. And you're aware over the last number of decades that there'd been suicide crises declared in NAN territory and Grand Council Treaty 3 territory, but also across the country?

DR. VALERIE GIDEON: Yes, I am aware.

MS. KRYSTYN ORDYNIEC: Okay. And I -- I think that your early -- your earlier testimony referred to recent suicide crises as one of the catalysts for the NAN Charter of Relationship Principles that was executed.

DR. VALERIE GIDEON: That's what was communicated to me by Nishnawbe Aski Nation leadership.

MS. KRYSTYN ORDYNIEC: Sure, thank you. Earlier, we heard from AFN council regarding the Wapekeka tragedy, which Wapekeka is a NAN community. So I'd just like to clarify for the record, that in the summer of 2016 the survivors of suicide proposal was submitted to the government, and in the summer of 2017 the tragedy struck in Wapekeka. Thereafter, Wapekeka was provided funding. Previously, in response to a question Mr. -- Mr. Blain posed, you said, "It would not be for us, meaning the government, to declare an emergency in First Nation communities. It's up to them to do that." Is that correct?

DR. VALERIE GIDEON: That's correct. And

there is several Nishnawbe Aski Nation communities that have declared states of emergency specifically related to suicide.

MS. KRYSTYN ORDYNIEC: Correct. So I -- I say all that to ask you to explain a government response that seems to wait for a First Nation to declare a state of emergency before it acts.

DR. VALERIE GIDEON: That's to declare the state of emergency. It doesn't mean that the government wouldn't proactively support communities if they identified risk factors and -- and brought those forward. I think we do try and collaborate with communities as much as possible with respect to supporting them, to address needs.

MS. KRYSTYN ORDYNIEC: Sure. Just unpacking that a little bit, there have been suicide crises over the past number of decades, and there are risk factors that are known, so I -- I wonder if in response a community -- how it sees that it continues to have to declare a state of emergency before it's provided funding, and specifically I refer to Wapekeka.

DR. VALERIE GIDEON: So Wapekeka did have funding for mental wellness services through a block agreement, which is the highest level of flexible agreement we have outside of a grant process. Prior to the crisis, they had a multi-year funding agreement that enabled them to

allocate resources based on their targeted priorities and to carry over funds from year to year. They did have funding as part of that agreement for the survivors of suicide, annual gathering that they organized, but the proposal that they had sent in was for supplementary youth mental health counsellors. I think we have now a tracking system within the regional office to make sure that these proposals are addressed through Jordan's Principle, and specifically the Choose Life initiative, which Nishnawbe Aski Nation designed in collaboration with us, but it was through their initiative. And that was submitted to the Tribunal as a consent order --

MS. KRYSTYN ORDYNIEC: Right.

DR. VALERIE GIDEON: -- and a response to Jordan's Principle on the decision.

MS. KRYSTYN ORDYNIEC: And that was because there was a court order that orders that -- that sort of funding; that's correct?

DR. VALERIE GIDEON: Choose Life, actually, was initiated outside of a specific order. We developed it, well, based on NAN coming forward and requesting us to participate in that process, and NAN submitted it or asked us to participate in the consent being submitted to the Tribunal.

MS. KRYSTYN ORDYNIEC: I'd like to move on to

-- to another segment, in respect of suicides have led to a number of inquests into deaths of -- of Indigenous youth; are you aware?

DR. VALERIE GIDEON: Yes. In Pikangikum, and I believe also -- I'm aware of the one in Pikangikum in particular, and also in Thunder Bay there was also a Coroner's Inquest with respect to youth.

MS. KRYSTYN ORDYNIEC: That's right, and I'm just going to ask on a general basis --

DR. VALERIE GIDEON: Okay, sorry.

MS. KRYSTYN ORDYNIEC: -- not in particular to any -- any inquest. And you're aware that as part of the inquest process, like this Inquiry, recommendations are made and come out of the inquest?

DR. VALERIE GIDEON: Yes.

MS. KRYSTYN ORDYNIEC: What is the government policy on implementation of those recommendations, even though they are not legally binding?

DR. VALERIE GIDEON: We have always, in my experience in the ten years that I've been involved with respect to Ontario and First Nation Inuit Health Branch, proactively sought to address those recommendations.

