THE CURRENT IMPLEMENTATION OF JORDAN'S PRINCIPLE IN MANITOBA

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EXECUTIVE SUMMARY

In this brief report, I draw on existing research, document review, and semi-structured interviews with key stakeholders to provide an overview of the implementation of Jordan's Principle in Manitoba. The goal is to offer a clear description of the current implementation of Jordan's Principle in Manitoba and to place this description in the context of an evolving understanding of Jordan's Principle.

My approach to gathering the information presented in this report, as well as a summary of the information obtained, is presented in Table 1. Given the short time frame for production of this report, I relied heavily on and, with my coauthors' permission, drew freely from prior work focusing on the implementation of Jordan's Principle in Canada as a whole and in Alberta. I also drew from prior research examining the barriers to service access for children with special health care needs in Pinaymootang First Nation.

In Chapter 1, I draw on existing literature and review of available documents to describe the evolving interpretation and implementation of Jordan's Principle. The implementation of Jordan's Principle in Manitoba is shaped by national level policies and legal decisions. Accordingly, the current implementation of Jordan's Principle in Manitoba can only be understood in the context of national level events that have shaped both the interpretation of Jordan's Principle and the federal approach to implementation of the principle. I find that:

- Jordan's Principle, as originally envisioned, was designed to ensure that First Nations children had access to the public services available to other children in Canada and that they were able to access these services in a timely fashion.
- Federal and provincial governments, including the Manitoba government, committed to implementing Jordan's Principle. Commitment and engagement of both federal and provincial governments was necessary for full implementation.
- In implementing Jordan's Principle, federal and provincial governments, including the Manitoba government, applied a narrow operational definition of Jordan's Principle and implemented a series of complex administrative procedures for recognition of a Jordan's Principle case. As a result, the federal government repeatedly announced that no Jordan's Principle cases existed in Canada.
- A series of groundbreaking Canadian Human Rights Tribunal (CHRT) decisions in *First Nations Child and Family Caring Society & Assembly of First Nations v. Canada* have radically shifted the federal government's approach to implementing Jordan's Principle.
- The CHRT decisions have linked Jordan's Principle to a standard of substantive equality that requires the provision of services exceeding normative provincial standards if necessary to meet a child's needs. The CHRT decisions have also obligated the federal government to take immediate action to implement Jordan's Principle.
- The conceptual basis for provincial involvement in the implementation of Jordan's Principle remains unchanged by the CHRT decisions. However, provincial roles in current Jordan's Principle implementation efforts are unclear.

In Chapter 2, I provide an overview of the implementation of Jordan's Principle in Manitoba. I draw on prior research and document review to describe the historical approach to implementing Jordan's Principle in the province. I then draw on findings from document review and interviews with key stakeholders to describe the current implementation of Jordan's Principle in Manitoba. I find that:

- First Nations in Manitoba have played a consistent and leading role in advocating for the full implementation of Jordan's Principle.

- The government of Manitoba has long expressed support for Jordan's Principle and was the first province to *agree* to implement the principle.
- However, the initial implementation of Jordan's Principle in Manitoba adopted the narrow eligibility criteria and complex administrative processes advanced by the federal government. As a result, few, if any, children in Manitoba were recognized as having Jordan's Principle cases. Processes for supporting children who did not qualify for Jordan's Principle were never formalized.
- The approach to implementing Jordan's Principle in Manitoba has shifted dramatically since 2016. In response to CHRT rulings, the federal government has committed significant Jordan's Principle funding across Canadian jurisdictions and worked with First Nations in Manitoba to support the development of an expanded system of services for First Nations children and families.
- The Manitoba government indicates that, while it is open to collaboration with First Nations and the federal government to support implementation of Jordan's Principle, it has not allocated new funds or created new policies to support the implementation of Jordan's Principle, as interpreted by the CHRT.

In Chapter 3, I use Pinaymootang First Nation as a case study to demonstrate both the expansion of services under Jordan's Principle and the gaps in and barriers to service under the current implementation of Jordan's Principle. I draw on prior work in which we described the history and context of Pinaymootang and documented the barriers to service for Pinaymootang children with special health care needs in 2016, prior to the current implementation of Jordan's Principle. I then draw on information from a recent group interview with community service providers to describe the services currently available. A full accounting of services available in Pinaymootang is beyond the scope of this report. Accordingly, the information presented focuses on the availability of medical and allied health services. In the final section I combine information from past work, the group interview, and document review to more closely examine federal and provincial roles in creating and responding to the need for mental health services in Pinaymootang. Key findings in this chapter are as follows:

- The context of public services in Pinaymootang today has been shaped by historic and contemporary policies that have systematically created service needs and failed to provide the resources to appropriately address those needs.
- The medical and allied health services available within Pinaymootang have dramatically increased since 2016. This is due primarily to increases in federal funding, through Jordan's Principle and other initiatives.
- Despite the increase in services, Pinaymootang service providers identify the clear need for additional resources, continued gaps in services, and a pattern in which the burden for addressing these gaps falls on First Nations.
- A recent increase in demand for mental health services in Pinaymootang demonstrates the complex factors that shape the need for services in First Nations. This demand is shaped by: historical disadvantage; persistent gaps in services provided through the provincial health system in the region surrounding Pinaymootang; the intentional flooding of First Nations in the region; and failures to address the needs of flooding evacuees – both during their evacuation and upon repatriation to their First Nations.

Collectively, the three chapters in this report highlight the complex contexts and decision making structures that First Nations must continually navigate in order to improve service access for First Nations children.

Table 1. Approach to gathering information, focus of gathering information, and information obtained for this report

Approach to information gathering	Focus of information Gathering	Information obtained
Document review	Disclosures from the Province of Manitoba & Manitoba Human Rights Commission	Minutes and other documents from the Joint Committee on Jordan's Principle Implementation and the Terms of Reference Official Working Group
	Publicly available policy documents, presentations, reports, and research summaries.	Presentations made at the Jordan's Principle Summit (September, 2018; Winnipeg) and other public events, parliamentary hansard, Assembly of Manitoba Chiefs (AMC) resolutions, academic literature
	Documents provided by the Assembly of Manitoba Chiefs (AMC) and the Pinaymootang health centre	Jordan's Principle evaluation and engagement reports, as well as terms of reference, briefing notes, and meeting minutes from different Jordan's Principle focused events
Group/individual interviews	Interviews with representatives of service coordination and specialized service provider agencies	Eagle Urban Transition Centre, St. Amant Centre, Manitoba Adolescent Treatment Centre, Rehabilitation Centre for Children, Manitoba First Nations Education Research Centre, Pinaymootang service providers
Written communication	Written response to interview questions posed in writing	Manitoba Department of Families and Department of Health, Seniors and Active Living
Excerpts and adaptation of prior publications	Prior research completed by my colleagues/research team and myself	Vives et al (2017); Vives & Sinha (In press); Churchill & Sinha (In press), Blumenthal & Sinha (2015), Jordan's Principle Working Group (2015), Kelsall et al (2018)

1 JORDAN'S PRINCIPLE IN EVOLUTION

Jordan River Anderson, a First Nations child from Norway House Cree Nation in Manitoba, was born with a rare neuromuscular disease in 1999.[1] Because his complex medical needs could not be treated in the First Nation, Jordan was transferred to a hospital in Winnipeg, far from his community and family home.[2] In 2001, a hospital-based team decided that Jordan's needs would best be met in a specialized foster home closer to his home community. However, federal and provincial governments disagreed regarding financial responsibility for Jordan's proposed in-home care.[3] The disputes ranged from disagreements over funding of foster care to conflicts over payment for smaller items such as a showerhead.[4] During these conflicts, Jordan remained in hospital for more than two years, even though it was not medically necessary for him to be there. In 2005, Jordan died in hospital, at the age of five, never having had the opportunity to live in a family home.[5,a]

In this chapter, I draw on existing literature and review of available documents to describe the evolving interpretation and implementation of Jordan's Principle. The implementation of Jordan's Principle in Manitoba is shaped by national level policies and legal decisions. Accordingly, the current implementation of Jordan's Principle in Manitoba can only be understood in the context of national level events that have shaped both the interpretation of Jordan's Principle and the federal approach to implementation of the principle. I find that:

- Jordan's Principle, as originally envisioned, was designed to ensure that First Nations children had access to the public services available to other children in Canada and that they were able to access these services in a timely fashion.
- Federal and provincial governments, including the Manitoba government, committed to implementing Jordan's Principle. Commitment and engagement of both federal and provincial governments was necessary for full implementation.
- In implementing Jordan's Principle, federal and provincial governments, including the Manitoba government, applied a narrow operational definition of Jordan's Principle and implemented a series of complex administrative procedures for recognition of a Jordan's Principle case. As a result, the federal government repeatedly announced that no Jordan's Principle cases existed in Canada.
- A series of groundbreaking Canadian Human Rights Tribunal (CHRT) decisions in *First Nations Child and Family Caring Society & Assembly of First Nations v. Canada* have radically shifted the federal government's approach to implementing Jordan's Principle.
- The CHRT decisions have linked Jordan's Principle to a standard of substantive equality that requires the provision of services exceeding normative provincial standards if necessary to meet a child's needs. The CHRT decisions have also obligated the federal government to take immediate action to implement Jordan's Principle.
- The conceptual basis for provincial involvement in the implementation of Jordan's Principle remains unchanged by the CHRT decisions. However, provincial roles in current Jordan's Principle implementation efforts are unclear.

1.1 THE NEED FOR JORDAN'S PRINCIPLE[b]

Jordan's Principle was created in response to evidence that Jordan River Anderson's experience was not an

[a] Drawn from Blumenthal, A., & Sinha, V. (2015). No Jordan's Principle cases in Canada? A review of the administrative response to Jordan's Principle. *The International Indigenous Policy Journal, 6*(1). doi: 10.18584/iipj.2015.6.1.6

[b] This section of the report is drawn from Blumenthal & Sinha (2015), Churchill, M. & Sinha, V. (In Press) Reclaiming the spirit of Jordan's Principle: Lessons from a Canadian Human Rights Tribunal ruling. *Canadian Review of Social Policy*; and Kelsall et al (2018) Chapter 1: The evolution of Jordan's Principle. In Sinha, V., Vives, L. and Gerlach, A. (Eds.)

isolated incident but an example of the denials, delays, and disruptions in public services that commonly result from the complex structure of services for First Nations peoples.[6,7]

This structure is shaped, in part, by colonial legislation. Article 92 of the *Constitution Act* assigns responsibility for the provision of most health and social services to the provinces. Accordingly, each province has its own health and social services legislation, programs, and administration.[8] Section 88 of the federal *Indian Act* extends provincial laws of general application to First Nations peoples living in First Nations. [9,10,11]

Article 91(24) of the *Constitution Act* assigns responsibility for "Indians, and Lands reserved for the Indians" to the federal government.[12,13] The *Indian Act*, in turn, defines eligibility, acquisition, and transmission of Indian Status, the mechanism used by the federal government to define the First Nations population directly under its jurisdiction.[14] In combination, these sections of *Constitution* and *Indian Acts* establish the federal government's jurisdictional responsibility for services in First Nations.[15]

Funding and delivery of public health, social and education services for the rest of the population falls, with only a few exceptions, under provincial or territorial jurisdiction. As a result, while non-Indigenous Canadians generally only need to navigate provincial bureaucracy in order to obtain public services, First Nations individuals who live in First Nations and/or hold Indian status may have to deal with First Nations, federal, and/or provincial governments to access public services. [16,17,18,19,20]

Services outside of First Nations are funded, legislated, and provided by the provincial government, either directly or through contracts with independent service organizations. In contrast, services for First Nations people in First Nations are held to provincially-legislated standards, but are federally funded. Services are often provided by First Nations, which are bound by both provincial standards and the terms of federal funding, but they may also be provided by the federal government or, in some cases, by provincial governments. Thus, the details of the provision of services in First Nations may vary from nation to nation.[21,22,23,24,25]

This historically entrenched approach in the funding of public services results in areas of jurisdictional ambiguity and, as in the case of Jordan River Anderson, disputes over responsibility for services.[26,27,28] Confusion regarding responsibility for "Indian health and health-related services" were flagged at least as far back as 1969 and has been identified recently, particularly in cases involving status-eligible children, responsibility for services to First Nations people temporarily living within or outside of First Nations, and transition from institutional care outside of First Nations to community settings.[29,30,31]

Systematic, recent national level research that clearly enumerates these areas of ambiguity is not available. However, a 2005 study from Manitoba did describe jurisdiction and jurisdictional ambiguity in great detail. A summary of jurisdictional ambiguities in provision of services for First Nations people, from that study, is presented in Table 2.[32] Similarly, a Manitoba-focused study completed in 2010 projected the impact of ambiguity in 1985 legislation amending the rules for Status eligibility. As reflected in Table 3, the study projected that, between 2004 and 2029, the health care costs for people within First Nations who were potentially not covered by either the federal or provincial government would increase by 800%. Uncovered health care costs for First Nations people outside of First Nations were projected to increase by 300%.[33]

In addition, prior studies of services for First Nations children have noted persistent federal underfunding across a broad range of service domains and made consistent recommendations around eliminating funding gaps. These include recommendations that

funding models: systematically incorporate inflation adjustments; be based on actual needs and services provided rather than population estimates; be regularly updated to reflect changes in provincial and territorial legal standards; include enhanced operations funding for small and geographically remote agencies; include allocations for development of data collection and research capacity; and include funds for infrastructure maintenance and improvement.[34,35,36,37,38,39,40,41,42,43,44,45,46,47,48]

Table 2: Allec (2005): Ambiguities in jurisdiction in public services to First Nations people: Who pays? Which standards apply? What are the rules of entitlement?[49]

