The Implementation of Jordan's Principle in Manitoba: Final Report

Assembly of Manitoba Chiefs
Empowering Our Nations

University of Colorado Boulder

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Executive Summary

The implementation of Jordan's Principle in Manitoba

Jordan's Principle is a legal principle that requires the government of Canada to address gaps in services for First Nation children, and to ensure timely services that meet the needs of First Nation children, without compounding historical disadvantage.[1,2,3] It was initially conceived as a child-first principle designed to ensure that First Nation children did not experience denials, delays, or disruptions as a result of the complicated framework for services to First Nation people.[4] Starting in 2016, a series of Canadian Human Rights Tribunal (CHRT) rulings expanded the interpretation of Jordan's Principle. The CHRT ruled that the federal government had an obligation to fully implement Jordan's Principle, that the principle applies to all First Nation children and a broad range of public services, and that the federal government must comply with strict timelines for responding to requests for Jordan's Principle funding/services.[5] In response to the CHRT rulings, the federal government revised its approach to Jordan's Principle and radically expanded the funding available for services for First Nation children.

The goal of this study was to examine the impact of Jordan's Principle on the structure of services for First Nation children in Manitoba.

More specifically, this study aimed to:

- Describe the structure of health, education, and social services for First Nation children in Manitoba;
- Describe the impact of Jordan's Principle on the structure of health, education, and social services for First Nation children in Manitoba;
- Describe current Jordan's Principle programs in a sample of First Nations in Manitoba;
- Describe successes and challenges in implementing a sample of Jordan's Principle programs;
- Understand how these programs link with and are shaped by existing resources and services; and
- Understand service providers' perspectives on how to build on existing programs, resources and services.

This study was commissioned by the Public Interest Law Centre and implemented by a research team working in partnership with the Assembly of Manitoba Chiefs (AMC). The research team included scholars in the fields of social policy, social work, child and youth care, and community health, as well as policy experts from the Jordan's Principle Service Coordination Unit at the AMC.[a] The study was guided by an Advisory Committee that included broad representation from First Nations across Manitoba. Funding for the study was allocated as part of the remedies outlined by the CHRT in the partial settlement of *Sumner-Pruden v. Canada.*

This report focuses on the development, implementation, and provision of services for First Nation children between summer of 2016, when CHRT rulings in Caring Society and the Assembly of First Nations v. Canada first began to transform the federal approach to Jordan's Principle, and summer of 2021 when data collection for the study closed. The study drew on diverse sources of information and included multiple methods of data collection (see Table 1 for details), including: Literature review, content analysis of policy documents, interviews and focus groups, a survey of Nation-level service directors and Case Managers, and participant observation of Jordan's Principle Technical Advisory Group (TAG) meetings, which brought Jordan's Principle Case Managers together to share experiences, questions and issues of concern.[b] The findings summarized in this report incorporate and build on an interim report that was completed in the summer of 2021.[6]

A key goal in analyzing and writing about the information we collected was to ensure that we placed study findings in appropriate historical and policy context. Contextualizing study findings supports an examination of the ways in which the current implementation of Jordan's Principle is shaped by and replicates - as well as the way it diverges from - the policies, practices, and power dynamics that have served to disempower and disadvantage First Nation people in the past and in the present day.

Structure of this report

The findings in this report reinforce key findings from prior research on Jordan's Principle, while also providing a more up-to-date, and much more detailed, picture of Jordan's Principle in Manitoba than was previously available.[7,8,9,10,11,12] This report is structured in eight chapters.

In ***Chapter 1***, we provide a brief overview of the historical and policy context that is essential to understanding the need for, and approach to, Jordan's Principle in Manitoba. We note that the implementation of Jordan's Principle must occur in accordance with other commitments and obligations around realizing First Nation rights to self-determination. We outline the policy framework that has shaped services for First Nation children in Canada and describe the complicated patchwork of services for First Nation children that existed in Manitoba prior to the implementation of Jordan's Principle. Within this disorganized patchwork of services, First Nation children faced gaps in services,

a See Appendix 1 for research team member bios.

b See Appendix 2 for an expanded discussion of study methods.

Table 1: Data collection methods and sample summary

Approach to Information Gathering	Focus of Information Gathering	Information Obtained
Document Review	Publicly available policy documents, presentations, reports, and research summaries	AMC resolutions, CHRT rulings, and orders, Manitoba focused reports, Jordan's Principle policy documents, presentations at Jordan's Principle events, parliamentary Hansard
	Internal documents provided by the AMC	Jordan's Principle engagement reports, terms of reference, briefing notes, information sheets, and meeting minutes from different Jordan's Principle focused events
	Prior research	Research on policy guiding services for First Nations, accessibility of services, and outcomes for First Nation children. In addition, we draw on prior research on Jordan's Principle in Manitoba
Individual/ group interviews and focus groups	28 Interviews/consultations with Nation and regional level Service Coordinators, Case Managers, administrators and policy specialists	▪ Seven Jordan's Principle Case Managers 14 regional level technicians, service providers, and policy specialists including AMC, Eagle Urban Transition Centre (EUTC), Special Needs Advocate Office, Indigenous Services Canada (ISC) ▪ Seven Specialized Service Provider (SSP) administrators ▪ Seven Tribal Council Service Coordinators (TSC) or Jordan's Principle at regional leadership organizations
	Five focus groups and three interviews with over 20 front line service providers	More than 20 frontline staff and Specialized Service providers including Manitoba Adolescent Treatment Centre (MATC), St.Amant, Rehabilitation Centre for Children (RCC), Manitoba First Nations Education Resource Centre (MFNERC), Frontier School Division (FSD)
Participant Observation	Jordan's Principle TAG meetings	Field notes and minutes, April 2020-April 2021
Administrative Data	National and regional level data	Data on the number of children served and services provided by service domain, region, and year
Survey Data	Jordan's Principle Case Manager, Health Director, and Education Director perspectives on access to services	Data on the range of services provided through Jordan's Principle and available through other sources
Case Studies	Details of Jordan's Principle services and implementation processes in two First Nations	Interviews and discussion with Jordan's Principle Case Managers and/or others central to Jordan's Principle in the Nation.

as well as service denials and delays; Jordan's Principle was intended to address these inequities.

In ***Chapter 2***, we describe the emergence of the current approach to Jordan's Principle in Manitoba, tracing the timeline for development of the current system of Jordan's Principle funded services. We place the recent developments around Jordan's Principle in the context of a persistent pattern in which:

- First Nations in Manitoba have called for a self-determined system of locally available services and for the capacity enhancement needed to achieve a service system that can address the physical, mental, social/emotional, and spiritual needs of children, and
- The federal government has responded with denials of funding, short-term funding, and funds allocated only to meet the needs of individual children.

The approach to implementing Jordan's Principle in Manitoba has defied this pattern in important ways, laying the foundation for a systemic approach to services.

In ***Chapter 3***, we examine tensions in the process of implementing Jordan's Principle in Manitoba. Study findings show that:

- There has been a systemic approach to implementing Jordan's Principle, but this approach is undermined by the provision of short-term, demand driven funding;
- First Nation leadership has been both supported and hampered by a discretionary, federal approach to the implementation of Jordan's Principle in Manitoba; and
- There has been a failure to support the formal development of needed, First Nation-led, regional coordination structures.

First Nations and the FNIHB regional office acted quickly to support an implementation of Jordan's Principle that features the extension of key services across First Nations, an emphasis on creating full time positions, and the flexibility to tailor services to the needs and contexts of their Nations. However, a lack of transparency around decision-making, failures to establish long-term funding, and failures to support the development of formal, First Nation coordination, governance and technical support structures undermine the goals of a systemic approach.

In ***Chapter 4***, we describe the Jordan's Principle funded services that have been added to the pre-existing patchwork of services. These include:

- First Nation developed programs implemented at the First Nation level,
- A system of region-wide allied health and mental health/wellness supports provided by Specialized Service Providers (SSPs) that have headquarters in Winnipeg and may also have teams based in smaller urban centers (such as Brandon or Thompson),
- Coordination of services for First Nation families living or accessing services off-reserve,
- Support in accessing Jordan's Principle funds to address the needs of individual children, and
- Additional, regional initiatives that focus on addressing specific gaps in services - such as the need for pediatricians and child psychologists in northern First Nations - and on supporting First Nations engagement with Jordan's Principle.

At the end of Chapter 4, we present 2, anonymized, Nation-level case studies. These studies integrate information from interviews and literature/media focused on a single Nation. However, in order to preserve anonymity, we have drawn from study data on other Nations to modify potentially identifying details.

In ***Chapter 5***, we examine ongoing gaps in services for First Nation children. Jordan's Principle has greatly increased available services and supports, adding important new patches in the patchwork of services for First Nation children. Even so, vulnerable groups continue to be excluded and important gaps in services persist. Participants noted several key gaps in service.

- Youth over the age of 18 are no longer supported by Jordan's Principle, even though Child and Family Services (CFS) and some other services in Manitoba can support youth through age 21. This leaves some First Nation youth unsupported during the transition to adulthood.
- A chronic housing crisis directly impacts the health, safety, and wellbeing of First Nation children. The process for accessing Jordan's Principle funding for housing renovations is complicated and lengthy. Study participants indicated that, in Manitoba, Jordan's Principle funding for housing renovations is only available for children whose housing needs are directly linked to disabilities; other First Nation children who lack safe and suitable housing are excluded.
- The real cost of Jordan's Principle implementation in remote northern First Nations is not covered. The failure to fully fund the real costs of service creates inequities across First Nations.
- Jordan's Principle services have not yet been equitably extended to First Nation children living off reserve.
- Mental health services are currently inadequate to meet the needs of First Nation children and families. Gaps in Nation-based mental health services perpetuate a harmful, crisis-focused approach in which children must often leave their Nations in order to access mental health services.

In ***Chapter 6***, we present a summary of the key elements of a common approach to practice that were identified by Jordan's Principle service providers and coordinators. Participants in interviews and focus groups highlighted the importance of:

- A time-intensive, relational approach that requires building trust with families and children, Elders and knowledge keepers, other service providers, and Nation leadership; and
- A broad and responsive approach to practice that requires service providers and coordinators to take on complex responsibilities that challenge normative practices and extend beyond traditional disciplinary boundaries.

These elements of practice were described as a necessary foundation for the development and provision of services that are tailored to the needs, priorities, and contexts of First Nation children, families, and Nations.

In ***Chapter 7***, we analyze inter-related structural factors that impede the implementation of Jordan's Principle in Manitoba. These include:

- The emergence of high caseloads and growing waitlists – As more families seek out Jordan's Principle services, high caseloads and growing waiting lists limit the time that Case Managers, Service Coordinators, and SSPs have to implement a relational approach.
- Complex roles, stress, and staff turnover – Implementing a new system of services, which features a broad and responsive approach to service delivery, while also managing high caseloads creates unmanageable workloads that contribute to stress and staff turnover, thus hindering a relational approach to services.
- The administrative burden of some Jordan's Principle requests – The approach to Jordan's Principle in Manitoba features the transfer of substantial power for decision-making around individual requests for Jordan's Principle funded services to First Nation Service Coordinators,

but the requests still assessed by the federal government have burdensome administrative requirements that cause delays in service and strain system resources.

- Inadequate physical infrastructure – Many Jordan's Principle programs lack appropriate physical space to house the growing range of activities and services necessary to support children's optimal health and development.
- Inadequate digital infrastructure – Many Nations lack the cell phone, Internet, and telehealth connectivity needed to facilitate ongoing engagement between service providers and children and families.
- Insufficient resources for capacity enhancement initiatives– Organizations providing Jordan's Principle services in Manitoba have developed a broad range of innovative capacity enhancement initiatives, but they lack the resources needed to sustain, expand, and extend these initiatives to every First Nation in Manitoba.
- Insufficient regional coordination and support – Participants expressed a strong desire for increased data collection and data sharing tools, policies or best practices that support Nations in achieving a common baseline of services, and other supports for enhanced collaboration. However, the funding to coordinate regional efforts along these dimensions is insufficient and formal, First Nations led infrastructures are currently too underdeveloped to support the required scope of work.

In ***Chapter 8*** we present recommendations that build on the study findings and engagement with key stakeholders. These recommendation reflect consideration of the variation in the contexts, needs, and pre-existing service capacity across Nations. They also reflect consideration of the legal and ethical obligations to both: ensure service equity for all First Nation children and honour and support self-determination for First Nations. Taken together, these recommendations outline a plan for moving from the current patchwork of services for First Nation children to a well-designed service quilt in which each Nation has access to the resources and supports to create a block of services that reflects its unique context, strengths, culture, and needs. Rather than a loosely basted patchwork, this service quilt would be designed so that the services in each Nation are reinforced by a strong backing and bound to a broader system of services with strong seams, neatly executed to ensure there are no more gaps in services for First Nation children.

Recommendations

The federal government should:

1. Commit funding and other resources to ensure adequate housing and clean water for every First Nation child.
2. Extend eligibility for Jordan's Principle through age 21.
3. Commit to working with First Nations to analyze and extend funds to cover the real costs of implementing Jordan's Principle in remote, northern Nations.
4. Commit to funding and supporting the development of dedicated, physical space for Jordan's Principle programs and services in each Nation.
5. Commit to funding and supporting the development of the digital infrastructure required to support a responsive, relational approach to the development and provision of Jordan's Principle services.
6. Commit to funding and supporting the development of communities of practice that provide space for Case Managers, Service Coordinators, and SSPs to share strategies and successes, discuss challenges, and connect to resources that may support ongoing service development.
7. Allocate long-term Jordan's Principle funding that is flexible enough to enable First Nations to develop services in accordance with their priorities and members' needs.
8. Commit to a systemic approach to Jordan's Principle funding that actively extends the resources needed to establish an equitable baseline of services in each First Nation.
9. Commit to establishing clear and consistent paths for communicating policy information to every First Nation and for engaging First Nations in policy development and decision-making processes.
10. Allocate long-term funding and other resources to support capacity enhancement initiatives that support every First Nation in Manitoba in moving towards a self-determined system of services.
11. Work with SSPs and First Nations to restructure Jordan's Principle funding in ways that support First Nations in taking on specific services/responsibilities in accordance with a self-determined pacing and sequence.
12. Support the development of formal, First Nations led structures to facilitate coordination and collaboration around Jordan's Principle.
13. Commit to funding a First Nations owned and controlled program of research to support the further implementation of Jordan's Principle.

Chapter 1:

Context for Jordan's Principle –The pre-existing structure of services for First Nation children

Jordan's Principle was initially conceived as a child-first principle designed to ensure that First Nation children did not experience denials, delays, or disruptions of needed services as a result of jurisdictional disputes between governments or government departments.[13] These disputes emerged because of the complex, colonial structure of services for First Nation people. Over time, and as a result of Canadian Human Rights Tribunal rulings, Jordan's Principle was expanded in order to address gaps in services for First Nation children, and to meet the needs of First Nation children without compounding historical disadvantage.

In this chapter, we provide a brief overview of the historical and policy context that is essential to understanding the need for, and approach to, Jordan's Principle in Manitoba. We outline the policy framework that has shaped a loosely bound, and disorganized patchwork of services for First Nation children in Canada. We also briefly consider other federal government commitments and obligations, around First Nation rights to self-determination, that must be taken into account in when enacting and implementing all policies related to services

for First Nation children. Finally, we outline the roles, responsibilities, and identified challenges in the complicated patchwork of services for First Nation children that existed in Manitoba prior to the implementation of Jordan's Principle. Services extended through Jordan's Principle, which are discussed in Chapter 4 of this report, seek to address gaps and inequities in these pre-existing services without fundamentally altering the fragmented and dynamic underlying service structure. Jordan's Principle has, in essence, added new patches to the service patchwork described in this chapter.

1.1 Brief historical context

There are 63 First Nations in Manitoba today; these Nations represent five different language groups including Nehetho/Ininew (Cree), Dakota Oyate (Dakota), Denesuline (Dene), Anishinaabe (Ojibway), and Anishininew (Ojibwe-Cree).[14] As seen in Figure 1, these First Nations stretch across the province's vast geography; Manitoba encompasses 650, 000 square kilometers and seven different Treaty territories.[15,16,17] Diverse cultural traditions are practiced by First Nation people in Manitoba, who account for 15% of the provincial population.[18,a] First Nations in Manitoba are supported in the negotiation, development and implementation of health, education, and social services by a complex network of regional organizations. See Textbox 1 for a description of key regional organizations.

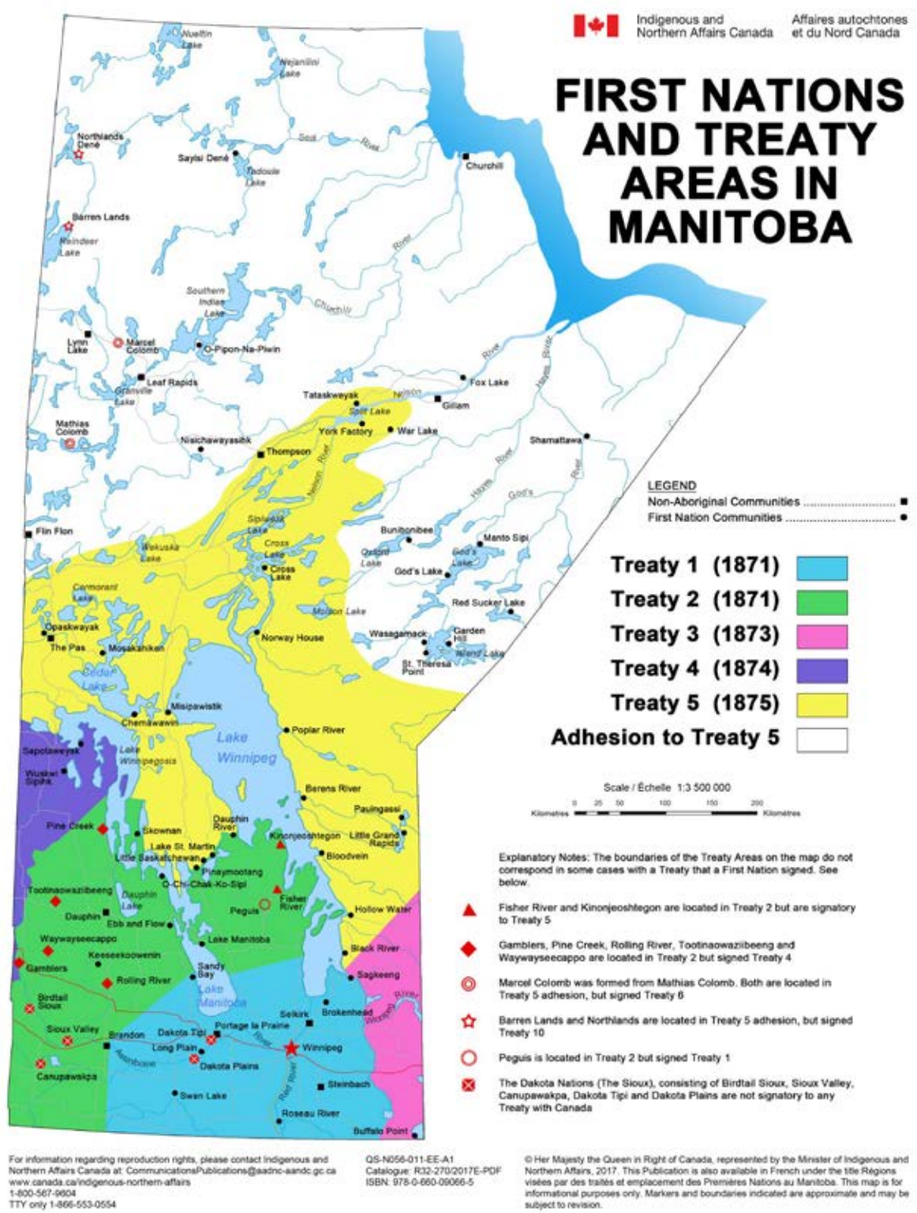
The context of services for First Nation children in Manitoba today is shaped by First Nation histories, cultures, and traditions, as well as settler colonial history and policies. Prior to settler colonization, First Nation peoples across Canada had diverse child rearing practices that were grounded in the knowledge, language, culture, economy, and worldview of each Nation. First Nations had, and continue to have, their own laws around and systems of caring for children and supporting families.[19] Caring for and educating children was not a responsibility exclusive to the nuclear family, but was instead viewed as a highly valued, shared responsibility of the extended family and Nation, in which all adults participated.[20,21] Families organized themselves to provide mutual aid through shared harvests in times of stability and scarcity.[22,23] The wellbeing of families was supported by the community, which was reliant on the surrounding environment for trade, shelter, medicines, and other basic needs.[24,25,26] Traditional medicine addressed individual needs with medicinal plants and emphasized the ways that individual wellbeing was interconnected to the surrounding community and the environment.[27,28]

The environmental impacts of settler colonialism affected the health and wellbeing of First Nations by reducing economic and resource stability, and increasing starvation.[29,30,31] With the increasing ecological instability, many Nations entered Treaty negotiations after years of resistance.[32] Canada approached the Treaty process with the aim to remove First Nations' land title and increase exploitive access to natural resources for settler populations.[33]

More than a century of oppression followed. Colonial settlers introduced assimilationist and genocidal policies including the imposition of the residential school system and the mass separation of families and children by the child welfare system, starting during the Sixties Scoop and continuing into the present day.[34,35,36] The residential school system shredded the fabric of First Nations communities, splitting up families, disrupting traditional systems of care, and placing children in schools where they faced neglect, as well as sexual and physical abuse.[37] The inter-generational impacts of family

a The 2016 census reported 223,310 respondents indicating Indigenous identity with 58.4% indicating First Nation identity.

Figure 1: Map of First Nations and Treaty areas in Manitoba[38]



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Textbox 1: Regional First Nation organizations in Manitoba (2021)

The Assembly of Manitoba Chiefs (AMC)—AMC was created in 1988 by the Chiefs-in-Assembly to coordinate technical supports and political actions around common issues experienced by First Nations in Manitoba. Currently the AMC receives its mandates from 62 member First Nations, the AMC provides advocacy in policy sectors such as Jordan's Principle, Treaties, social development, Child and Family Services, gaming, health, education, and citizenship.[39]

- Eagle Urban Transition Centre (EUTC)—The EUTC was created by AMC in 2005. The organization provides culturally appropriate supports and referrals to all First Nations in Manitoba to ensure children and families have access to health, social, education, housing, employment, legal, and Jordan's Principle supports when relocating to urban centres in Manitoba.[40,41]
- First Nations Family Advocate Office—The First Nations Family Advocate Office was created by AMC in 2015, following community consultations and the publishing of the Bringing our Children Home report. The office is mandated to "support and advocate for First Nations families" who have CFS involvement through advocacy and reforms to policy, laws, and organizations by utilizing First Nations traditions and knowledge.[42]

Manitoba First Nations Education Resource Centre (MFNERC)—MFNERC was created in 1998 by the Assembly of Manitoba Chiefs. The organization provides "education, administration, technology, language and culture services to First Nations schools in Manitoba."[43] Currently MFNERC serves 58 First Nations schools in 49 First Nations.[44]

First Nations Health and Social Secretariat of Manitoba (FNHSSM)— FNHSSM was created in 2014 and currently works with all First Nations to support the development of programs and policies that protect "Indigenous values and systems", support training and education, and support the development of "First Nations controlled and administered research and evaluation."[45,46] FNHSSM aims to support increased First Nations participation in and control of health and social services.[47]

Southern Chiefs Organization (SCO)—SCO was established in 1999 and currently represents 34 Anishinaabe and Dakota First Nations in southern Manitoba. The SCO's mission is to create an "independent political forum" that preserves and enhances the inherent rights of First Nation peoples by pursuing the implementation of the "spirit and intent" of the "Treaty-making process."[48]

Manitoba Keewatinowi Okimakanak (MKO)—MKO was established in 1981 as a non-profit that provides political advocacy surrounding Treaty and human rights for the 26 First Nations that signed treaties 4, 5, 6 and 10 (including one reserve in Saskatchewan).[49] MKO's areas of work are diverse and include education, housing, child welfare, and others.[50]

Tribal Councils – Seven Tribal Councils provide support and advocacy for 50 Nations across Manitoba.[51,52] Tribal Councils have diverse mandates to oversee the implementation of services including but not limited to: housing, education, social services, health, public works, and Nation governance. Tribal Councils also provide technical oversight and support to ensure the effective transition of services from provincial or federal oversight to Nation oversight.[53] Tribal Council membership changes over time; the list below is based on a 2021 review of Tribal Council websites.