MS. KRYSTYN ORDYNIEC: And -- it -- would it be then your position that Indigenous Services Canada if there are recommendations that are directed to your branch

that come out of this Inquiry that you will also implement those?

DR. VALERIE GIDEON: I can't speak on behalf of the Minister, but I would say that we value the advice and the recommendations that will be provided by Commissioners, as we have done with the interim report, and it is informing the consideration of the government response.

MS. KRYSTYN ORDYNIEC: Thank you. I -- I'd like to move to -- and it still has to do with suicide. Are you aware of how many youth healing centres there are in northern communities, so communities that serve -- NAN and Grand Council Treaty 3 communities?

DR. VALERIE GIDEON: I am aware of some of the centres. I don't have a specific number in my head, but we have been working with Treaty 3 leadership in particular because there is a gap with respect to a specific child or youth centre in that territory. And we are -- we have been working with Nishnawbe Aski Nation and both Treaty 3 to look at youth at risk and specific strategies, such as through the Choose Life initiative as an example where there are a lot of on the land initiatives that are being driven by communities.

MS. KRYSTYN ORDYNIEC: Right. So -- so it's your position that going forward there are -- there are

certainly the intent that there would be youth healing centres in -- in that -- those communities?

DR. VALERIE GIDEON: Yeah, so we -- through the provincial government, they've recently gone through a process of sending out a call for proposals for youth treatment centres. They were able to fund a certain number, but not all the requests. They have shared those with us to see if we can provide resources for those centres that have not been able to be funded, and we're in the process of assessing those against the $200 million that was just recently announced in budget 2018.

MS. KRYSTYN ORDYNIEC: Thank you. With respect to collecting statistics on the tragedies of youth suicide, is there a database with respect to those statistics?

DR. VALERIE GIDEON: It's interesting. So there isn't currently one database, but Grand Chief Fiddler raised this when several NAN communities were going through a crisis state in 2016 and '17, and we developed a specific working group with Nishnawbe Aski Nation, the public health agency and ourselves, and other provincial partners. In order to explore a suicide surveillance system, the Public Health Agency of Canada has developed a suicide surveillance framework, and so we have been working in a tripartite way to be able to look at the adaptation of that suicide

surveillance framework, specifically for NAN communities. The Weeneebayko area health authority had a particular interest. They had already launched a population health data surveillance initiative, and so the public health agency has visited them and is working with them initially as -- as one of the areas of focus, so we've never forgotten in our working to address that particular need that has been highlighted several times by Grand Chief Fiddler.

MS. KRYSTYN ORDYNIEC: Sure. And not only in NAN and Grand Council Treaty 3 communities, but is that an important aspect of the work that you're doing across Canada?

DR. VALERIE GIDEON: We would absolutely take the results of that particular initiative and broaden it to look at how we could apply it nationally.

MS. KRYSTYN ORDYNIEC: Thank you. We talk a lot about what is culturally appropriate, and I -- and I know that there are a lot of new policies, new government initiatives that are coming out as we respond and as we deal with -- with health initiatives going forward. Is there any sort of definition in your policies that define what is culturally appropriate?

DR. VALERIE GIDEON: I think the best resource document would be the First Nations Mental Wellness Continuum Framework From a First Nations

Perspective, and that was developed as a partnership between First Nations representatives, First Nations mental health experts and also departmental representatives. So while it's not a policy, we refer to it a lot in our policy documents.

MS. KRYSTYN ORDYNIEC: And I ask, would "culturally appropriate" extend to include infrastructure and not just the way a program may be delivered?

DR. VALERIE GIDEON: Yes, I would agree with that, absolutely.

MS. KRYSTYN ORDYNIEC: My last set of questions would focus around a situation that occurred where an individual in a community required access to mental health supports that were specialized, so that those mental health supports were not available in the community. And we've heard testimony throughout the community hearings and throughout these expert hearings on how difficult it is for some community members to travel to urban centres to get those services, so the community decided to request that the mental health professional come into the community. And one of the responses received was that it takes too long for me to be reimbursed, so I am not able to come.

So I would ask if there is a certain -- a government policy around reimbursement and specifically

providing services to the communities when they don't have them?