	On-Reserve	Off-Reserve
Professional Services		
Podiatry / Chiropody	Ambiguity	Manitoba Health
Chiropractic	Ambiguity	Manitoba Health
Optometric	FNIHB / Manitoba Health	Ambiguity
Home / Community Based Services		
Respite Care	Ambiguity	Manitoba Health
Palliative Care	Ambiguity	Manitoba Health
Community Rehabilitation		
Physiotherapy	Ambiguity	Manitoba Health
Speech & Language	Ambiguity	Manitoba Health
Audiology	Ambiguity	Manitoba Health
Aids to Persons with Physical Disabilities		
Communication Aids	Ambiguity	Ambiguity
Orthodontic / Prosthetic Devices	Ambiguity	Ambiguity
Respiratory Equipment & Supplies	Ambiguity	Ambiguity
Wheelchair, Mobility Aids & Seating	Ambiguity	Ambiguity
Medical Supplies & Equipment	FNIHB	Manitoba Health
Public Health		
Public Health Inspector and Monitoring	Ambiguity	Manitoba Health
Food and Drug Safety	Ambiguity	Manitoba Health / Health Canada
Residential Long Term		
Personal Care Homes (higher levels of care)	Ambiguity	Manitoba Health
Personal Care Homes (lower levels of care)	INAC	Manitoba Health
Residential Care Facilities	Ambiguity	Ambiguity
Independent Living Units with Support Services	Ambiguity	Ambiguity
Chronic Care Hospitals	Ambiguity	Ambiguity
Mental Health Services		
Crisis Counseling	FNIHB	Ambiguity
Prevention	Ambiguity	Manitoba Health
Transportation		
Medical Transportation	Ambiguity	Ambiguity
Ambulance Services		
Ground Ambulance	Ambiguity	Manitoba Health
Air Ambulance	Ambiguity	Manitoba Health

Source: The information presented above is based on interviews and a review of information provided by Manitoba Health, FNIHB, INAC, AMC, the Romanow report, and a presentation by Josee G. Lavoie at the Primary Health Care Conference on First Nations Health and Wellness, Winnipeg (March, 2005)

Table 3: Lavoie, Forget & Brown (2010): Total projected First Nations Health costs, in $1000s of dollars, by payer[50]

	Population living on reserve				Population living off reserve			
	Province	Federal government	Costs no longer covered by either government	Total	Province	Federal government	Costs no longer covered by either government	Total
2004	$193,070	$283,089	$2,559	$478,718	$155,697	$49,155	$4,121	$208,973
2009	$214,661	$313,278	$4,321	$532,260	$171,410	$52,634	$5,646	$229,690
2014	$237,320	$343,749	$7,371	$588,440	$187,402	$55,379	$7,754	$250,535
2019	$260,154	$373,327	$11,575	$645,056	$203,360	$57,423	$10,344	$271,127
2024	$282,610	$401,316	$16,782	$700,738	$219,050	$58,774	$13,352	$291,176
2029	$304,005	$426,791	$22,990	$753,786	$234,196	$59,362	$16,756	$310,314
% growth	57.5	50.8	798.4	57.5	50.4	20.8	306.6	48.5

1.2 THE EVOLUTION OF JORDAN'S PRINCIPLE[c]

1.2.1 Original vision

The initial articulation of Jordan's Principle closely mirrored the details of Jordan's case. One of the first appearances of the term "Jordan's Principle" in print was in the 2005 report entitled Wen:de: We are coming to the light of day. One of the recommendations made in the report was to implement Jordan's Principle:

> In keeping with the United Nations Convention on the Rights of the Child, we recommend that child first principle be adopted in the resolution of inter-governmental jurisdictional disputes. Under this procedure the government (provincial or federal) that first receives a request to pay for services for a Status Indian child where that service is available to other children, [. . .] will pay for the service without delay or disruption. The paying party then has the option to refer the matter to a jurisdictional dispute resolution table. In this way the rights of the child come first whilst still allowing for the resolution of jurisdictional issues. In honor and memory of Jordan we recommend the child- first principle to resolving jurisdictional disputes be termed Jordan's principle [sic] and be implemented without delay.[51]

Elsewhere in the Wen:de report, the need to address disputes between government departments (intra-governmental disputes) was explicitly acknowledged. Blackstock, Prakash, Loxley, and Wien noted that "First Nations child and family service agencies have long reported that jurisdictional disputes between government departments and levels of government (provincial/federal) have resulted in children unnecessarily being denied services or experiencing delays in service."[52]

In 2007, New Democratic Party Member of Parliament Jean Crowder tabled Motion 296 in the House of Commons, a resolution for the Canadian government to support the full scope of Jordan's Principle. Crowder's motion was unanimously endorsed.[53] The motion called for immediate adoption of a child-first principle based on Jordan's Principle, which MP Steven Blaney summarized this way:

> In other words, when a problem arises in a community regarding a child, we must ensure that the necessary services are provided and only afterwards should we worry about who will foot the bill. Thus, the first government or department to receive a bill for services is responsible for paying, without disruption or delay. That government or department can then submit the matter for review to an independent organization, once the appropriate care has been given, in order to have the bill paid. I support this motion, as does the government.[54]

1.2.2 Initial implementation

In May 2008, the Minister of Health and the Minister of Indian Affairs and Northern Development invited provincial and territorial governments "to work together to implement a child first principle to resolve jurisdictional disputes involving the care of First Nations children."[55] Over the next few years, the federal government entered into agreements that narrowed the eligibility for, and complicated access to Jordan's Principle across jurisdictions. In all provinces for which information was publicly available, including

[c] This section of the report is drawn largely from: Blumenthal & Sinha, (2015), Kelsall et al (2018), and Churchill & Sinha (In press).

Manitoba, Jordan's Principle was operationalized as applying only if:

1. A First Nations child who had status or was eligible to have status is involved;
2. The child was ordinarily a resident in a First Nation;
3. The child had been assessed by health and social service professionals and had been found to have multiple disabilities requiring services from multiple providers;
4. A jurisdictional dispute existed between the federal and a provincial/territorial government; and
5. The assessment of services needed was made based on normative standards of care provided to similar children in a similar geographic location.[56,57,58]

A case that met these strict criteria had to then pass through an eight-step case conferencing process in order to be recognized by the government as a Jordan's Principle case. Six of the eight steps had no prescribed time limit. One of the steps required two individual Assistant Deputy Ministers to agree, in writing, that a jurisdictional dispute existed. Only then would the child receive needed services. [59]

Under this administrative response, some cases were resolved without ever being identified as Jordan's Principle cases. For example, there was a four-year old First Nations girl who, after experiencing cardiac arrest and a brain injury, received a specialized hospital bed from an anonymous donation after multiple federal government departments claimed they had no authority to pay.[60] In other cases, such as the case of Maurina Beadle and Jeremy Meawasige (discussed below), the narrow application of Jordan's Principle led to denials of service and lengthy legal proceedings.[61] In an unknown number of other cases, the needs of First Nations children likely went unrecognized and were thus never met.

The impact of this restrictive application of Jordan's Principle was evinced in federal government assertions – in 2010, 2012, and 2015 - that it knew of no Jordan's Principle cases in Canada and in a federal official's testimony, before the Canadian Human Rights Tribunal that no child in Canada ever accessed a federal fund, which existed between 2008 and 2012, that was established to resolve jurisdictional disputes in Jordan's Principle cases.[62,63,64]

1.2.3 *Pictou Landing Band Council & Maurina Beadle v. Canada*

The ruling in *PLBC & Maurina Beadle v. Canada*, described in Textbox 1, delivered a powerful rebuke of the federal approach to Jordan's Principle implementation. The court ruled that, in assigning Jordan's Principle focal points (government representatives charged with facilitating Jordan's Principle processes in individual cases), the federal government accepted the task of implementing Jordan's Principle and, thus, incurred a responsibility to do so.

The court rejected the idea that dispute over payment for services was required in order for Jordan's Principle to be invoked, stating:

> I do not think the principle in a Jordan's Principle case is to be read narrowly. The absence of a monetary dispute cannot be determinative where officials of both levels of government maintain an erroneous position on what is available to persons in need of such services in the province and both then assert there is no jurisdictional dispute.[65]

Instead of focusing on a payment dispute, the court suggested that the failure to provide services in keeping with legislated provincial standards invoked Jordan's Principle. The Court stated:

The Nova Scotia Court held an off reserve person with multiple handicaps is entitled to receive home care services according to his needs. His needs were exceptional and the SAA [. .] and its regulations provide for exceptional cases. Yet a severely handicapped teenager on a First Nation reserve is not eligible, under express provincial policy, to be considered despite being in similar dire straits. This, i n my view, engages consideration under Jordan's Principle which exists precisely to address situations such as Jeremy's. [66]

Textbox 1. Summary of *Maurina Beadle and Pictou Landing Band Council v. Canada*

Maurina Beadle, a resident of Pictou Landing First Nation (PLBC) in Nova Scotia, was a single mother and the primary caregiver for her son, Jeremy Meawasige. Jeremy had been diagnosed with hydrocephalus, cerebral palsy, spinal curvature, and autism; he had high care needs and could be self-abusive at times. In May 2010, Ms. Beadle suffered a stroke and was hospitalized. She subsequently required assistance with her own care and could no longer care for Jeremy at the level that he needed. The PLBC began funding 24-hour in-home care to assist both Ms. Beadle and Jeremy. After Ms. Beadle's condition improved, in October 2010, the Pictou Landing Health Centre recommended that the Beadle family continue to receive in-home care services from a homecare worker to meet Jeremy's needs.

The PLBC health director estimated that Jeremy's in-home care expenses totaled around $8,200 a month, which amounted to nearly 80% of the total monthly funding that PLBC received for home care services for the entire community. The health director contacted Health Canada to request support to address Jeremy's needs. During the case conferencing meetings between provincial, federal, and PLBC representatives, a provincial representative explained that an off-reserve child requiring similar care would receive a maximum of $2,200 per month for in-home respite services. The PLBC health director pointed out a recent Nova Scotia Supreme Court ruling that the $2,200 limit violated provincial legislation and ordered the province to provide additional in-home care funding in a similar case. She was told that Jordan's Principle did not apply to Jeremy's case because there was no jurisdictional dispute: provincial and federal government agencies agreed that services provided to Jeremy should not exceed $2,200 per month. In contrast, she was told that the province and the federal government would fund the cost of institutional care at an estimated cost of approximately $10,500 per month, or 130% of the cost of Jeremy's in-home expenses at the time.

In June 2011, the Pictou Landing Band Council and Ms. Beadle asked the Federal Court to quash the focal point's decision in Jeremy's case, and to declare that the federal government's actions in the case violated Nova Scotia legislation, Jordan's Principle, and the *Charter*. The federal government argued that Jordan's Principle was not engaged because the province and the federal government were in agreement. They further argued the provincial failure to reform policy and practice in response to the Nova Scotia Supreme Court ruling meant the $2,200 per month cap was the normative provincial standard. Finally, they argued that PLBC was not entitled to reimbursement for the cost of Jeremy's care, suggesting that if PLBC could not cover these costs with the current funding they should renegotiate their federal funding agreement. In 2013, the Federal Court ruled in favour of PLBC and Maurina Beadle, finding that the federal government's interpretation and application of Jordan's Principle was inadequate. The ruling stated that Jordan's Principle "exists precisely to address situations such as Jeremy's" and identified the failure to engage Jordan's Principle in the case as "unreasonable". The federal government appealed the decision, but formally discontinued the appeal in July of 2014.

Drawn from: Jordan's Principle Working Group. (2015). Without denial, delay or disruption: Ensuring First Nations children's access to equitable services through Jordan's Principle. Retrieved from https://www.afn.ca/uploads/files/jordans_principle-report.pdf

Accordingly, the ruling in *PLBC & Maurina Beadle v Canada* suggested that the existence of a disparity between the services available to First Nations children and legislated provincial standards should trigger the provision of Jordan's Principle protections.

1.2.4 *Caring Society & AFN v. Canada*

The reform of the restrictive federal response to Jordan's Principal has been largely driven by the Canadian Human Rights Tribunal's (CHRT) response to a human rights complaint filed by the First Nations Child and Family Caring Society (Caring Society) and the Assembly of First Nations (AFN) in 2007. The complaint alleged that the underfunding and administration of child welfare services in First Nations constituted systemic discrimination against First Nations children "because of their race and national ethnic origin."[67] One component of the complaint identified the failure to implement Jordan's

Principle as a factor perpetuating discrimination in child welfare.[68]

In 2016 the CHRT ruled that Canada had discriminated against First Nations children through its funding and administration of child welfare services. Finding that departments of the federal government had already signed a Memorandum of Understanding, committing to the implementation of Jordan's Principle in 2009, and renewed this memorandum in 2013, the CHRT ordered Canada to immediately adopt the full scope of Jordan's Principle.[69] Between April of 2016 and February of 2018 the CHRT issued four additional rulings responding to Canada's continued failure to comply with the Tribunal's orders. The first ruling reinforced the original vision of Jordan's Principle, stating:

> Jordan's Principle is a child-first principle and provides that where a government service is available to all other children and a jurisdictional dispute arises between Canada and a province or territory, or between departments in the same government regarding services to a First Nations child, the government department of first contact pays for the service and can seek reimbursement from the other government or department after the child has received the service. It is meant to prevent First Nations children from being denied essential public services or experiencing delays in receiving them.[70]

Subsequent non-compliance orders enforced the broad application and eligibility criteria originally envisioned for Jordan's Principle and specified timelines for government response to Jordan's Principle's requests. These rulings indicated that:

- Jordan's Principle applies to all First Nations children regardless of ability, disability, or their place of residence within or outside First Nations.[71] [72]
- Jordan's Principle addresses the needs of First Nations children by ensuring there are no gaps in government services to them.[73] [74]
- Jordan's Principle applies to a broad range of health, social, and education services; it can address, but is not limited to "mental health, special education, dental, physical therapy, speech therapy, medical equipment and physiotherapy."[75,76]
- The government must respond to Jordan's Principle request within specific time limits.[77]
    - Within 48 hours of an initial request for service for an individual child, 12 hours for urgent requests. Consultation or case conferencing is permitted only if needed to determine a child's clinical needs. If clinical consultation is required, the federal government must ensure that it responds "as close to the [initial] 48-hour time frame as possible"[78] and is required to respond within 12-48 hours of receiving all necessary clinical information.[79]
    - Responses to group requests, which address service gaps affecting large numbers of children, are required within 48 hours for urgent cases and one week for non-urgent cases.[80]

The rulings also linked Jordan's Principle to a standard of substantive equality, extending its application far beyond those cases in which a First Nations child is denied a "government service available to all other children and a jurisdictional dispute" exists.[81,82]

The CHRT did not offer an explicit definition of substantive equality. However, it did note that, under a substantive equality standard, the federal government must "consider the distinct needs and circumstances of First Nations children and families living in First Nations—including their cultural, historical and geographical needs, and circumstances—in order to ensure equality."[83] Accordingly, the CHRT has indicated that services beyond normative provincial standards of care must be funded when required to achieve substantive equality for First Nations children.[84]

In 2018, the federal government released a list of nine questions to guide assessment of substantive equality when making decisions about services requested under Jordan's Principle.[85] These questions (listed in Textbox 2) outline broad parameters for shifting from a goal of ensuring that First Nations have access to the same services available to other children in Canada, to one of providing services that reflect consideration for First Nations rights to self-determination, cultural and linguisitic appropriateness, and a holistic approach to children's needs. This shift aims at eliminating some of the systemic barriers in access to services that are a result of racism and colonialism in Canada.[86]

1.2.5 Short-term approach to Jordan's Principle

In July of 2016, the federal government announced the creation of the Jordan's Principle Child-First Initiative (CFI). The CFI is a short-term response to Jordan's Principle; its $382.5 million budget extends only until the end of the 2018–2019 fiscal year.[87,88]

The CFI established the Service Access Resolution Fund (SARF) to pay for services for individual children whose requests were approved under Jordan's Principle.[89] In addition, federal SARF funds have been used to fund group requests, which address service gaps affecting large numbers of children.[90] As the SARF is nested within federal CFI funding, the funding is currently set to expire in March of 2019.