SCO Affiliated Nations

Southeast Resource Development Council
- Berens River First Nation
- Black River First Nation
- Bloodvein First Nation
- Brokenhead Ojibway Nation
- Hollow Water First Nation
- Little Grand Rapids First Nation
- Poplar River First Nation
- Pauingassi First Nation

Dakota / Ojibway Tribal Council
- Birdtail Sioux Dakota Nation
- Dakota Tipi First Nation
- Long Plain First Nation
- Roseau River Anishinabe First Nation
- Sandy Bay First Nation
- Swan Lake First Nation
- Waywayseecappo First Nation

Interlake Reserves Tribal Council
- Kinonjeoshtegon First Nation
- Little Saskatchewan First Nation
- Dauphin River First Nation
- Lake Manitoba Treaty 2 First Nation (Dog Creek)

West Region Tribal Council
- Pine Creek First Nation
- Skownan First Nation
- O-Chi-Chak-Ko-Sipi First Nation
- Keeseekoowenin Ojibway Nation
- Rolling River First Nation
- Ebb and Flow First Nation
- Gambler First Nation

- Peguis First Nation*
- Pinaymootang First Nation*
- Lake St Martin First Nation*
- Sagkeeng First Nation*
- Tootinaowaziibeeng Treaty Reserve*
- Buffalo Point First Nation*
- Canupawakpa Dakota Nation*
- Dakota Plains Wahpeton Nation*
- Fisher River Cree Nation*

MKO Affiliated Nations

Swampy Cree Tribal Council
- Chemawawin Cree Nation
- Granville Lake First Nation
- Marcel Columb First Nation
- Mathias Colomb Cree Nation
- Opaskwayak Cree Nation
- Mosakahiken Cree Nation
- Wuskwi Sipihk First Nation
- Sapotaweyak Cree Nation
- Misipawistik Cree Nation – Grand Rapids

Swampy Cree Tribal Council
- Sayisi Dene First NationShamattawa First Nation
- Northlands Denesuline First Nation
- Barren Lands First Nation
- Manto Sipi Cree Nation–God's River
- Bunibonibee Cree Nation
- Fox Lake Cree Nation
- God's Lake First Nation
- War Lake First Nation
- Tataskweyak Cree Nation
- York Factory First Nation

Nations not affiliated with SCO or MKO

Island Lake Tribal Council
- Red Sucker Lake First Nation
- Wasagamack First Nation
- Garden Hill First Nation
- St. Theresa Point First Nation

- Nisichawayasihk Cree Nation*
- Norway House Cree Nation*
- O-Pipon-Na-Piwin Cree Nation – South Indian Lake*
- Cross Lake First Nation*

* Independent Nation, not affiliated with a Tribal Council

separation through the residential school system, and continued separation of families through the child welfare system, include increased risk of: suicidal ideation, suicide attempts, and mental health distress; child and family service involvement; and growing up with food insecurity in crowded, low income households.[54,55,56,57,58,59,60,61,62,63,64,65,66,67]

These increased risks and the corresponding service needs were created by colonial, federal, and provincial/territorial policies, yet federal and provincial/territorial governments have failed to take necessary steps towards reconciliation by redressing past and ongoing harms.[68,69] Numerous reports and legal decisions have noted the federal government's ongoing failures to provide adequate funding for health, education, and social services for First Nation children living on reserve. These reports have also noted the failures to reform federal and provincial policies in order to eliminate racial discrimination, honour Treaty obligations, and fulfill Crown responsibilities to Indigenous peoples across Canada.[70,71,72,73,74,75,76,77,78]

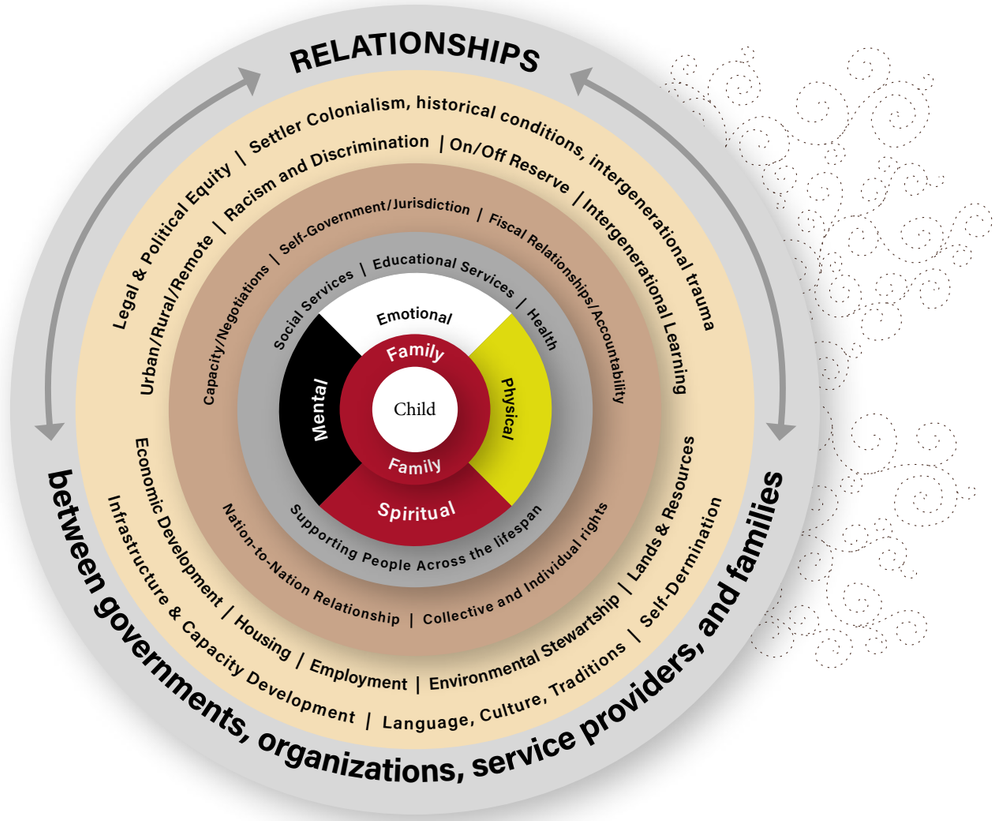
The ravages of settler colonial history, notwithstanding, First Nations in Manitoba have consistently advocated for their rights to self-determination.[a] Canada has recently taken multiple actions that reinforce, in principle, federal government commitment to honouring Indigenous self determination. These include ratification of the *United Nations Declaration on the Rights of Indigenous People* and the passage of *An Act respecting First Nations, Inuit and Métis children, youth and families* which affirms "the right to self-determination of Indigenous peoples" including the inherent right to self-government and jurisdiction over child and family services[79,80] Self-determination in services is consistent with a growing focus on cultural safety in service provision, and is increasingly recognized as being fundamental to fostering the health and wellbeing of Indigenous children.[81,82] Thus, commitments around self determination, along with consideration of the ongoing and intergenerational impacts of colonial policies, must inform decision-making around services for First Nation children and families. Figure 2 depicts the complex context and considerations that must be taken to account in making decisions and crafting policies to meet the needs and interests, and honour the self-determination of First Nation people.

1.2 Existing policy framework

The current structure of services for First Nation children is shaped, in part, by colonial legislation. Articles 92 and 93 of the *Constitution Act* assign responsibility for the provision of most health, education, and social services to the provinces.[83,84,85] Section 88 of the federal *Indian Act* extends provincial laws of general application to First Nation people living in First Nations.[86,87,88] Article 91(24) of the *Constitution Act* assigns responsibility for "Indians, and Lands reserved for the Indians" to the federal government.[89,90] The *Indian Act*, in turn, defines eligibility, acquisition, and transmission of Indian status, which is the mechanism used by the federal government to define the First Nations population directly under its jurisdiction.[91] In combination, these sections of *Constitution* and *Indian Acts* have been interpreted as establishing the federal government's jurisdictional responsibility for on-reserve services.[92]

Funding and delivery of public health, education, and social services for the rest of the population falls, with only a few exceptions, under provincial or territorial jurisdiction. As a result, off-reserve services are funded and legislated by the provincial government, either directly or through contracts with independent service organizations. In contrast, on-reserve services are typically federally funded.[93,b] Services are often provided by First Nations, which are bound by both provincial laws and standards and the terms of federal funding, but they may also be provided by the federal government. In some cases, provincial services may also be extended on reserve. The details of service provision varies from Nation to Nation. Some of this variation is celebrated as an expression of self-determination, and of responsiveness to local needs.[94,95,96,97,98,99,100,101]

Figure 2: The context of First Nation policy decisions (adapted from Kmetic & Gideon, 2007)[102]



a Self-determination entails the development and implementation of independent First Nations' political structures and systems, the pursuit of economic self-reliance, and territorial independence. Non-exhaustive examples of areas that can be impacted by self-determination include religion, cultural heritage and contemporary cultural celebrations, and economic and resource development such as gaming, business, and natural resources. Jurisdiction over services such as healthcare, social services, and education is also an integral aspect of self-determination.

b The configuration and names of federal government departments responsible for First Nations services and programs have changed over time. The current configuration places all services under the auspices of Indigenous Services Canada (ISC). Within ISC, structures and responsibilities are the vestiges of two, previously distinct departments – the First Nations Inuit Health Branch (FNIHB) and Indigenous and Northern Affairs Canada (INAC). At the time of writing the FNIHB, which is nested within ISC, continues to oversee health and Jordan's Principle. Other units within ISC oversee education, child welfare, and other social services.

This historically entrenched approach to the funding of public services results in areas of jurisdictional ambiguity and disputes over responsibility for services.[103,104,105] Recent examples of jurisdictional disputes include cases involving status-eligible children, First Nation people temporarily living on or off reserve, and children who transition from institutional care outside of First Nations to on-reserve settings.[106,107,108]

1.3 The current structure of services for First Nation children in Manitoba

"Patchwork" is a metaphor that has often been used to describe the structure of services in Canada, and services for First Nation people in particular. We also use patchwork as a metaphor in this report. The image of a loose patchwork, that lacks an underlying structure or predetermined pattern, is apt because it conveys the potential for gaps and inequities within a complex structure of services. This potential is amplified within a system of services that were created to serve a broader population and may not fit well with First Nations' contexts, cultures, and service needs. Programs and services for First Nation people may be operated, funded, and administered by provincial or federal governments. First Nations may also have responsibility for the provision and administration of services. Within each government there is further potential for disconnections between health, education, and social services. Consistent issues of underfunding, lack of administrative flexibility, and lack of coordination translate the potential for gaps and disconnections into reality.

We use the metaphor of a patchwork knowing that it fails to capture the dynamic nature of the systems which deliver services to First Nation children. Due to the complexity of the Canadian policy framework, services for First Nation children in Manitoba are a complicated mix of federal and provincial funding, and are provided by diverse service providers. Arrangements and options differ by service domain and are affected by changes in provincial and federal policies, as well as First Nations decisions, on-going advocacy, and program development. Funding, policies, and service priorities may shift within any service domain at any time, creating new gaps and inequities in services.

In this report, we draw on the most recent, publicly available, information to document the structure of health, education, and child welfare services, as well as services for children with disabilities. We searched for and drew on the most up-to-date publicly available information about the structure of services in Manitoba that we could locate. However, as is clear in our discussion of these services, each service system is continuing to change and evolve. Existing research on services for First Nation people yields several consistent findings that apply across diverse contexts and service domains, and over time.

- Service delivery is hampered by a complex and fragmented administrative structure which can lead to gaps in services. In addition, jurisdictional confusion and disputes, between governments or government departments, over responsibility for funding services can cause denials and delays in services. First Nation families, along with First Nation leadership and service providers serving First Nation families must navigate through these challenges and fight for needed services for their children.[109,110,111,112,113,114]
- There is a persistent pattern of underfunding of services for First Nations. Numerous studies, as recent as 2020 and dating back multiple decades, have noted a need for service funding models to: 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 service agencies, include allocations for development of data collection and research capacity, and include funds for infrastructure maintenance and improvement.[115,116,117,118,119,120,121,122]
- Challenges in service delivery are compounded in rural and remote communities where qualified service providers can be limited and the cost of supplies can be high. As a result, First Nation people may have to travel or relocate to urban centres, or even place their children in care of CFS, in order to access needed services.[123,124,125,126,127,128]

As a result of all these factors, First Nation children consistently experience higher levels of risk and poorer outcomes, across a broad range of health and wellbeing measures, than other children in Canada. See, for example, the data on key indicators for First Nation and other children in Manitoba, which are presented in Table 1. The high levels of risk and poor outcomes experienced by First Nation children are also driven by the harmful effects of systemic issues such as racism and poverty. Current systemic issues compound the impacts of policies of cultural genocide and settler colonization that disrupted First Nation family and community networks, culturally based systems of care, and traditional economies while inflicting intergenerational trauma. Though First Nations have advocated for increased control of services, the transfer of power is often constrained by provincial or federal policies and procedures, and amount to a pro forma transfer of administrative duties.[129,130,131,132,133]

Table 1: Inequitable outcomes for First Nation children in Manitoba (data for 2012-17)[134]

Child Health and Wellness Outcomes (% or rate/hundred children)				
Infant mortality	.3	.8	.9	.6
Children in care	2	14	12	17
Grade 3 reading meets/approaches expectations	84	56	52	61
Grade 3 math meets/approaches expectations	81	56	52	61
Graduated high school	90	47	42	55
Teen births	1.1	8.7	9.9	6.6
Suicide attempts	.1	.7	.9	.4
Substance use disorders	1.5	7.6	7.7	7.5
Child poverty [135]	18	--	65	54

We focus our analysis on health services, education, child welfare, and services for children with disabilities, but note the following important caveats:

1. There are other service domains – such as early childhood education – that are integral to the meeting the needs of First Nation children.
2. Though we discuss each service domain separately, they actually intersect and overlap in complicated ways. For example, supports that pre-school aged children access through health services may be provided to school-aged children through the education system during the school year.
3. The needs addressed by these service systems are shaped by underlying structural factors and social determinants of health that must be redressed in order to fully meet children's needs and best interests.

1.2.1 Health services

In Manitoba, all Nations manage at least part of their on-reserve health services.[136,137] The federal government directly funds First Nations to provide preventative services such as immunizations, child development screenings and other prevention programs.[138] It also funds, or provides, primary care delivered on-reserve by nurses (in remote communities only) and funds physicians remunerated by the province for additional costs associated with traveling to selected communities.[139] The provincial health system may support "resource sharing" between regional health authorities and First Nations by, for example, testing blood samples that are drawn by a phlebotomist working on-reserve and delivered to a regional testing site. It is left to each First Nation to individually negotiate such arrangements and navigate shifting provincial policies and expectations.[140]

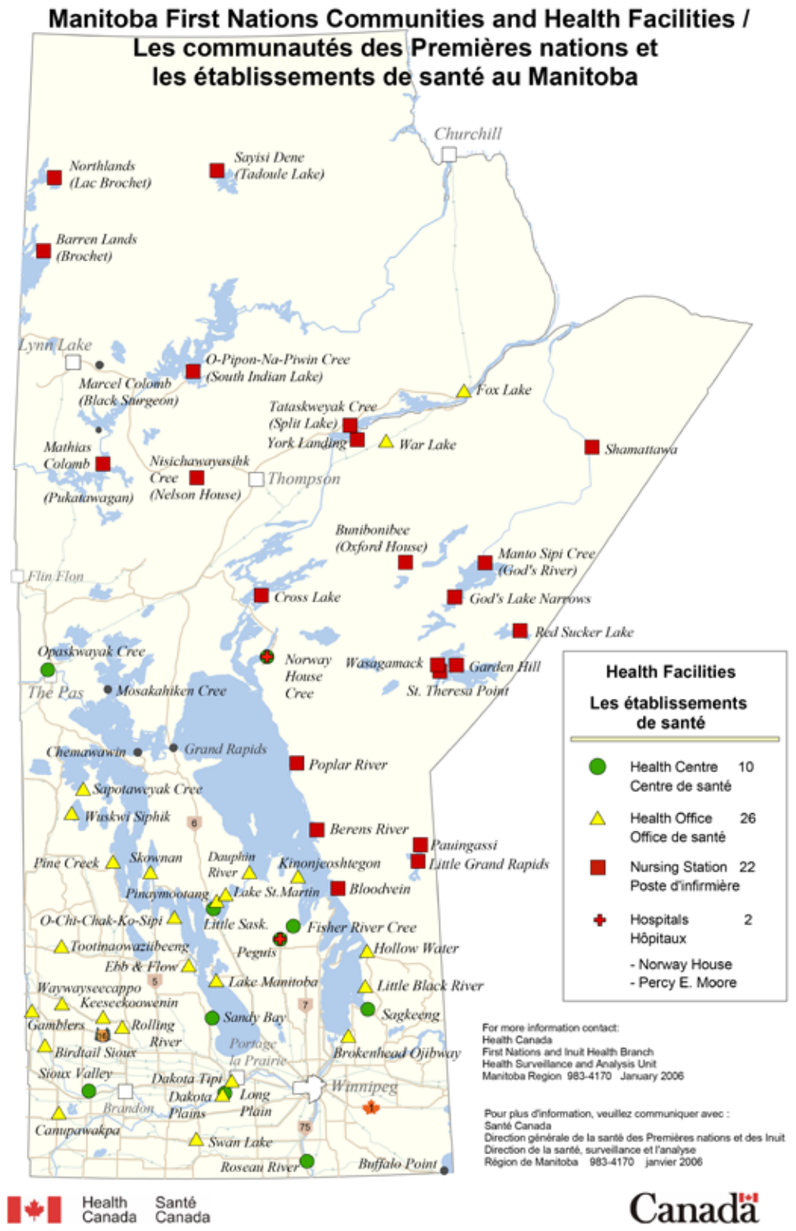
First Nation people living on reserve must utilize provincial health services for needs that extend beyond what is available in their Nations. Through the Non-Insured Health Benefits (NIHB) program, the federal government provides status First Nation people and Inuit, regardless of on- or off-reserve residence, with supplementary health benefits "to meet medical or dental needs not covered by provincial, territorial or third-party health insurance plans."[a,141] Apart from NIHB, health care for off-reserve First Nation people is provided through the provincial health system. Figure 3 displays a map of First Nations health centers and nursing stations with a map of the provincial health districts within which First Nations are nested.

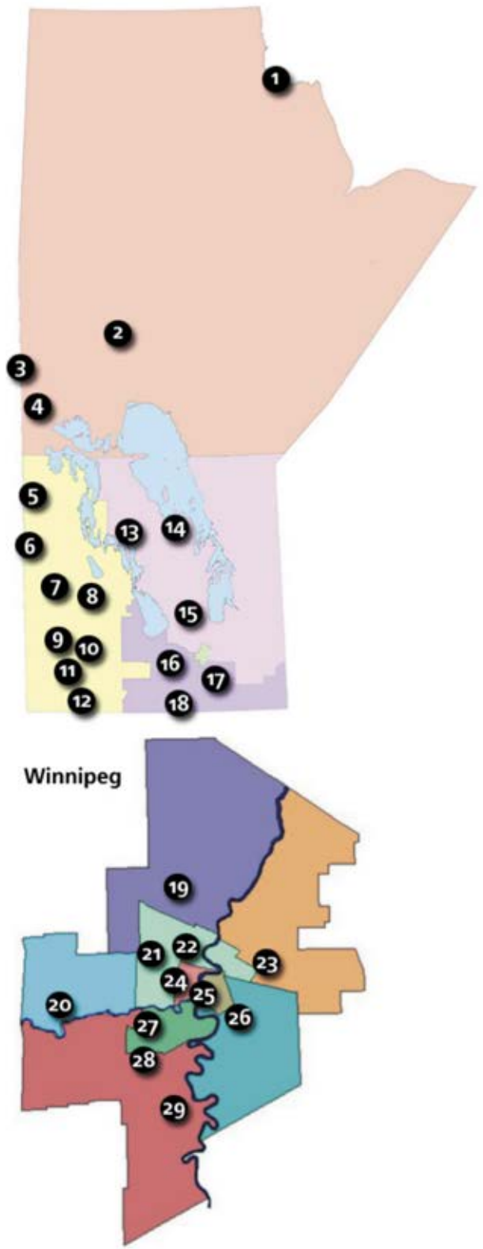
In Manitoba, where First Nation people constitute 15% of the overall population, approximately 30% of healthcare expenditures in 2015 were for services provided to First Nations. Accordingly, both the federal and provincial governments carefully make decisions to avoid creating precedents and thereby entrenching additional financial responsibility that each government sees as the other government's responsibility.[142,143,144,145,146,147]

Inequities and inefficiencies in federally funded, on-reserve primary and preventative care have been well documented, and recently proposed reforms include a focus on prevention, primary care, and increased diagnostic capacity that reduces the need for medical transportation and relocation. Reform recommendations highlight the need for an integrated approach to health care that offers access to both western medicine and traditional healing modalities. First Nations have also advocated for additional training, competitive salaries, adequate staffing, and infrastructure

a Eligibility for most federal First Nations health programs is limited to First Nation individuals living on reserve, NIHB is an exception to this general pattern.

Figure 3: Health facilities and regions, First Nations in Manitoba[148, 149]





Manitoba Area

1. Churchill Health Centre
2. Thompson General Hospital
3. Flin Flon General Hospital
4. St. Anthony's Hospital
5. Swan Valley Health Centre
6. Roblin District Health Centre
7. Dauphin Regional Health Centre
8. Ste. Rose General Hospital
9. Minnedosa Health District
10. Neepawa Health District
11. Brandon Regional Health Centre
12. Tri-Lakes Health Centre
13. E.M. Crowe Memorial Hospital
14. Arborg & Districts Health Centre
15. Selkirk & District General Hospital
16. Portage District General Hospital
17. Bethesda Regional Health Centre
18. Boundary Trails Health Centre

Winnipeg Area

19. Seven Oaks General Hospital
20. Grace General Hospital
21. Health Sciences Centre
22. CancerCare Manitoba
23. Concordia Hospital
24. Western Surgery Centre
25. St. Boniface General Hospital
26. Breast Health Centre
27. Misericordia Health Centre
28. Pan Am Clinic
29. Victoria General Hospital

development to support self-determined development of First Nations health services to a level that is comparable to similarly sized, non-First Nation communities.[150,151,152]

The limitations in on-reserve health care services mean that both on and off-reserve First Nation people must access services through the provincial health system. Thus, for example, at the Health Sciences Centre in Winnipeg up to 40% of emergency department visits are made by someone who is Indigenous, including transfers from other parts of the province.[153] Evaluations of the provincial healthcare system have documented the barriers created as a result of this complex service and funding structure, including limited access to primary and preventative care, as well as diagnostic services in rural and remote regions across the province.[154,155,156] These limitations, along with the closures of some emergency departments create high caseloads for the remaining emergency rooms. Data on wait times in the Manitoba health care system demonstrate widespread challenges, including the lack of MRI scanners in the Northern health region, and wait times of up to 41 weeks for CT scans and 28 weeks for ultrasounds in the Interlake region.[157,158,159] In addition, significant gaps and barriers in access to mental health services in rural and remote communities have been connected to increased child deaths.[160, 161,162] For First Nation people these limitations are compounded by issues related to racism, culturally inappropriate and unsafe services, and distrust of governmental systems based on past experiences and history. [163,164,165]

1.2.2 Education services

Off-reserve public schools are typically provincially operated, though the Manitoba education system also includes independently operated schools that are monitored, supported, and sometimes funded by the Manitoba Education Ministry.[166] On-reserve schools are federally funded. First Nations may maximize local control by administering their own on-reserve schools. In order to increase access to resources, multi-disciplinary expertise, and other benefits of economies of scale, First Nations may also choose to enter into educational agreements that mandate a provincial public school division to administer an on-reserve school. Alternately, First Nations may opt to receive support from MFNERC, a First Nation organization that provides First Nation schools with coordinating and support structures similar to those available within the provincial school system. MFNERC also provides services that assist "in education development, accreditation, certification, curriculum, training, advocacy, and other supports."[167,168,169,170,171,172]

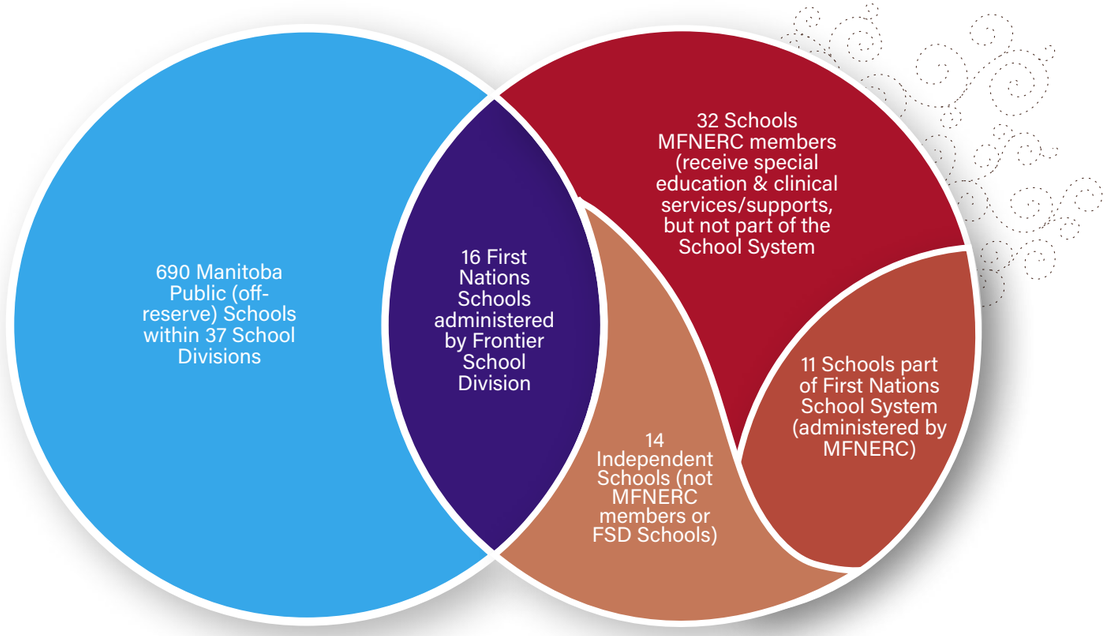
Frontier School Division, which is part of the provincial school system, has education agreements to administer schools in 15 First Nations.[173] An additional 43 on reserve schools, in 39 different Nations are supported by MFNERC. Of these MFNERC supported schools, 11 participate in the Manitoba First Nations School System (MFNSS), operated by MFNERC, which was created to ensure First Nations schools had the benefits provided by school divisions.[174,175] An additional 14 schools, in seven Nations are independently operated by First Nations. The structure of the school system in Manitoba is summarized in Figure 4.