DR. VALERIE GIDEON: Well, I'm surprised by that situation because with registered mental health providers we have regular ability to reimburse them for expenses. However, we don't -- the majority of service providers that are delivering mental health services are not directly paid for by us, they are paid for through First Nations organizations, Tribal Councils, Nishnawbe Aski Nation, (indiscernible) through the Sioux Lookout First Nations Health Authority, Kenora Chief's Advisory, so it would depend on that particular situation.

I certainly can say to you that we are always actively cognizant of the fact that we need to promptly pay service providers in order to ensure that they continue to be registered with the program and are participating in the delivery of services to clients, and that would include the Indian residential school health support program.

But, for instance, Treaty 3 delivers that program specifically to its members and there are health authorities also in NAN and Treaty 3 communities that are receiving those dollars directly so that they are able to contract service providers that they choose and that they feel are going to provide culturally competent services.

MS. KRYSTYN ORDYNIEC: Right. And I would suggest that this was not one of those situations where the First Nation was able to provide their own services, but thank you for your answer.

And just lastly, with respect to specifically women's health and sexual assaults that may occur in communities, and the necessity of gathering evidence and information right away in those communities, are -- are communities provided with necessary supports to administer something like a rape kit?

DR. VALERIE GIDEON: The sexual assault kits, so they are -- in some jurisdictions the RCMP detachment has those kits and they were brought to the primary health care facility. So, you know, depending on how it's actuality regulated in the provinces, but in most provinces those kits are actually housed in the primary health care facility in the community.

MS. KRYSTYN ORDYNIEC: And do you have any information as to whether the nurses that are in those communities are able to administer those kits, because I understand that there's special training that is required to do that?

DR. VALERIE GIDEON: Yes, so we have ensured even as recently as last year again, we do monitor that to ensure there is capacity in communities for sexual assault

kits to be utilized.

Now, that being said, there are many community members who prefer to be flown out when they're in that situation and they don't necessarily want to remain in the community, so that is also a consideration. So if the client consents and wishes to have those kits administered in the community, we are -- we would be able to do it in most cases, unless it's within the context of the RCMP detachment having the kit or whichever, but it is still -- we still run into the issue where clients don't necessarily want that to be administered in the community.

MS. KRYSTYN ORDYNIEC: Thank you. And I'll just take my last few seconds to thank you very much for the work that you do, and to everybody on the panel and the Commission. Thank you.

MS. JENNIFER COX: The next party is *Directeur des poursuites criminelles et pénales* in French.

MS. ANNY BERNIER: *Je vais d'ailleurs vous laisser un peu de temps pour prendre le temps de mettre vos écouteurs, parce que je vais effectivement parler en français.*

MS. JENNIFER COX: And 13 minutes, Mr. Registrar.

MS. ANNY BERNIER: *Alors, bonjour. Anny Bernier, Directeur des poursuites criminelles et pénales*

pour le Québec, communément appelé DPCP.

Alors, d'abord un très grand merci à tous les panelistes. Vous étiez extrêmement intéressantes. J'aimerais d'abord préciser que le DPCP n'a pas de témoins présents cette semaine. Par contre, nous avions... et quand je dis nous, je parle au nom de l'organisation, bien sûr... nous avions transmis une lettre aux avocats de la Commission le 2 mai dernier. Si vous me permettez, je vais vous lire les passages de cette... les deux premiers paragraphes de cette lettre simplement pour vous mettre en contexte. C'est une lettre qui a été envoyée dans le cadre d'une demande de témoins potentiels pour les audiences de cette semaine. Alors la lettre se lit comme suit :

> *« Au cours des dernières années, le DPCP a mis sur pied et participé à différents programmes visant l'accessibilité et l'accompagnement de clientèles fragiles et vulnérables à travers le processus judiciaire notamment avec les victimes et les personnes souffrant de problèmes en santé mentale. Il va sans dire que ces initiatives impliquent la collaboration de plusieurs procureurs chez nous, mais également de différents intervenants issus du système judiciaire et du réseau de santé*

des services sociaux. Ainsi bien que le DPCP souhaite collaborer activement aux travaux de la Commission, sans obtenir davantage de précisions quant aux programmes sur lequel ou lesquels les commissaires souhaitent traiter lors de cette audition, nous ne sommes malheureusement pas en mesure d'identifier le témoin approprié. Nous vous soumettons néanmoins la liste des différents programmes et directives pertinents du DPCP en Annexe 1 afin de faciliter le travail des commissaires en prévision de ces audiences et de la rédaction du rapport final. »

Donc, cette lettre est malheureusement demeurée sans réponse. Nous n'avons donc personne cette semaine ici à faire entendre.