As in the earlier implementation of Jordan's Principle,[91] all requests for federal Jordan's Principle funding under the CFI are administered by government representatives known as "focal points." Focal points are responsible for facilitating the review and approval of requests for services under Jordan's Principle.[92] In addition to advertising contact information for focal points, the federal government also launched a 24-hour, nationwide Jordan's Principle call centre to facilitate access to Jordan's Principle.[93]

The Jordan's Principle CFI also included federal funding for an "Enhanced Service Coordination model of care" (ESC) which was intended to help maximize access to health, social, and educational services while reducing service delays.[94] ESC was envisioned as a resource to help families navigate *existing* federal and provincial services rather than duplicating services.[95,96] Details of service coordination programs and services funded federally

Textbox 2. Questions for Assessing Substantive Equality

1. Does the child have heightened needs for the service in question as a result of an historical disadvantage?
2. Would the failure to provide the service perpetuate the disadvantage experienced by the child as a result of his or her race, nationality or ethnicity?
3. Would the failure to provide the service result in the child needing to leave the home or community for an extended period?
4. Would the failure to provide the service result in the child being placed at a significant disadvantage in terms of ability to participate in educational activities?
5. Is the provision of support necessary to ensure access to culturally appropriate services?
6. Is the provision of support necessary to avoid a significant interruption in the child's care?
7. Is the provision of support necessary in maintaining family stability? As indicated by:
   - o the risk of children being placed in care; and
   - o caregivers being unable to assume caregiving responsibilities.
8. Does the individual circumstance of the child's health condition, family, or community context (geographic, historical or cultural) lead to a different or greater need for services as compared to the circumstances of other children (e.g. extraordinary costs associated with daily living due to a remote location)?
9. Would the requested service support the community/family's ability to serve, protect, and nurture its children in a manner that strengthens the community/family's resilience, healing and self-determination?

Source: Government of Canada. (2018, April 4). Jordan's Principle—Substantive Equality Principles. Retrieved from https://www.canada.ca/en/indigenous-services-canada/services/jordans-principle/jordans-principle-

differ between provinces/territories and even across First Nations within provinces. Though there has been no systematic description or evaluation of these initiatives, a recent summit held in Manitoba demonstrated that a rich and diverse range of initiatives have been federally funded through Jordan's Principle CFI.[97]

The federal government reports that, between July 2016 and September 2018, more than 165,000 requests for federal Jordan's Principle funding have been approved. These include requests for a broad range of services, including: "respite care, speech therapy, schooling supports, medical equipment, mental health services and more."[98]

1.2.6 Long-term approach to Jordan's Principle

Though the short-term federal CFI funding is set to expire in March 2019, long-term plans for implementation of Jordan's Principle are still unclear. In September 2018, an Assistant Deputy Minister of Indigenous Services Canada laid out the plan for the future of federal Jordan's Principle funding. The plans included: further First Nations control over resources; an innovation fund for new types of community-based programs; and funding for new infrastructure to house service delivery.[99] However, the specifics of how much federal funding will be put in place, its distribution, or whether it will continue to support the diverse models developed under CFI remains unclear.[100]

Long-term plans for Jordan's Principle may be shaped by the decisions of and interactions between multiple national groups and initiatives. The Jordan's Principle Action Table (JPAT), was founded in June of 2017 to look at "policy options for the long-term implementation of Jordan's Principle."[101] It is currently exploring "new federal program authorities, different service delivery models and approaches to funding."[102] The JPAT is one of five technical tables of the National Advisory Committee on First Nations Child and Family Services Program Reform (NAC) which was developed in 2017 to provide "key recommendations for the medium and long-term relief related to" the CHRT rulings, "including the application of Jordan's Principle."[103] Long term Jordan's Principle plans may also be shaped by decisions made by other NAC technical tables, by the CHRT – which has retained jurisdiction until at least December 2018, and/or by several other national initiatives related to services for First Nations children (e.g. the Spirit Bear Plan or federal child welfare legislation).[104]

1.3 PROVINCIAL ROLES IN JORDAN'S PRINCIPLE IMPLEMENTATION [d]

1.3.1 Prior implementation of Jordan's Principle

In its initial formulation, Jordan's Principle emphasized jurisdictional disputes between governments or government departments and a child-first approach in which the first government or department approached would pay for or provide services, covering costs until resolution around jurisdiction could be subsequently reached. The focus on jurisdictional disputes, particularly on inter-jurisdictional disputes, clearly required the active engagement of both provincial and federal government. The need for provincial engagement was reified under initial implementation of Jordan's Principle. The federal operationalization of Jordan's Principle, as applying only in cases involving inter-governmental (but not intra-governmental) disputes necessitated provincial engagement, and between 2008 and 2012, the federal government pursued the development of Jordan's Principle agreements with provincial governments.

In May 2008, the Minister of Health and the Minister of Indian Affairs and Northern Development invited provincial and territorial governments to collaborate on implementation of Jordan's Principle.[105] A 2010 federal assessment of its administrative response to Jordan's Principle summarized the results: Manitoba entered into a bilateral agreement in 2008; Saskatchewan and the Federation of Sovereign

[d] This section of the report is drawn largely from Blumenthal & Sinha (2015) No Jordan's Principle cases in Canada? A review of the Administrative response to Jordan's Principle. *The International Indigenous Policy Journal 6(1).* DOI: 10.18584/iipj.2015.6.1.6

Indigenous Nations (then the Federation of Saskatchewan Indian Nations) signed a trilateral agreement in 2009; Ontario, British Columbia, Alberta, and New Brunswick were described as 'wishing to' reach an agreement; while Nova Scotia, Newfoundland and Labrador, Prince Edward Island, and Quebec were described as uninterested in establishing formal dispute resolution processes. British Columbia and New Brunswick, as well as the First Nations Chiefs of New Brunswick, subsequently entered into agreements in 2011. Despite the mixed assessments reported in 2010, the federal government stated in 2012 that all provinces "have been engaged in discussions and have put joint processes in place."[106,107]

The federal government's 2012 assessment was sharply contradicted by the Canadian Paediatric Society's (CPS) 2012 status report on Canadian public policy and child and youth health. CPS rated the implementation of Jordan's Principle in all provinces and territories. Drawing on government documents, websites, and personal communications, CPS assessed Jordan's Principle implementation on the four-category rating scale.

- A 'poor' rating was assigned when a province/territory had not adopted a child-first principle,
- 'Fair' was assigned when a child-first principle had been adopted but no specific strategies for resolving jurisdictional disputes had been developed or implemented,
- 'Good' was assigned if a province/territory had adopted a child-first principle and put in place a dispute resolution process, and
- 'Excellent' was assigned if both had been formally adopted and implemented.[108]

CPS assessments in 2012 were identical to those from three years earlier, in 2009. Eight of the provinces and territories were rated as "poor," meaning that there was no child-first policy in the jurisdiction. Four provinces were rated as "fair." Nova Scotia, the only jurisdiction that CPS rated as "good," was the site of the *PLBC v. Canada* legal challenge that is discussed above. [109,110]

Four years later, in 2016, CPS again surveyed all provinces and territories about their definition of and practices around Jordan's Principle.[111] The responses received, summarized in Table 4, demonstrated failures to implement Jordan's Principle in some jurisdictions that expressed support, the failure to commit resources to implementation in other jurisdictions, and evidence that these implementation failures, in combination with the narrowed operational definition of Jordan's Principle advanced by the federal government, resulted in very few (if any) children receiving services under Jordan's Principle.

1.3.2 Current implementation of Jordan's Principle

The justification for provincial involvement in Jordan's Principle established under the original vision, and reinforced under initial implementation, remains central. The CHRT affirmed both the application of Jordan's Principle to inter-governmental disputes and the child-first nature of the principle.[112] Therefore, the engagement of provinces is still required.

Further, Jordan's Principle, as interpreted and defined by the CHRT may necessitate an even greater provincial role than was required under the original vision or initial implementation of Jordan's Principal. The CHRT has ruled that Jordan's Principle addresses "gaps in service" (rather than just jurisdictional disputes) and that Jordan's Principle applies to First Nations children living outside of First Nations.[113] In linking Jordan's Principle to a standard of substantive equality, the CHRT has indicated that provision of service above and beyond provincial normative standards may be required in order to meet the needs and best interests of First Nations children. [114] In addition, it has established strict timelines for responding to requests for services.[115]

Thus, Jordan's Principle requires the timely provision of services to First Nations children living both within and outside of First Nations in order to address service gaps. It also requires the timely provision of

Table 4: Canadian Paediatric Society ratings of Jordan's Principle implementation (2009, 2012, 2016) [116,117,118]

Province/ Territory	Rating 2009	Rating 2012	Highlights of provincial/territorial response to Jordan's Principle 2016
British Columbia	Fair	Fair	No response at time of publication.
Alberta	Poor	Poor	Expressed support for Jordan's Principle in 2008, but did not describe how this works in practice.
Saskatchewan	Fair	Fair	Limits Jordan's Principle to "all First Nations children with intensive health care needs." Reports three "potential" Jordan's Principle cases as resolved through case conferencing protocol.
Manitoba	Fair	Fair	First province to announce an agreement to implement Jordan's Principle (September 2008), although no resources have been dedicated to the process. Reports that "informal case conferencing" has minimized impact of jurisdictional disputes, but did not provide the number of cases addressed in this manner.
Ontario	Fair	Fair	Applies Jordan's Principle to children with "complex medical conditions" but reports no cases to date or "any jurisdictional disputes between Canada and Ontario that have been resolved by reference to Jordan's Principle."
Quebec	Poor	Poor	No response at time of publication.
New Brunswick	Poor	Poor	Tripartite agreement (First Nations' Chiefs of New Brunswick, province, and federal government) reached in December 2011, which includes "public services" such as health care, child welfare and other social services, and special education. The document includes a dispute resolution process, as well as communications material for the public in four languages. New Brunswick reports that two potential Jordan's Principle cases were resolved.
Nova Scotia	Good	Good	No response at time of publication.
Prince Edward Island	Poor	Poor	No response at time of publication.
Newfoundland & Labrador	Poor	Poor	Reports that programs and services are provided by the government "consistent with Jordan's Principle while waiting for funding decisions from another source." But the province "has not implemented the jurisdictional dispute mechanism of Jordan's Principle."
Yukon	Poor	Poor	Has not formally adopted Jordan's Principle, noting "Yukon's health system funds services on a universal basis for all Yukon residents and does not distinguish between First Nation and non-FN, nor does our insured program embody a 'child-specific' lens."
Northwest Territories	Poor	Poor	Has not formally adopted Jordan's Principle, noting that "NWT has a single health and social services system that does not have separate health and social services for on-reserve First Nations children and families, and does not differentiate between the provision of any health or social service based on ethnicity."
Nunavut	Poor	Poor	The population of Nunavut is approximately 85% Inuit. "The Government of Nunavut is interested in any discussions regarding the inclusion of Inuit children under the protections of Jordan's Principle."

services extending beyond normative standards of care if needed in order to ensure substantive equality for First Nations children living within or outside of First Nations. Services for children outside of First Nations have historically fallen under provincial/territorial jurisdiction. Accordingly, the CHRT ruling has potentially created new bases for provincial engagement with Jordan's Principle.

Despite these implications of the CHRT rulings, action in response to the rulings has come primarily from the federal government. The CHRT orders apply directly to the federal government, and, as discussed above, have mobilized federal action. The response of provinces to the evolution of Jordan's Principle interpretation and application is less clear.

A summary of a July 2018 meeting of the provincial and territorial ministers responsible for social services, reflected a wait-and-see approach. It described their collective position this way:

> Ministers look forward to receiving more information from the federal government about its plans to develop federal Indigenous child and family services legislation and plans to address the requirements of Jordan's Principle. It is critical to ensure that these federal directions will work effectively with provincial and territorial initiatives already underway. Ministers highlighted the importance of respecting the responsibilities of each order of government, most of all the constitutional and fiduciary responsibilities of the federal government toward Indigenous peoples.[119]

As will be detailed in Chapter 2, the Manitoba government has adopted a similar wait-and-see approach.[120]

While no formal systematic review of provincial roles in the current implementation of Jordan's Principle exists, Dr. Cindy Blackstock of the First Nations Child and Family Caring Society of Canada summarized her assessment in October of 2018 testimony before the Missing and Murdered Indigenous Women and Girls, Institutional and Expert / Knowledge-Keeper Hearings. She noted that:

> No province or territory has adopted a Canadian Human Rights Tribunal compliant definition of Jordan's Principle, and so too often what we're seeing [. . .] is that the provinces are kind of taking the position of well the feds now are on the hook for Jordan's Principle so we're not going to step up to the plate; we're just going to try and see if the feds can pick it up. Which is totally contrary to the whole issue of Jordan's Principle. Jordan died in that hospital because the Province of Manitoba and the Government of Canada failed to put his best interests first. So I would urge all provinces and territories to implement and fully adopt a CHRT compliant definition of Jordan's Principle and to do so and implement it in tandem with First Nations.[121]

Subsequent to that assessment, a memorandum of understanding (MOU) on the implementation of Jordan's Principle in Alberta was signed between Indigenous Services Canada, Alberta Children's Services, and the First Nations Health Consortium (an organization that receives federal Jordan's Principle funding to provide service coordination for all First Nations children in Alberta).[122] The MOU indicates that all parties agree on the working definition of Jordan's Principle established by the CHRT, specifies a shared commitment to collaborating on the implementation of Jordan's Principle, and outlines a process for collaboration.[123] However, the details of how the commitments outlined in the MOU will be operationalized remain to be seen. As of this writing, I do not know of a similar MOU or agreement in any other jurisdiction.