Funding for provincially operated schools is based on a formula that takes into account the previous year's enrollment, increased costs associated with remoteness, and specialized grants to address the unique needs of the student population. These include the needs of children in the care of CFS, children with complex health needs, or children with unique psycho-social or socio-economic needs.[176] For several years, there have been calls to reform the funding of services such as mental health and learning supports.[177,178] School districts received baseline funding for a continuum of school-based services to address the districts' needs. Funding for students who require tailored supports for physical and

mental health needs must be applied for on an individual (student-by-student) basis. Children and families who require individualized services are reliant on school staff to submit funding applications, which must include diagnosis or assessment documentation such as a hearing assessment or mental health diagnosis.[179,180]

First Nation operated schools follow a funding formula that utilizes annual enrollment numbers from the prior year to fund the upcoming school year. Documented challenges in federal funding for on-reserve schools operated by First Nations include: variations in funding for remoteness, insufficient funding for high cost special education programming, insufficient resources to address the unique needs presented by inter-generational trauma, reliance on proposal based funding, and chronic underfunding of infrastructure and capital needs.[181,182,183]

Figure 4: The education system for First Nation children in Manitoba[184]



In 2019, First Nation education funding was reformed to ensure core funding was more comparable to provincial funding levels, and to stabilize funding by shifting some funds from project/application based models to core funding. Despite these reforms, high cost special education continues to be underfunded due to a lack of comprehensive, needs-based data and continued failures to address the real costs of education programming, professional development, data sharing and technological infrastructure, physical infrastructure, and other expenses.[185] The integration of community wellbeing indexes and substantive equality considerations into funding formulas have been proposed as reforms to address on-going and unaccounted for funding deficits.[186] MFNSS schools follow a slightly different funding formula that utilizes enrollment numbers alongside "price and volume adjustments" which account for shifting expenses - such as the price of fuel and changing enrollment numbers - and additional human resource, operations, and student support expenditures.[187] Through advocacy and strong leadership MFNSS was able to secure $18,878 per student in the 2017-18 school year; the provincial expenditure per student sits at $14,733.[188,189,190]

Data from the 2016 Statistics Canada National Household Survey indicates First Nation people in Manitoba have low rates of high school completion when compared to other people in Manitoba. Overall, 50.9% of First Nation people aged 20-24 reported not having a certificate, diploma, or degree. The percentage was higher for First Nation people living on reserve: 64% of on-reserve First Nation people and 39% of First Nation people living off reserve did not have a certificate, diploma or degree. In comparison, in Manitoba as a whole, 14% of the total population aged 20-24 had no certificate, diploma, or degree.[191]

1.2.3 Child welfare services

Manitoba has a unique system in which First Nation child welfare agencies receive both provincial and federal funding, serving First Nation children and families both on and off reserve. The Manitoba CFS system provides services to families and children voluntarily seeking support and intervenes, including through out-of-home placement, when a child is in need of protection.[192] The Manitoba system also makes provision for voluntary placement agreements (VPAs) through which caregivers place their children in the care of CFS. Provincial standards explicitly note that a VPA may be entered into because a child has a "mental disability" or "suffers from a chronic medical disability requiring treatment which cannot be provided if the child remains at home." [193,194] The implication is that families may sometimes be forced to enter into VPAs in order to access services or specialized care that the provincial or federal governments may not otherwise provide. In Manitoba the age of majority is formally recognized as 18, however, with youth consent, CFS services can be extended until the age of 21.[195]

The current structure of the child welfare system in Manitoba emerged from the Aboriginal Justice Inquiry – Child Welfare Initiative, sometimes referred to in Manitoba as the "devolution" of the CFS system. In order to address inequities and inadequacies within the child welfare system, services were restructured to include off-reserve authority for First Nations.[196] The system is organized under four "authorities": the Southern First Nations Network of Care, First Nations of Northern Manitoba CFS Authority, Métis CFS Authority, and the General Authority. These authorities oversee 24 child welfare agencies which provide services across the Manitoba region. Initial intake and assessment is conducted by 14 "designated intake" child welfare agencies within a defined geographic catchment area.[197,198]

At the end of the intake period, the intake agency does an assessment to determine the most culturally appropriate child welfare authority and any case remaining open is transferred to an agency within that authority for ongoing services. Manitoba policies indicate that families have the right to determine the authority from which they receive services; the Authority assigns the family to an agency. In many cases, this means a child and family are being followed by a local agency within their First Nation. In other cases, it means they are served by workers at an urban office or by another First Nation agency.[199,200] The transfer of cases means that all First Nation child welfare agencies may also serve children living both on and off reserve.[201,202] Accordingly, these agencies receive both provincial and federal funding. The structure of CFS services is summarized in Figure 5.

Manitoba has a high number of Indigenous

children and youth in foster care. As of March 31, 2020, there were 9,849 children in care, 90% of whom were Indigenous.[203] Recent research indicates that, in 2016-17, 14% of First Nation children in Manitoba were in care compared t0 2.0% of non-Indigenous children.[204] Manitoba has the highest rate of children in care of any Canadian province, and nearly 60% of children in care in Manitoba are permanent wards of the state. Annual provincial funding for off-reserve services nearly tripled between 2004 and 2016-17, but there was an 85% increase in the number of children in care between 2006 and 2016.[205]

The limitations on child welfare practice that perpetuate the overrepresentation of Indigenous children in the child welfare system have been explored in a series of reviews and public consultations. Examples of these limitations include the chronic and

Figure 5: The child welfare system in Manitoba[206, 207]

Southern First Nations Network of Care	First Nations of Northern Manitoba Child and Family Services Authority	Metis Child and Family Services Authority	General Child and Family Services Authority
10 Agencies, 4 DIAs	7 Agencies, 3 DIAs	2 Agencies, 1 DIA	8 Agencies, 5 DIAs
Agencies	***Agencies***	***Agencies***	***Agencies***
Animimkii Ozoson Child and Family Services	Awasis Agency of Northern Manitoba	Metis Child, Family and Community Services Agency	Child and Family Services of Central Manitoba*
Anishinaabe Child and Family Services*	Cree Nation Child and Family Caring Agency*	Michif Child and Family Service Agency*	Child and Family Services of Western Manitoba*
All Nations Coordinated Response Network (ANCR)*	Island Lake First Nations Family Services		Jewish Child and Family Services
Dakota Ojibway Child and Family Services	Kinosao Sipi Minisowin Agency*		Rural and Northern Services - Eastman*
Intertibal Child and Family Services*	Nikan Awasisak Agency		Rural and Northern Services - Interlake*
Peguis Child and Family Services*	Nisichawayasihk Cree Nation Family and Community Wellness Centre*		Rural and Northern Services - Parkland
Sagkeeng Child and Family Services	Opaskwayak Cree Nation Child and Family Services		Rural and Nothern Services - Northern*
Sandy Bay Child and Family Services			Winnipeg Child and Family Services
Southeast Child and Family Services			
West Region Child and Family Services			

** Designated Intake Agency (DIA)*

discriminatory underfunding of on-reserve CFS agencies, a lack of culturally relevant supports and services, and limited access to prevention services, amongst others.[208] Public consultations have recommended developing: First Nations led CFS agencies that address needs across the lifespan, education programs to ensure CFS measures are implemented by First Nation workers, and the development of offices that advocate for First Nation children.[209,210,211]

In recent years, there have been several important developments affecting child welfare for First Nation children.

- Starting in 2016, the CHRT issued a series of decisions and orders in response to the *First Nations Child & Family Caring Society of Canada and the Assembly of First Nations v. Canada*. These decisions and orders highlighted the inequitable nature of federal funding for on-reserve child welfare services and ordered the federal government to fund the full cost of on-reserve child welfare prevention services.[212,213,214] In response, the federal government has increased funding to First Nations CFS agencies by 68% since 2016. Nonetheless, a 2018 study found that additional funding was needed in order to support: salaries comparable to those of provincial child welfare workers, anti-poverty programming, universal prevention services, data collection, and infrastructure development.[215,216]
- In January of 2020, the federal legislation *An Act respecting First Nations, Inuit and Métis children, youth and families* came into force. The act specifies the terms under which First Nations, Métis, and Inuit groups and communities that have created their own child welfare legislation may assume jurisdiction over CFS at a pace they choose.[217,218] An AMC analysis comparing the new federal legislation to the *Bringing Our Children Home Act*, Manitoba-specific federal legislation that the AMC Chiefs in Assembly endorsed in 2018, highlighted the ways in the new federal act fails to adequately ensure First Nations control over child welfare.[219]
- In February of 2019, the Manitoba government announced a shift to single-envelope funding, which provides each CFS authority with block child maintenance funding, allowing the flexibility to move provincial funding toward prevention, early intervention, community and kinship involvement, and other positive supports. Agencies participating in a pilot project noted they were forced into deficit spending when the number of children in care spiked and advocated for the development of a contingency fund to cover increased expenditures.[220,221] Available documentation does not indicate the provincial plan for covering the unanticipated costs.[222,223]
- In 2020, Manitoba passed legislation to shield the provincial government from lawsuit around their practice of holding back Children's Special Allowance (CSA). The CSA which provides payments to CFS agencies to support the care, maintenance, education, training, or advancement of the child for whom it is paid. In Manitoba, Indigenous CFS organizations, have been required to remit any CSA funding they received directly to the government of Manitoba.[224,225] AMC has launched a legal challenge the validity of this element of *The Budget Implementation and Tax Statues Amendment Act*.[226]

1.2.4 Services for children living with different abilities

In addition to the services provided through the health, education, and social service systems, specialized services for children with different abilities address important child and family needs. The federal government is fiscally responsible for all disability supports and services available on reserve. Federally funded

programs serving adults and children include the ISC Assisted Living program and the First Nations and Inuit Home and Community Care Program.

Assisted Living funds: transport supports, short-term respite, attendant care, and supports to provide meals and housekeeping.[227,228,229] Home Care is typically provided by a nurse or personal support worker and includes services such as assessment, respite, and referrals.[230] Federal funding can also provide supports for adults who receive care in institutional settings or through foster care programs. A proposal-based diabetes initiative is also available. Funding for the Assisted Living program is insufficient to meet the needs of on-reserve First Nation people. The program operates at a deficit, with documented gaps in: weekend services, transit and out-of-home assistance, respite services, supports to address needs associated with substance use or traumatic brain injury, and palliative care. The lack of culturally relevant services has also been identified as a limitation of the program, and limited information sharing with Nations has presented barriers to fully implementing available funding.[231,232,233,234]

Home Care programming varies across Nations, with specialised services such as rehabilitation, at-home mental health services, and adult day services being offered based on program development in each individual Nation. Concerns have been raised that increasing demand, increasing complexity of needs, challenges in recruitment and training of staff, and the lack of funding to address social determinants of health will present barriers to Home Care access in the coming years.[235]

Tax benefits can also provide limited financial relief to the families of on-reserve children living with disabilities, if they choose to file federal taxes and are able to navigate multiple barriers to accessing benefits. These barriers include: limited access to information about the benefits that are available, difficulty in obtaining or presenting the information required to qualify for the tax credit, service fees and other barriers to disability assessments, and lack of knowledge about the process for applying for benefits.[236,237,238]

The minimal availability of on-reserve supports can force the families of children and youth with disabilities to leave their Nations to seek services in urban areas. In addition, as reflected in provincial VPA policy, placing a child in the care of CFS through a VPA may sometimes be the only option for accessing needed services.[239,240,241]

Off reserve, Children's disABILITY Services (CDS) is a key component of services for children with different abilities. Families accessing services through seven regional offices, spread across Manitoba, are matched with care coordinators who provide recommendations for available services and follow families until their children reach the age of 18.[242,243,a] CDS provides a broad range of services and subsidies ranging from transportation subsidies, funding for products, specialized services and programs including physical therapy (PT), occupational therapy (OT), speech language pathology (SLP), autism services, and in-home or out of home respite supports.[244] However, access to CDS services is limited due to extensive waitlists, particularly in remote or rural regions, and many families are faced with paying for costly private services or entering VPAs with CFS to access necessary services for their children.[245,246] Status First Nation children living on reserve are not eligible for CDS services.[247]

Alongside CDS, additional off-reserve organizations provide supports and services to children with disabilities and their families. For example, St.Amant, the Rehabilitation Centre for Children (RCC), Manitoba Possible, school districts, and health authorities provide a variety of therapy services, including SLP, OT, PT and audiology services.[248] The Specialized Services for Children and Youth Center (SSCY) and the Manitoba Adolescent Treatment Centre (MATC) provide neurodevelopmental diagnostic services.[249,250,251] The provincially administered Disability and Health Supports Unit offers assessment services and approval for medical products; and the Early Learning and Childcare Division provides professional licensing and funding for childcare programs to reduce barriers to services for children with disabilities. The federal government also provides income supports through tax and benefit programs to supplement the incomes of families with low incomes or people who provide ongoing care to family members.[252,253,254,255]

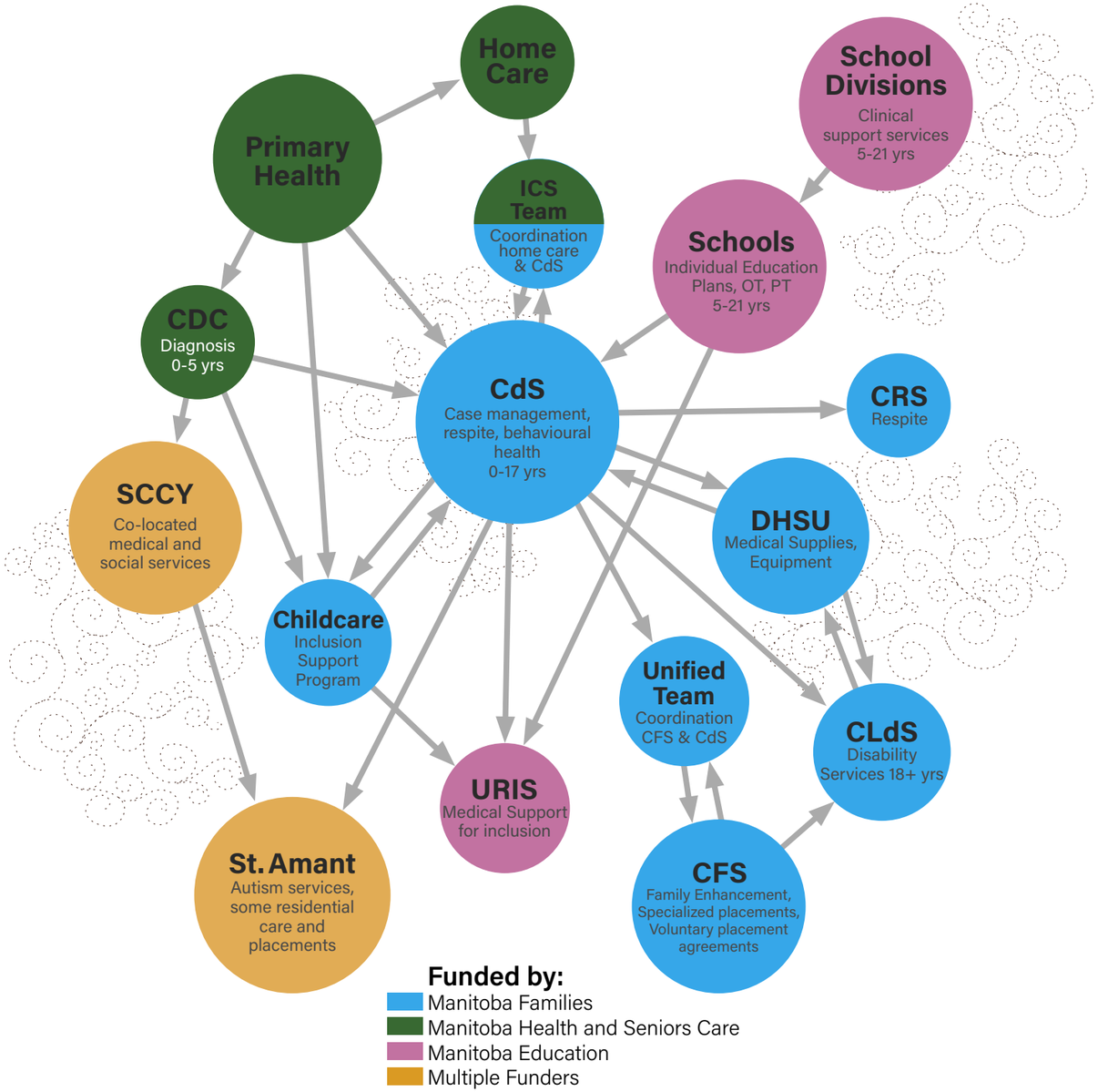
Minimal off-reserve services, such as the co-located medical and social services at the SCCY center and their outreach clinics or Winnipeg based services provided through St.Amant are available to on-reserve families that are able to access services off reserve. However, **many off-reserve services for children with different abilities are not available to on-reserve families. For some services, the government of Manitoba takes the official position, and explicitly notes in policies/standards, that funding for services to status First Nation children living on reserve is the responsibility of the federal government and should be provided through Jordan's Principle. In other cases, services for on-reserve children may be unofficially denied by the province.**[256,257] See Appendix 3 for a province of Manitoba guide on services available to off-reserve children with disabilities.

Off reserve, services for adults with disabilities are minimal and difficult to access. In certain cases, the province funds therapies - such as OT, PT, SLP, and audiology - for which adults must have a referral from a family doctor.[258] Regional health authorities also provide limited homecare services and employment assistance programs.[259] Services provided through the Community Living disABILITY Services program (CLDS) for adults who have "significantly impaired intellectual functioning accompanied by impaired adaptive behavior" include residential and transitional supports, employment support, and on-going assessment and case coordination supports. CLDS services are not accessible to families living on-reserve.[260] For families who can access services in Winnipeg, many of the specialized services St.Amant provides to children are also available to adults.[261,262,263,264] See Appendix 4 for a provincial explanation of off reserve services for adults with disabilities.

The complex web of off-reserve services for children with disabilities is shaped by 12 different provincial acts that address services for children with disabilities and their families. A 2021 Manitoba Advocate for Children and Youth (MACY) report detailed the complexity of service navigation for service providers, families, and their children. Figure 6 depicts the many organizations involved in the case of a single family. MACY recommended the development of legislation and protocols, as well as the allocation of funding, to ensure: continuity of care, flexible and easily accessible respite care, supports for families to access services, and basic rights for children with disabilities. Additional recommendations included review of CSD caseloads, reduction of assessment wait times, and provision of systems navigation support for waitlisted families. The report also called for development of: policies and procedures to ensure the transparency of CDS organizations, a system to regularly collect child and family experiences and adapt policy based on findings, and a plan for collecting accurate data on the needs of Indigenous children in order to ensure the provision of culturally relevant services.[265]

a A March 2021 report from the Manitoba Advocate for Children and Youth indicates that there are currently no data available to a growing number of children are served through the CDS, but there are no statistics available to indicate the number of children receiving CDS services who are First Nations, Métis, or Inuit. CDS indicated it would begin collecting data on children with Indian status as of May 2020.

Figure 6: Example of services involved in the case of a child with complex needs[266]



1.3 Current context – the COVID-19 global pandemic[a]

The current, fragmented system of services for First Nation people poses many challenges to meeting the needs of First Nation children. During the period of data collection during this study, these challenges were compounded by the COVID-19 pandemic.

The COVID-19 respiratory virus was discovered in Wuhan, China in 2019 and quickly spread across the globe.[267,268] On March 12th, the Manitoba government confirmed presumptive cases in the province and by March 20th a state of emergency was declared.[269] First Nations across Manitoba responded quickly to COVID-19. Some Nations went into lockdown as early as the following week. Other measures included the imposition of travel bans and independent collection and monitoring of COVID 19 data.[270,271,272] Despite the proactive public health measures, by May 5th, 2021, First Nation people – who comprise 15% of the total Manitoba population – represented 35% of active cases in the province.[273,274] The elevated COVID-19 infection rates in First Nations reflect long-term historical patterns. First Nation people have increased risk of contracting communicable diseases as a result of settler colonial and ongoing discriminatory policies that have undermined local economies and food security, impacted Nations' capacities to deliver health services and trust in health services, and created unmet needs by contributing to a high prevalence of underlying medical conditions, underfunding of health centres, and failing to ensure access to essential services, safe drinking water, or adequate housing.[275,276,277,278,279,280,281,282]

For First Nation children and families living on reserve, the impact of COVID-19 has been severe. Some schools have been closed for close to a year.[283] Many off-reserve organizations that typically provided on-reserve services through a mix of in-person and distance services transitioned to exclusively offering services through online platforms, telehealth, and phone.[284,285] As a result of the shift to remote services, interviewees noted: delays in service provision; disruptions of services because of technological challenges and unreliable internet and telephone service; limitations in specialized services such as assessment; and difficulties building trust with children and families.[286,287,288,289,290,291,292] Supporting families who required access to off-reserve services was also complicated by the COVID-19 pandemic, which necessitated coordination of transport, off-reserve accommodations, and quarantine accommodations when families returned to their homes.[293,294,295,296,297]

Staff working within the Nations were required to shift and expand their work to adjust to the changing pandemic-related conditions. One Jordan's Principle Case Manager described the urgency of the situation in her Nation.

> *We are in a crisis here ... in a complete lockdown where nobody will be able to leave the house and so we're kind of in an urgent state to make sure we have enough supplies in the community for our babies and our children.*[298]

Another Case Manager described the services being implemented in their Nation in response to COVID-19 measures.

> *Right now, our water treatment plant is down. There is shortage of essentials for families ... We need to take care of their spirituality, mental wellness, emotional wellness and the physical wellness. At this time, I have a group of people cutting wood and collecting grandfather*

a This section of the report draws on data spanning the Spring of 2020 to the Spring of 2021; the contexts within Nations have shifted rapidly since the beginning of the pandemic and continue to evolve.

rocks with the youth and holding sweat lodge ceremonies ... for their mental wellness and physical wellness ... We are looking at this time as COVID-19 as a time given to us by Creator to be able to do this. We have made home visits to be able to support expectant mothers and their families to be able to provide for respite. We have also made health packages ... Our youth need help and Every Child Matters. We need to keep them busy ... For Halloween we are having at home decorating outside the homes contest again for family bonding and participation ... Right now, all the moose hunters are out and, along with Jordan's Principle and the school, we will be cutting the moose meat with the students. We will also be looking at a community fish fry. As well we asked one of the moose hunters to bring back the moose hide so that we can make leather ... children youth and adult bonding is important. During this time, we will be speaking our language around the children and youth.[299]

Attempts to address the COVID-19 pandemic were complicated by a lack of the necessary infrastructure to ensure basic social determinants of health, such as a reliable water source. An interviewee discussed pandemic planning without access to a reliable water supply.

> *We are facing many challenges. We have had no water. Our school is closed right now ... During COVID-19 we are at state of urgent care, especially for the youth mental wellness ... What are we doing for them to understand their mental wellness needs, many at six years old and up, are unable to read therefore they come to school with frustration and behavioural issues? ... How can the therapist help at this level? Because of this, we need a number of people of our own to be able to work with the unmet needs.*[300]

Thus, the COVID-19 pandemic amplified pre-existing challenges faced by First Nations in Manitoba, highlighting the interconnectedness of different types of services and the ways in which underlying infrastructure challenges constrain abilities to meet the need of children and families.

Chapter 2:

The Implementation of Jordan's Principle in Manitoba

Jordan River Anderson was a citizen of Norway House Cree Nation, where his parents lived at the time of his birth. Jordan was born in Winnipeg in October of 1999. He was born with a complex genetic disorder and severe developmental delays which required a tracheotomy, ventilator dependence, and a gastrostomy tube. He was formally diagnosed with Carey-Fineman Syndrome and, as a result of his medical needs, he remained in the Children's Hospital – Health Sciences Centre following his birth.

In 2001 medical officials deemed Jordan could leave the hospital if it was possible to secure placement with foster parents who were trained to support his medical needs and lived in Winnipeg, in close proximity to the hospital, in case he needed to access immediate medical attention. Jordan's family entered into a VPA, placing him in the care of Kinosao Sipi Minisowin child welfare agency so that the agency could help facilitate Winnipeg-based supports and family visits.

However, there were disputes between the province and the federal government over responsibility for the costs associated with

Jordan's daily care. His parents were deemed to live "on reserve" when Jordan was placed under a VPA and, accordingly, responsibility for services could be seen as resting with the federal child welfare program operated by the Department of Indian and Northern Development (DIAND, now known as ISC). However some medical related costs, such as tubing for feeding, special formula, and on-going medications, could also be seen as a fiscal responsibility of the federal First Nations and Inuit Health Branch (FNIHB). Manitoba Family Services, which is mandated to provide CFS for all children in care of the province, and Manitoba Health, which has responsibility for insured health costs, could also be seen as having responsibility. Kinosao Sipi Minisowin would not have him discharged from hospital into a foster home without knowing that the costs of his care would be covered and hospital officials grew frustrated knowing that Jordan was unnecessarily being held in hospital.

By late 2002 or early 2003, hospital staff, who were concerned that Jordan was being denied the opportunity to be released from hospital to a foster home, contacted the Manitoba Children's Advocate office for assistance. The Children's Advocate intervened without success and subsequently contacted the AMC for support. While the federal and provincial governments were disputing the costs of his care, Jordan died, in Winnipeg, on February 2nd, 2005. He never had a chance to live outside of the hospital because of jurisdictional disputes over who was responsible to pay for his care. Jordan's Principle honours the legacy of Jordan River Anderson by calling for every First Nation child to receive needed services without denial, delay, or disruption.

In this chapter we briefly trace the history of Jordan's Principle, in the Manitoba context, and outline the process of implementing Jordan's Principle as it exists in Manitoba today. Considering the current approach to Jordan's Principle in Manitoba within the context of long-term, ongoing advocacy by First Nations, we outline a persistent pattern in which:

1. First Nations in Manitoba have called for a systemic approach to developing First Nations led, locally available services and for the capacity development needed to achieve this system, and
2. The federal government has responded with denials of funding, or with short-term funding, to meet the needs of individual children.

The implementation of Jordan's Principle in Manitoba has, in important ways, defied the federally imposed pattern of a demand-driven, individualized approach to services. Instead, it has laid the foundation for a new, more systemic approach to services for First Nation children.

2.1 First Nations' Advocacy and Jordan's Principle prior to 2016

First Nations in Manitoba have long advocated for a self-determined approach to ensuring the physical, mental, social/emotional, and spiritual wellbeing of First Nation children. First Nations' advocacy has prioritized the development of systems of services rather than a case-by-case approach to addressing the needs of specific children.[301,302,303,304] The current implementation of Jordan's Principle in Manitoba reflects the ongoing advocacy by First Nations. Though a thorough historical accounting is beyond the scope of this report, a small sample of case studies of First Nations' advocacy efforts are described in Appendix 5. These examples start in the mid-1990s and extend up to 2016. Timeline 1 summarizes AMC resolutions, passed between 2001 and 2014, that endorsed a systemic approach to services.