Alors, j'aimerais avoir votre autorisation afin de pouvoir déposer en preuve la lettre et son annexe puisque leur contenu contient une mine d'informations pertinentes aux audiences de cette semaine.

Je crois humblement que, tel que le mentionnait d'ailleurs Monsieur Phelps hier, les commissaires devraient pouvoir avoir le plus d'information pertinente possible pour dresser un portrait complet des services gouvernementaux offerts pas l'ensemble des

auprovinces et territoires.

Je vous soumets le tout respectueusement, conformément aux règles de pratique de la Commission, soit le Legal Path. Je vous soulève les Règles 8 et 30 dans la version anglaise et les Règles 11 et 31 dans la version française. Il y a une petite incohérence au niveau de la numérotation et aussi au niveau de la traduction, mais on va rester avec les Règles 8 et 30 de la version anglaise, si vous le souhaitez.

Les Règles, ce qu'elles disent, en fait, c'est que Règles de pratique sont flexibles et que les commissaires doivent pouvoir admettre tout élément de preuve pertinent, et ce même si ces éléments de preuve ne seraient pas admissibles devant un tribunal.

Également, que les Règles de preuve ne doivent pas être appliquées selon leur sens stricte pour déterminer leur admissibilité.

Par ailleurs, j'aimerais préciser que bien qu'un document pour préciser les Règles de pratique, notamment les Règles 56 et 66, a été transmis par les avocats de la Commission vendredi dernier, soit après des échanges qui ont eu lieu avec moi et les avocats. Ces règles visaient notamment les ajouts suivants. Je fais référence à l'article 56. La partie ajoutée était :

« La partie ayant qualité pour agir

doit présenter un document en preuve pendant le contre-interrogatoire d'un témoin ou d'un expert. »

Et la partie ajoutée à l'article 66 était... cette partie est présente. Je lis le début de la phrase :

« Les parties ayant qualité pour agir qui entendent déposer des documents à titre de pièces pendant... »

Ici on a changé « les audiences » pour « le contre-interrogatoire » :

« ...le contre-interrogatoire doivent en remettre copie... »

Et cetera. Donc, deux portions ont été ajoutées et modifiées. J'aimerais préciser qu'il s'agit de droit nouveau qui est entré en vigueur vendredi, le 25 mai, suivant des précisions des avocats de la Commission et que cela ne figure pas dans les Règles de pratique de la Commission.

En conclusion, en tout respect pour opinion contraire, dans l'esprit de collaboration qui caractérise cette Commission, je vous demande de permettre à mon organisation, le Directeur des poursuites criminelles et pénales du Québec, de pouvoir déposer en preuve la lettre et l'annexe préparées pour éclairer les commissaires quant aux services en santé mentale et aux victimes offerts par le

DPCP afin de permettre d'avoir le plus d'information pertinente possible pour vous permettre de soumettre les meilleures recommandations possibles.

Merci. Et, pardon, je voudrais simplement souligner que j'ai naturellement respecté la Règle 66 et j'ai communiqué mon avis d'intention de déposer le tout comme preuve vendredi dernier.

Merci.

MS. CHRISTA BIG CANOE: I would like to make an objection, so I'm going to suggest we stop the time at this point. And -- sorry. Commission Counsel would like to make -- actually, I'll have two objections. The first objection is a little more procedural. The intention of cross-examination was to cross-examine. There was not a motion properly put before you, but I believe that we should just deal with the issue. So I don't want it to be on a technical latch that this was not the proper form, nor was there notice of the motion, nor was it presented as a motion prior.