2 Implementation of Jordan's Principle in Manitoba

In this chapter of the report, I provide an overview of the implementation of Jordan's Principle in Manitoba. I draw on prior research and document review to describe the historical approach to implementing Jordan's Principle in the province. I then draw on findings from document review and interviews with key stakeholders to describe the current implementation of Jordan's Principle in Manitoba. I find that:

- First Nations in Manitoba have played a consistent and leading role in advocating for the full implementation of Jordan's Principle.
- The government of Manitoba has long expressed support for Jordan's Principle and was the first province to *agree* to implement the principle.
- However, the initial implementation of Jordan's Principle in Manitoba adopted the narrow eligibility criteria and complex administrative processes advanced by the federal government. As a result, few, if any, children in Manitoba were recognized as having Jordan's Principle cases and processes for supporting children who did not qualify were never formalized.
- The approach to implementing Jordan's Principle in Manitoba has shifted dramatically since 2016. In response to CHRT rulings, the federal government has committed significant Jordan's Principle funding across Canadian jurisdictions, and worked with First Nations in Manitoba to support the development of an expanded system of services for First Nations children and families.
- The Manitoba government indicates that, while it is open to collaboration with First Nations and the federal government to support implementation of Jordan's Principle, it has not allocated new funds or created new policies to support the implementation of Jordan's Principle, as interpreted by the CHRT.

2.1 Early Advocacy from First Nations

Jordan's Principle is a First Nations principle. Jordan's Principle advocacy started with Jordan's family and community and was extended by a child advocate with the Assembly of Manitoba Chiefs (AMC). Leaders from Norway House Cree Nation and the Assembly of Manitoba Chiefs continued advocacy in partnership with the First Nations Child and Family Caring Society and the Assembly of First Nations.[124] A 2006 AMC resolution called on federal and provincial governments to implement without delay a child-first principle, to be known as Jordan's Principle for resolving inter-governmental jurisdictional disputes.[125]

2.2 Attempts at Legislation

In 2008, concern over slow and informal implementation of Jordan's Principle led to the drafting of the Jordan's Principle Implementation Act.[126] The proposed act focused on health and social services, defining a jurisdictional dispute as "a dispute between the federal government and the provincial government or a government agency that is responsible for paying for the health care or social services required by a child."[127] The bill would have affirmed the right of all children to receive the best health care and social services on a timely basis in their homes or communities. The bill was introduced three times between 2008 and 2010, but never proceeded beyond first reading in the legislature.[128,129]

2.2.1 Initial Implementation and Ongoing First Nations Advocacy[130]

In 2008, Manitoba became the first province to reach a bilateral agreement with the federal government to implement a jurisdictional dispute resolution process for First Nations children.[131,132] A Joint Committee composed of federal and provincial representatives was established in 2008 and began work on a Jordan's Principle case conferencing and dispute resolution document.[133] Despite requests from the AMC Secretariat to participate in the Joint Committee, no First Nations representatives was included.[134]

A Terms of Reference Official Working Group (TOROWG) established by the Joint Committee drafted a report outlining the spectrum of cases that

would fall under Jordan's Principle and described potential processes for determining the agency with primary responsibility for funding services. It also described potential case conferencing mechanisms, dispute resolution processes, and appeal processes.[135]

The report described a narrow application of Jordan's Principle which mirrored the federal approach. Jordan's Principle would apply only in cases involving a status or status eligible child, ordinarily resident on reserve, whom health and social service providers had assessed as having multiple disabilities requiring services from multiple service providers. In addition, Jordan's Principle was only to apply in cases involving a jurisdictional dispute between the federal and provincial government, and assessments were to be based on normative standards of care for similar children in similar geographic locations. [136]

The report explicitly tied application of Jordan's Principle to the restrictive interpretation of jurisdictional disputes which would eventually be rejected in *Maurina Beadle and Pictou Landing v. Canada* (see Section 1.2.3, above). It enumerated a number of service gaps and service disparities, or situations in which the federally funded services in First Nations were not equal to the provincially funded services provided off-reserve, but described these as falling outside the scope of Jordan's Principle.[137] Examples included provision of only one new assistive device (e.g. a lift or wheelchair) every five years for children in First Nations, while funding outside of First Nations covered multiple devices and installation; and the limitation of physiotherapy for First Nations children to hospital settings, while off reserve children could access free physiotherapy at home or in health care centres.[138]

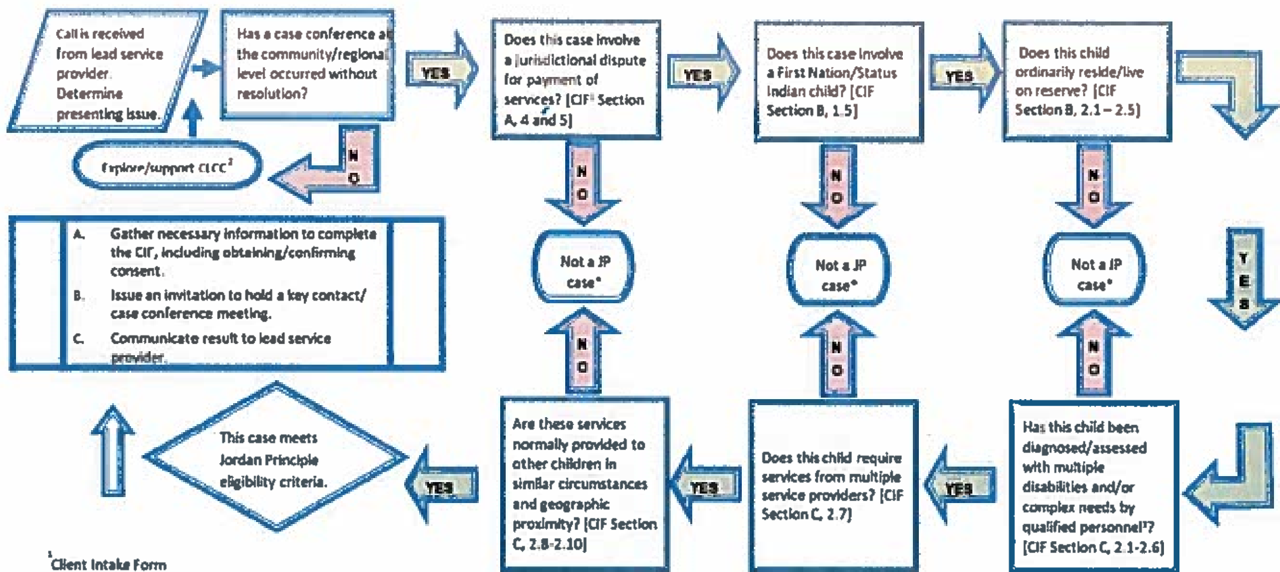
The report stressed that "these examples of service disparities are not the result of a dispute between the Federal and Provincial jurisdictions over responsibility for the provision or funding of services. As such, these differences do not relate to Jordan's Principle, as there is no jurisdictional dispute."[139] The report also suggested that out-of-home placement through the child welfare system would be one way for children in First Nations to more easily access services in keeping with normative provincial standards.[140]

The narrow approach to Jordan's Principle implementation persisted over several years. Criticism of this narrow approach to implementing Jordan's Principle was reflected in a 2011 AMC resolution that renewed the call for implementation of Jordan's Principle. The resolution also laid out a five-point plan for AMC action on the issue. In 2012, a representative of AMC was invited to join the Joint Committee and a representative of the AMC Secretariat was included in the TOROWG. However, later that year, the CPS assessed the implementation of Jordan's Principle in Manitoba to be "fair", noting that, while a child-first principle had been 'adopted', no specific policies for resolving jurisdictional disputes had been developed or implemented (see Table 4, in Chapter 1).[141] Notes from a Joint Committee meeting in October of 2013 indicate that a Jordan's Principle process had been tested in only two cases, with one being resolved through the provision of funding by a private donor.[142]

In 2014, the governments of Manitoba and Canada circulated a letter announcing that a Jordan's Principle case conferencing process had been formalized.[143] However, in that same year, an affidavit from the acting director of the AMC secretariat, which accompanied the AMC Secretariat's motion to intervene in *Canada v. PLBC & Maurina Beadle*, described the continued, narrow implementation of Jordan's Principle in Manitoba. [144]

The affidavit indicated that, despite meeting regularly, the TOROWG had failed to formalize a Jordan's Principle case conferencing process. In addition, it indicated that the AMC Secretariat knew of many cases in which First Nations children were not receiving equitable services but were denied access to Jordan's Principle because of its narrow interpretation.[145] In addition, the affidavit asserted that, "to the AMC Secretariat's knowledge the only way First Nations children in Manitoba are able to

Figure 1: Graphic representation of Jordan's Principle decision process, prior to 2016, from Manitoba Jordan's Principle documents [146]



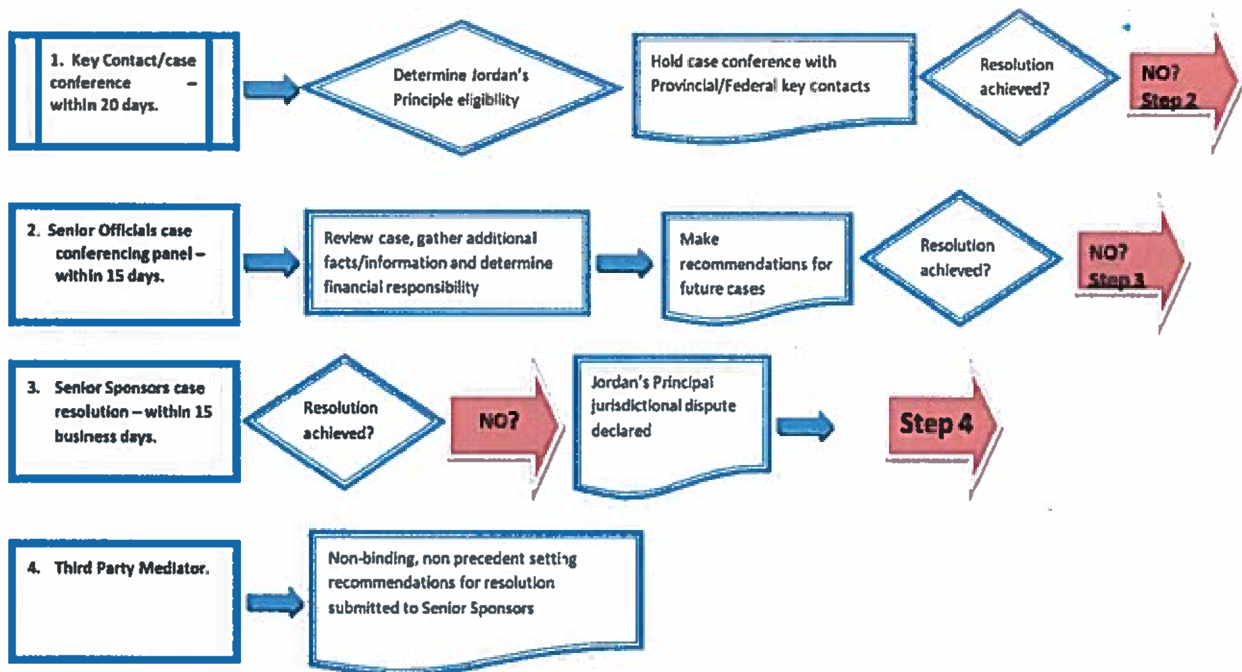
[1]Client Intake Form

[2]Community-level Case Conference (CLCC)

[3]There is an assumption that a medical diagnosis or other assessment has been completed or is pending

*Cases not involving payment: Such cases should be tracked, including gathering the remaining information on the intake form, reviewed and efforts made to explore and resolve internal to a particular government and /or in partnership with other governments, organizations, providers as appropriate.

Figure 2: Graphic representation of Jordan's Principle dispute resolution process, prior to 2016, from Manitoba Jordan's Principle documents[147]



access comparable services is if they are put into the child welfare system." [148]

A process evaluation commissioned by AMC began in 2014; it examined the case conferencing and case resolution process. A 2016 report on results confirmed that Manitoba continued to apply the narrow federal interpretation of Jordan's Principle. This is demonstrated in Figure 1, which the report identifies as appearing in key Jordan's Principle documents. The figure was described as tool for "program and service providers working with First Nations children" to "explain the federal and provincial process being implemented in Manitoba to respond to Jordan's Principle-related federal-provincial payment (and other) disputes." [149] It depicts the way in which the eligibility criteria systematically prevented the declaration of Jordan's Principle cases. As reflected in Figure 2, also used in key Jordan's Principle documents, there was no guarantee of services even if a case was declared eligible for Jordan's Principle. The conclusion of the multi-step Jordan's Principle dispute resolution process adopted in Manitoba were "non-binding, non-precedent-setting recommendations."[150]

The AMC commissioned evaluation focused on five cases which were determined ineligible for Jordan's Principle under the narrow interpretation being utilized, but which, nonetheless, proceeded through case conferencing and dispute resolution. At least two of the five families whose cases were examined decided to move outside of their First Nation in order to access services and at least one entered into a voluntary agreement to place their child in out of home care in order to access services.[151] The report concluded that there was no formalized process for addressing such cases but that, in practice, the process roughly resembled steps 1, 2 and 4 in Figure 2. The report highlighted concerns about: the definition of Jordan's Principle applied in Manitoba; the length of time it took to complete case conferencing and dispute resolution processes; and poor communication around Jordan's Principle processes. [152]

2.3 EMERGENCE OF THE CURRENT APPROACH TO JORDAN'S PRINCIPLE IN MANITOBA

The current approach to implementing Jordan's Principle in Manitoba is tied to the series of CHRT decisions discussed in Section 1.2.4 of this report and to the subsequent announcement of the short-term Jordan's Principal Child First Initiative (CFI), that included federal funding for enhanced service coordination and response to Jordan's Principle requests, which is summarized in Section 1.2.5.