Advocacy for the full implementation and the meaningful participation of First Nations in the implementation of Jordan's Principle was central to ongoing efforts to achieve a systemic approach to addressing the needs of First Nation children in Manitoba. An outline of key events in the implementation of Jordan's Principle in Manitoba, between 2007 and 2016, is also included in Timeline 1. Jordan's Principle, as it was initially articulated, stated that when a First Nations child required services, the government or department to which the request was originally made should pay for or provide the needed services without delay.[305] Since its inception in 2005, Jordan's Principle has been championed by Jordan's family, Norway House Cree Nation, and other First Nations and First Nation organizations, such as the First Nations Child and Family Caring Society (the Caring Society). The Principle also received strong support from First Nation, Canadian, and international bodies and, in 2007, the House of Commons unanimously endorsed a resolution in support of Jordan's Principle.[306,307,308,309,310]

In response, the federal government adopted a narrow interpretation of Jordan's Principle that only applied to children who:

- Had been professionally assessed as having multiple disabilities,
- Required services from multiple providers,
- Were ordinarily resident on-reserve, and
- Requested services that were comparable to existing provincial services in a "similar geographic" location.[311]

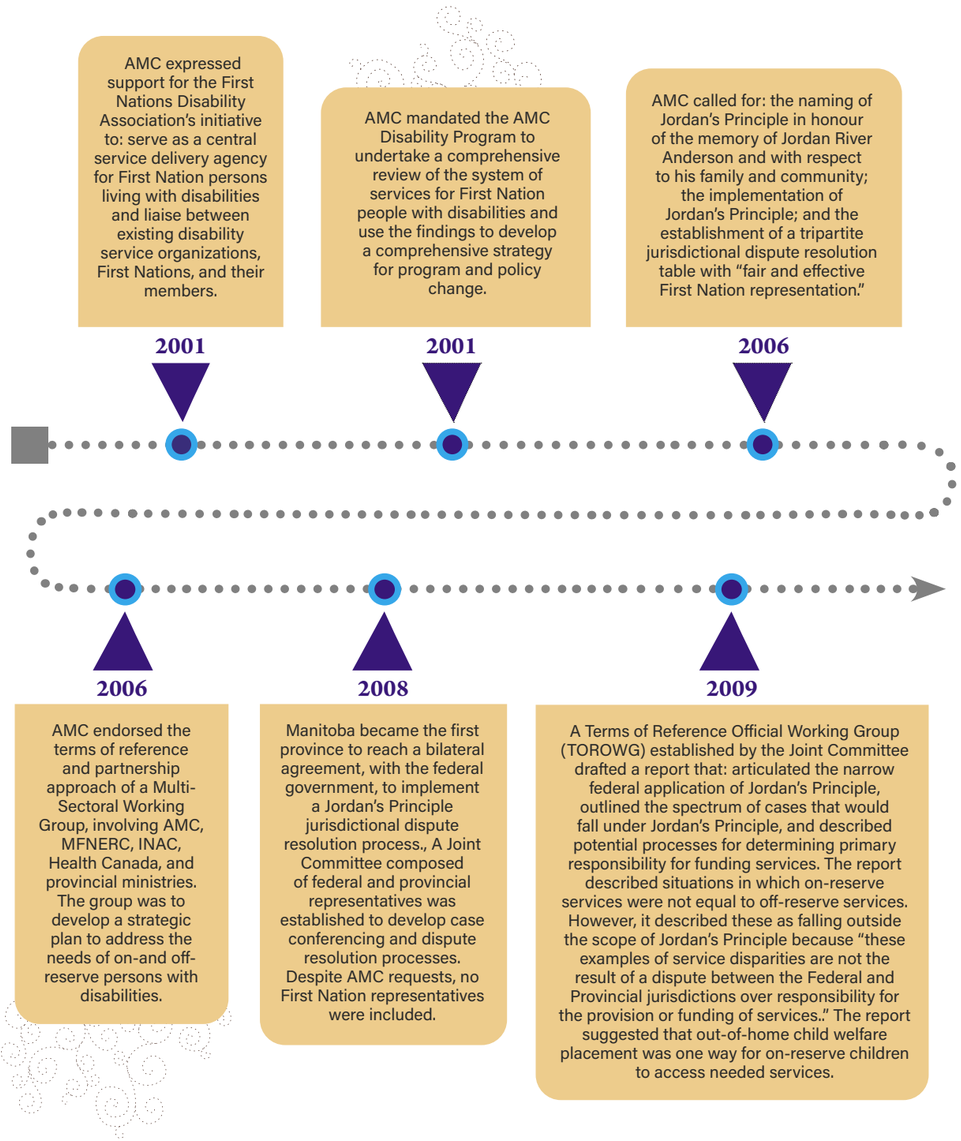
A case that met these strict criteria had to pass through a lengthy, eight-step case conferencing process in order to be recognized as a Jordan's Principle case by federal and provincial/territorial governments.[312] The impact of the restrictive definition was that, between 2008 and 2012, not a single child in Canada accessed federal funding allocated to resolve jurisdictional disputes in Jordan's Principle cases.[313,314] The restrictive definition also allowed the federal government to assert—in 2010, 2012, and 2015— that it knew of no Jordan's Principle cases in Canada, despite ongoing reports indicating that jurisdictional disputes continued to impact children's care.[315,316,317]

The implementation of Jordan's Principle in Manitoba was shaped by the narrow federal approach to Jordan's Principle.[318] Attempts to facilitate the broader implementation of Jordan's Principle within Manitoba included the drafting of provincial legislation; *The Jordan's Principle Implementation Act*.[319] The bill would have affirmed the right of First Nation children to receive the best health care and social services, on a timely basis, in their homes or Nations. The bill was introduced three times between 2008 and 2010, but never proceeded beyond a first reading in the legislature.[320,321] Accordingly, the implementation of Jordan's Principle continued within the narrow parameters outlined by the federal government.

2.2 Jordan's Principle as interpreted by the CHRT– 2016-present

The federal approach to implementing Jordan's Principle in Manitoba began to shift as a result of a series of CHRT decisions in 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 poor administration of on-reserve child welfare services constituted systemic discrimination against First Nation children.[322] The failure to implement Jordan's Principle was identified as one component of the ongoing discrimination against First Nation children in child welfare services.[323] The federal government fought the case on technical grounds until 2013, and the first decision in the case was released in 2016.[324]

Timeline 1: First Nation advocacy and early implementation of Jordan's Principle[325]



Timeline 2 – Key CHRT decisions and federal response[326,327,328]

January 2016 – CHRT 2
CHRT orders Canada to cease discriminating against First Nation children through inequitable and insufficient funding of child welfare services, and to cease applying a narrow definition of Jordan's Principle.

April 2016 – CHRT 10
CHRT orders Canada to take immediate measures to address the findings of the previous decision, including considering Jordan's Principle to include all jurisdictional disputes and all First Nation children.

July 2016 – Federal funding announcement
Canada's first compliance report includes commitment to $382 million in funding to broaden the scope of Jordan's Principle, and deliver service coordination services for First Nation families.

September 2016 – CHRT 16
Canada ordered to fund First Nation Child and Family Service Agencies based on actual service needs rather than estimates, and to immediately apply Jordan's Principle to all First Nation children, not only those living on reserve and with multiple disabilities.

November 2016 – House of Commons Motion to comply with CHRT
Federal MP Charlie Angus calls on government to comply with CHRT rulings and motion passes unanimously, across party lines.

November 2017 – CHRT 35
Ruling amended with agreement from all parties to clarify that clinical case conferencing is permitted while administrative conferencing cannot delay service delivery. Timeline amended to 12hrs for urgent requests, 48hrs for non-urgent requests and urgent group requests, and 1 week for non-urgent group requests. Canada subsequently drops judicial review request.

February 2018 – ISC announces new 24hr Jordan's Principle Hotline
Hotline advertised on government websites in addition to phone numbers for provincial focal point contacts.

February 2019 – CHRT 7
CHRT orders Canada to provide Jordan's Principle funding to First Nation children who live off-reserve, do not have *Indian Act* status, and are recognized by their Nation as members.

March 2019 – Federal Budget released
Federal budget proposes $1.2 billion of funding for the next three years. No details are provided surrounding the allocation of funds.

June 2019 – Bill C-92 receives royal assent
Bill C-92, *An Act respecting First Nation, Inuit, and Métis children, youth and families* receives royal assent. The bill outlines the purpose and principles that are integral to the provision of child welfare to First Nation, Inuit, and Métis children and families.

September 2019 – CHRT 39
The CHRT orders Canada to compensate First Nation children and their caregivers who were affected by Canada's discriminatory child welfare practices. Children and caregivers who were denied Jordan's Principle requests also qualify for compensation.

October 2019 – Federal election
A minority federal government is elected. During the campaign the federal government files an appeal requesting review CHRT 39 to review the compensation for First.

November 2019 – Federal court dismisses appeal of CHRT 39
The Federal Court of Appeal dismisses federal attempts to stay CHRT 39. The federal government is required to determine compensation for children and families impacted by the child welfare system.

July 2020 – CHRT 20
The CHRT ordered Canada to expand eligibility for Jordan's Principle, to include: First Nation children who are eligible for *Indian Act* status under S-3 reforms; First Nation children without status recognized by their Nations as members, and children ineligible for status who have a parent/guardian who is status-eligible.

November 2020 – CHRT 36
The CHRT clarifies eligibility, stipulating First Nation have the authority to recognize the children that qualify for Jordan's Principle. In urgent cases, when Canada cannot contact the Nation, the child's services will be covered to resolve the imminent risk. Further, the CHRT states that Jordan's Principle is not a fixed budget program but a legal obligation for which funding will continually expand with the number of eligible children.

December 2020 – Application for judicial review of CHRT 20 and CHRT 36
Canada filed an application for judicial review of the CHRT decisions 20 and 36 regarding Jordan's Principle eligibility.

February 2021 – CHRT 6 and 7
The CHRT approves a final compensation framework, awarding compensation to First Nation children and family members who were affected by discriminatory conduct within child and family services on reserve, such as First Nation children who were removed from their homes, did not receive services, or experienced unreasonable delays due to the previous narrow interpretation of Jordan's Principle.

March 2021 – CHRT 7
The CHRT orders Canada to provide Jordan's Principle funding to First Nation children who live off-reserve, do not have *Indian Act* status, and are recognized by their Nation as members.

August 2021 – CHRT interim letter - decision
The CHRT orders Canada to fund capital assets for the delivery of First Nation child and family services and supports under Jordan's Principle.

September 2021 – Dismissal of application for judicial review
The federal court dismisses Canada's applications for judicial review of CHRT decisions on compensation and Jordan's Principle eligibility.

October 2021 – Appeal of federal court decision upholding CHRT 39 and decision to pursue settlement
Canada files to appeal the federal court decision upholding CHRT 39, then announces it will pause the appeal and pursue a global resolution regarding compensation, Jordan's Principle eligibility and other issues.

November 2021 – CHRT 41
The CHRT released final reasons for its August letter-decision orders on funding capital assets related to First Nation child and family services and Jordan's Principle.

In 2016, the CHRT ruled that Canada discriminated against First Nation children through its funding and administration of child welfare services. Between April of 2016 and March of 2021, the CHRT issued more than 15 additional orders clarifying decisions and responding to Canada's continued failure to comply with the Tribunal's orders.[329] These orders required Canada to develop revised child welfare funding and administration policies. They also required Canada to provide funding that corresponded to the "real needs of First Nations [CFS] agencies" including, but not limited to: infrastructure repair, prevention services, assessment, service gaps, and costs associated with remoteness.[330,331,332] The CHRT orders, as well as key federal responses are summarized in Timeline 2.

The CHRT also ordered Canada to immediately adopt the full scope of Jordan's Principle.[333] Subsequent orders specified that Jordan's Principle:

- Applies to all First Nation children, regardless of ability, disability, or their residence on or off reserve.[334,335]
- Requires the federal government to provide funding in cases of emergency involving First Nation children, living off reserve, without status, including children who are ineligible for First Nation status.[336]
- Requires that the federal government address the needs of First Nation children by ensuring there are no gaps in the government services provided to them.[337,338]
- Applies to a broad range of health, education, and social services including, but not limited to "mental health, special education, dental, physical therapy, speech therapy, medical equipment and physiotherapy."[339,340]
- Requires the government department of first contact to pay for a government service or assessment that is "available to all other children" and do so "without engaging in administrative case … conferencing, policy review, service navigation or any other similar administrative procedure before the recommended service is approved and funding is provided."[341]
- Requires the government department of first contact to pay for a government service or assessment that is "not necessarily available to all other children or is beyond the normative standard of care." Further requiring that "the government department of first contact will still evaluate the individual needs of the child to determine if the requested service should be provided to ensure substantive equality in the provision of services to the child, to ensure culturally appropriate services to the child and/or to safeguard the best interests of the child." Provincial and federal government officials may engage in administrative case conferencing, policy review, service navigation, or other administrative procedures only after services are approved and funding provided.[342]
- Applies to a broad group of First Nation children including: (1) children, residing on or off reserve, who are recognized by a First Nation as belonging to their community; (2) children who neither have nor are eligible for *Indian Act* status, but have a parent who has or is eligible for *Indian Act* status. The Federal government sought judicial review of this decision, and the Federal Court recently upheld the CHRT decision on eligibility for Jordan's Principle.[343]

The CHRT's linking of Jordan's Principle to "substantive equality" means that full implementation of Jordan's Principle may necessitate provision of services that extend beyond normative standards of care.[344,345] Substantive equality is a legal principle that, in certain cases, may require provision of additional services to groups who experience unique disadvantages so that they may achieve equivalent outcomes.[346] In the CHRT orders on Jordan's Principle, the focus on substantive equality shifts the goals of Jordan's Principle beyond simply ensuring access to equal services and necessitates the development of mechanisms for responding to the needs, culture, and best interests of First Nation children. The Touchstones of Hope—that include the values of self-determination, culture and language, a holistic approach to meeting the needs of children, structural interventions, and non-discrimination- which were originally defined as key to achieving reconciliation in child welfare, have also been integrated into the federal government's understanding of substantive equality.[347]

The CHRT also established a timeline for assessing Jordan's Principle requests. The government must respond to a Jordan's Principle request for services for an individual child within 48 hours of an initial request for services and within 12 hours for urgent requests.[348] Consultation or case conferencing is permitted only if needed to determine a child's clinical needs. The federal government is required to respond within 12-48 hours of receiving all necessary clinical information and must ensure that it responds "as close to the [initial] 48-hour time frame as possible."[349,350] Responses to group requests, which provide funding for services to address the needs of multiple children, are required within 48 hours for urgent cases and one week for non-urgent cases.[351]

The CHRT exercises ongoing oversight of response to orders in Caring Society and AFN v. Canada. In November, the CHRT issued a detailed explanation of an August letter-decision specifying, among other things, that the federal government must fund capital expenses required to "support the delivery of Jordan's Principle services on-reserve."[352,353] Recent actions include federal government appeal of a federal court decision upholding a CHRT ruling on compensation to First Nation children and families denied services, and subsequent government announcement that it will pause the appeal while pursuing a settlement.[354]

2.3 Emergence of the current approach to Jordan's Principle at the national level

Following multiple orders and on-going CHRT monitoring, the federal government slowly began incorporating the CHRT's criteria for Jordan's Principle eligibility and timelines in its implementation of Jordan's Principle.[355] In July of 2016, the federal government announced the creation of the Jordan's Principle Child-First Initiative (CFI), and initially allocated $382.5 million to support the initiative between 2016-19.[356]

The CFI included funding for a Service Access Resolution Fund, which was to pay for services for individual children approved under Jordan's Principle and for Jordan's Principle group requests, for funding to address service gaps affecting large numbers of children.[357,358] The CFI also included federal funding for an "Enhanced Service Coordination model of care," under which organizations in each province and territory would receive funding for Service Coordinators to help families to navigate existing federal and provincial services.[359,360,361] The initial announcement of the CFI reflected a continued, narrow approach to Jordan's Principle, focusing on ensuring that "children with a disability or interim critical condition living on reserve have access to needed health and social services within the normative standard of care in their province/territory of residence."[362]

Building on the initial announcement of the three-year CFI, the federal government described their plans for the long-term implementation of Jordan's Principle as a "phased approach."[363] The first, transitional phase involved continued funding of Enhanced Service Coordination, First Nations service delivery, and innovation in service delivery. The

first phase also involved seeking a mandate and funding from Cabinet for consultation with First Nations. The goal of the second phase was described as the "implementation of a First Nation vision for Jordan's Principle based on the results of First Nations-led dialogue sessions, including funding needed to fill persistent gaps in service." [364]

In line with phase one, the 2019 federal budget allocated $1.2 billion over three years for Jordan's Principle, and Jordan's Principle funded organizations had their funding renewed for the 2019–20 fiscal year.[365] However, federal projections taking into account the tripling of Jordan's Principle requests during the 2017–18 year estimated $840.5 million would be required to adequately fund nationwide Jordan's Principle requests in 2019–20 alone, concluding that if demand continued to grow as estimated, an additional $1.3 billion would be required over three years.[366]

Publicly available budget information indicates expenditures of $392 million in 2018-19, including administrative and operational costs, and $561 million in 2019-20; planned spending projections indicated a reduction in funding in 2020-21, with projected spending at $436 million, rising only slightly to $446 million in 2021-22 and $494 million in 2022-23.[367] Available budget information, reported in Figure 7, indicates that expenditures increased dramatically between 2018 and 2020, and requests for Jordan's Principle funding also increased quickly. These costs quickly extending beyond the funds originally allocated in year three of the CFI.[368] Yet, projected spending for 2020-21, was $436 million, rising only slightly to $446 million in 2021-22 and $494 million in 2022-23.[369] In early 2021, when we collected this budget information, we could find no public information about funding beyond 2022-23, nor any public documentation of the progress towards phase two of the implementation of Jordan's Principle.

2.4 Emergence of the current approach to Jordan's Principle in Manitoba

In Manitoba, response to the federal announcement of the Jordan's Principle CFI proceeded along two streams. One stream of action was centred in the regional FNIHB office and led by the Jordan's Principle Regional Coordinator. His approach was influenced both by his prior experience working as a Home Care director in a First Nation and by his work with Pinaymootang First Nation as they sought funding for and established a program to support children with special needs and their families. A parallel stream of action was centred in regional First Nation organizations, which continued to advocate for a First Nations led, systematic approach to services. See Timeline 3 for a summary of events.

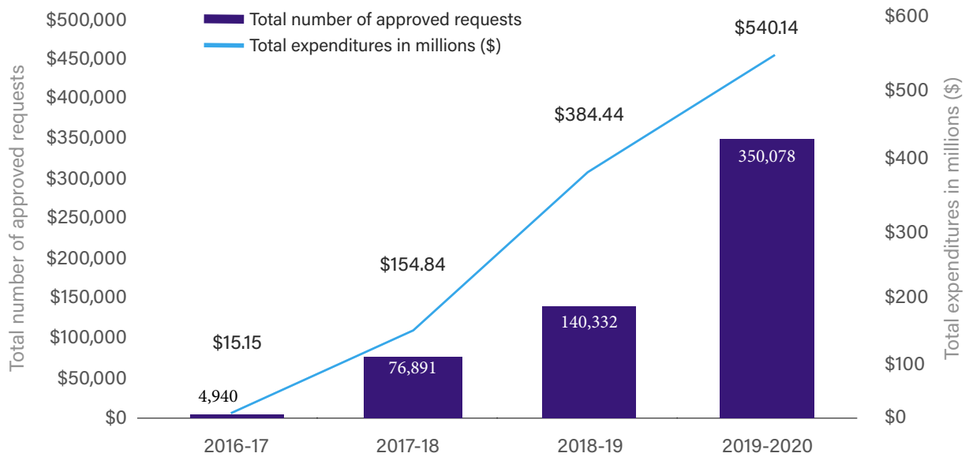
2.4.1 Developing the current Jordan's Principle service structure

During initial consultations between FNIHB and AMC, AMC advocated for an encompassing approach in which Jordan's Principle funding would address the education, health, housing, and social service needs of children and their families.[370] After initial consultations with AMC, the regional FNIHB office acted quickly to ensure that First Nations in the Manitoba region could take advantage of the time-limited funds dedicated to the CFI. Even as they began taking action, the FNIHB regional office's approach to Jordan's Principle was evolving in line with CHRT rulings, shifting from one focused on children with special needs and responding to First Nations requests, to a more expansive approach focused on meeting the needs of First Nation children.[371]

The FNIHB Regional Jordan's Principle Coordinator initiated a long series of consultations to support First Nations in developing Jordan's Principle requests. He also began to take stock of existing organizations that might be able to provide centralized allied health (SLP, OT, PT, and audiology), mental health and wellness services. The goal was to ensure that all First Nations had equal opportunity to receive these services, and to reduce expenses.[372] AMC continued to advocate for the full implementation of Jordan's Principle, and for more specific developments, such as designation of Eagle Urban Transition Centre (EUTC) to lead service coordination, and the revival and implementation across

Manitoba of the Awasis Agency/Norway House Cree Nation Children's Special Services Program.[373,374]

Figure 7: Approved requests for products and services, and expenditures by fiscal year – all of Canada (2016/17-2019/20)[375,a,b]

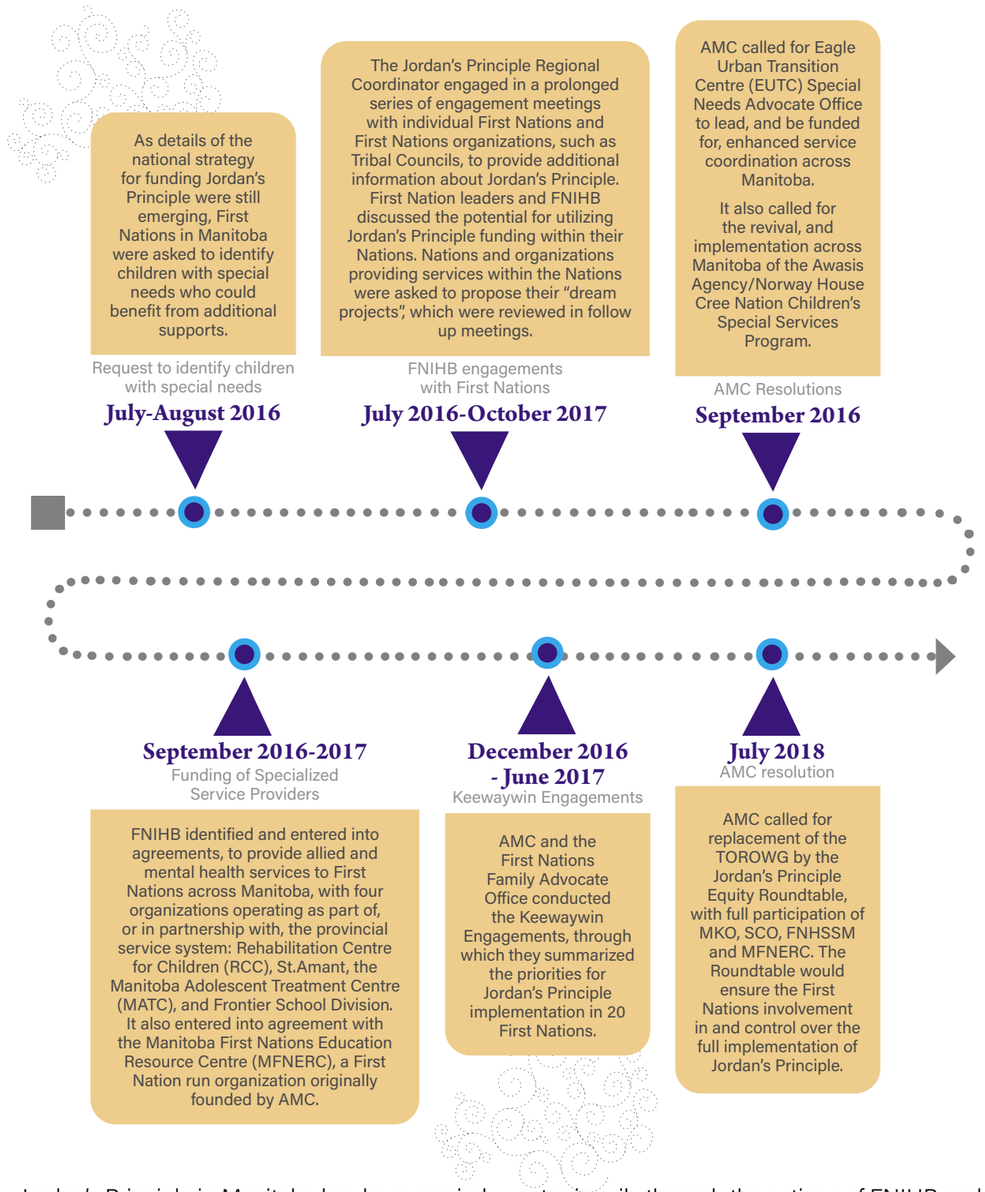


These processes led to the development of the current structure of Jordan's Principle in Manitoba. The services and supports provided through Jordan's Principle are new patches in the patchwork of service described in Chapter 1. As discussed in Chapter 6, there can be substantial collaboration between individual staff members or between organizations providing services through Jordan's Principle and service providers within the pre-existing structure for health, education, and social services. However, the implementation of

a Approved Inuit individual requests and community managed requests from Nunavut are not included in the number of approved requests.

b FY 2016-17 includes November 1, 2016 (when the first contribution payment for Jordan's Principle was paid out) to March 31, 2017.

Timeline 3: The initial implementation of Jordan's Principle in Manitoba[376]



Jordan's Principle in Manitoba has been carried out primarily through the actions of FNIHB and First Nations, independent of the pre-existing systems of services described in Chapter 1.[c] The First Nations and regional level programs[d] and services established through these early processes included:

- First Nations developed programs implemented at the First Nations level;
- A system of region-wide allied health and mental health/wellness supports provided by Specialized Service Providers that are headquartered in Winnipeg and may also have teams that travel to First Nations from smaller urban centers (such as Brandon or Thompson);
- Service-coordinators to support First Nation families in accessing services off-reserve, including support in accessing Jordan's Principle funds to address the needs of individual children; and
- Additional, regional initiatives that focus on addressing specific gaps in services and support First Nations engagement with Jordan's Principle.

2.4.2 Envisioning and advocating for a systemic approach

Alongside the rapid development of Nation-level Jordan's Principle programs and the extension of SSP services on-reserve, regional First Nation organizations continued to advocate for a First Nations led, systematic approach to provision of services. In September of 2016, as FNIHB was pursuing initial implementation of the Jordan's Principle CFI, AMC proposed and received funding to support First Nations engagement around Jordan's Principle. Between December 2016 and June 2017, AMC and the First Nations Family Advocate Office conducted the Keewaywin engagements, through which they summarized the priorities for Jordan's Principle implementation in 20 First Nations. The result was the broad set of recommendations that are summarized in Textbox 2. As summarized in Figure 8, participants also reaffirmed the long-standing commitment to a systemic approach to service provision, reiterating the commitments—to First Nations leadership, a holistic approach, local access to services, and long-term funding-—that were articulated in proposals dating back at least to the 1990s.[377,378]

At the same time that it proposed the Keewaywin engagements, AMC called for the restructuring of the Terms of Reference Official Working Group (TOROWG), which was established by the federal and provincial governments, in 2009, to oversee implementation of Jordan's Principle. The TOROWG continued to function through 2016, with First Nations participants in these meetings calling for restructuring to promote greater First Nations leadership and more meaningful engagement with First Nations across Manitoba. They also called for an approach that more systematically responded

c In this chapter, we focus on the structure of Jordan's Principle within Manitoba, but implementation within Manitoba is partially shaped by a complicated Jordan's Principle structure at the National level. The national level structure includes both the JPAT and the JPOC. These national-level tables, are comprised of different representatives who have advisory responsibilities surrounding the implementation of Jordan's Principle. AFN issued a resolution calling for clarification of roles/responsibilities for these two groups and extension of JPOC membership to include regional First Nations representation, but the results of that resolution are not clear.

d In order to address the needs of First Nation children and families, and in keeping with the CHRT's delineation of Jordan's Principle as a legal obligation that must be continually upheld, First Nations are working to establish long-term, sustainable service programs. Accordingly, we use the term 'program' to describe Jordan's Principle funded services throughout the remainder this report. However, we note that, because of its initial classification as an initiative, Jordan's Principle continues to be funded in a way that is more commonly used to support short-term 'projects.'