So I'm going to suggest that I make the second objection, which is the objection to putting the material in, and I would like to provide the reasons why. Because they're not just unilateral, and I do respect -- and I will stop just 'cause I noticed Commissioner Audette, do you need your --

COMMISSIONER MICHÈLE AUDETTE: Yeah. Yeah. No. I'm answering your questions.

MS. CHRISTA BIG CANOE: Okay. Perfect. Thanks. So I would appreciate the opportunity to respond, so the -- my objection on behalf of Commission Counsel is the manner in which the exhibits being presented in this form. And we understand and respect the cooperation that the party is actually speaking to. And we don't believe that -- that the documents are not important. They are important, but there's other manners and means to put the documents before the Commission.

So we did re-apply and I feel at a loss because I just learned of this motion this afternoon. And I feel unprepared in that I could have actual exhibits to respond to it, but my -- my friend here has presented the letter and she read the letter in, which you have received a copy is because a reply to putting these exhibits in on Friday was that there were other means and that there were no witnesses that could answer specifically the questions that this document arises, and therefore we recommended that there were a number of other means to get the documents before the Commissioners. And I undertook and did actually provide the documents to the Commissioners via e-mail in response first to my friend, and then forwarding a copy to Commissioners.

The concerns -- and let me actually explain why I have concerns. It's not that the documents aren't important. In the context of the hearing, we put the documents before witnesses that can't answer any questions specifically in relation to the programs that are detailed in annex one. So the document, the annex one that's being referred to, does list programs about victim services that on a higher topical level absolutely have been spoken to. But they're not being put before witnesses that actually have any knowledge or awareness of the Government of Quebec's actual programs.

So there are a couple ways that the party is enabled and we have advised to put these documents properly before you. One is in rule 31 in English and in 30 in the French version of the rules. At -- sorry, in rule 33 in the English version, you have the authority of essentially -- and this is completely in line as well with provision "H" of the Federal Terms of Reference: (as read)

> The Federal Terms of Reference direct the Commissioners to conduct the Inquiry as they consider appropriate with respect to accepting as conclusive or giving due weight to the findings of facts set out in relevant reports, studies, researches, examinations,

whether national or international.

And then it lists particular reports. And rule -- rule 33 actually gives you -- and I don't know if you want the opportunity to turn up the rules. Gives you the authority to rely on: (as read)

> Pre-existing reports, studies and other substantive materials as evidence to make findings of fact as Commissioners consider relevant to the discharge of their mandate.

The documents that are being proposed is essentially a document created by the party that lists the programs they have. The ability to source it pursuant to rule 66 will be difficult as these witnesses will not have knowledge of those particular programs, nor would any other prior or future witnesses being hauled here.

Having said that, you guys have the authority and ability to receive report and give it weight. Rule 4 of the Legal Path also -- and my friend had listed rule 8 -- and can you help me? I -- rule 8 and rule --

MS. ANNY BERNIER: 30.

MS. CHRISTA BIG CANOE: 30, thank you -- in the French version which is 31 in the English. That in an ordinary course -- so rule 31: (as read)

> In the ordinary course, Commission

> Counsel will call and question witnesses to testify at the Inquiry. Counsel for a witness may apply to the Commissioners to lead witness' evidence in-Chief if counsel is granted.

Is that the same rule that you intended?

MS. ANNY BERNIER: Pardon me?

MS. CHRISTA BIG CANOE: I don't know if that's the same rule you intended to cite.

MS. CHRISTA BIG CANOE: (as read)

> can accept any information as evidence they decide will further object as of National Inquiry, including where that evidence might not be admissible in the court of law. The strict rule of evidence will not apply to determine admissibility of evidence, except with respect to the law of privilege immunity and respect to the cabinet confidences and statutory bars.

I do want to also bring up though two important rules that have to be considered. The first one is that rule 4: (as read)

> All parties and their counsel agree to follow the rules as a condition of their

standing.

That first part, but in rule 4: (as read)

Subject to the various governing laws, the conducts and procedures to be followed at the National Inquiry is under the complete control and discretion of the Commissioners.

Rule 8 states: (as read)

The Commissioners may receive any and all relevant inference.