The current implementation of Jordan's Principle within Manitoba also reflects ongoing advocacy by First Nations. In September of 2016, AMC issued two resolutions related to Jordan's Principle. The first again called for the immediate implementation of the full scope of Jordan's Principle, both within and outside First Nations.[153] The second put forward four recommendations for Jordan's Principle implementation in Manitoba. It called for: restructuring of the TOROWG; funding for the AMC/Eagle Urban Transition Centre to provide Enhanced Service Coordination and support capacity development at the Tribal Council and community level; and the creation of three additional service coordinator positions to northern First Nations. The final recommendation called for the revival and implementation across Manitoba of the Children's Special Services program, [154] a pilot project that provided voluntary, community-based services to children born with technological dependencies in Norway House Cree Nation between 2004 and 2006 (with more limited provision of services for some children continuing through 2010).[155] The resolution also called for a meeting between AMC, the federal ministers of health and Indigenous affairs, and provincial minsters of health and families in order to establish an intergovernmental task force which define authorities for and uphold the implementation of Jordan's Principle. [156]

Discussions at Joint Committee and TOROWG meetings in October and November of 2016 demonstrate the emergence of the current approach to implementing Jordan's Principle in Manitoba. The

federal government was moving quickly to fund services requested by First Nations and to respond to the needs of individual children with identified needs. FNIH Manitoba region identified the initial approval of $8 million in Jordan's Principle funding for Manitoba, with $1.3 million to be spent during the 2016-17 fiscal year. FNIH representatives described an initial approach in which they would respond to First Nations requests on a first come first serve basis, noting that they had already received eleven requests for respite care funding and 426 requests for services for individual children with assessed needs.[157,158]

In keeping with the resolutions passed by AMC, First Nations participants in these meetings called for restructuring the Joint Committee and TOROWG to facilitate greater First Nations leadership and meaningful partnership and engagement with First Nations across Manitoba. They also called for an approach that more systematically responded to needs identified by all First Nations and for the development of a sustainable First Nations service delivery model. [159,160]

The government of Manitoba has described the move towards First Nations leadership as shaping their current role in Jordan's Principle implementation. In written response to questions about Jordan's Principle, the Manitoba Department of Health, Seniors and Active Living (Department of Health) and the Department of Families indicated that:

> Up to the decision by the CHRT in 2016, the Joint Committee on the Implementation of Jordan's Principle had been developing the Case Conferencing to Case Resolution process. However, following release of that decision, First Nations organizations engaged with the Committee indicated their view that the Committee and its sub-committee should be restructured to give a greater leadership role to First Nations. Since then, Canada has worked exclusively with First Nations communities and organizations to implement Jordan's Principle in Manitoba in accordance with the CHRT rulings. Manitoba has not been included in decision-making around the use of the funding committed by Canada to respond to the rulings.[161]

AMC, in partnership with the First Nations Family Advocate Office, and with funding from the federal government, subsequently undertook a series of engagement sessions and meetings between December 2016 and June 2017. They gathered feedback and priorities for Jordan's Principle implementation from 20 First Nations. Information from this engagement provides guidance to the current implementation of Jordan's Principle in Manitoba.[162]

2.4 CURRENT IMPLEMENTATION OF JORDAN'S PRINCIPLE IN MANITOBA

The current implementation of Jordan's Principle in Manitoba features multiple components designed to ensure coordination of services for First Nations children and families both within and outside of First Nations, and to extend delivery of needed services within First Nations. It also incorporates resources, for support and capacity building at both the regional and Tribal Council levels. An ISC summary of the different components of the current implementation are summarized in Figure 3. In this section of the report, I draw on existing documentation, such as the ISC summary, and a series of semi-structured interviews with representatives of specialized service providers and service coordination organizations to describe the current implementation of Jordan's Principle in Manitoba.

2.4.1 Planning/support/capacity building

The Jordan's Principle Technical Advisory Group (TAG) is a First Nations led technical advisory group which has replaced the TOROWG. The TAG includes representatives from the First Nations Health and Social Secretariat of Manitoba (FNHSSM), the Manitoba First Nations Education Resource Centre (MFNERC), the Eagle Urban Transition Centre (EUTC), the First Nations Family Advocate Office, the Southern Chief's Organization (SCO), Manitoba Keewatinowi Okeemakanak (MKO) and the AMC.[163]

Figure 3: Current implementation of Jordan's Principle in Manitoba[164]

Off Reserve

Jordan's Principle

Child First Initiative

On Reserve

Assembly of Manitoba Chiefs (AMC)

AMC (Assembly of Manitoba Chiefs):

MKO (Manitoba Keewatinowi Okimakanak), and

SCO (Southern Chiefs Organization):

Tribal Councils (TC):

Community Level:

Social Needs Advocate #1

Social Needs Advocate #2

Social Needs Advocate #3

Social Needs Advocate #4

Respite Short Term Service Coordinator

Specialized Service Providers (SSPs)

Ndinawe Youth Resource Centre

Indigenous Services Canada (ISC)

Independent Communities

In addition federal Jordan's Principle funding has supported a Jordan's Principle First Nations engagement process, multiple Jordan's Principle forums, and planning and communication activities.[165]

2.4.2 Projects and service coordination within First Nations (on-reserve)

In 2016, all First Nations in Manitoba were invited by First Nations Inuit Health (FNIH), Manitoba Region, to submit proposals for Jordan's Principle projects that would be funded through the federal CFI funds.[166] The projects developed differ in approach and focus. Describing them is beyond the scope of this report. However, a five-module Implementation Toolkit based on the Pinaymootang First Nations project,[e] provides an in-depth description of the approach to developing a project, which is now funded through Jordan's Principle, but was already developed and implemented prior to the availability of Jordan's Principle CFI funding.

All First Nations subsequently received federal funding for a **Jordan's Principle Case Manager,** charged with facilitating "identification and assessment of clients, families, and groups needing services or supports" and coordinating with internal and external agencies, including the Specialized Service Providers and the focal points discussed below, to address the holistic needs of children aged 0-21.[167] In addition, First Nations may also receive funding for **child development workers, respite workers,** and **administrative assistants.** [168] First Nations can also receive additional funds that can be flexibly allocated to enhance available services.[169] Data provided by First Nations and Inuit Health, Manitoba Region, indicates that the number of full time staff supported by Jordan's Principle funding ranged from a minimum of 5 per First Nation to a maximum of 43 in one of the larger First Nation in Manitoba, in 2017-18.[170]

In addition, each of the seven Tribal Councils receive funding for two **Service Coordinators**, who "support and coordinate development-training, design, implementation, and evaluation at the community level."[171]

2.4.3 Service coordination outside of First Nations (off-reserve)

The Eagle Urban Transition Centre (EUTC) was created by the AMC in 2005 "to act as a culturally relevant and non-discriminatory gateway for Indigenous people transitioning into an urban center" and provide "a single window from which clients receive support, advocacy and access to needed programs." [172] EUTC, which is located in Winnnipeg, operated on a diversified funding base, that included provincial funding, prior to receiving Jordan's Principle funding.[173]

The EUTC receives federal Jordan's Principle funding for four **Special Needs Advocates** who support First Nation families and special needs individuals (children and adults) in accessing needed services and advocate to ensure their rights are met. EUTC also receives federal funding for a **Respite Short Term Service Coordinator** charged with "supporting children and families when they are living off-reserve for short periods of time."[174] These EUTC staff members work in conjunction with Jordan's Principle Service Coordinators, Case Managers, and Specialized Service Providers to help ensure a culturally based continuum of care both within and outside of First Nations. EUTC advocates and service coordinators support families in navigating health, education, child and family, employment and income assistance, and housing policies and systems. They also support families through the status registration processes.[175]

The range of supports provided by EUTC includes, but is not limited to: accompanying families to meetings with service providers, facilitating coordination between service providers, advocating for families to receive needed services, advancing requests for Jordan's Principle funding, supporting families through complaint and legal processes, and providing necessary instrumental support to meet

[e] The toolkit is available here: https://www.pfnhealth.com/copy-of-home-community-care-program

family needs.[176,f] EUTC also provides interested children, youth, and families with support in connecting with and reclaiming cultural identity through monthly sweats, weekly elder visits, use of a smudge room, and other culturally-based activities and approaches to service.[177]

In addition to the advocates and service coordinator based at EUTC, FNIH, Manitoba region, has recently announced federal funding for 7 **Off-reserve Service Coordinators** who will be based with Tribal Councils.[178] These service coordinators will play a role similar to that of EUTC advocates and service coordinators, concentrating their efforts on the smaller urban centers, outside of Winnipeg.[179]

2.4.4 Specialized Service Providers

Specialized Service Providers (SSP) are pre-existing organizations that have received federal Jordan's Principle funding to support the extension of services to First Nations children (aged 0-21), families, and special needs individuals. Across interviews, organizations indicated they were approached about service coordination and provision in the first half of 2017 and began providing/coordinating services later that year. In addition to the services described below, SSP have been working with FNIH, Manitoba Region, to develop a 6-day training for respite workers in First Nations communities.[180]

Rehabilitation Center for Children (RCC) – The RCC's mission is to support "children and youth in Manitoba and surrounding areas in achieving their goals and participating in their communities."[181] The organization's board of directors is appointed by the Department of Health and it operates on a diversified funding base, combining provincial funding with private foundation funding and fee-for-service revenues.[182] Located in the Specialized Services for Children and Youth (SSCY) Centre in Winnipeg, RCC provides diagnostic imaging, outreach, occupational and physiotherapy services, support for children who use assistive technology, specialized communication resources and a variety of occupational, physio and speech and language therapies. It also offers multidisciplinary clinics, which allow families to see health professionals from different areas at the same time. [183]

RCC first received provincial funding to provide outreach services to rural Manitoba communities in 1987. It has long served First Nations children accessing services outside of First Nations, in rural Manitoba communities, and in its Winnipeg office. Federal Jordan's Principle funding has allowed RCC to extend its services directly in First Nations.[184] RCC currently delivers services in 53 First Nations and has partnered with Southern Health-Santé Sud to provide services in an additional seven First Nations. RCC provides home and community-based rehabilitation services, occupational therapy, and physiotherapy as well as some speech and audiology services to pre-school age children and children/youth who are not attending school. In addition, it has begun providing some FASD and child development clinics in larger First Nations, inviting children and families from neighboring First Nations to attend.[185]

St. Amant Centre - Located in Winnipeg, the St. Amant Centre is an independent not-for-profit that receives funding from the Manitoba Departments of Health and Families. It provides a wide range of programs and services to individuals with intellectual or developmental disability, acquired brain injury, or other conditions necessitating similar supports, and to their families.[186] St. Amant also operates a large residence for complex-care, more than 100 community sites and homes, a research centre, a school, and two child-care centres.[187] The organization is guided by the values of collaboration, hospitality, excellence, and respect. [188]

[f] For a detailed description of a similar service-coordination effort in Alberta, see Larlee et al (2018) The Enhanced Service Coordination Model in the Alberta Region. In Sinha, V., Vives, L. and Gerlach, A. (eds.) Implementing Jordan's Principle Service Coordination in the Alberta Region: The First Nations Health Consortium. Calgary/Edmonton, AB: The First Nations Health Consortium.

St. Amant has a long history of providing clinical services; it has supported individual First Nations people accessing clinical services outside of First Nations for decades. Federal Jordan's Principle funding has allowed St. Amant to provide a broad range of services in First Nations. [189] These services are offered to children who have been diagnosed with, or are suspected of having, a developmental disability or complex medical needs, and to their families.[190]

The services offered in First Nations include psychological supports to address behavioural challenges identified by family members or care providers and clinical counselling focused on the impact of disability on a child or family. St. Amant also offers: a family care program that supports the families of children with disabilities in meeting self-identified goals, support from dieticians specializing in needs of children with developmental disabilities, and consultation with nurses experienced in working with children with complex needs. It also offers psychometric testing to youth in care. This service is intended to assess eligibility for provincially funded adult disability services.[191] In combination, these services allow St. Amant to support First Nations children and families with a broad range of supports provided by a multidisciplinary team.