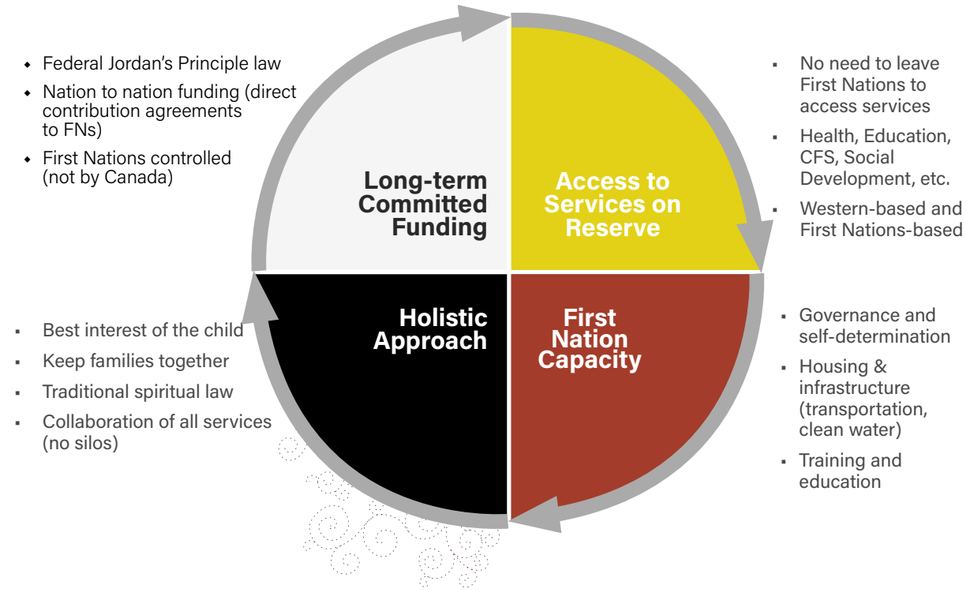
Textbox 2: Keewaywin (2018) recommendations for long-term Jordan's Principle implementation[379]

1. Restore First Nations' jurisdiction of children, especially in areas such as family law, health services and social services, and draft Jordan's Principle 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 apprehensions at all costs.
3. Establish a Jordan's Principle resource program and service medical centre in each First Nation to build capacity and 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 Jordan's Principle 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 Jordan's Principle 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 Jordan's Principle 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 Jordan's Principle using recommendations contained in this report.

to needs identified by all First Nations and for the development of a sustainable First Nation service delivery model.[380,381] At an April 2017 meeting of the TOROWG, the AMC, in collaboration with representatives from the MKO, SCO, MFNERC and FNHSSM, proposed that the TOROWG be restructured. Representatives from INAC (now ISC) and FNIHB agreed.[382]

A group known as the Jordan's Principle Technical Advisory Group (TAG), including AMC, MKO, SCO and FNHSSM began meeting regularly in place of the TOROWG until a new, formal governance structure could be put in place. In July of 2019 an AMC resolution called for replacing the TOROWG with the Jordan's Principle Equity Roundtable. The Roundtable was intended to facilitate regional level coordination and oversee the full implementation of Jordan's Principle.[383]

Figure 8: Manitoba First Nations approach to Jordan's Principle implementation[384]

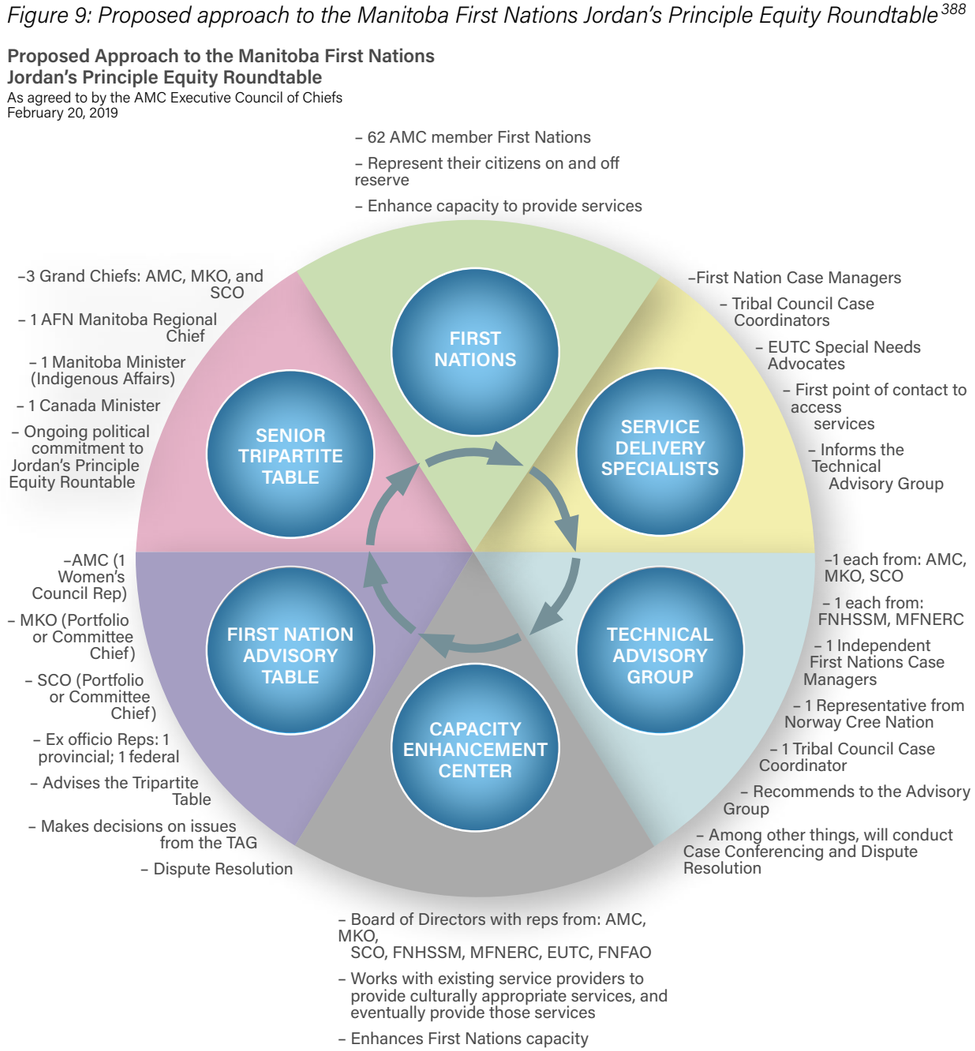


As depicted in Figure 9, the Roundtable was to incorporate multiple, distinct, but interconnected forums. Some were to focus on addressing challenges in day-to-day service provision, while others would allow key stakeholders to consider long-term governance and funding questions surrounding the implementation of Jordan's Principle. Through these activities, the Equity Roundtable would seek to ensure that First Nations were involved in and maintained control of Jordan's Principle in Manitoba. Alongside development of plans for a new governance structure, the AMC Jordan's Principle Service Coordination team outlined a work plan designed to follow up on the recommendations in the Keewaywin Engagement and, receiving approval from the AMC Women's Council, began work to implement the plan and establish the Equity Roundtable.[385] AMC's work to develop and implement the Equity Roundtable was slowed by staff turnover and, in the interim, a parallel group that initially brought together Jordan's

Principle Service Principle Service Coordinators employed by Tribal Councils (Tribal Council Service Coordinators; TSCs) and representatives from the FNIHB regional office began informally meeting. Over time, SSPs and some independent Nation representatives were also invited to join this group. The group, which was informally known as the TSC/ISC/SSP group, began work on a regional agenda similar to that outlined in the AMC Jordan's Principle service coordination work plan.[386,387,e]

e We hoped to include details of the Terms of Reference for this group but were unable to obtain formal documentation of the group's membership or mandate. Informal conversations indicate that the TSC/ISC/SSP group is a decentralized group that originally emerged out of collaborations between TSCs and has evolved over time, in accordance with member expertise, focus and turnover.

Figure 9: Proposed approach to the Manitoba First Nations Jordan's Principle Equity Roundtable[388]



By spring of 2019, the AMC Jordan's Principle Service Coordination Unit drafted a proposal entitled Support for a Manitoba First Nations Capacity Enhancement Centre (CEC) for submission to ISC.[389] The proposal sought resources for completion of the Jordan's Principle service coordination work plan, and for the development of the knowledge and capacity needed to transition to a First Nation led system of services for First Nations in Manitoba. The details of this proposal are outlined in Textbox 3.[390] The national Jordan's Principle office declined to fund that proposal and also declined funding for a similar proposal submitted by AMC in April 2020.[391] In September of 2020 the Executive Director of Jordan's Principle (ISC) wrote to AMC offering support for a much narrower scope of work. He noted that, "to support a phased approach, we are recommending that we support AMC to develop a Case Management model." The communication noted the need for engagement with First Nations and Tribal Councils and framed the focus on case management as "a concrete step in increased First Nation control over the Jordan's Principle service delivery model in Manitoba."[392]

In response, AMC began work to understand what a First Nation developed case management model could do and look like, while also continuing to pursue the items on the Jordan's Principle service coordination work plan and potential development of a CEC. The Senior Tripartite Table and the First Nations Advisory Table, which are central to the planned Equity Roundtable, have not yet officially met because of time and human resource issues related to the COVID-19 pandemic.[393] The TAG has continued to meet, but has evolved significantly. During the period of COVID-19 related restrictions, TAG meetings were expanded to include Jordan's Principle Case Managers and transformed into a forum for Case Managers to meet and discuss developments and concerns, share information, and make collective progress towards addressing policy issues and shared interests.[394,395] The TSC/ISC/SSP group also continued to meet and to discuss parallel concerns.[396] This group briefly expanded its meetings to include AMC and FNHSSM representatives in the fall of 2020 before suspending meetings in December of 2020 because of COVID-19 related time and workload issues.[397]

Textbox 3: Support for a Manitoba First Nations Capacity Enhancement Centre (CEC)[398]

AMC's CEC funding request included support for the following positions, for the fiscal years 2019-23:

- **A Jordan's Principle Relations Specialist** – To liaise and further develop relationships with First Nations; First Nation organizations; service providers and federal/provincial governments.
- **Two Policy Analysts** – To assist AMC in analyzing qualitative and quantitative data to identify needs and best practices, and to support decision-making around services for First Nation children in Manitoba.
- **Repatriation Coordinator** – To liaise and further develop relationships with Manitoba First Nations; First Nation organizations, specialized service providers, and federal/provincial governments. They would also identify and develop options for building on ideas from Jordan's Principle forums and regional engagement.
- **Business Development Specialist** – To assist AMC to evaluate the development needs and start-up of a First Nations Specialized Services entity/body that would exist at arms-length from the AMC.
- **Researcher** – To assist AMC to conduct primary and secondary research on issues affecting First Nation children and families, support the policy analysts and gather data for a First Nations CFS Database.
- **Clinical Director** – To research specialized programs of the clinical department, be responsible for supervising and directing everything from employees and budgets to technology and operations. The goal is to ensure the smooth running of the clinical department aiming to maximum performance.
- **Communications Writer/ Researcher** – To provide written content for the CEC's information and referral programs, and in particular, the Caregiver Support Program. These programs would respond to needs from CEC clients, their relatives or caregivers, and professionals in community agencies. Programs provide information, education, support, and referral to enable clients to make choices about services needed, and to utilize information and learning in order to pursue healthy living.
- **Contracted Database Administrator** – To assist AMC to design and build a First Nation database to document children and families' involvement in the CFS system and to determine database policies, procedures and standards to follow going forward.[399]

Chapter 3:

Context for Jordan's Principle – The pre-existing structure of services for First Nation children

In this chapter, we examine tensions in the process of implementing Jordan's Principle in Manitoba. First Nations and the FNIHB regional office acted quickly to implement Jordan's Principle, while prioritizing elements that align with a systemic approach to services. They prioritized the establishment of services for groups of children, full time positions and other elements designed to support service sustainability, and flexibility for First Nations to tailor services to their needs and contexts.

Available administrative data indicates that the approach in Manitoba effectively extended a broad range of services and established economies of scale in service provision. However, a lack of transparency around decision-making and failures to establish long-term funding and support the development of formal, First Nation coordination, governance, and technical support structures have undermined efforts to achieve a systemic approach to Jordan's Principle services.

3.1 A systemic approach

As discussed in Chapter 2, and in Appendix 5, First Nations in Manitoba have long advocated for a systemic approach to service provision. Though we did not find a clearly articulated definition of this term in documents related to services for First Nations in Manitoba, there is broad consensus on the key elements of a systemic approach in the existing literature on systems theory. Existing literature characterizes a systems approach as being grounded in an understanding that "the whole is greater than the sum of its parts," and in a focus on the complex ways in which different systems and subsystems intersect and interact to shape outcomes.[400,401,402,403,404] At the most basic level, a systemic approach to Jordan's Principle would be embodied in policies, processes and decisions that moved beyond a case-by-case approach to meeting the needs of individual children, families, or Nations. More specifically, a systems approach requires: "Not only a new way of examining problems, but also bold decision-making that fundamentally challenges public sector institutions. This entails:

- Putting desired outcomes first instead of institutional interests and resource control;
- Promoting value-based decisions (instead of simply regulating) to allow individual organizations to set their own processes to achieve shared goals; and
- Designing functions and organizations around users – not government."[405]

Several elements of the approach to Jordan's Principle in Manitoba are consistent with the basic elements of a systemic approach. As shown in Figure 10, Jordan's Principle funding in Manitoba was established rapidly and at a high level relative to other jurisdictions with similar First Nation population sizes, such as Saskatchewan and Alberta.[a] This is likely linked to an initial approach of extending funding opportunities directly to each First Nation, rather than waiting for Nations to come forward one-by-one, and request funds, as was done in some jurisdictions.[406] Each First Nation was asked to submit a proposal for Jordan's Principle funding and initially received base funding for a full-time Case Manager, accessible vehicle, and additional child development or respite workers as requested.[407,408] This process prioritized outcomes for First Nation children by proactively extending resources and allowed individual First Nations to set their own processes to achieve shared goals.

The level of funding for these positions also reflected a values-based approach to promoting the development of a long-term, system of services. One interviewee noted:

> *I believe if we expect quality work for First Nations, then we have to pay our people very well so they can attract the First Nations [people] who have left the community to come back home, and that's what we have been able to do.*[409]

This initial approach established, from the outset, an emphasis on funding services through group requests, which support the development of services for multiple children, rather than individual requests, which require a separate funding request for each child in need of services. Figure 11 shows that, in 2019-20 in Manitoba, 99% of Jordan's Principle funded services and products were funded through group, rather than individual, requests. Figure 12 breaks down the services and products funded in Manitoba by service domain.

a Considerations of First Nations population counts can be complicated, and only the very roughest of comparisons is considered here. We consider the total First Nation population which includes status + non-status and both on-reserve + off-reserve First Nation people of all ages, with no consideration of factors like the size of the child and youth population, the number of Nations, or geographic remoteness.

Figure 10: Total Jordan's Principle request expenditures, by region (2017-20)[410,411]

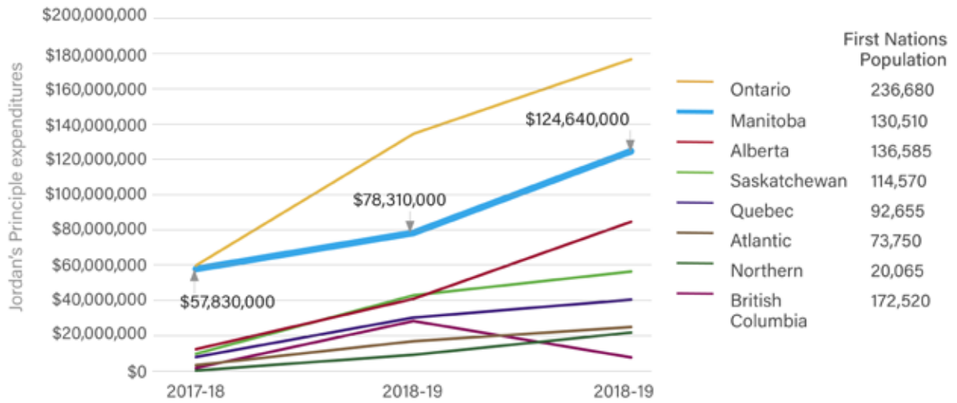


Figure 11: Proportion of Jordan's Principle funded services & products funded through group and individual requests, by region (2019-20)[412]

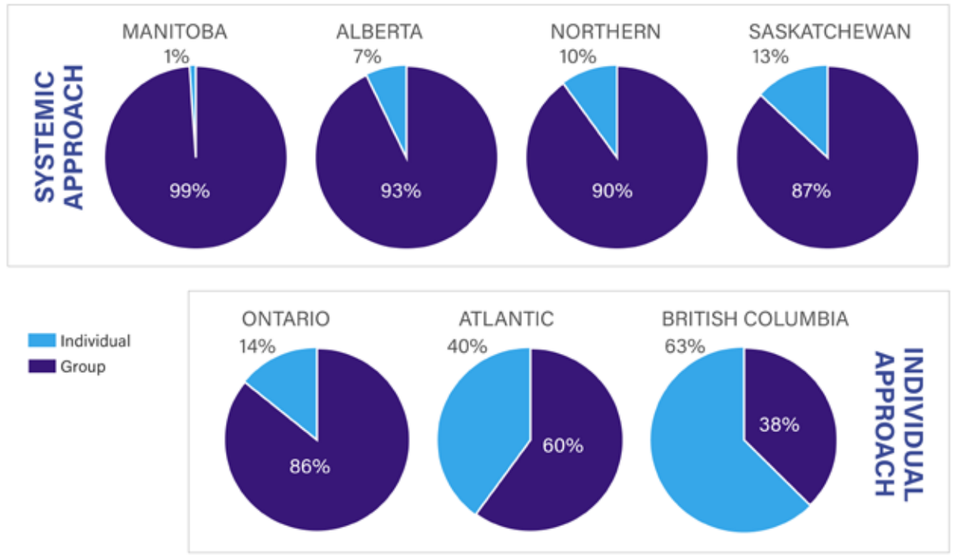


Figure 12: Proportion of products/services by service area, and proportion of products services funded through group or individual request by service area[413]

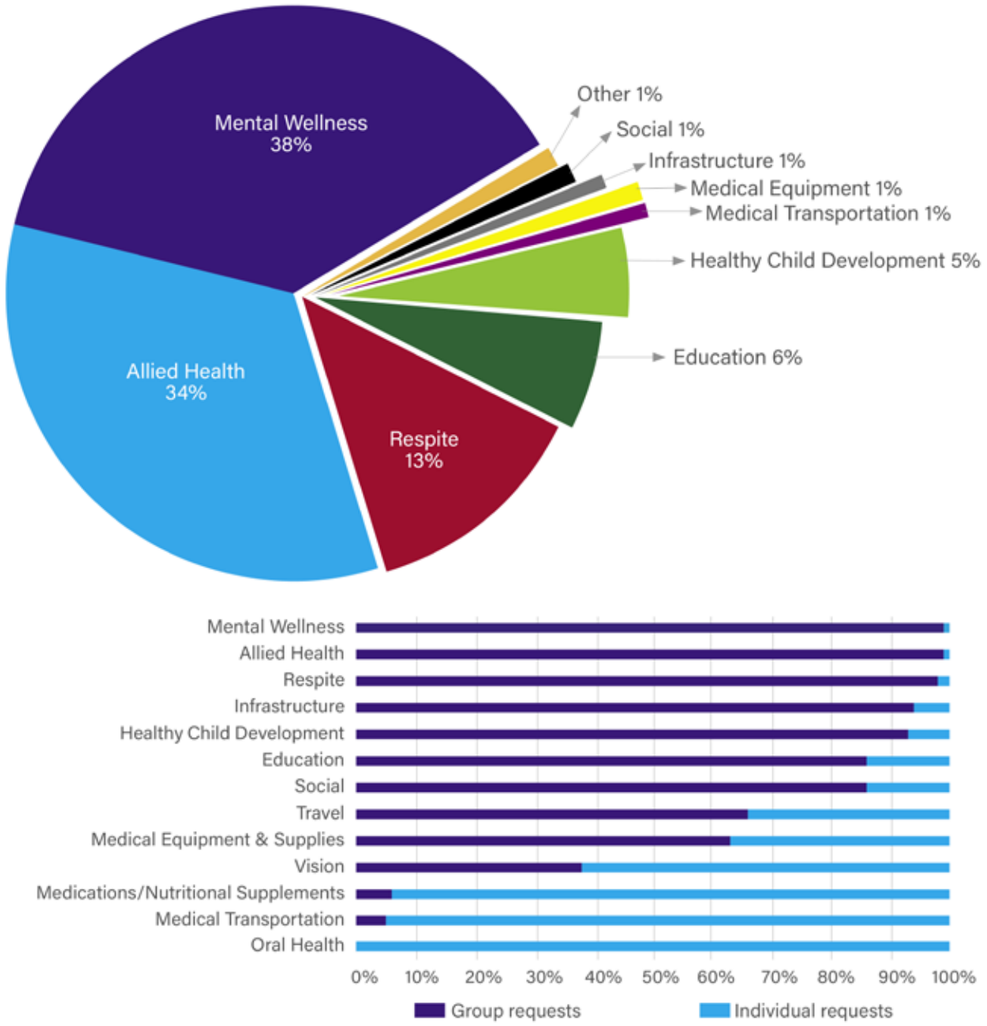
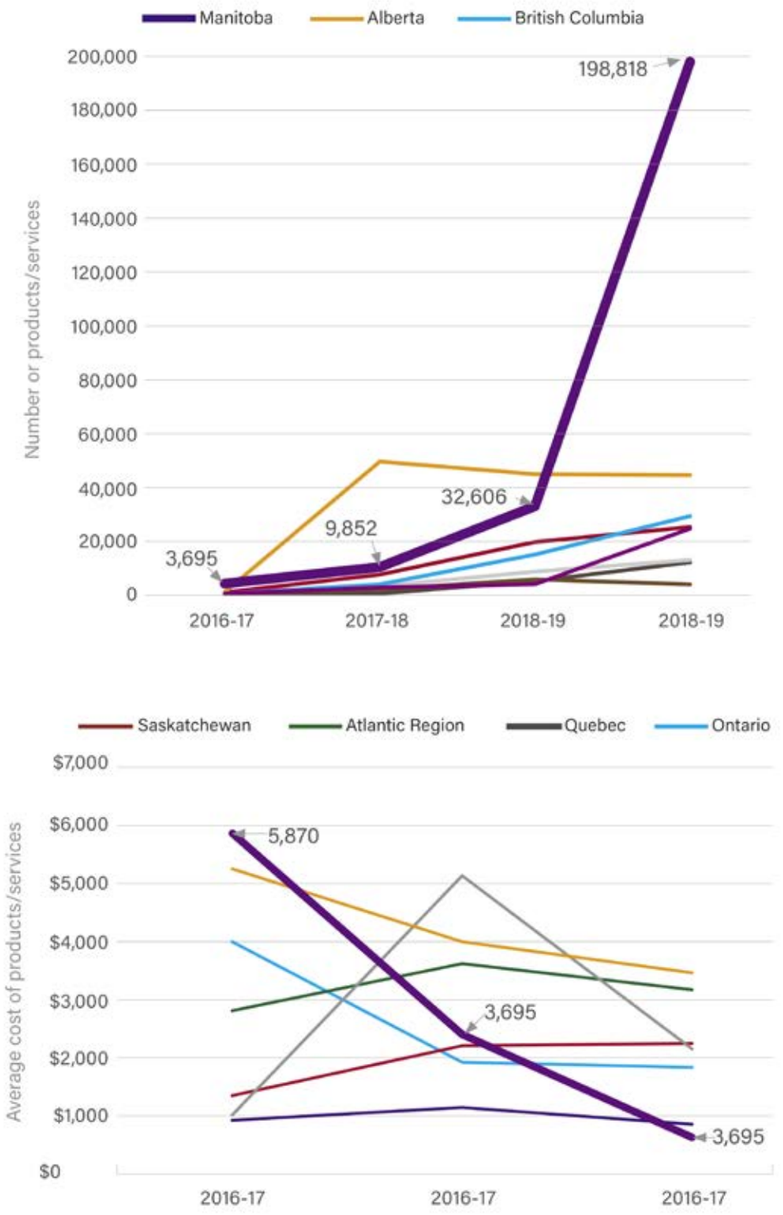


Figure 13: Number and average cost of Jordan's Principle funded services and products, by region (2016-20)[414]



It shows that the 95% of products and services funded through Jordan's Principle in Manitoba were within five service domains: mental wellness, allied health, respite care, education, and healthy child development. In each of these service domains the vast majority of products and services were funded through group requests in 2019-20.[b] Funding services for broad groups, rather than individual children reduces the delays and barriers to accessing services associated with individual requests that have been documented in prior research.[415, 416, 417]

As shown in Figure 13, the approach taken in Manitoba supported a rapid growth in the number of products and services funded through Jordan's Principle, and pronounced reductions in per-unit service costs, over time. Between 2018-19 and 2019-20, there was a six-fold increase in the number of products and services funded in Manitoba. The increase in Manitoba far exceeded that in any other jurisdiction and appears to be driven by: the funding of land-based healing services for all First Nations and Tribal Councils; the introduction of rehabilitation assistants and mental wellness services across First Nations; an increase in child development/respite care workers in some Nations; and the introduction of Off-Reserve Case Managers at the Tribal Council level.[418] It may also reflect the ongoing expansion of the range of programs and services being provided at the Nation level, and growing caseloads reported by SSPs (see Chapter 7).