This is a permissive clause. This does not say they shall receive. And so there -- although that the rules speak to the fact that you don't have to accept it in the same manner as a court of law would, there should be a principle approach taken to evidence in terms of when we're putting it to witnesses. So it's permissive, it's not shall. And if we look at a broader principle of evidentiary law and evidence, is there's -- and I'm talking broad principles. I would like to have cases before you, or some more authority, but on the short notice of the motion, I have been unable to do so.

Essentially, the -- one of the broader principles is that the material or evidence that goes before a witness, they should be able to answer, or have knowledge to speak to. So if she was to source the document to my

friends, and have them identify it, they would not be able to identify it because the creation of her parties.

And then they may be able to review it, but they wouldn't be able to speak to the intimate details of those programs, because as my friend has shared, there's not a member from her party that's actually on the panel of witnesses.

One of my concerns is that they have ability and opportunity to put this evidence to you in other manners and means, and by putting it to the witnesses before us today, it's not testable, so they won't be able to answer questions. We won't be able to explore the documents in any great detail. So in your weighing and balancing of the credibility of the evidence before these witnesses no different than if you were receiving them by virtue and using your authority under 33 or by provision H, because these witnesses will not be able to speak to that document. It's no different than if they submitted to you through another mechanism.

So putting it on the record -- and I'm not saying the sky is falling here, but by submitting this document in this particular process sets a precedent to allow any party -- because every party, all 101 of them, would have the ability -- and I believe in this part 2 portion, there's 82 parties of which we have 32

here -- would then be able to create a document that talks to their programs and policies and submit it before any witness that may or may not be able to answer questions, and in this case would not be able to answer questions about their programs.

I would suggest the better result is to receive, absolutely receive it, but not in the context of evidence that's going before you in this format, which is to put evidence to witnesses and then have them answer questions, because the proper way to do it on a principled evidentiary basis is to make sure that questions can actually be answered about the evidence that's going in in this part of the process.

I do feel at a bit of a loss because I would like to give you some more citation on authority on this. Unfortunately, in the short duration and notice of when the motion would come up, I have been unable to. So for now, those are my submissions, and I thank you.

Me ANNY BERNIER: *Si vous me permettez, simplement pour répondre à ma consoeur, en fait, c'est un peu... l'idée derrière tout ça c'est vraiment que nous voulions collaborer. Personne ne nous a donné d'indication pour pouvoir préciser quels témoins seraient pertinents.*

Bien sûr nous aurions pu amener plusieurs témoins, mais une semaine n'aurait pas été suffisante pour

les entendre et le Québec et l'ensemble des 10 autres provinces et trois territoires, ainsi que toutes les parties ayant statut qui voulaient se faire entendre.

Nous sommes dans une audience institutionnelle pour les services gouvernementaux. Je pense que l'objectif de la Commission comme telle c'est vraiment de connaitre les détails les plus pertinents pour pouvoir vous guider.

Ma consoeur nous rappelle que les règles de la preuve déposée devraient passer par un témoin. Ça ne fait pas partie des règles de procédure de la Commission. Elle nous réfère aux Termes de Référence, au cadre de référence de la Commission comme tel. La lettre (h), je m'excuse, je l'ai regardée rapidement tout à l'heure, je ne trouve pas qu'il y a une grande pertinence au point que j'apporte aujourd'hui.

Par ailleurs, la différence de pouvoir vous soumettre un document pour considération suivant l'article... la Règle 33, telle que mentionnée par ma consoeur, oui, c'est certainement une façon de faire. Par contre, ce n'est pas un document qui devient déposé en preuve.

Et puisque nous sommes toujours dans l'attente des règles qui entoureront le dépôt de mémoires, s'il y a dépôt de mémoire, vous me permettrez de vous

suggérer à quel point ceci a de l'importance pour mon organisation, que les éléments pertinents du DPCP puissent faire partie de la preuve lors des audiences sur les services gouvernementaux entendus cette semaine.

Merci.

MS. CHRISTA BIG CANOE: So, sorry. I -- it was my objection. She had the right to respond, but I have a right to reply in relation to what she said, if I may actually exercise that right? So I agree. And I'm not sure if the translation was completely accurate. My friend's reference to the rules. Do you mean, like, the process for the next steps?