Manitoba First Nations Education Resource Centre (MFNERC) – The AMC founded MFNERC in 2005, "to provide coordinated second and third level education services to Manitoba's First Nations schools."[192] MFNERC now provides services to nearly 60 First Nations schools in almost 50 First Nations.[193] It offers a broad range of programs and services, spanning from the domains of early learning to high school, First Nations language and culture, numeracy and literacy, physical education and health, science and education technology, student learning assessments, and special education.[194] MFNERC also has developed partnerships with universities in order to support the development of the First Nations capacity needed to provide clinical services for First Nations children.[195]

Federal Jordan's Principle funding, combined with other increases in federal funding, has enabled MFNERC to expand and enhance the special education services it provides to nearly 60 schools in almost 50 First Nations. MFNERC's funding for special education increased dramatically in 2016, when the federal government increased investment in Indigenous Services Canada's High Cost Special Education program.[196] Federal Jordan's Principle funding added to MFNERC's special education funding. Jordan's Principle funding supports provision of occupational therapy, speech language pathology, physiotherapy, school psychology, mental health and wellness, deaf and hard of hearing and ASL instruction, and nursing services in all schools supported by MFNERC.[197]

Frontier School Division (FSD) - FSD was created in 1965 by a Ministerial order, with a mandate of providing educational services to Metis and northern students based on the provincial curriculum. Over time, the programs and services offered by FSD have been tailored and expanded to include programs like: Native Studies, Career Education, Fine Arts, Character Education and First Nations Languages.[198] FSD receives Jordan's Principle funding for five Mental Health Therapists who support on reserve communities and Cranberry High School. [199]

Manitoba Adolescent Treatment Centre (MATC)- MATC provides mental health services to children and youth who experience psychological or emotional disorders. It is governed by a provincially appointed board of directors and falls under the jurisdiction of the Winnipeg Regional Health Authority Mental Health Program.[200] MATC first opened in 1984 and, since that time, has developed a continuum of community and hospital-based services for children, youth and their families. Services range from "brief interventions to intensive, long-term treatment."[201]

Federal Jordan's Principle funding allowed MATC to extend and expand on an existing psychiatric telehealth service, which was designed to fill gaps in services by providing consultation with child and adolescent psychiatrists. The telehealth service originated as a provincially funded service; people

living in First Nations could only access the service through community mental health workers outside of First Nations. In 2010, the Manitoba Department of Families began providing limited Youth Suicide Prevention Strategy funding for MATC to extend the telehealth service to some First Nations. The program began with five First Nations in 2010 and expanded to 15 First Nations. It won a Manitoba award for its innovative partnership between First Nations, and provincial and federal governments.[202]

The federal Jordan's Principle funding that MATC receives has allowed the organization to extend services in First Nations. It has also allowed MATC workers to travel to First Nations, effectively converting the telehealth program to a hybrid model that incorporates visits to meet with children and youth in First Nations in order to establish a connection, with follow up and ongoing therapy through telehealth. In addition, the presence of Jordan's Principle case managers and respite workers (discussed above) in First Nations has allowed MATC to establish more consistent and active partnerships supporting the identification of children with psychiatric needs in First Nations.[203]

2.4.5 Individual Jordan's Principle requests

The CFI established the Service Access Resolution Fund (SARF) to pay for services which are not covered by existing programs and are approved under Jordan's Principle.[204] Nationally, all requests for Jordan's Principle funding under the CFI are administered by government representatives (focal point) charged with facilitating the review and approval of requests for services.[205] The CHRT has mandated that responses to these requests reflect consideration of the principle of substantive equality and be given within strict timelines (12-48 hours).[206] In the Manitoba context, the focus on developing and extending a system of services in First Nations means that Jordan's Principle funding is being used to proactively provide services. However, as in other jurisdictions, families, communities and service providers can also request Jordan's Principle funding in order to meet the needs of an individual child.[207]

2.5 What Service Providers and Coordinators Said About Jordan's Principle Implementation

I conducted 5 informal, individual or group interviews with 10 representatives of organizations providing specialized services or service coordination through Jordan's Principle. Organizations involved in the interviews included Eagle Urban Transition Centre, St. Amant Centre, Manitoba Adolescent Treatment Centre, Rehabilitation Centre for Children, and Manitoba First Nations Education Resource Centre. I also received data from, and personally communicated with, a representative of FNIH, Alberta Region, and received written responses to interview questions from the Manitoba Department of Families and the Department of Health. Several key themes, which cut across interviews, provide a more detailed portrait of the current approach to implementation of Jordan's Principle in Manitoba.

2.5.1 Jordan's Principle is facilitating access to needed services

Across interviews, respondents spoke about the positive impact of the services and programs being provided through Jordan's Principle. They shared examples of cases in which federal Jordan's Principle funding allowed them to meet child/family needs and reunite families.[208,209] Respondents described Jordan's Principle funding as addressing historical discrepancies in services that had been observed over years,[210] and framed the extension of SSP services as removing damaging barriers to the systematic provision of services in First Nations.[211,212,213,214] One respondent described recent funding increases as allowing for the provision of services for children who previously either had to leave their home communities to access care, be placed in out-of-home care through the child welfare system, or go without services.[215]

As discussed below respondents clearly identified ongoing disparities in services within and outside of First Nations, but two respondents also pointed to very specific areas in which they felt the services extended in First Nations through Jordan's Principle compared favorably to provincial services. One respondent suggested that residents of the First Nations served by her organizations might now be

able to secure psychiatric consultation more quickly than people living in other communities. [216] Another respondent offered the example of a drop-in day program for pre-school age children as a service that is now available in many First Nations, but unavailable in some provincial centres. [217]

Respondents' reflections on the importance of Jordan's Principle is evinced in data, provided by FNIH, Manitoba Region, that indicates federal Jordan's Principle funding supported the provision of 26,331 services to First Nations in the 2017-18 fiscal year.[218] 5,586 children participated in the programs that First Nations implemented with federal Jordan's Principle funding. First Nations provided an additional 20,745 services with federal Jordan's Principle funding. These services spanned the domains of: mental health, occupational therapy, physical therapy, speech and language pathology, audiology, day programs, individual and group respite care, and traditional cultural supports, as well as other events and activities.[219] In addition, a September 2018 scan of Tribal Councils, service coordinators outside of First Nations, and specialized service providers indicated that 12,595 services provided to First Nations children since the initial receipt of federal Jordan's Principle funding in 2017.[220]

2.5.2 Jordan's Principle funding is insufficient to meet the needs of First Nations children

While respondents were clear in their identification of the improvements in services available to First Nations children and families because of Jordan's Principle, they also indicated more resources were needed in order to meet children's needs and to achieve equity in services. One respondent made a comparison between the resources available for services within First Nations and those available through the provincial school system, noting deep disparities even when Jordan's Principle was taken into account.[221] Others pointed to the absence of services to support those with severe intellectual or physical disabilities, FASD, or other conditions requiring ongoing support once they 'aged-out' of Jordan's Principle eligibility at age 21.[222,223,224,225] Multiple noted the absence of First Nations led services which, as discussed below, they saw as being essential[226,227,228] Others noted the pre-existing demand for services that resulted from historical disparities in service, the growth in demand for services from First Nations as community members come to know about their services, the existence of long wait lists for services, and the resulting need to triage in order to address the most urgent cases.[229,230,231,232,233]

2.5.3 Jordan's Principle is federally funded

Across interviews, respondents identified Jordan's Principle as being federally funded. They described the federal government as funding both the extension of Jordan's Principle services by specialized service providers in First Nations and service coordination for First Nations people living outside of First Nations. [234,235,236,237,238] The level of federal funding for Jordan's Principle services is described in Table 5. Expenditures in Manitoba during the 2017-18 fiscal year totaled nearly $58 million dollars.[239]

Table 5: Federal Jordan's Principle expenditures in Manitoba (April 2017-February 2018) [240]

Type of service/support	Amount
Tribal Councils Service Coordination	$1,309,392
Specialty Service Providers (MFNERC, RCC, St. Amant, FSD, MATC)	$9,471,207
First Nations Respite Funding (63 communities)	$44,571,564
EUTC Funding for Off-Reserve Interim Respite, KTC off reserve	$584,687
EUTC Special Needs Advocate Positions AMC Service Coordination Engagement Coordination of Jordan's Principle gatherings in September & December, Jordan's Principle information binder	$1,436,848
Other Special Projects IRTC Logic Model, MKO Jordan's Legacy Project, IRTC Mental Health Partners process	$198,416
Individual Jordan's Principle requests (services/supplies that could not be covered under existing programs)	$397,373

In contrast to the clear identification, across interviews, of federal funding for Jordan's Principle, the province was simply absent from discussion of Jordan's Principle in most interviews. When asked directly about the provincial role, respondents indicated that there was no meaningful provincial role in provision of funding for Jordan's Principle.[241,242,243] Some expressed frustration at this, noting that the province received health transfer funds for residents of First Nations communities but refused to provide services, or characterizing the primary role as dictating the choice of services available to First Nations people. [244,245]

A description of Jordan's Principle funding received from the Departments of Families and Health corroborates respondents understanding of Jordan's Principle being federally funded. With respect to provincial funding allocated for Jordan's Principle since the CHRT rulings, the document indicates that "Canada has committed funding and engaged with First Nations to implement Jordan's Principle in a manner consistent with the CHRT decision." [246] It further notes that:

> Indigenous Services Canada has entered into agreements with organizations such as Regional Health Authorities, Manitoba Adolescent Treatment Centre, Specialized Services of Children and Youth, Rehabilitation Centre for Children, Manitoba First Nations Education Resource Centre, and the St. Amant Centre to provide assessments and therapeutic services to address a variety of health and social service needs of children living on-reserve in Manitoba.[247]

The Manitoba Departments of Health and Families further noted that, in their understanding, "Canada and First Nations organizations are engaged in a planning process to develop long-term federal funding and program options."[248]

With respect to funding or resources provided specifically by the province, the responses provided by the Departments of Health and Families identified only the pre-existing commitments and the support and information sharing functions outlined in Table 6.

Table 6: Contributions to the current implementation of Jordan's Principle identified by the Manitoba Department of Families and Department of Health[249]

Provincial role
Three provincial departments jointly administer the Unified Referral and Intake System ("URIS"), a program which supports children with specific health care needs or procedures in schools and daycare centres while they are apart from their caregivers. An interdepartmental committee is sharing clinical resources and operating standards in order to assist MFNERC and St. Amant to those organizations in setting up similar services in First Nations communities.
The Department of Health is responsible for the management and direct operations of three Provincial Nursing Stations in First Nations and the three adjacent communities. It is working with those communities and the federal government to coordinate services and identify gaps in services as those communities implement Jordan's Principle
The Department of Health has been providing funding, for a number of years, through a Service Purchase Agreement to Community Therapy Services, to provide physiotherapy services to 11 First Nations communities.
Annual Youth Suicide Prevention Strategy funding provided to MATC since 2008 to enhance telehealth capacity for child and adolescent mental health consultation to 13 First Nations.
The Department of Families' Children's disABILITY Services staff coordinate with other Jordan's Principle service providers to ensure the most appropriate assessed services and supports are provided for each family and child.
The Department of Health is chairing an advisory group that is developing a research project to monitor and evaluate expanded delivery of community mental health services for First Nations in order to improve mental health services in a manner that is rooted in Jordan's Principle.
Staff have been available to Jordan's Principle coordinators and case managers to provide consultation on all aspects of service delivery in Manitoba.
Representatives from First Nations communities and organizations have been invited to share experiences and information with provincial service delivery staff. Staff have participated in conferences and committee meetings with Jordan's Principle stakeholders and representatives from First Nations organizations have been invited to share information with service delivery staff.

2.5.4 Existing provincial policies restrict realization of Jordan's Principle

Respondents pointed to the underfunding of provincial services as a factor that affected First Nations children living both within and outside of

First Nations. They noted long wait lists for occupational, physical and speech and language therapy, mental health services, and neurodevelopmental services, with wait times lasting weeks or even months.[250,251] One linked this to the chronic underfunding of disabilities services, pointing to an increase in demand that outstripped the allocation of resources.[252] Others pointed to a generalized underfunding of services and noted that the effectiveness of the mental health and other interventions they offered were diminished because provincial policies did not address the social determinants of health.[253,254]

These observations mirror existing research, which demonstrates, among other patterns, a rate of child mental health diagnoses that is almost twice the national average and mental health funding that is lower than the federal benchmark.[255,256] Identified barriers to accessing mental health care for children include "long waitlists, shortage of mental health professionals, the cost of private therapy" as well as a "lack of mental health supports in rural and remote communities."[257] Additional research documents gaps in services for children with disabilities, noting that a large number go without the assessments, interventions, and supports that they need to flourish in the education system, and that there is a lack of services for children with complex needs, such as neurological disorders.[258,259]

Respondents indicated that federal Jordan's Principle (SARF) funding was available to address some gaps in provincial services, but the process for accessing these funds could be confusing and prolonged, requiring them to exhaust all provincial services and obtain clinical assessments before Jordan's Principle funds would be approved.[260] They further noted that, even if federal funds were secured to support provision of services for children living outside of First Nations there was no mechanism for bypassing lengthy wait lists for provincial services.[261,262]

A statement from the Manitoba Departments of Health and Families confirms that the provincial government has no special mechanisms for efficiently addressing First Nations childrens' needs through Jordan's Principle. The statement notes that the departments take a family-centered approach that may allow for provision of supports above normative standards in order to overcome barriers such as those "related to geography/human resource."[263] However, it also notes that, in cases involving First Nations children living outside of First Nations, "any requests for services or funding are responded to in the same manner as they would for any other child living off reserve."[264]

One service provider noted that his organization had used federal Jordan's Principle funds to provide services, beyond provincial normative standards, to children living outside of First Nations. He identified this as posing an ethical dilemma because it reduced the funding his organization had to provide supports to children in First Nations, who had no access to the other supports available to children living outside of First Nations.[265]

2.5.5 The overrepresentation of First Nations children in the child welfare system is linked to barriers in accessing services

Respondents suggested that fear of child and family services' involvement prevented some families from accessing needed services. They also noted failures to ensure that children in care received needed assessments and supports and worried that youth aging out of eligibility for Jordan's Principle might only be able to access services though institutional care.[266,267] Three respondents also mentioned that current provincial policies restrict access to some services to children placed in care, pointing to cases in which the only option for accessing needed services was to enter into a voluntary placement agreement. They noted that such policies perpetuate the overrepresentation of First Nations children in care.[268,269]

The concerns voiced by respondents are mirrored in available child welfare data. It is estimated that as many as 30% of children in care may have complex needs and a 2015 study concluded that these children "are often unable to secure the services and supports they need for long-term success."[270] The study further noted that, despite multiple reports documenting the need for broad-scale reform of provincial policies in order to better support these children, little had changed over a fifteen -year period.[271] The links

between child welfare and service access compound the profound and persistent overrepresentation of First Nations children in out-of-home care. Data from the Department of Families indicates that 7,825 First Nations children, more than 15% of all First Nations children in Manitoba, were in out-of-home care on March 31, 2018. First Nations children represented 75% of the children in care, but only 13% of the child population. The rate of First Nations children in care was more than 50 times the rate of non-Indigenous children in care.[272,273]

2.5.6 First Nations led services are necessary

All interviewees acknowledged the desire for and importance of First Nations led services.[274,275,276,277,278] Some explicitly described their provision of services by non First Nations organizations as a stop gap measure in place until needed First Nations capacity was developed.[279,280,281] They reflected on a mismatch between the approaches that work in provincial communities and those that work in First Nations, highlighting the need to listen, to follow family/community lead, to collaborate closely with Jordan's Principle case managers and other community workers, and to work towards identifying and implementing effective practice as they go along.[282,283,284] Others noted that families are reluctant to access non-Indigenous services, because of their discomfort in these settings, experiences of discrimination, and fear of being reported to child and family services.[285,286] Multiple respondents viewed the development of a network of First Nations led services as addressing goals that extended beyond the provision of appropriate services, linking the existence and further development of First Nations led services to the broader goals of self-determination and reconciliation.[287,288,289]

2.6 THE PROVINCIAL ROLE IN THE CURRENT IMPLEMENTATION OF JORDAN'S PRINCIPLE

The government of Manitoba's description of its role in the current implementation of Jordan's Principle mirrors the wait-and-see approach taken by other jurisdictions. The Manitoba Departments of Health and Families characterizes Manitoba's current approach to Jordan's Principle this way:

> While Manitoba was not a party to the proceedings before the CHRT, and the decisions in that case are not directed at Manitoba, Manitoba is open to working with First Nations and Canada to understand federal policies and funding as they relate to Jordan's Principle, and also understand First Nations' direction within Manitoba. This will allow government partners to work together in aligning and coordinating services and policies to ensure equitable services for First Nations children both on and off reserve.[290]

This response indicates a *willingness* to engage in collaboration in order to *understand federal policies and funding*. However, the statements provided by the Departments of Health and Families also depict a demand driven approach to Jordan's Principle that is both passive and static. With respect to funding of Jordan's Principle, the statement provided by the Departments of Health and Families notes that:

> While Manitoba has received general inquiries about services for First Nations children living on reserves, it has not received any formal requests under Jordan's Principle for services, funding or reimbursement. To the extent that any issues relating to the provision of services to children on reserve have been raised, they have been resolved at a front-line level through service navigation efforts to connect the children and families to CFI-funded services.[291]

Manitoba's response indicates that, at this time, they rely on federally funded initiatives to address Jordan's Principle cases. The response does not indicate the development of any materials, processes, policies, or strategies to facilitate the communication of formal requests to the province.