The available administrative data also indicates significant reductions in the average cost of products/services over time. The right-hand side of Figure 13 shows a marked decline in the average cost of Jordan's Principle funded products and services between 2017-18 and 2019-20. This pattern is consistent with the establishment of an economy of scale: a reduction in the per-unit cost of service occurs when an increase in the number of services results in the fixed costs of service provision being spread across more units.[419] For example, the per-unit cost of providing an allied health service to children falls when the cost of a service provider's flight to/from the Nation is divided across a greater number of children who receive services during the service provider's visit.

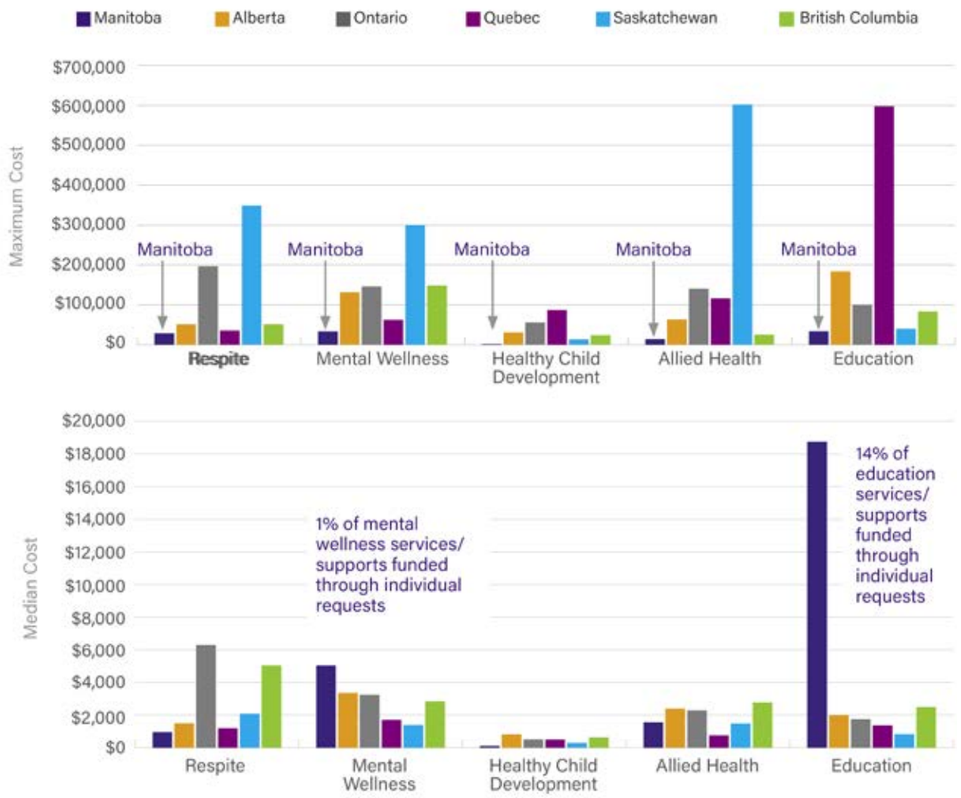
As seen in Figure 14, across the five service domains that account for 95% of funded products and services in Manitoba, the maximum cost of individual Jordan's Principle requests is lower in Manitoba than in other jurisdictions. This pattern is also consistent with an approach that has established an economy of scale by attempting to extend services across First Nations. For example, the cost of providing an individual child with allied health services that extend beyond the services that are typically available in their Nation is reduced if some allied health services are already provided through Jordan's Principle group request funding. This is because service providers are already travelling to the Nation, have some understanding of the context in the Nation, and have developed relationships needed to support service provision.

3.2 Demand driven approach

A systemic approach to the implementation of Jordan's Principle is in tension with a demand-driven approach which has sometimes been imposed, by the federal government, on the implementation of Jordan's Principle in Manitoba. In interviews and meetings, people pointed to the events surrounding the development of Jordan's Principle funded land-based healing initiatives as an example of this tension. In 2018, based on discussion

b There was a slight error in the group vs. individual request calculations presented in the interim report. The revised calculations presented here tell the same story, but are not identical to prior calculations.

Figure 14: Maximum and median cost of individual Jordan's Principle requests by service domain and region (2019-20)[420, 421, c]



with Case Managers who shared mental health challenges faced by youth in their Nations, the regional FNIHB office extended an invitation to all First Nations in Manitoba to submit requests for land-based healing initiative funding. Each Nation that proposed an initiative was funded at $150,000.[422, 423] The approach of circulating a request for land-based funding proposals was consistent with a systemic approach to extending services across First Nations; it prioritized the mental health needs of First Nation children, rather than strict federal control over resources. However, in 2019, after the national Jordan's Principle office conducted an internal audit of Jordan's Principle in Manitoba, the regional office was informed that its approach to distributing land-based healing funding was not in keeping with national policy.

c Data for Northern and Atlantic regions not available.

Rather than reaching out all First Nations to invite group requests, the regional office was instructed to wait for individual First Nations to independently initiate funding requests, then identify needs, and fund accordingly.[424,425]

Discussion in interviews and meetings indicated that the instruction to wait for each individual First Nation to demand funding was also accompanied by a shift in decision-making power: after the 2019 audit, group requests for funding over $100,000, which were previously assessed at the regional level, were sent to the national Jordan's Principle office for assessment.[426] Many of the requests assessed at the national office were denied.[427]

This same pattern was subsequently replicated in interactions between the regional FNIHB office and First Nation organizations within Manitoba. An interviewee coordinating access to services for a group of First Nations indicated that she developed a work plan that involved reaching out to each Nation in the region directly, to inquire if they were interested in the services she coordinated. When she shared this plan with the regional FNIHB office, she was informed that she should instead wait for Nations to approach her and request services. She noted that she was recently approached by a First Nation requesting services because they heard about the opportunity from another First Nation.[428] In these examples, and others discussed by interviewees, the national Jordan's Principle office emphasized a demand-driven approach that conflicted with the focus, within Manitoba, on achieving a systematic approach to Jordan's Principle.

3.3 Short-term funding

A systemic approach to services is also in tension with the federal provision of short-term funding for Jordan's Principle. Funding for Jordan's Principle was initially designated for three years (2016-19) and then extended for an additional three years (2019-22).[429,430,431]

Interviewees indicated that their organizations were notified of funding renewal annually, with no guarantee of renewal the next year.[432,433] This short-term approach to funding conflicts with the CHRT's recognition of Jordan's Principle as an ongoing "legal requirement." The CHRT has stated:

> *Jordan's Principle is a legal requirement not a program and thus there will be no sun-setting of Jordan's Principle ... There cannot be any break in Canada's response to the full implementation of Jordan's Principle.*[434]

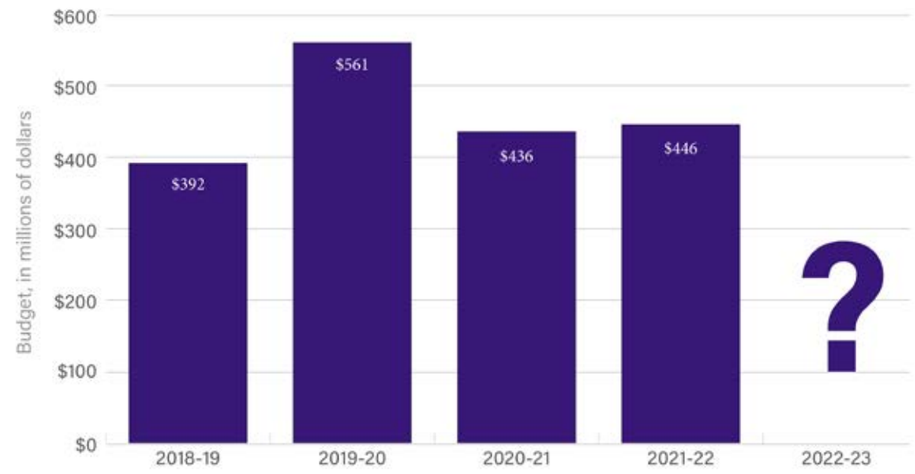
Despite the long-term legal obligation to implement Jordan's Principle, funding is only currently committed through 2021-22 (see Figure 15 for funding levels), and First Nations and service organizations continue to receive annual notification of funding renewal.[435,436] An interviewee explained that the provision of short-term funding resulted from the designation of Jordan's Principle as an "initiative" rather than a program. He noted that:

> *Initiatives are usually short-term. Piloting projects ... the government of the day can start an initiative based a survey, or a report, or research and start an initiative as a way forward to maybe creating a program in the future.*[437]

He further explained that classification as an initiative meant that First Nations could not easily spend funds on capital expenses or infrastructure development.[438]

In light of the CHRT orders and federal efforts at compliance, interviewees expressed optimism about the continuity of Jordan's Principle funding. However, they also saw the short-term nature of the funding as problematic, noting that annual funding renewal created uncertainty and risk.[439,440]

Figure 15: National Jordan's Principle budget (2018-23; in millions of dollars)[441]



One Case Manager explained:

> *So I know that after next year we're not sure if the funding will continue, right? There hasn't been an announcement or anything made in regards to ... what's going to happen after 2022. So...what we're hoping for is that it will continue, but we – it's still that unknown, that uncertainty of not knowing what's going to happen. I think that's the scary part is what are these families going to have ... if Jordan's Principle should [not] continue. And I'm pretty sure that if they try and stop it there'll be a big noise ... that's always at the back of my mind, what's going to happen after 2022?*[442]

Despite the uncertainty about the continuation of Jordan's Principle funding, Nations and organizations continue to plan for the future and work to keep meeting the needs of children and families. In many cases, this means recruiting and hiring people for long-term positions even though funding is only short-term. For example, a SSP explained:

> *Although we're aware that nothing is for certain, we haven't received any information that would make us worry about, "Well, what are we going to do next?" We're going to just keep doing what we need to do and we're going to just have, I think, faith that it will continue...We hired people, by the way, just in – in that spirit, we hired – all of our positions were hired as permanent employees. And we did that purposefully because you ... get a different type of applicant if you post term positions. And we made a decision that we were going to post permanent positions and we would just, you know, have faith and see where it goes.*[443]

Thus, short-term funding requires that First Nations and service provider organizations manage uncertainty and assume risk associated with long-term planning.

The burden, uncertainty, and risks that accrue to service providers working with short-term funding were previously documented in

research on the implementation of Jordan's Principle in Pinaymootang First Nation and in Alberta. Organizations and service providers working to meet the needs of First Nation children must shoulder the burden of onerous and unclear administrative processes, on top of the day-to-day work of providing services and, within the current context in Manitoba, responding to a global pandemic. They must deal with the uncertainty of building service systems without any clear sense of what level of funding will be available for the next year, or whether funding for specific services will be renewed at all. They must accept the risk associated with knowing that, if funding does not come through, they will be the ones to deliver the news that jobs must be eliminated to their staff. Service providers and organizations also carry the risk of informing families and communities, with whom trust and strong relationships have been established, that needed services are being cut.[444,445,446,447]

As shown in Figure 16, reports from Alberta, which suggested a sharp decline in funding approved in 2020-21, serve as a cautionary tale about the range of fluctuation that is possible in an annual approach to funding renewal.[448] Figure 16 shows a steep decline in Jordan's Principle funding in 2020-21. If funding approval for the end of the fiscal year mirrored that of the first five months, then funding for Jordan's Principle group funding in Alberta would have dropped to less than 1/2 of the funding provided in 2019-20. Data for the final months of the 2020-21 fiscal year was not publicly available at the time this report was written, and it is possible that a large number of second-half funding approvals could have significantly reduced the overall gap between 2019-20 and 2020-21 funding. However, the small amount of funding approved during the first five months of the fiscal year could only be accomplished by cutting or delaying the approval of funding for existing programs and positions. Even

Figure 16: Jordan's Principle group funding in Alberta, by year (2017-2020)[449]

those organizations that eventually had their funding renewed would experience burden, uncertainty, and risk as they sought to plan for the continuation of services without new funds or indication of funding renewal. Delays in funding have the potential to disrupt services for children and families. Thus, the annual renewal of funding conflicts with a systemic approach in which First Nations and service providers work towards the long-term transformation of services to ensure the health and wellbeing of First Nation children.

3.4 A discretionary approach to Jordan's Principle

Another tension highlighted in interviews and meetings had to do with governmental use of administrative discretion in the implementation of Jordan's Principle. Administrative discretion refers to the flexibility that civil servants and service providers have in the interpretation and application of rules in complex situations.[450] Interviewees highlighted this flexibility, describing a context in which the outcome of Jordan's Principle requests and other decisions around funding seemed dependent on the person or organizational unit (FNIHB region or the National Jordan's Principle office) making the decision. Within Manitoba, administrative discretion exercised by the FNIHB regional office, and by the Jordan's Principle Regional Coordinator in particular, was largely understood as supporting and empowering First Nation leadership. However, interviewees also discussed situations in which a federal discretionary approach led to confusion, and even conflict, complicating understanding of roles and responsibilities in relation to Jordan's Principle and hampering efforts to establish a First Nations led approach to the implementation of Jordan's Principle in Manitoba.

At the National level, the existence of a discretionary approach to the implementation of Jordan's Principle is evident in the comparison of group request and individual request trajectories across jurisdictions. Figure17, which shows the trajectory of group requests (2019-20) by region suggests there is broad leeway in decision-making at the regional level. The trajectory of group requests differs dramatically across jurisdictions, with over 85% of group requests approved within the fiscal year in some regions, and as few as 20-30% approved within the fiscal year in other regions. The trajectory of individual requests, depicted in Figure 18, suggests a similar, but less pronounced, pattern of discretion across jurisdictions; less than 50% of individual requests were approved within the fiscal year in some jurisdictions and over 80% were approved in others.

Within Manitoba, discretion in Jordan's Principle decision-making has largely been understood as being used to support and empower First Nations. As described in Chapter 2, the Jordan's Principle Regional Coordinator acted quickly to support the systemic approach to services that First Nations had long advocated. The initial approach to Jordan's Principle, in which each Nation was invited to submit a proposal and encouraged to outline their dream program, as well as the extension of a request for proposals for land-based healing proposals, exemplified this supportive use of administrative discretion.

Interviewees expressed strong appreciation for the Regional Jordan's Principle Coordinator's consistent support for First Nations, and his use of administrative discretion to support the development of a systemic approach to services in Manitoba. One Case Manager simultaneously voiced her appreciation for the Regional Coordinator and highlighted the precariousness of a situation in which support for a systemic approach to Jordan's Principle depended on the use of discretion by an individual.

One Case Manager simultaneously voiced her appreciation for the Regional Coordinator and highlighted the precariousness of a situation in which support for a systemic approach to Jordan's Principle depended on the use of discretion by an individual:

Figure 17: Jordan's Principle group request trajectory, by region (2019-20)[451]

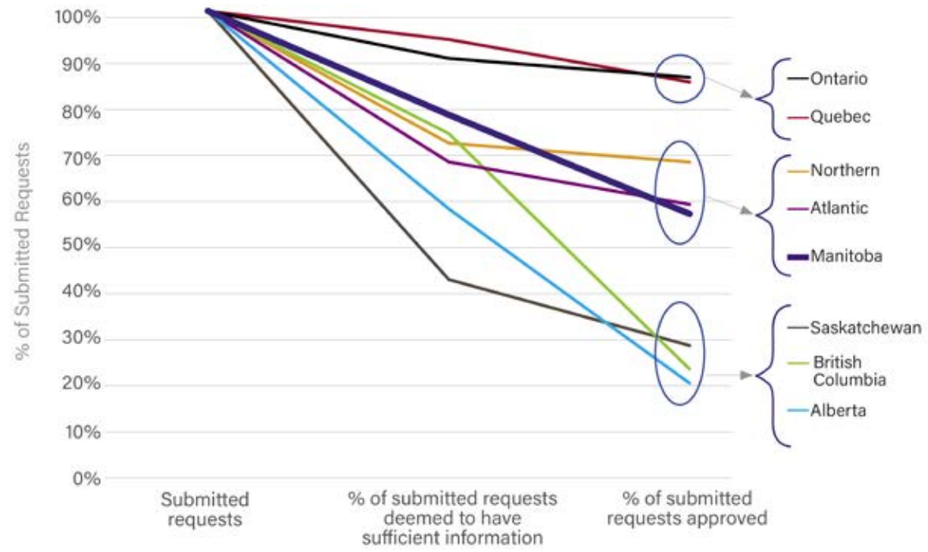
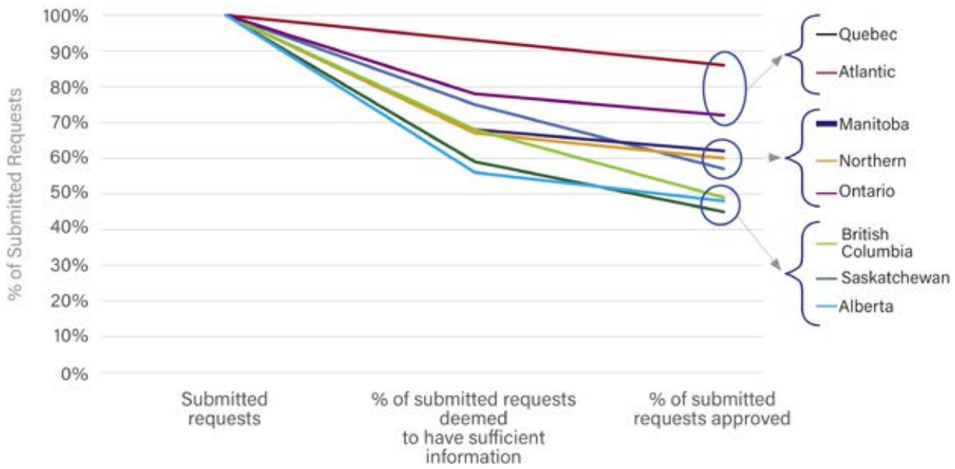


Figure 18: Jordan's Principle individual request trajectory, by region (2019-20)[452]



I think ... the person that's there has really made a difference because the person that's there continues to advocate for the wellbeing of the children ... And I think if he's gone, I think things would eventually change and become bureaucratic.[453]

3.4.1 Decision-Making that excludes First Nations

Despite the use of discretion to support and empower First Nations, interviewees also shared examples of situations in which the federal government's discretionary approach to the implementation of Jordan's Principle created new challenges. Key among these were situations in which significant policy changes were enacted without engaging First Nations and announced without advance notice or explanation. Communication around policy shifts was often cursory, transmitted without the benefit of backgrounders or other explanatory policy documents, and last minute. Case Managers sometimes received notice that additional funding was available (to support home modification, rehabilitation assistants, wellness workers, assistant case coordinators or EAs), "effective immediately", with as little as a paragraph of accompanying explanation, a template for new position descriptions, and instructions that funds were to be spent within a fixed time period. Even when policy announcements responded directly to needs identified by First Nations, the limited information provided and short timelines for implementing policy changes meant that Case Managers and service providers were left scrambling to figure out the details of how to spend the funds and meet expectations on their own.[454,455,456]

Other policy changes involved sudden shifts in eligibility for, or decision-making around, Jordan's Principle. Some of these policy changes are discussed in more detail in the Chapter Five of this report. Notable policy shifts included:

- Unilateral decisions to enter into service agreements with Specialized Service Providers;
- A decision, handed down from the national Jordan's Principle office in Ottawa, to change the age of Jordan's Principle eligibility from 21 to 18;
- The transfer of decision-making around housing modification requests from the regional FNIHB office to the national Jordan's Principle office, and then back again;
- The transfer of decision-making for proposals over $100,000 from the regional FNIHB office to the national Jordan's Principle office.

In some cases, such as the change in age eligibility, policy changes explicitly and directly prevented services providers from meeting the needs of children and youth who had previously been supported through Jordan's Principle. Other shifts in policy, such as those involving the transfer of decision-making to the national office, brought delays and increased denials of funding. In each case, a shift in policy created confusion about how decisions relating to Jordan's Principle were made and uncertainty about the shape of Jordan's Principle moving forward.

3.5 Failure to establish formal regional coordination structures

First Nations have clearly identified a need for First Nation led, regional coordination to support the implementation of Jordan's Principle in Manitoba. However, resource limitations, compounded by COVID-19 related constraints, have slowed progress towards development of formal, First Nation led regional coordination structures. In the interim, a discretionary approach to coordination has created tensions and challenges.

Several interviewees highlighted a need for regional coordination to support the

development of more open working relationships between First Nations, service organizations, the federal government, and the province of Manitoba. They noted that a discretionary approach to Jordan's Principle, combined with a lack of transparency around Jordan's Principle funding allocation, created tension and perceptions of unfair treatment. They pointed to regional coordination as a means of addressing these challenges.[457,458,459,460]

The task of developing regional coordination structures is complicated because Jordan's Principle does not fit neatly into the mandates of pre-existing service, administrative, or political structures. Jordan's Principle crosses:

- First Nations, regional, and national levels of decision-making,
- The domains of both direct services and governance, and
- Multiple service domains (e.g. health, education, and social services).

The AMC Secretariat considered the implications of the mismatch between Jordan's Principle and existing regional structures and found that no existing entity had the mandate to oversee the regional coordination of Jordan's Principle. It recommended "that the AMC Secretariat continue to explore options on how to implement Jordan's Principle together with the MKO and SCO, FNHSSM and MFNERC." [461]

AMC Chiefs' resolutions have clearly outlined mechanisms through which regional collaboration could be embodied. For example, a 2016 resolution called for the formation of an intergovernmental task force to "define the ethical, moral, and legal authorities for implementation of Jordan's Principle including but not limited to: legislation and First Nations governance standards" that "uphold the implementation of Jordan's Principle to its fullest extent." [462] A tripartite task force requested by AMC was never established.

In 2018, another resolution called for the establishment of a Jordan's Principle Equity Roundtable to facilitate collaboration and coordination; AMC approved a structure for this roundtable in early 2019.[463] However, the federal government has refused to provide funding for the roundtable, or for similar structures, such as the Capacity Enhancement Centre. Efforts to establish the roundtable have also been slowed by COVID-19 related issues and human resource restrictions.[464,465]

As discussed in Chapter 2, in the absence of a fully developed, formal coordination structure, two independent groups have provided some level of regional Coordination and support: the TAG and the TSC/ISC/SSP group. AMC has regularly organized meetings of the TAG. The TAG initially brought together regional stakeholders and has more recently emerged as a forum that brings Case Managers together to share information and address challenges in Jordan's Principle implementation. Specialized Service Providers and the Regional Jordan's Principle Coordinator have also sometimes been invited to share information with this group.[466,467,468,469]

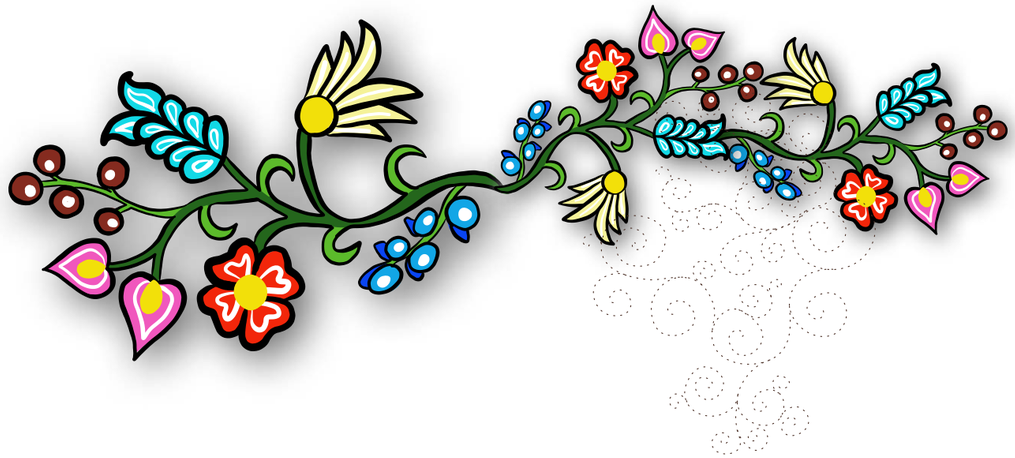
The TSC/ISC/SSP group initially emerged as a forum in which TSCs with in-depth knowledge supported SSPs in building connections with and adapting their practice for work in First Nations. Over time SSPs gained familiarity with First Nations and the TSCs group experienced significant turnover; group dynamics and focus shifted accordingly. Meetings were suspended at the end of 2020 because of COVID-19 related responsibilities and constraints.[470,471,472]

In the fall of 2020, the TSC/ISC/SSP group expanded to include some Case Managers and representatives of regional organizations, including AMC. At that time, the AMC noted that "it appears discussion items identical to objectives the Jordan's Principle Technical Advisory Group (TAG) of the Jordan's Principle Equity Roundtable are working towards." [473]

While AMC was developing plans for, and working towards the establishment of, the Equity Roundtable and a CEC, under a mandate from First Nations leadership, the TSC/ISC/SSP group was pursuing parallel work in partnership with FNIHB. For example, both groups were working on the development of tools to support Case Managers in Jordan's Principle implementation.

Interviewees indicated that a lack of open communication and coordination between the TAG and TSC/ISC/SSP group sometimes created inefficiencies, tension, and duplication of efforts.[474,475] For AMC, the lack of coordination between these efforts raised questions about the level of funding being provided to the TSC/ISC/SSP and, by extension, about potential links between that the TSC/ISC/SSP work and the denial of funds for the CEC.[476] Disconnection between two groups working along parallel lines risked further inefficiency or duplication of efforts. In addition, there is potential for confusion, if Case Managers are presented with alternate sets of tools or supports that do not align, and for further division moving forward.

New structures, like the TSC/ISC/SSP, can serve a critically important role, in the regional coordination and ongoing implementation of Jordan's Principle. However, when new structures are developed and allocated resources in a discretionary fashion, they can add to pre-existing challenges within the complex, and siloed pre-existing system of services to First Nation children. A discretionary approach to decisions around the basic structure and infrastructure of Jordan's Principle can bypass the collaborative and, sometimes time-consuming or contentious, consensus building measures that are needed to align, or realign, existing structures with Jordan's Principle. Discretionary decision-making may have the unintended consequence of inflaming tensions or even causing conflict. In contrast, more formalized and transparent decision-making processes can offer opportunities to avoid duplication of efforts and other inefficiencies, and to demonstrate that decisions are being made based on the needs and interests of First Nation children rather than governmental and institutional interests or attempts to control resources. Time and resources are required to support the development of formal, new, regional structures to support the implementation of Jordan's Principle.