MS. ANNY BERNIER: À propos des closing submission?

MS. CHRISTA BIG CANOE: Gentlemen. Yes. So the rules -- the only reference to the rules in the -- in the legal path in relation to a party's right as it relates to closing submissions is in Section 25, which clearly states there is a right. We have not yet actually provided the procedure that will apply to parties with standing in their closing submissions, but the closing submissions and that process will be forthcoming.

Also, just -- just in reply to my -- my friend's comments, there clearly is a Rule 66. So she did meet it in terms of the duration, like the 48 hours'

advance notice, but we also did -- Commission counsel did reply to that response, and we stated our position at that time. We did not get notice of a motion until today.

And I don't disagree. We do want this to be a cooperative process. So the objection I'm making is not because I don't value that -- the contents may, indeed, be very helpful for the party in their closing submissions or to point to resources. But I still would suggest that in this particular process where we're having witnesses provide oral testimony and evidence on their knowledge, it's not the appropriate forum. Thank you.

CHIEF COMMISSIONER MARION BULLER: Is the expectation that this document will be identified or spoken to by any of the witnesses? No? Okay. On that basis, then, for today's purposes, anyway, I appreciate it's been a very long day, and all of the witnesses are free to go for the day. And we look forward to seeing all of you again tomorrow morning at 8:30. So thank you very much for --

UNIDENTIFIED SPEAKER: We'll sort this out without you.

CHIEF COMMISSIONER MARION BULLER: Yeah.

(LAUGHTER)

UNIDENTIFIED SPEAKER: I have the answer.

CHIEF COMMISSIONER MARION BULLER: And we

need to caucus about this. We'll take about a ten-minute break. Thank you.

--- Upon recessing 5:37 p.m.

--- Upon reconvening at 5:54 p.m.

CHIEF COMMISSIONER MARION BULLER:

Ms. Bernier, Ms. Big Canoe, thank you for your submissions. We're not going rule on the motion today, of course. If parties wish to provide submissions, if they have anything to add to submission that have been made, we will accept those submissions in writing through Commission Counsel, and the deadline is 12 noon tomorrow for any written submissions from parties on the motion.

And can I emphasize that's only if you have anything to add to the submissions that have already been made. There will be no further submissions by Commission Counsel or Ms. Bernier. We will give our oral ruling by the end of the -- by the end of this hearing, so by the end of this week.

MS. CHRISTA BIG CANOE: May I just ask a procedural question in relation to Ms. Bernier's seven remaining minutes on cross-examination?

Am I to understand that she will be allowed to use those to proceed with the witnesses before us because she will now not be able to put these documents to these witnesses, but will be putting them potentially,

based on your ruling, to other witnesses, so I just want to ensure because her request was to put them before these witnesses. These witnesses will be completed their chief and cross-examination prior to your ruling.

CHIEF COMMISSIONER MARION BULLER: Okay. Ms. Bernier, if you have further cross-examination -- or any cross-examination, rather, of the witnesses that we heard from today, you may use your seven minutes tomorrow morning starting at 8:30.

MS. CHRISTA BIG CANOE: Thank you.

CHIEF COMMISSIONER MARION BULLER: Okay.

MS. BETH SYMES: May I address -- in your absence there was a lot of discussion amongst the other parties withstanding. I am not certain what is the nature or scope of what is being requested or of what you are considering. One of the questions is, what is the nature and scope of Rule 33, which is other documents that have not been identified by -- by a party.

CHIEF COMMISSIONER MARION BULLER: Ms. Symes, I'm going to interrupt you because I want to make it very clear that if there are further submissions from parties we will accept those submissions, however they must be in writing and we must receive them by 12 noon tomorrow.

MS. BETH SYMES: Sorry, I'm not asking to

make submissions. What I'm simply asking is what is in dispute because, depending upon what the issues are, we may or may not want to make submissions. That's my question.

CHIEF COMMISSIONER MARION BULLER: Okay. The -- as I understand them, the specifics of the motion are -- or the --

UNIDENTIFIED SPEAKER: Objection.

CHIEF COMMISSIONER MARION BULLER: -- the decision sought by counsel is that the documents in question be admitted into evidence not through a witness at a hearing. Is that correct?