Indeed, in response to query about Jordan's Principle policies implemented by Manitoba, the Departments of Health and Families acknowledge that "the 2016 CHRT decisions set out an expanded scope of Jordan's Principle that went beyond that addressed" in the case conferencing and resolution model developed in 2014. However, they also indicate that "Manitoba has not [subsequently] developed any policies specific to Jordan's Principle."[292]

The persistence of some elements of an interpretation of Jordan's Principle that predates the CHRT rulings is evident in the Manitoba description of specific actions to ensure the implementation of Jordan's Principle for First Nations children living outside of First Nations. Highlighting the provision of services by Children's disABILITY Services, the statement notes:

> All health and social services available to non-First Nations children living off-reserve are equally available to First Nations children living off-reserve with similar needs and in comparable locations.[293]

There is no mention of mechanisms for ensuring provision of services in keeping with standards of substantive equality or the timelines prescribed by the CHRT.

2.6.1 Moving forward

The current implementation of Jordan's Principle in Manitoba, is rapidly evolving. The CHRT rulings and the resulting federal response have fundamentally reshaped the approach to Jordan's Principle across Canada and, within Manitoba, roles, responsibilities and strategies are still being redefined. The current implementation of Jordan's Principle is still far from producing substantive equality for First Nations

Figure 4: Keewaywin (2018) recommendations for long term Jordan's Principle implementation[294]

1. Restore First Nations' jurisdiction of children, especially in areas such as family law, health services and social services, and draft JP implementation into First Nation constitutions.
2. Deconstruct a child welfare system whose preference is the easy solution of child apprehension, rather than the more difficult and costly solutions needed to prevent child apprehension at all costs.
3. Establish a JP resource, program and service medical centre in each First Nation to build capacity and to equip First Nations as they seek to end voluntary surrender of children into CFS care related to receipt of medical services.
4. First Nations take the lead in designing and implementing a JP system based on First Nation original systems of child rearing, education and nurturing of spirit in order to promote spiritual, physical, mental and emotional health and well-being.
5. Educate and train First Nation people living on First Nations, establishing a professional workforce dedicated to caring for and providing services for children with special needs. Until this capacity is built, ensure non-Indigenous service providers have knowledge of First Nation cultural practices and languages.
6. Create an education and awareness campaign about the challenges children with special needs face and how to best care for them and create a resource booklet outlining how to navigate the CFS system and access supports and services under the JP program.
7. Provide basic human rights to Indigenous children and families living on reserve in terms of adequate housing, medical services, resources and education and employment opportunities.
8. Inject infrastructure funding for all First Nations—poverty is one root cause for the high number of Indigenous children in care.
9. Funnel prevention dollars towards bodies independent of the CFS system to minimize any real or perceived conflict of interest in agencies tasked with both child apprehension and child protection.
10. Design a new funding model to support a model of care based on prevention, reunification and strengthening of families, directing prevention funding dollars to Manitoba First Nations, rather than to agencies, to allow First Nations to build their visions for JP implementation.
11. Establish customary care/kinship care in all First Nations to ensure Indigenous children stay with their families and in their First Nations.
12. Develop a range of First-Nation-led options to implement JP using recommendations contained in this report.

children. Respondents I spoke with clearly identified the need for additional resources and ongoing policy changes. However, the current implementation has offered an opening for meaningful change. The path forward has been described in recommendations for the long term implementation of Jordan's Principle that identified through the Keewawin engagement project (see Figure 4). The role that the province of Manitoba will play in realizing these recommendations remains to be seen.[295]

3 PINAYMOOTANG: A CASE STUDY

In this chapter, I use Pinaymootang First Nation as a case study to demonstrate both the expansion of services under Jordan's Principle and the gaps and barriers to service under the current implementation of Jordan's Principle. I draw from prior work in which my colleagues and I described the history and context of Pinaymootang and documented the barriers to service for Pinaymootang children with special health care needs in 2016, prior to the current implementation of Jordan's Principle. I then draw on information from a recent group interview with community service providers to describe the services currently available. A full accounting of services available in Pinaymootang is beyond the scope of this report. Accordingly, the information presented focuses on the availability of medical and allied health services. In the final section I combine information from past work, the group interview, and document review to more closely examine federal and provincial roles in creating and responding to the need for mental health services in Pinaymootang. Key findings in this chapter are as follows:

- The context of public services in Pinaymootang today has been shaped by historic and contemporary policies that have systematically created service needs and failed to provide the resources to appropriately address those needs.
- The medical and allied health services available within Pinaymootang have dramatically increased since 2016. This is due primarily to increases in federal funding, through Jordan's Principle and other initiatives.
- Despite the increase in services, Pinaymootang service providers identify the clear need for additional resources, continued gaps in services, and a pattern in which the burden for addressing these gaps falls on First Nations.

A recent increase in demand for mental health services in Pinaymootang demonstrates the complex factors that shape the need for services in First Nations. This demand is shaped by: historical disadvantage; persistent gaps in services provided through the provincial health system in the region surrounding Pinaymootang; the intentional flooding of First Nations in the region; and failures to address the needs of flooding evacuees – both during their evacuation and upon repatriation to their First Nations.

3.1 INTRODUCTION TO PINAYMOOTANG FIRST NATION[g]

Fairford reserve is the land, within Treaty 2 territory, that was allocated by the Canadian government to Pinaymootang First Nation. It spans 413 hectares of land (1/15th of the Winnipeg metropolitan area) and is situated in the Manitoba Interlake Region, between Lake St. Martin, Pineimuta Lake, and Lake Manitoba, about 250 km north of Winnipeg along Highway 6.[296] Pinaymootang First Nation has roughly 2,800 members, with over 1,200 living in Fairford and more than 1,500 residing elsewhere.[297] Pinaymootang's population is young when compared to the overall Canadian population: approximately 50% are under the age of 20. The majority of community members are Status First Nations.[298]

The ancestors of Pinaymootang First Nation's members were Anishinaabe people who migrated west from Ontario starting in the early 15th century.[299] During this period and until the signing of Treaty Number 2 in 1871, members of the band relied on local resources for their needs. "[F]ish were plentiful, sap was available for sugar production, small game animals such as rabbits were abundant, and from local gardens a variety of vegetables were grown".[300] Unlike other groups in the area, Pinaymootang had limited contact with non-Native settlers and its members were

[g] This section of the report is drawn from Vives, L., Sinha, V., Burnet, E. & Lach, L. in collaboration with Pinaymootang First Nation (2017) *Honouring Jordan's Principle: Barriers to accessing equitable health and social services for children with complex needs in Pinaymootang First Nation.* Fairford, MB: Pinaymootang First Nation. It is based on document review, participant observation, and interviews conducted in 2016-17.

only partially dependent upon trade with non-Native settlers for their survival.[301]

That changed in the second half of the 19th century with the signing of the first four numbered treaties between the Crown and Indigenous populations in the territory that is Manitoba today.[302] The Nations in the Interlake region, and parts of Parkland and Westman, entered Treaty Number 2 with the Crown in August 1871 at Manitoba House.[303,304] These communities exchanged land rights and the promise of peace, law, and order for limited reserve land, an annual monetary compensation ($5 per band member, from 1871 to present), farming tools, and education. Subsequent to signing Treaty Number 2, members of Pinaymootang First Nation settled in Fairford reserve.

More than a century of oppression followed. The new settlers interpreted Treaties with Indigenous populations as a tool for conquest and control. From this colonial mindset followed assimilationist, colonialist, and genocidal[305306] policies, including the imposition of the residential school system, the sixties scoop, and the persistent overrepresentation of Indigenous children in the child welfare system.[307]

Provincial policies have also contributed to the historic disadvantages faced by Pinaymootang members. Since 1967, the provincial government has operated a dam located in Fairford reserve, and periodically caused extensive seasonal flooding on the reserve in order to protect other areas of southern Manitoba. This flooding has systematically destroyed traditional trapping lines, fishing spots, and hunting grounds. It has also caused the closure of a small fur industry, forced the conversion of productive fields into marsh lands, and negatively impacted the community's insufficient housing stock.[308]

Such policies have shaped a need for services that is compounded by the discriminatory policies and practices imposed on First Nations today. The employment rate in Fairford for self-identified Aboriginal individuals (26.7%) is significantly lower than the average for all self-identified Aboriginal people in Manitoba (50%) and for the total population of the province (63.1%).[309] Low labour force participation reflects the lack of employment opportunities in the community. The few sources of revenue and employment are all small and band-operated (Pinaymootang School, Pinaymootang Health Centre, Pinaymootang Band office, gas bar, etc.). Educational attainment figures further depict Pinaymootang's struggle to succeed. In 2011, 48% of (self-identified Aboriginal) residents of Fairford between the ages of 25 and 64 had no certificate, diploma or degree, compared to 37% of the overall self-identified Manitoba population of Manitoba and 17% of the total population.[310]

While these statistics do partially describe Pinaymootang today, community members pointed to other important aspects of life in the community. They spoke of Pinaymootang First Nation as a place of great beauty where people worked together to overcome challenges. They took pride in the community's rich and diverse spiritual life: Band members are predominantly Christian, with some embracing traditional spirituality or a combination of Christian and traditional beliefs. They also pointed to the fact that many community members are fluent in Salteaux (the local dialect of the Ojibwe language), the persistent respect for elders, and the strength of extended family relations as examples of the vitality of traditional culture.

Community members described Pinaymootang as a friendly and welcoming place where individual and community achievements are celebrated. Families are large and close-knit; relatives often step in to support each other when the need arises. When that is not enough, community members organize fundraisers, silent auctions, or collect money at church to help families who, for example, need to relocate to Winnipeg to access medical services.

This sense of pride and kinship informs local governance. Community members emphasized Pinaymootang's successes over the last few decades, attributing them to the creation of strong partnerships between the band, the health centre, the school, and other regional stakeholders. Service providers take pride in their efforts to meet high quality standards.

For example, the health centre was fully accredited by Accreditation Canada in 2014; and reaccredited, with the second-highest distinction, in 2018. The Niniijaanis Nide program, which the Health Centre started in 2016 to support the families of children with special healthcare needs has been showcased as a Jordan's Principle model and, over the past two years, the health centre has hosted visitors from 37 First Nations and from Alberta and Ontario who wished to learn about the program.[311]

The Pinaymootang School has also sought out opportunities to meet the needs of Pinaymootang children. For example, it has partnered with MFNERC for many years in order to access additional resources and supports. In addition, it recently joined a First Nations School System, an innovative collective of ten First Nations schools, managed by MFNERC, which supports the development of shared resources for participating schools. [312]

3.2 SERVICES AVAILABLE IN MARCH 2016[h]

In March 2016, before Jordan's Principle was implemented, the Pinaymootang Health Centre was only funded to administer education and awareness programs.[313] There were no physicians or nurse practitioners on staff but the health centre employed a team of registered nurses that provided medical services including basic checkup and immunization services, administration of medication, and assistance with regular treatments. The centre's staff also coordinated services with other healthcare providers in other communities, advocated for patients to be placed in physicians' waiting lists, and coordinated travel arrangements for medical visits outside of First Nations.

There were no early intervention services for children between the ages of 0 and 5 and difficulties obtaining assessment services further prevented most children in this age group from accessing early intervention allied health services outside of First Nations. The school was able to hire contract workers to provide limited allied health services, including assessment services roughly twice a year, as well as support for the development of Individualized Education Programs, and one-on-one support from educational assistants. A partnership with MFNERC allowed the school to fund some of the allied health services provided, sponsor the training of educational assistants and parents in Winnipeg, and provide assistive devices for students with communication impairments. School staff was not equipped to ensure individualized programs were followed, monitored, or adapted to children's evolving needs. Other services, like physiotherapy and counselling, were not provided at all due to a lack of funding.

New supports for the children with special healthcare needs and their families had recently become available through the Niniijanis Nide program, which was created in early 2016. This program, which was designed and implemented by Pinaymootang Health Centre with temporary federal funding, featured child development workers who provided qualified respite care, and supported caregivers in order to help children thrive. The program initially employed two child development workers and served thirteen children and their families.

3.3 SERVICES CURRENTLY AVAILABLE[i]

Two and a half years later, some basic elements of the service structure have stayed the same. But, through a combination of Jordan's Principle funding, increases in other funding sources (such as the funding for the High Cost Special Education Program) and creative partnerships, access to services is much improved for Pinaymootang's children.

[h] This section of the report is drawn from Vives et al (2017). It is based on document participant observation, and interviews conducted in 2016-17.

[i] The information presented in this section of the report comes from an interview with four Pinaymootang service providers that was conducted on November 1, 2018.