Chapter 4:

Current Structure of Jordan's Principle in Manitoba

The current structure of Jordan's Principle in Manitoba features multiple components designed to move beyond a case-by-case approach to service provision and systematically extend delivery of needed services to First Nation children and families, living both on and off reserve. The current Jordan's Principle structure also incorporates some support and capacity building resources at both the regional and Tribal Council levels. Figure 19 presents a summary of the different components of Jordan's Principle in Manitoba.

In addition to the services and supports identified in Figure 19, the current structure of Jordan's Principle includes the possibility for Nations or organizations serving First Nation children to make group requests for Jordan's Principle funding to address gaps in services that affect groups of First Nation children. Individual requests may also be made for Jordan's Principle funds to support the provision of products/services to individual First Nation children whose needs are not met through existing programs.[477] The CHRT has mandated that responses to individual requests must reflect consideration

of the principle of substantive equality and be rendered within strict timelines (12-48 hours).[478] Nationally, individual requests for Jordan's Principle funding are typically administered by government representatives (focal points) charged with facilitating the review and approval of requests for services.[479] In the Manitoba context, the first line of support and response is from Tribal Council and Off-Reserve Service Coordinators, who either support the preparation of a request to be assessed by regional focal points or, in the majority of cases, assess and respond and directly respond to the request.[480] The FNIHB regional office assesses some categories of requests (e.g. requests for dental care, medical equipment and educational supports).

Figure 19: Jordan's Principle services in Manitoba[481]

First Nations

Each Nation is funded for 1 Case Manager and may also receive funding for rehabilitation assistants, wellness workers, assistant case coordinators, additional services and accessible vans.

Case Manager: Identifies and assesses clients and families. Responsible for ongoing development of services and coordination of care with internal and external agencies to address holistic needs. Coordinates respite services.

Specialized Service Providers (SSPs)

SSPs are funded to provide services on and off reserve. They also receive funding for a Jordan's Principle Education Coordinator

Manitoba First Nations Education Resource Centre (MFNERC): Provides a broad range of services to 57 First Nations schools in 46 Nations with a combined student population of more than 15,500 children from nursery school go Grade 12.

Rehabilitation Centre for Children (RCC): Provides child and family centered preschool and home based rehabilitation services. Delivers services in 63 First Nations in partnership with other agencies.

St. Amant: Provides holistic services to children and families with developmental disabilities and autism in 52 First Nations.

Frontier School Division (FSD): Seven wellness workers address mental health needs across 16 on-reserve schools.

Manitoba Adolescent Treatment Center (MATC): Mental health clinicians provide assessments, support, and treatment, primarily via telehealth, to 63 First Nations.

Ndinawe Youth Resource Center (Tina's Safe Haven): A 24/7 youth drop-in centre providing comprehensive supports, in memory of Tina Fontaine.

Mino Bimaadiziwin (The Good Life): Provides culturally grounded support and peer leadership, encourages successful educational outcomes in Winnipeg and four Nations.

Eagle Urban Transitional Centre (AMC)

Funded for seven Jordan's Principle positions to serve First Nation families living or seeking services in Winnipeg.

Off-Reserve Service Coordinators: Six coordinators support First Nations families and/or special needs individuals. They work with families and service providers to develop care and support plans that address holistic needs. Work across jurisdictions, networking with on and off reserve providers to support continuity of care

Respite Short-Term Service Coordinator – Support First Nation children and families living off reserve short term.

Tribal Councils

Seven TCs are funded for two positions each.

Off reserve Service Coordinators: links with case managers providing training, support, and coordination.

Off reserve Case Manager – same role as the EUTC Off-reserve Service Coordinators for regions outside Winnipeg.

Assembly of Manitoba Chiefs (AMC): Funded for three positions + administration to support planning, communication and engagement processes, as well as implementation of recommendations from engagement efforts.

Manitoba Keewatinowi Okimakanak (MKO) and Keewatinohk Inniniw Minoayawin (KIM) – Funded for two positions to support engagement, and on-reserve pediatrican and clinical psychology services to 13 Nations

Southern Chiefs Organization (SCO) Funded for two positions to coordinate discharge and client care for First Nations people at the Health Sciences Centre Children's Hospital and RCC.

Indigenous Services Canada (ISC)/First Nations Inuit Health Branch (FNIHB)

Regional coordination of Jordan's Principle. Also supports St.Amant in managing psychometric assessments for youth aging out of Jordan's Principle.

ISC/FNIHB Beyond Jordan's Principle

FNIHB: On-reserve community programs including nursing stations hospitals (Percy E. Moor, Norway House), health centres, public health, home care, respite. Environmental health (housing, facility inspections, food safe training)

Non-Insured Health Benefits (NIHB) – insurance coverage for eligible First Nations people (pharmacare, dental care, vision care, medical supplies, equipment, mental health counselling, medical transportation).

Regional Operations (education and social programs and partnerships): Identify children in care that can be cared for in the community with appropriate supports. (CFS, infrastructure and housing, income assistance, skills and job training, education.)

Other categories of requests, which change over time (e.g. housing renovation requests, requests involving youth at or over the age of majority, and requests in which a focal point recommends denial), are sent to the national office for assessment.[482,483]

4.1 Service overview

4.1.1 First Nation level services

As described in Chapter 2, in 2016 and 2017 all First Nations in Manitoba were invited by FNIHB, Manitoba region, to submit proposals for Jordan's Principle programs that would be funded through the federal Jordan's Principle CFI funds.[484] All First Nations received funding for a Jordan's Principle Case Manager and accessible vans to facilitate the accessible transit of children.[485] Case Managers are charged with facilitating "identification and assessment of clients, families, and groups needing services or supports" and coordinating with organizations within and outside of their Nations to address the holistic needs of children aged zero-18.[486,487] The Case Managers have a complex role that includes: identification of collective needs and gaps in service, development of Jordan's Principle group requests for funding to address these needs, hiring and supervising staff, working directly with families and children, and overseeing program development and implementation. Case Managers may also advocate for children and families by preparing, submitting, and following up on individual requests for Jordan's Principle funding. They also work with leadership, health and/or education directors, SSPs, and TSCs to facilitate access to needed services and to support continuity of care.[488,489,490,491,492]

Based on the work and leadership of Case Managers, each First Nation developed a Jordan's Principle program that could also receive funding for child development workers, respite workers, and administrative assistants.[493,494] Federal funding was subsequently made available for land-based healing, EAs, rehabilitation assistants, wellness workers, and assistant case coordinators.[495,496,497] First Nations could also make a group request for additional, Jordan's Principle funds that to support the implementation of additional services.[498] Each First Nation developed their own approach to Jordan's Principle, prioritizing needs identified within the Nation and building up on existing strengths and available resources.

The Nation–level services developed with Jordan's Principle funding cover a broad spectrum that includes, but is not limited to, education supports (including EAs and tutors), land-based education and healing, language and cultural supports, recreational activities, supports for children and youth with disabilities, after school and early childhood activities, parent and caregiver supports, activities to support healthy lifestyles, and supports for basic needs.[499] Textbox 4, which compiles the services that 31 Jordan's Principle Case Managers identified as being funded by Jordan's Principle in their Nations highlights variation in focus of and approach to the implementation of Jordan's Principle across First Nations. Some Nations incorporate a strong focus on meeting basic needs through services such as emergency assistance, monthly foodbanks, or school lunch programs. Others may build on the expertise and knowledge of Jordan's Principle Case Managers and staff to emphasize, for example, early childhood development. Survey responses from Case Managers also suggest broad variation in the range of services provided by different Nations; while some Nations reported many as a dozen, distinct types of Nation-level services provided through Jordan's Principle, others reported only a couple.

In keeping with the federal government's initial focus on children with disabilities and special needs, most First Nations Jordan's Principle initiatives are housed within health services. However, some First Nations have developed Jordan's Principle within education, and Jordan's Principle programs may also operate independently of pre-existing, Nation-level

Textbox 4: Range of Jordan's Principle funded services/supports across 31 First Nations[500]

- Respect care(Group and in home)
- Mental health & wellness supports
- Occupational therapy (+ assistance)
- Physio therapy (+assistance)
- Speech & language (+ assistance)
- Behavioural Health Clinician
- Rehabilitation Servives
- ASL supports
- Medical supports (including pediatrician and physicians)
- Denal supports (including braces)
- Vision supports
- Audiology
- Pediatrician Education Assistants
- Education support (including tutorial)
- Land-based education and activities
- Language classes
- Land-based healing and one-on-one counselling
- Cultural worker
- Traditional teachings
- Cultural/Spiritual services
- Weekly playgroup outdoor education
- One-to-one/ group mentorship
- Youth recreational services
- Youth leadership training
- Weekly preschool program
- Homework club
- Child Development Workers (in health & education)
- Development Centre for children ages 0-4
- Supports for families/ caregivers
- Parent Advisory Group
- Advocacy Training
- Screening Clinics
- Clinical Assessment
- Case Management
- Referrals
- Cooking classes
- Monthly foodbank
- Assistance with healthy foods in school
- Emergency assistance
- Lunch program for children
- Life skills training/supports
- Support for basic needs
- Fitness assistance
- Medical/other transportation
- Medical equipment
- Laptops
- Community events
- Group activities
- Partnerships with school/CPNP

service structures.[501,502,503] Data provided by FNIHB regional office in 2018 indicated that the number of full time staff supported by Jordan's Principle funding ranged from a minimum of five per First Nation to a maximum of 43 in a larger First Nation in Manitoba.[504]

4.1.2 SSPs

SSPs are pre-existing organizations that have received federal Jordan's Principle funding to support the extension of a broad range of allied health services, mental health and wellness services, and services for children with complex needs and developmental disabilities to on-reserve First Nation children (aged 0-18) and their families. Across interviews, administrators of organizations indicated they were approached about service provision in 2016 or the first half of 2017 and began providing and coordinating services later that year. SSPs provide services to diverse First Nations, with complex service structures, across vast geographies. All organizations have headquarters and staff based in Winnipeg, some also have staff based in smaller centers such as Thompson or Brandon. Table 2 briefly summarizes the Jordan's Principle funded services offered by SSPs. A more extended discussion of the work of SSPs is provided in Appendix 6.

Table 2: Specialized Service Providers

Specialized Service Provider	Nations Served	Jordan's Principle Funded Services After
Rehabilitation Centre for Children (RCC; in partnership with other agencies)	63	Home and community-based OT, PT, SLP and audiology services for children from birth to school entry; child development, FASD and assistive technology clinics; in partnership with MFNERC, supports school transition for both the child and family during the kindergarten year.
St. Amant	52	Psychological supports to address behavioural challenges; clinical counselling focused on the impact of disability on a child/family; care program that supports families of children with disabilities; dieticians services for children with developmental disabilities; nurse consultation for children with complex needs; psychometric testing to assess eligibility of youth in care for provincially funded adult disability services; educational workshops.
Manitoba First Nations Education Resource Centre (MFNERC)	45	Clinical services in 57 schools, including OT, PT, SLP, school psychology, mental health and wellness, deaf and hard of hearing and American Sign Language instruction, intergenerational trauma supports, respiratory therapy, and nursing services.
Manitoba Adolescent Treatment Centre (MATC)	63	Mental health services to children and adolescents, aged 3-18, provided through hybrid model in-person and teletherapy model. Services geared towards ensuring complex mental health needs are addressed through long-term supports. Cases can include, but are not limited to, addressing complex trauma, providing on-going.
Frontier School Division (FSD)	16	Seven wellness workers; 1 for each area within Frontier School Division, and 2 additional workers, address mental health needs for First Nations students. FSD is also working on extending telehealth services, to facilitate mental wellness supports in 16 sites and establishing a program to involve Elders in the therapy plans of children in crisis.

4.1.3 Service coordination and off reserve supports

4.1.3.1 Service coordination and respite care in Winnipeg (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 to provide "a single window from which clients receive support, advocacy, and access to needed programs."[505] EUTC receives Jordan's Principle funding for six Off-Reserve Service Coordinators who support First Nation families and special needs individuals (children and adults) in Winnipeg in accessing needed services and advocating to ensure their rights are met.

In addition to connecting families with existing services, EUTC Service Coordinators support preparation of Jordan's Principle requests, and directly assess and process payments for requests for low-cost services/supports and services/supports that cannot be easily covered under rigid federal government administrative guidelines.[a] Processing requests from children and families occurs within the CHRT mandated timelines and, when

a For a comprehensive discussion of the ways in which federal guidelines limit the ability of the federal government to respond to emergent needs, see Sinha, Knott, and Phillips (2021) The First Nations Health Consortium Service Access Resolution Fund Pilot Project.

administrative documentation becomes a barrier, EUTC prioritizes resolving the child's needs as quickly as possible.[506]

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."[507] EUTC supports families in identifying and formalizing relationships with respite caregivers that are known to and trusted by the family/child. EUTC also maintains its own list of respite care workers and can facilitate introduction to those workers when families are not able to identify a caregiver from within their own networks.[508]

4.1.3.2 First Nations capacity development and off reserve service coordination (Tribal Councils)

Each of the seven Tribal Councils receive funding for one Service Coordinator who "supports and coordinates development-training, design, implementation, and evaluation at the community level."[509] Their work may include some level of support to help both on and off-reserve families, spread across vast geographic regions, access existing services. They also support Case Managers by coordinating group meetings and trainings, making regular visits to communities (in some cases, this may require extensive travel), and supporting proposal/group request writing.

Tribal Councils also receive funding for Off-Reserve Case Managers who, like the EUTC Service Coordinators support the development and submission of individual Jordan's Principle requests for First Nation families living off reserve, in the smaller urban centres, outside of Winnipeg. They assess, process, and respond to requests involving low cost and Nation based services within CHRT mandated guidelines and timelines.[510,511] They forward requests for other types of services to FNIHB for assessment; the requests assessed by FNIHB include those involving dental care, medical equipment, educational supports, or housing.[512,513]

4.1.4 Regional Supports

4.1.4.1 Manitoba Keewatinowi Okimakanak (MKO) and Keewatinohk Inniniw Minoayawin (KIM)

The MKO is a non-profit, founded in 1981, which provides political advocacy to support 26 northern Nations in Treaties 4, 5, 6, and 10.[514] KIM is a self-governing, First Nations led health organization that was created, in 2020, by the MKO Chiefs Task Force on Health to serve as a First Nations-led aggregate health transformation entity. KIM currently coordinates and provides on-reserve pediatric and clinical psychology services in 13 northern Nations, through both in-person and telehealth platforms.[515,516] A liaison at KIM developed outreach initiatives, which enabled KIM to identify Nations which had on-going gaps in pediatric and clinical psychology services. The KIM liaison works to: build relationships with Nation-based service providers through virtual meetings, understand the unique needs of the Nation and facilitate work of pediatricians and psychologists in remote northern Nations to ensure gaps in physician and psychiatric services are filled.[517]

4.1.4.2 Southern Chiefs Organization (SCO)

SCO is an independent political organization created in 1999. The SCO represents 34 Anishinaabe and Dakota First Nations in southern Manitoba. The SCO coordinates discharge and client care for First Nation children at the Health Sciences Centre Children's Hospital (in Winnipeg) and through the Specialized Services for Children and Youth.[518,519,520] Implementation of this service is just beginning.

4.1.4.3 FNHSSM eHealth Support Desk

The FNHSSM eHealth Service Desk maintains a process for communities to formally request assistance with issues of digital connectivity related to Jordan's Principle. Some of these issues include access to connectivity, software installation, hardware set-up, and maintenance.[521]

4.1.4.4 Assembly of Manitoba Chiefs (AMC)

AMC originally received Jordan's Principle funding to support First Nations "engagement" around Jordan's Principle through the Keewaywin Engagement process. In addition, AMC has used Jordan's Principle funding to support multiple Jordan's Principle forums, as well as planning and communication activities.[522,523] Beyond these activities, AMC has defined the role of its Jordan's Principle Services Coordination team as being that of implementing the recommendations identified in Jordan's Principle forums and the Keewaywin Engagement Jordan's Principle Implementation report.[524] To this end, the AMC Jordan's Principle Services Coordination Unit developed an expansive work plan that includes, but is not limited to:

- Supporting the development of tools, policies, governance structures, funding plans, and laws to facilitate full implementation of Jordan's Principle by First Nations.
- Supporting First Nations in identifying gaps in services, evaluating Jordan's Principle services, and budgeting.
- Supporting the development of a fully developed customary care model as well as policies and programs to facilitate repatriation and reunification of children in care with their families.
- Facilitating ongoing collaboration and communication about Jordan's Principle with First Nation leadership and citizens, parents and the general public, Jordan's Principle Case Managers and Service Coordinators, and service providers.

4.1.5 First Nation centres

Jordan's Principle funding helps support the work of two First Nations Centres.

4.1.5.1 Mino Bimaadiziwin (The Good Life)

The Mino Bimaadiziwin program provides support services in Wasagamak, Garden Hill, Cross Lake, and Berens River. The program aims to provide culturally grounded services to support wellbeing and self-esteem with a focus on successful educational outcomes. Peer leadership and implementation of youth-led changes within Nations are also aims of the program.[525]

4.1.5.2 Ndinawemaaganag Endaawaad (Tina's Safe Haven)

Tina's Safe Haven began in 2018, in memory of Tina Fontaine. It provides 24-hour drop-in services such as on-site laundry, computer and phone services, and a gaming room. Recreational activities, camping, celebratory dinners and dances, referrals, employment, and housing supports are also provided.[526,527,528] Ndinawe also provides a training program to support youth seeking to enter careers in community-based care work.[529]

4.2 Anonymized Case Studies

4.2.1 Jordan's Principle in a Southern First Nation

4.2.1.1 The Nation

Our first case study is a southern First Nation with fewer than 2,000 residents. It is a few hours drive from a major service centre. People speak of the Nation as a place of great beauty

where people work together to overcome challenges. The Nation's population is young when compared to the overall Canadian population: more than 40% are under the age of 20. Families are large and close-knit; relatives often step in to support each other when the need arises and individual and collective achievements are celebrated. Many of the Nation's citizens are fluent in their traditional language, and they take pride in the Nation's rich and diverse spiritual life, their persistent respect for Elders, and the strength of extended family relations.

The long-term impacts of colonial violence can be seen in education and employment statistics: the employment rate is less than 35%, significantly lower than that for the total population of the province (62%) and over 50% of residents over the age of 15 have no certificate, diploma or degree (compared to 22% of the total Manitoba population aged 15 or over). Governmental policies have systematically destroyed traditional economies (trapping lines, fishing spots, fields and hunting grounds) and caused displacement of Nation citizens.

4.2.1.2 Services

The services available to children and families are shaped by a combination of the gaps and improvements in federal and provincial service systems, the determination of those within the Nation to ensure high quality services, and the opportunities for both accessing services and recruiting/retaining staff that come from being within less than a-day's drive of a service centre. Front line services are provided through the Health Centre and school, Child and Family Services, and Jordan's Principle. Availability of off-reserve health and allied health services in the region is affected by staff turnover and other problems in the provincial health system. Some additional services for children and adults are available at a nearby hospital, or through telehealth services.

The Health Centre receives core federal funding for health education and prevention programs. This funding supports registered nurses to provided medical services including basic checkup and immunization services, administration of medication, assistance with regular treatments, and service coordination. Through creative partnerships, ongoing advocacy, and successful proposal-based funding applications, the Health Centre has expanded the services it provides. Additional services include access to an on-site physician and mental health services. In addition, the health centre hosts health or allied health students each year; past cohorts have included nurses, occupational therapists and dental students.

The local school has also played an important role in meeting the needs of Nation children, with support from MFNERC. An increase in federal funding for high cost special education and the implementation of Jordan's Principle increased resources dramatically between 2016 and 2019. Prior to these developments, the school was able to hire contract workers to provide limited allied health services roughly twice a year, sponsor some training for educational assistants and parents in Winnipeg, and provide assistive devices for students with communication impairments. There were no early intervention services for children between the ages of 0 and 5, and long waitlists along with other challenges prevented most children in this age group from accessing early intervention allied health services outside of the Nation. Recent changes have supported additional specialist services – psychologists, speech and language pathologists, occupational therapists and physical therapists. These gains are supplemented by the Jordan's Principle funded services discussed below.

4.2.1.3 Jordan's Principle funded services

When Jordan's Principle funding was announced in 2016, it provided a source of funds for services for children and youth with extra support needs that the Health Centre had been working hard to develop. The initial child and family support program was supplemented by SSP services. MFNERC was able to increase psychology, speech and language pathology, occupational therapy and physical therapy services. The RCC provides occupational, physio, and speech and language therapy three days per month and leaves child development workers with recommendations for ongoing support. The MATC also provides mental health supports. Finally, clinicians from St. Amant make regular, in-person visits to the Nation, providing access to a dietician and nurse practitioner, assessments, behaviour analysts, and family counselling. There has been some turnover in the Case Manager position and other Jordan's Principle positions, but the development of programs and services has consistently been supported by the Nation's Health Director, who has strong ties to Nation leadership.

By fall of 2021, over 100 children were receiving Jordan's Principle services and Jordan's Principle staff included:

- A Case Manager who oversees Jordan's Principle programming, supports Jordan's Principle staff, and works directly with families.
- An administrative assistant, who supports program logistics and administration, and also directly interacts with families.
- A rehab aid who works with SSPs to ensure therapy plans are followed between SSP visits.
- Five child development workers/respite care staff who work with children and youth in and out of school.
- A transition coordinator who works with youth in transition to adulthood and supports them in navigating adult services.
- Two land-based programming staff who work directly with children and youth.
- A language educator who works to revitalize language through diverse activities.

In addition, with Jordan's Principle funding and support from across Nation-level services, the Nation recently established a family wellness camp, and space for land-based and cultural activities that includes lodging, and communal and activity space.

Services, and the need for services, have been greatly affected by COVID-19 lockdowns and social distancing measures. The disruption of regular life and routines has highlighted, and increased, the extent of child and family needs. Key aspects of Jordan's Principle have been disrupted; these include disruption of an open-ended parent's group which previously brought families together and meetings which allowed service providers to share information and coordinate services.

4.2.1.4 Key gaps and challenges

Jordan's Principle has greatly enhanced the services and supports available to children and families, but gaps and challenges remain. Key among these are a need for capital funding to support the development of the infrastructure needed for Jordan's Principle services, and the need for programs and supports for youth in transition to adulthood.

Jordan's Principle services are currently based out of the Health Centre. The Health Director describes it as "busting at the seams." Five staff members share one Health Centre office, and four share another. The staff lunch room has been converted to office space, and the community health room is not big enough to accommodate all the children in Jordan's Principle programs. The Health Director notes that no one anticipated the need for space to

accommodate Health Centre staff, Jordan's Principal staff, and visiting SSPs. Other areas of needed capital funding include a sensory room to house and make use of sensory equipment obtained through Jordan's Principle. The lack of sufficient and appropriate space negatively impacts the ability of Jordan's Principle staff and SSPs to meet the needs of children and families.

Another ongoing challenge has to do with the lack of supports for youth transitioning to adulthood. The Health Centre has been working to plan and pilot programs to support youth in transition to adulthood, but have not been able to secure consistent funding for this work. The absence of appropriate supports, leaves some youth at risk of isolation, homelessness, or sexual exploitation.

4.2.2 Jordan's Principle in a Remote Northern First Nation

4.2.2.1 The Nation

Our second case study is a Nation with fewer than 2,000 residents. It is a remote, fly-in Nation surrounded by beautiful scenery. The nearest town is lengthy drive and only accessible via winter roads. Weekday flights connect the Nation to a service center. The Nation has a close-knit community that holds events and activities that bring Nation citizens together. The Nation's population is young when compared to the overall Canadian population: more than 50% are under the age of 20. Knowledge of traditional language is strong, with more than 50% of population speaking the language at home. The Nation is equipped with a grocery/general store, nursing station, gas station, and recreation facilities. It has also worked to ensure the construction of many new homes during recent years.

Still, the Nation suffers from infrastructure deficits and other challenges. Despite the new construction, there is a severe housing crisis. Many homes with 4 or fewer bedrooms house eight to 15 people. Mold, broken plumbing, broken windows, and lack of heat are among the other challenges in some Nation homes. The Nation has ongoing challenges with its water system.

The long-term impacts of colonial violence can be seen in education and employment statistics: fewer than 35% of adults participate in the labor market, significantly fewer than that for the total population of the province (62%) and over 70% of residents over the age of 15 had no certificate, diploma or degree, compared to 22% of the total Manitoba population aged 15 or over. The Nation also experiences substance misuse and alcohol issues. There are lengthy waiting lists for substance abuse treatment facilities and people must leave the Nation to access treatment.

The Nation also struggles with food insecurity. Most food is flown into the Nation via airplane, or transported on the winter road during the cold months. As a result, the quality and variety of food is limited, and can cost double to triple the typical cost in a metropolitan region of Manitoba. The price of healthy food is unattainable for most residents, causing them to purchase more affordable processed foods. Hunting and fishing are still important aspects of community life and Chief and Council offer meat packages to citizens when available, but the Nation lacks the infrastructure needed to support consistent sharing of traditional meat.

4.2.2.2 Services

Services for children and families are provided primarily through the nursing station, school, Child and Family Service agency and, recently, Jordan's Principle. Primary dental care is also available within the Nation; however, if dental surgery is needed, individuals have to be flown out of the Nation to access such medical care. The Nation has strong Wi-Fi, but this is not available everywhere within the Nation; and cellular service is also limited.

The school is housed in a relatively new facility, and is working on developing a land-based curriculum. School staff work with the community and will provide children with time off from school to ensure they can attend with their families and participate in traditional hunting activities. As in other Nations, an increase in federal funding for high cost special education has increased school based resources significantly.

The Nation has a nursing station, which provides primary and emergency services. The nursing station is understaffed, often leaving the medical care of the entire Nation in the hands of only three to four nurses on a 24 hour and seven days a week, four-week rotation. General practitioner physicians are available to the nurses on a consultation basis via telephone and to the residents via telehealth; however, face-to-face services in the Nation are sporadic.

Many children, youth, and families have to be flown out of the Nation to regularly receive specialized services, and the waiting period for these services is often quite long. Others are medivac'd out of Nation for emergencies. Many of the children in the Nation are living with diagnosed or undiagnosed developmental and physical disabilities. Services within the remote Nation are impacted by infrastructure and human resource challenges. For example, the nursing station often experiences shortages in water, whether to flush toilets, to wash their hands, or for dentistry procedures that require water.