MS. ANNY BERNIER: It is correct.

CHIEF COMMISSIONER MARION BULLER: Okay. Thank you. And we will close for the day. We will reconvene tomorrow morning at eight o'clock for our wonderful opening. Thank you.

MR. JASON GOODSTRIKER: Thank you and congratulations to a very successful day to all of the Commission -- Commissioners. And I was -- I was just kind of excited about this afternoon, sorry I had to step out for a few moments, I had some work stuff to worry about, but my two girls that came in here, they're teenagers, they're 15 and -- one is older 15, the other one is younger, but they're very special to me, like each and every one of our children are special to us. But something

that nobody knows about is that I have six daughters and adopted children I have 20 all together, so these are -- you know, they're young people, they're very excited and they were happy to come down and to sit and to listen, even though it was a few moments. And hopefully if they skip school tomorrow I'm going to ask them to come back.

(LAUGHTER)

UNIDENTIFIED SPEAKER: No good.

MR. JASON GOODSTRIKER: But it's very pressing and thank you very much to all of the participants, all of the staff members for a successful day.

We will try our best again for tomorrow and for Friday coming in the -- so what I would just like to leave you all with, as many of you -- as it happens in all of the gatherings where we go to, I always encourage people to meet new people, meet new people that are important to not only this process, but down the road.

A lot of you don't know that Valerie Gideon and I, (indiscernible), we've been friends for nearly 20 years now, and this is a very, very important undertaking. And you don't want to leave an event like this thinking, gee, I wish I would have said something, I wish I would have questioned this, I wish I would have (indiscernible) conversation.

Anyway, in our closing I'm going to ask these boys, this is -- these are -- we say Siksika (indiscernible) they're the singers from Siksika, and one thing that's very interesting about Blackfoot singing is that many of our songs follow the contours of the land, river ways, hills, mountains, and we have a unique melody about our singing from -- that comes from (indiscernible). We're very proud of it, so I'm going to ask the boys to -- just a good time song. (Indiscernible) that song. But first off, I'm going to ask the Elders just to stand right where you're at, and if you could say a closing prayer for us. Again, I'm going to introduce Spike and Alvine Eagle Speaker, Métis Elder, Henry (indiscernible), our Stony Elder, my big brother there with the hat, that's, of course, John Wesley, and he's an uncle of mine at the end, the Elder from Tsuu T'ina. He's also the richest of those Elder, Gerald Meguinis. He's got the most heart. Anyways, come to Brave Eagle tonight, if you have time, or I'll ask if you could just join with us and we're going to have a word of prayer on behalf of our Elders. Okay.

MR. SPIKE EAGLE SPEAKER, MS. ALVINE EAGLE SPEAKER, HENRY, JOHN WESLEY AND GERALD MEGUINIS: (Speaking in Native language).

MR. JASON GOODSTRIKER: Louise, I'm sorry, I don't want to leave out our Inuit Elders and our special

people that travelled here from such a far aways away. I'll you if you would help us to put out the -- the --

COMMISSIONER MICHÈLE AUDETTE: Qulliq.

MR. JASON GOODSTRIKER: Qulliq. Qulliq. (Indiscernible).

UNIDENTIFIED SPEAKER: Getting there.

MR. JASON GOODSTRIKER: Okay. I'm getting close. I'm -- I'm a bit better tomorrow.

(LAUGTHER)

MR. JASON GOODSTRIKER: So our Inuit Elder Louise Haulli to help us (indiscernible).

MS. LOUISE HAULLI: Blow it.

MR. JASON GOODSTRIKER: Oh, okay.

(LAUGTHER)

MR. JASON GOODSTRIKER: I don't make (indiscernible) grandmother, so. All right. Thank you. Thank you to Louise. Thank you. Give her a round of applause and to --

(APPLAUSE)

MR. JASON GOODSTRIKER: -- to the young Ms. Gladue (phonetic) back there, thank you again. Okay. So enjoy yourselves. We're going to sing a happy song. You could open the doors, you could start packing up, whatever. So have fun tonight, and enjoy Calgary.

--- Upon adjourning at 6:06 p.m.

LEGAL DICTA-TYPIST'S CERTIFICATE

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