The Pinaymootang Health Centre is still only federally funded for education and prevention. But, through partnerships with the Regional Health Authority (RHA) and a private health care provider based in Winnipeg, the health centre has a physician on-site three days a week. A physician from the RHA is on-site one day each week. In addition, a physician associated with Life Smart, a private company, comes two days a week. He works long hours, seeing as many as 40 to 50 clients a day. He also brings a pharmacist with him, so pharmacy services are available in the community two days a week.

Both the RHA and the Life Smart physician work on a fee for service basis. The health centre covers travel, and other base fees; the direct cost of service is billed directly to the province.[j,314] The Pinaymootang health centre opened its doors to allow anyone in the region to access these physician services, which are now regularly used by people from neighboring First Nations and non-First Nation communities in the region.

The health centre has also recently received approval of federal funding that will allow for the employment of a full-time mental health worker. The need and process for securing this mental health funding is discussed at length in section 3.5, below.

The Pinaymootang School has also seen a dramatic increase in resources, resulting from a variety of factors which include: its decision to join the Manitoba First Nations school system (a collective of ten First Nations schools which is coordinated by MNFNERC), the increase in high cost special education funding implemented within the 2016 federal budget, and Jordan's Principle funding. Between the three initiatives, school administration estimate that they have 8 to 10 times more resources than they did before. Both the school system and MFNERC, as a specialized service provider, have hired specialists – psychologists, speech and language pathologists, occupational therapists and physical therapists like any other school division. As a result, the school is no longer reliant on contract workers.

The services provided by the professionals working through the schools are supplemented by services provided by other SSP. The RCC provides occupational, physio, and speech and language therapy three days per month and leaves Niniijaanis Nide (Jordan's Principle) child development workers with recommendations for ongoing support. The MATC also provides mental health supports. Finally, clinicians from St Amant regularly come to Pinaymootang, providing access to a dietician and nurse practitioner, assessments, behavior analysts, and family counselling.

The Niniijaanis Nide Program has also grown. The program shifted from a one-time special project funding to Jordan's Principle funding in April of 2017, which dramatically increased the resources available for the program. Program staff now include a Jordan's Principle case manager, four child development workers, and one administrative assistant who also provides American Sign Language education. The program currently serves 71 children. In addition to supporting the provision of respite services to a greater number of families, increased funding through Jordan's Principle has allowed the program to provide more group activities and outings, to purchase a play structure, and to build a picnic shelter and a sharing circle area.

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[j] The costs of partnering with Life Smart exceed those of partnering with RHA and are higher than the budget for such expenses that the health centre receives from the federal government. The fee for the Life Smart physician to travel from Winnipeg is higher the travel fee for the local RHA physician and the cost of keeping the health centre open for extended hours, and of providing follow up nursing care, also exceeds the health centre's budget. Still, the health director feels strongly that the cost is worth it. Turnover is high with the RHA physicians, who are often relatively inexperienced; this stands in contrast to the Life Smart physician, who is a consistent presence, and has extensive knowledge of and lengthy experience within the Manitoba health system.

3.4 THE NEED FOR ADDITIONAL SERVICES AND RESOURCES[k]

While Pinaymootang service providers are happy to share the long list of improvements in the range and quality of services that children can now access within the community, they also clearly identify the need for more resources in order to address child and family needs. Both the health director and school administrators highlight the need for capital investments. Despite a recent expansion, five staff members share one health centre office, and the community health room is not big enough to accommodate all the children in the Niniijaanis Nide program.

The director of education notes that the school received funding, and has purchased sensory equipment, for use by children with Autism and other special needs, but they have a lack of rooms in which students could use the equipment. She also shares that a feasibility study of school faculty/teacher housing is underway, noting that the School has the funds to hire additional staff, but, with the housing shortage in Pinaymootang, there's no place for new faculty to live.

The health director points to the growing wait times for access to MATC services and worries about the implications for families. She also speaks about her concern about the lack of services for youth who 'age out' of eligibility for Jordan's Principle services at 21. As discussed in section Chapter 2, Section 2.5.2, the absence of services for this population was also highlighted in interviews with specialized service providers.

3.5 FIGHTING FOR NEEDED SERVICES[l]

The director of the Pinaymootang health centre has been working with the University of Manitoba to develop a program for adults with special needs and is gearing up to seek funding for the project, which she describes as the next 'fight.' She anticipates an extended, uncertain and time-consuming process, like that which was necessary to establish the Niniijaanis Nide program.[315]

In 2014, Health Canada officials asked the health center to submit a proposal to fund services for one Pinaymootang child, with special health care needs. The health centre director pushed back against this, arguing that the centre had an ethical obligation to provide services to all children in the community. In August of 2014, she submitted a proposal to fund services for eleven Pinaymootang children with special health care needs. She was again asked to submit a proposal for funding for one specific child, and did so in October of 2014 .Neither proposal was funded.

In early 2015 the health centre submitted a separate proposal for federal Health Services Integration Funds (HSIF) to support a patient navigator system which would address persistent challenges that First Nations in the region faced at the nearby hospital. The centre director was informed that this proposal would not be funded, but that HSIF would, instead, be used to support the proposal, focused on children with special health care needs, which she submitted in October.[316] During this time period, the health centre also submitted a proposal to fund services to young adults with special needs, the same population for which the health centre director still hopes to develop services.[317]

The experience of the health centre surrounding these efforts attests to the persistent burden created by competing for grant money in a service-based setting already strained by staff shortages. In total, the grants submitted in a half-year period in 2014-2015 required 4–6 weeks of full-time labour to complete. The health centre received no news for several months after submitting a grant application and, ultimately, only one of the five proposals was successful. [318]

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[k] The information presented in this section of the report comes from an interview with four Pinaymootang service providers that was conducted on November 1, 2018.

[l] The information presented in this section of the report comes from Vives et al (2017) and an interview with four Pinaymootang service providers that was conducted on November 1, 2018.

The 'fight' continued even as the Niniijaanis Nide program received funding. Initial notice of funding for Niniijaanis Nide was received in the summer of 2015 but funds were was not transferred to Pinaymootang until December. The program started in January 2016 and the federal government required the health centre to submit an accounting report and evaluation of the program by March 31, 2016—three months after the start of the program. The initial funding covered only a four-month period. Funding for the program has now been renewed three times, with each renewal only covering a one-year period. [319]

The provision of short term funding created risk for both service providers and the families involved in the project. Staff hired for the program risked being left without jobs if funding was not renewed and feared disappointing families with whom they had developed trusting relationships. Families and children faced risks to their emotional wellbeing if needed services were terminated. [320] Uncertainty around the future of the Niniijaanis Nide program has greatly reduced now that the program is well established and receiving regional and national recognition, but, reflecting on the program's success, the health director notes, "They really make you fight for it."[321]

3.6 THE FIGHT FOR MENTAL HEALTH SERVICES – HIGHLIGHTING THE COMPLEXITY OF PROVINCIAL AND FEDERAL ROLES AND RESPONSIBILITIES[m]

The Health Centre's most recent fight, to secure additional funding for mental health services highlights the complex ways in which provincial and federal decisions shape the context of services in Pinaymootang. The general need for mental health services in Pinaymootang and a recent increase in demand for mental health services have been shaped by both historic and current federal and provincial policies.

3.6.1 The context of mental health in Pinaymootang

A recent report has highlighted the need for sweeping reform of the mental health and addictions services in Manitoba, highlighting elevated rates of mental health problems and significant gaps in services.[322] The child advocate's office has criticized the failure to act on recommendations made in the report, and linked services gaps to a recent spike in child deaths.[323,324]

The challenges in mental health services faced in Manitoba may be compounded for First Nations populations. Research consistently documents elevated rates of mental health issues, particularly substance abuse and suicide, for Indigenous populations in Canada, linking them to intergenerational trauma and the long-term impacts of policies of cultural genocide.[325] These disparities have been compounded by persistent failures to adequately fund the development of support and prevention services for First Nations children and families.[326]

The context of mental health services in Pinaymootang First Nation, in particular, is shaped by the management of and provision of services through the Interlake Eastern Regional Health Authority (IERHA), which is part of the provincial health system. IERHA suffers from an acute shortage of mental health services. There are no designated acute care psychiatric units in the region hospitals[327] and the Pinaymootang health centre director indicates that entire region is served by a mental health professional employed for a total of only 2 days per week.[328]

Further, provincial health services in the region have been plagued by staffing shortages, communication failures, and limitations in the availability of emergency care and specialized health services.[329,330,331,332,333,334335,336,337] For families in Pinaymootang, these problems with the IERHA system have been compounded by a history of discrimination that has been acknowledged by the nearby Ashern hospital.[338] As documented in our 2016-17 research, these factors negatively impact the

[m] Portions of this section of the report are drawn from Vives et al (2017).

willingness of families in Pinaymootang to access the services that are provided through IERHA.[339]

These generalized problems with health services in the region have potential mental health impacts. For example, for the caregivers of Pinaymootang children with special healthcare needs, the lack of health services in the region compounded the gaps in services available in Pinaymootang, increasing their stress significantly. Families who chose to remain in Pinaymootang were faced with difficult choices of constantly travelling to access services or seeing their children go without the services they needed.[340]

As a result of the lack of services within Pinaymootang and in the surrounding region, we found that caregivers were exhausted and overwhelmed as well as isolated and experiencing extreme financial strain when we interviewed them in 2016-17. Some were sleep deprived and all worried about the care of their children once they transitioned into adulthood. The burdens of ensuring their children's wellbeing meant that caregivers became socially isolated and also found themselves under significant financial pressure. If the child lived with their parents, at least one of them had to give up their job to take care of their child – at a time when families faced increased expenses to provide for their child's needs.[341] Similar challenges have been described for families of children with special healthcare needs living in First Nations throughout the province; these strains impact their overall health and well-being.[342]

3.6.2 The impact of intentional flooding

The Pinaymootang health centre director reports recent increases in demand for mental health services in Pinaymootang and attributes this demand to the repatriation of flood evacuees in nearby communities.[343] During the great flood of 2011, the province used a dam located in Fairford to protect more populated areas downstream along the Red and Assiniboine Rivers. It intentionally flooded the area around Fairford, forcing the emergency evacuation of 4,000 members of First Nations in the region.[344,n]

In November of 2018, more than seven years later, 1,541 individuals remained evacuated, living in rental homes, apartments, and hotels.[345] Most are from Lake St. Martin First Nations, which borders Pinaymootang.[346] Since 2012, nearly 100 evacuees have died from suicide and diseases, which has been linked to the high levels of stress and extreme diet changes they experienced upon relocation to Winnipeg.[347] Evacuees also faced significant cutbacks in government allowances since the beginning of their displacement, and this has also reportedly affected their wellbeing.[348,349] The sustained displacement evacuees have experienced has brought with it separation from the land, from community, and from traditional cultural practices. The construction of replacement housing is still underway in most communities affected by the flood and the estimated completion date has been set to November 2019.[350]

3.6.3 The failure to prepare the region's health system for repatriation of flood evacuees

Pinaymootang was persistently advocating for IERHA to take action to ensure it could meet the needs of repatriated flood evacuees as early as 2017. In spring of 2017, with support from the First Nations Health and Social Services Secretariat (FNHSSM), leadership from Pinaymootang raised the need for attention to persistent problems with health services in the region. Between August and October of 2017, representatives from Pinaymootang and the Interlake Tribal council met with provincial and regional health authority officials several times to discuss strategies for addressing First Nations health needs, including the needs of evacuees repatriating to First Nations in the region. Pinaymootang and the Tribal council held a gathering of First Nations in the Interlake region to get feedback on potential solutions to the health service problems.[351,352]

[n] In January 2018, the Manitoba Court of Queen's Bench approved a settlement in a class action lawsuit. The government of Manitoba agreed to pay $90 million for legal and administrative fees as well as compensation payments towards members of the communities who had been severely affected by the flood.[n,n]

With support from FNHSSM, they assembled the top six recommendations in a comprehensive quality health services plan[353] which called on regional health directors for IERHA to:

- Provide culturally safe and respectful services,
- Broaden the scope and mandate of health centers in First Nations,
- Ensure retention of health care providers in IERHA,
- Improve access to comprehensive mental health and addiction services,
- Improve access to emergency care, and
- Improve access to dialysis services.[354]

Highlighting the needs of both current residents and evacuees living in Winnipeg, First Nations in the region subsequently identified the development of comprehensive mental health and addiction services as the most pressing reform. As a result, between November 2017 and March 2018, IERHA organized multiple meetings in which evacuees and community members shared their experiences with regional health authority representatives and representatives from FNIH, Manitoba regions. However, the health director notes that this process "fizzled out"; no concrete action was taken as a result, and there were no meetings after March.[355]

In the fall of 2018, the Pinaymootang health director received an invitation to present, on the topic of "long term care", before an October meeting of standing committee of the Manitoba Legislative Assembly. She took this invitation as an opportunity to again present the comprehensive quality health services plan, arguing that the creation of a comprehensive system of supports was essential to the provision of long term care.[356] Pinaymootang has not received any feedback or follow up as a result of this presentation to the province.[357]

In the absence of provincial funding for needed mental health services, the Pinaymootang Health Director subsequently approached the federal government to secure funding. After several requests, the federal government agreed to increase the level of mental health funding provided to Pinaymootang. Pinaymootang previously received funding for a mental health worker to provide services one day a week; this funding was increased to cover five days a week of mental health services.[358]

This allocation of mental health funding by the federal government is in keeping with an existing structure of services for First Nations people, under which the federal government is responsible for funding of services in First Nations. However, as demonstrated in this chapter, the current demand for mental health services in Pinaymootang has been shaped by historic and current policies and actions of **both** federal and provincial governments. The mental health needs in the community today have been shaped by a colonial history that has systematically inflicted individual, family and community level trauma on First Nations people and by federal failures to fund and support the development of services needed to address this trauma. It has also been shaped by a more recent history of provincial policies. These include, but are not limited to the intentional flooding of First Nations in the Interlake region and the failure to address persistent physician shortages and other problems with health services in the Interlake region.

First Nations have been left to bear the burden of navigating complex contexts and decision making structures and to continually fight in order to improve service access for First Nations children. The current implementation of Jordan's Principle in Manitoba has dramatically increased the services available to First Nations children, but the fight for equitable services continues.

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