The Nation started to receive Jordan's Principle Initiative funding in 2017. Jordan's Principle programming was originally based in health, and the Nation was able to hire someone who had previously worked in the Nation to take on the role of Case Manager. The Case Manager worked remotely, from their home in another province. Prior work within health services meant that the Case Manager was able to effectively facilitate some health-related referrals and connections to both specialists and primary care providers. However, planned connections with other service domains, such as education, did not develop and connections to Jordan's Principle services in these domains depended on the efforts of staff who informally took on Jordan's Principle responsibilities on top of their regular duties.

Without an on-site Case Manager to actively oversee work within the Nation, Jordan's Principle programming was slow to develop. Equipment purchased for a land-based education program went unused because the Nation was unable to hire staff to facilitate land-based activities; case files and financial records were not systematically filled out or maintained; the few staff that had been hired as teacher's aids, respite workers, or administrative support had no supervision or clearly defined duties; and, many children referred for services did not receive them.

In 2020, a new Case Manager was hired and the Nation also made other changes to the structure of its Jordan's Principle Program. The new Case Manager also lived outside of the Nation, but travelled to the Nation more frequently, in order to build relationships and oversee programming, and undertook a dizzying array of roles and responsibilities. These included:

- Establishing program infrastructure – A filing and referral system, systems meetings to build connections between service providers, and case coordination meetings to track work with individual children.
- Building relationships with external service providers – Establishing regular schedules for service providers to visit the Nation.
- Building relationships with families – Meeting with families, attending clinical service appointments with them when needed, working with them to identify needs and connect them to services.
- Planning events that helped to build community ties - A summer feast, Halloween and Christmas events, a Mother's day event.

- Helping to address families' basic needs – Organizing events such as toy and donation drives to bring essential necessities to Nation families during the pandemic, arranging for needed infant and toddler equipment such as car seats, cribs, and highchairs, and supporting the submission of requests for Jordan's Principle funding, including requests for home renovations.
- Advocating for new and expanded services – Working to secure additional services at the Nation level and to expand the time that professionals allotted for work in the Nation.
- Developing new programs - Introduced an mental health/wellness program intended to provide crisis management, one-on-one counselling sessions, psycho-educational, life-skills and recreational groups, as well as in-home supports and respite; the plan was to hire several therapists.

That Case Manager recently resigned and another person was hired in this role.

As of the writing of this case study, Jordan's Principle services, that were not previously available in the Nation, included services provided through: MFNERC, St. Amant, MATC, and RCC. MFNERC was able to increase psychology, speech and language pathology, occupational therapy and physical therapy services. The RCC provides occupational, physio, and speech and language therapy. The MATC also provide some mental health supports. St. Amant provides access to a dietician and nurse practitioner, assessments, behaviour analysts, and family counselling. MKO provides pediatric services, and 4 wellness workers are working in the Nation, running groups for the children in the Nation, intervening in crisis situations, and involving children, youth and their families in therapeutic interventions on a monthly basis. COVID-19 restrictions have compounded service challenges. Service from providers who typically fly into the Nation has been restricted, the nursing shortage has increased, and school was suspended for almost a full year.

4.2.2.3 Key gaps and challenges

Through Jordan's Principle, the Nation has made important gains in the provision of services for children and families. However, significant challenges remain. Underlying these challenges are remoteness of the Nation, the limits on pre-existing services, and the severity of the infrastructure challenges the Nation faces. Working in a context in which few services were previously available, heavy expectations fall on the Jordan's Principle initiative to support the development of both clinical and community services and programs. The Nation is funded for a single Case Manager to oversee the development and implementation of this broad range of initiatives.

The challenge of developing and implementing these initiatives is compounded by limits on the frequency and level of services that can be provided by external service providers who are stretched between several Nations and face growing caseloads and waitlists. Some service providers have indicated that the severity of environmental challenges faced by the Nation – such as lack of consistent water and adequate housing – undermine the potential benefits of the services that they are able to provide. The limited time that service providers have allocated for the Nation is further compromised by a lack of physical space to house visiting service providers. Coordination of care is challenging under these conditions.

Development of Jordan's Principle services has been slowed by challenges in recruiting, retaining, and overseeing qualified staff. The complex roles and responsibilities of the Case Manager position carry a heavy workload and burden, which is complicated by a lack of clear pathways for coordinating with leadership as well as an absence of clearly defined human resource policies to structure personnel decisions and other key aspects of Jordan's Principle work. Without strong support/guidance from others working within the Nation, turnover in the Case Manager position compounds these challenges – each new person must again begin critical relationship building processes and do so while working to make sense of and shouldering responsibility for the prior work around Jordan's Principle.

Chapter 5:

New Patches in the patchwork – tensions in the structure of Jordan's Principle

In this chapter, we examine ongoing gaps in services for First Nation children in Manitoba. Jordan's Principle has added important new patches to the pre-existing patchwork of services. Even so, vulnerable groups continue to be excluded and important gaps in the structure of services persist. Participants noted several key gaps in service.

- Youth over the age of 18 are no longer supported by Jordan's Principle, even though Child and Family Services (CFS) and some other services in Manitoba can support youth through age 21. This leaves some First Nation youth unsupported during the transition to adulthood.
- A chronic housing crisis directly impacts the health, safety, and wellbeing of First Nation children. The process for accessing Jordan's Principle funding for housing renovations is complicated and lengthy. Jordan's Principle funding for housing renovations is only available for children whose housing need is linked to disabilities. Current policy excludes other First Nation children who lack safe and suitable housing.

- The real cost of Jordan's Principle implementation in remote northern First Nations is not covered. The failure to fully fund the real costs of service creates inequities across First Nations.
- Jordan's Principle services have not yet been equitably extended to First Nation children living off reserve.
- Mental health services are currently inadequate to meet the needs of First Nation children and families. Gaps in Nation-based mental health services perpetuate a harmful, crisis-focused approach in which children must often leave their Nations in order to access mental health services.

5.1 Expanded services

The services available to First Nation children have been greatly expanded through Jordan's Principle. All Nations now have some access to allied and mental health services, and services for children with disabilities, that are provided by SSPs who travel to deliver services in First Nations across Manitoba. The RCC and MATC provide services in all 63 Nations, St. Amant provides services in 52 Nations, MFNERC serves 58 First Nations schools in 49 Nations, and FSD serves an additional 15 First Nation schools. (See Chapter 4, Table 2 or Appendix 6 for a summary of the services provided).[530,531,532,533,534]

In addition, Jordan's Principle has also created the opportunity for a broad set of new and enhanced services developed at the Nation level. All First Nations in Manitoba receive funding for a Case Manager and respite care or child development workers; many also receive funding for land-based healing, therapy assistants and wellness workers. A broad range of additional services can be provided at the Nation level – these include diverse programs including classes and supports for culture and language, child and youth recreational activities, educational supports, child care, supports for families and caregivers, community events and group activities, courses and activities focused on healthy living and life skills, and emergency assistance.[535] (See Chapter 4, Textbox 4 for a sample of Nation-level Jordan's Principle services.) Regional programs and services complement these Nation level services and seek to address known gaps in services. Thus Jordan's Principle has dramatically expanded access to services.[536,537,538,539]

Though systematic data linking Jordan's Principle services with CFS involvement was not available to us, some interviewees suggested the new services funded through Jordan's Principle may prevent apprehensions into CFS by responding to the needs of children and families.[540] In other cases, funding for services through Jordan's Principle has supported the return of First Nation children to their home communities, allowing them to access services that were previously unavailable at the local level and required placement in long-term care. A SSP gave an example of repatriation.

> *One of our favourite stories is one of the very first things that we got to do with our Jordan's Principle resources. So, way back in the fall of 2017, I had mentioned earlier on that we have a long-term care facility ... and at that time, we had a child from a northern First Nation who was quite young, who had been living in our building because [the child's] home community didn't have the resources to meet [the child's] needs.*[541]

The SSP went on to explain that a change in the child's health created an opportunity for the child to be cared for at home and Jordan's Principle funding facilitated the transition. He continued:

> *We arranged in very short order for, you know, all the brothers and sisters and the parents to come, to fly down and come to Winnipeg and get training from nurses on how to meet [the child's] care needs ... so that they would be not only knowledgeable of how to meet [the child's] needs, but confident that they could do it. It's been ... over three years since [the child] returned home – still there, you know, thriving at home.*[542]

Jordan's Principle funding has also increased access to products that support child and youth wellness and participation in community events, such as devices that assist mobility or sensory rooms.[543,544] (See Textbox 5 for additional examples.) A Case Manager discussed an example of creating modified winter clothing for a child with significant disabilities. She noted the ways the modifications built on the strengths of family and Nation members to address the needs of the child.

> *We've got a [child] in our community with a very debilitating disability ... [who has] not been able to experience outdoor activities in the winter for a very long time because they cannot get clothing or winter gear – because it gets up to -60 in our community. This year we secured funding – well, no secured funding; we paid for it out of our budget. We had a local community member make [a] bunting bag snowsuit with wraparounds for [the child's] feet because [they] can't wear any kind of boots or anything like that. And for the first time this year [the child] gets to go out with family and sit around the bonfire and go for walks and things like that in the winter. So that to me – you should just see the pictures ... It was priceless. It was a beautiful story.*[545]

Jordan's Principle funding also played a vital role in supporting delivery of products and services to Nations that otherwise would have been significantly limited during the COVID-19 pandemic and subsequent lockdowns. Staff associated with Jordan's Principle services in First Nations noted being engaged in crisis response operations throughout the COVID-19 pandemic. Vital COVID-19 supports implemented by Jordan's Principle staff included, but were not limited to: wellness checks; delivery of groceries, medications and other supplies; creation and distribution of activities for periods of lockdown; and the purchase and distribution of electronic equipment to facilitate access to on-line resources for children and families.[546,547,548] Jordan's Principle staff also supported the implementation of checkpoints, contact tracing efforts, and innovative approaches to community outreach, such as a radio talk show to provide information on mental health during periods of lockdown and isolation.[549,550,551] Pre-existing wellness focused services and activities continued, playing a vital role in bringing families together through land-based traditions and socially distanced community contests around Halloween and Christmas.[552] Many of these initiatives required long, taxing hours in response to emergency COVID-19 measures.[553,554,555,556]

5.2 Significant gaps in services

Interviewees and focus group participants also drew attention to groups of children whose access to services was particularly limited and to persistent gaps in services. In particular, interviewee and focus group members highlighted:

- The lack of supports for on-reserve youth older than 18,
- The urgent need for housing supports, and
- Unresolved challenges to providing services in small and remote First Nations
- Limited access to Jordan's Principle for off-reserve First Nation children,
- The need for additional mental health services and supports.

Textbox 5: Jordan's Principle success stories

A Case Manager discussed a day-care aged boy with cerebral palsy who couldn't sit or hold a bottle.

> *I've watched him develop, this little guy ... Now he's using a sippy cup, he's, he couldn't crawl before either, he's crawling – and he can sit up. And, you know, like his strength is, he's gotten so much stronger.*[557]

She continued and described the child's progress.

> *Like even the sounds, like he's trying to say something because right now, you know, he'd just kind of cry and try and babble. But now you can try and make out something that he's trying to [say] – or even a feeding I guess, he started to eat and gain weight.*[558]

The Case Manager credited Jordan's Principle funded service providers with his progress.

> *Occupational therapists and the physiotherapists coming in and teaching our workers how to work with him and the parents of course ... and they've provided so much equipment to him.*[559]

Speaking of the impact of Jordan's Principle more generally, she said,

> *It has been amazing seeing the progress of our children."*[560]

A health director shared the situation of a family with one hard of hearing child and other young children in the home to take care of:

> *Jordan's Principle provided all the safety equipment for this family. So they provided a gate, a fence to secure the child in because the child's already getting to that age where curiosity is getting the best of him and ... the family's expanding so they were able to renovate the home to meet the child's needs. And then this time around we were able to secure Internet as well as [a] computer system for him to learn. To me I liked seeing him happy because we're able to connect with him virtually through this program and he's slowly learning the different signs. So we're able to help secure the family because you know financially, on reserve, you don't get a good income and now that we made sure that all the barriers the family placed were taken down. It took a while, months, to get where the family needed to be and now that they are where they feel more comfortable, more space, more secure then it's different with the way we interact with the family now where you know we go on and the child is already learning the scheduling. So to me I find that successful.*[561]

Another Case Manager spoke of the impact of mental health services:

> *We had one young person who was really, really struggling, had had a lot of – some trauma and some losses. And when I started they weren't leaving the community. They haven't been going to school for a year ... Would not leave the community, would not go out of town at all. And they've been seeing a mental health counsellor from St. Amant for three years and will actually probably graduate this year.*[562]

In addition to these specific gaps in service, interviewees and focus group participants spoke of ongoing difficulties accessing services because of factors such as a lack of necessary regional coordination, growing caseloads and waitlists, staff turnover, delays in provision of Jordan's Principle funding, and insufficient physical and digital infrastructure. These issues are discussed in more detail in Chapter 7 of this report.

5.2.1 Youth over age 18

When Jordan's Principle was initially implemented in Manitoba, funding was available to support youth up to age 21. The age of eligibility for Jordan's Principle was changed to 18 in 2019, without any consultation or discussion with First Nations in Manitoba.[563,564,565,566,567,568] The discontinuation of services for children over 18 meant that service providers had to wrap up services for youth they had been supporting and turn away others who were previously eligible for services.[569] One SSP reflected on the impact for families and communities.

> *Initially, Jordan's Principle mirrored that age 21 cut off. I can't remember exactly when it happened, but a year and a half or maybe two years ago, that was reduced to 18. And that was quite impactful for families and people, and we had to make some hard decisions around what to do for people who were on our wait lists, what to do for people who were mid-stream through services ... And so, suddenly, when those people turn 18, their needs have not gone away, we know that. These are lifelong needs, but the supports are gone. And so, it's experienced as a loss in ways that it wasn't a few years ago, because it's hard to experience as a loss something that wasn't there in the first place, right?*[570]

The cut off of services at age 18 affects many youth, whose health conditions and/or disabilities are lifelong, including those learning to live with diabetes, attention deficit hyperactivity disorder (ADHD), schizophrenia, autism spectrum disorders, or other lifelong conditions, as well as youth with long-term needs that cannot be met through Nation based assisted living.[571,572,573] Interviewees suggested that youth with cognitive disabilities were among the those most significantly impacted by this restriction, noting an absence of services to support these youth into adulthood. One of the participants mentioned:

> *[For children] with severe autism and some major cognitive delays that are in play right now, they would not be able to live independently as an adult ... I've got two children that have aged out of the program. There are no services within First Nations for young adults ... But it's those services that are required for the young adults that have cognitive disabilities that just because they are chronologically aged, cognitively they're like five-year-olds and there's nothing in the community or the services to fill that gap. So that's an area that I really feel is hugely missed even though we've come to the table with it several times.*[574]

Case Managers indicated that these youth and their families need ongoing supports and education. They highlighted, for example, the need for independent living supports for youth and also for supports for families navigating new administrative challenges, such as filing taxes and applying for social assistance, once youth reach adulthood.[575,576]

Many interviewees noted that disability can extend across the life span and asked what happens when a child reaches the age of 18 and retains the same level of needs without the corresponding services.[577,578,579] They pointed to the Home and Community Care program as the only option on reserve and noted the inadequacy of this program when

it came to the needs of youth with long-term disabilities.[580,581] One Case Manager noted that:

> *The delivery approach of Home and Community Care is just for short-term care needs where the youth and adults with disabilities, their disabilities will never end.*[582]

Some interviewees pointed to the discrepancy between the age 18 cutoff for Jordan's Principle services and the extension of other services through to age 21. One SSP noted that:

> *In Manitoba, youth who have a disability and who are still in school are able to access, you know, school funded or youth disability services until the age of 21.*[583]

Another described children living in First Nations as being:

> *At a pretty significant disadvantage when they turn eighteen, because they now no longer can get the services they require through Jordan's Principle. But they also can't get CLD [Community Living disABILITY Services] because it's provincially funded.*[584]

Importantly, child welfare services in Manitoba can also be extended, by agreement, to youth up to age 21.[585] These discrepancies in age eligibility mean that, for the families of youth denied services through Jordan's Principle, the alternatives are to place the youth in the care of the child welfare system through a VPA or to move off reserve in order to access provincial services.

Case Managers and other service providers shared the concerted efforts that they made to advocate for services for youth aging out of Jordan's Principle. For example, one respondent described efforts to secure supports for individual children, saying:

> *I wrote letters and I provided letters of support from the nurse practitioner, from the doctor, from the specialist that I've seen, SLP/OT/PT; I provided everything. And I said these kids need services and I even got a letter of support from the Band saying, you know, we need these services. And yeah, it was denied at the Ottawa level because of their age.*[586]

Another described years of effort to secure funding through other (non-Jordan's Principle) sources for a program that would support youth transitioning to adulthood.

> *We've applied for funding through the Assisted Living program to hire a disability coordinator and her role is ... [to] work with them to talk about life skills training. I've been applying for this for about three or four years and they only just recently approved it.*[587]

The program was funded for two years, but denied a funding for a third year without any clear explanation of the reasons for funding termination.[588]

In the absence of resources to support youth and adults with disabilities, some families had to place their children in institutional settings. For example, one Case Manager shared a story of a child that aged out of Jordan's Principle and had to enter a personal care home in the Nation. She noted:

> *So that was a time where I felt very helpless because I didn't know what we could do for him or where else we could send him.*[589]

Case Managers and SSPs indicated that inclusion of these youth in the community has benefits for not only the youth and their families, but also the whole Nation.

> *You know what? It's important to me that these kids are involved and that we teach the other children that we don't want them segregated. We want them included, they're part of, they're here to give us a teaching. They're here to teach us. Believe it or not, they're here to teach us. And whether that lesson be patience, whether that lesson be love, whether that lesson be innocence, whatever it is, they're here to teach us something and every person can learn from them.*[590]

5.2.2 Safe and adequate housing

Service providers also highlighted the urgent need for additional funds to support the renovation and construction of housing to address First Nation children's needs and best interests. Recent ISC data indicates that over 4,100 of the roughly 17,200 homes in First Nations in Manitoba need major renovations and over 1,200 additional homes need replacement; discussions focused on the importance of social distancing during COVID-19 also highlight the severe overcrowding of housing in some First Nations in the province.[591,592,593] A Case Manager explained the urgency and necessity of addressing on-reserve housing conditions.

> *In any community, housing is always a big issue regardless, if you have a child with a disability or not. And the homes that are built in our community never meet the needs of the child just because they have to build these houses a specific way and the amount of funding that they get is only enough to make as many of these same types of houses that they have to build, just because of the budget and the cost. So every single time there's a new home built, it does not include meeting any of the needs of any of our kids in the program. At any moment, at any time that I've ever known.*

She shared an example of a case in which inappropriate housing posed a severe health risk for a child with disabilities, along with other examples of inadequate housing.

> *We did have one kid that needed a lift in his home. He needed a washroom ... The mom was carrying him all the way from his room all the way to the end of the hall just to bathe him ... So those were things that were happening. And the home was not equipped to meet his needs ... he was on oxygen and you know, there were times when he'd run low on that right? So the ambulance would have to come and there were all these struggles getting the stretcher into the hall because the halls weren't built for stuff like that.*

She continued, discussing other ways in which housing problems affected the health and wellbeing of children.

> *Some of our families live in one bedroom and there's five of them. You know. And that could be so overstimulating for a child that has autism or ADHD or a child with special needs that has to have one specific bed for them, and then they all crowd on one bed...then we have homes where there's mice as an issue or you know, homes that are so old, like, these families move into these old houses just to have their own home. So those are the types of housing situations that they run into that we don't have to fit their needs.*[594]

The same Case Manager discussed the role of housing in the decision to institutionalize a youth who aged out of Jordan's Principle.

> *We went to the home, tried to assess the home, tried to get what [was] needed to be in the home for him, and ... that room could not be fixed. It was just too old and the condition of the home wasn't great and it wasn't recommended for*

him to stay there.[595]

A SSP drew attention to her understanding, which was shared by other study participants, that housing modifications through Jordan's Principle were only available when children had housing needs that were directly related to a disability. She shared a story that highlighted the very real and immediate ways in which housing supports were needed in order to meet the needs of other First Nation children.

> *One brother showed me that the other brother's hair was burned at the front from the fire. And it turns out they were heating their home with a barrel in the middle of their living room because there was no other way to heat the home. The home was, it was the worst house I've seen. Like, you could see through the walls. They just had a sheet of plastic, and this was a minus 30 Manitoba winter. I wrote a home assessment report but knowing there was no way in heck this would ever get funded by Jordan's Principle because these children have no accessibility needs [that are directly related to disabilities], they're just developmentally delayed, and barely – and really, considering what their parents were dealing with, it was amazing ... they're now living in, like, an uninsulated eight by 12 fishing shack, that they are working to insulate somehow.*[596]

Service providers also noted the ways in which poor and limited housing quality curtailed the capacity to deliver services that could meet the needs of children and families. One service provider pointed out that overcrowded housing limited the possibilities for out-of-home respite care, which allowed caregivers to rest and relax within their own homes while their children were cared for elsewhere. She noted that, in some of the Nations she worked in, there were no homes that had space available to provide respite care.[597] Another SSP drew attention to the challenges of providing housing for visiting service providers, noting that "availability of accommodations in community was actually a very common reason to have to cancel a visit."[598]

Another service provider reflected on the ways in which poor quality and overcrowded housing affected her work with children and families.

> *There are numerous, numerous communities and homes that their homes are not, not livable, but that's what they have. I know there's a sense of embarrassment that numerous families that I am involved in have stated to me, so they don't want us in their home ... So, when a child is having behaviours and especially as generalized to the home and only the home, that makes it difficult for us because we cannot help to distinguish that behaviour or replace that behaviour because of the environment...It is a barrier.*[599]

Jordan's Principle can, in theory, currently fund the modification of homes to meet housing needs linked to children's disabilities. However, Case Managers noted multiple challenges in accessing housing modification funds. They described a long and extensive application process that requires support letters from the Housing Department, Chief and Council, and the Director of Health. Applications must also include labor and materials quotes that cover the costs of the renovation. In addition, in some cases, an Environmental Health Officer, who has multiple responsibilities and may only visit a Nation three or four times a year, may also be required to submit assessments.[600,601,602]

The complications and delays in approval of housing modifications through Jordan's Principle were further exacerbated by shifts in decision-making procedures. Housing requests were initially assessed by the regional FNIHB office. However, at some point, this changed and applications were sent to the national office in Ottawa instead. Many requests were denied at the national level, even though the supporting letters and assessments verified the need for home modification.[603,604,605] Case Managers noted that, as a result of the restrictive approach to housing modification funding, they know of long lists of families whose housing needs have gone unmet. In addition, they noted that, in some cases, they waited several months or over a year to get a response to housing modification requests.[606] By early 2021, the Regional Jordan's Principle Coordinator noted that housing modification decision-making had recently reverted to the regional office. Although there were still restrictions on the range of requests that could be approved, modification requests were once again being approved regionally.[607]

5.2.3 Remote, northern Nations

Manitoba covers a vast geographic area, encompassing nearly 650,000 square kilometers.[608] The geographic remoteness of some First Nations plays a significant factor in the implementation of Jordan's Principle. In Manitoba, there are only four large service centres where supplies, materials, equipment, a skilled or semi-skilled labour pool, financial institutions and provincial health, social, and environmental services are available: Winnipeg, Thompson, Brandon, and the Pas. Only four First Nations are within 50km of, and have year-round road access to, a service centre. An additional 39 First Nations have year-round road access, but are 50-350 km away from a service centre. One First Nation is over 350km with year-round road access, and 17 First Nations have no year-round road access.[609] These 17 fly-in First Nations are the most remote in Manitoba. However, road conditions, weather, and driving distance to access a service centre can also present challenges for Nations that have year-round road access.

Interviewees and focus group participants indicated that Jordan's Principle funding was not sufficient to address the unique barriers to the implementation of services associated with remoteness.

Extensive travel demands prior to the COVID 19 pandemic limited the time that service providers could spend in remote First Nations and highlighted the urgent need for capacity building to develop a cadre of service providers, who live and work in First Nations, in order to ensure continuity of care.[610] One of the SSPs described the challenge of serving small, remote Nations this way:

> *Manitoba is really big, and just the geography and the logistics create a lot of challenges ... Fortunately, we have the financial support to travel, so that – the cost isn't our problem ... the balance between caseload size and number of communities is a real challenge for us. So, if it takes hours to get to a place, you want to provide services to as many kids while you're there as you can, but if there's just a handful of kids in that community, those children still deserve service, so you still have to provide supports to them. But the travel, the consequence of that extended travel time, is there's fewer paid hours available to work with other kids in other places, right? And so, there's an ongoing – it's an ongoing puzzle that we're trying to resolve.*[611]

The difficulties in travelling to communities are compounded by limited access to costly Internet services, which present a challenge when attempting to contact Nation based service providers, families, and children.[612] A SSP explained how the lack of digital infrastructure interferes with providing services to First Nations:

> *There's lots of logistic problems with communication. [A] number of homes*

without telephones, without Wi-Fi or Internet, there's all sorts of issues around that.[613]

She noted that the difficulty in connecting with families took up time and resources, and could extend the period that families remained on waiting lists. Telehealth services provide some access, but burdensome booking processes and limited Internet access remain barriers to wide-scale implementation.[614]

For cases in which services could not be accessed or provided within a Nation, arranging medical transport services became a complex and time consuming task.[615] A Case Manager discussed the important role that access to consistent medical transport can have in preventing the involvement of Child and Family Services (CFS) while ensuring children have access to necessary healthcare.

We had one family where she would get the funds to take her child to his appointments, and he has a disability and needs to go at least monthly and he would – she would get the funding for it, but then her ride wouldn't be able to take her. So she would miss the trip to go to the appointment. So they – the clinic where she was taking her child phoned Child and Family Services and said you need to check on this family, this child is not getting in for their appointments and needs to be getting in for their appointments. So, Child and Family Services stepped in.[616]

She described the measures taken to avoid CFS involvement, noting, "every time they need to go, we book a hotel room, and I book a driver, and they go and get to all of his appointments."[617]

Factors that can complicate families' experience with medical transfers include remoteness, attrition of local service providers, limited access to local specialized services, under-equipped medical providers, and limited cultural safety across service provision.[618] Case Managers also noted that the paperwork and approval processes for medical transportation were complicated and restrictive. For example, only one family member is usually allowed to accompany a child, and families face challenges even after the paperwork is complete and the reservation for travel is confirmed.

When a child has to go into Winnipeg, we still have some parents that do fly in but require a second escort for the child. But that's been our nightmare... it has to be a severe situation before they approve. So, like the little guy I just talked about, they finally approved him to have two, both his parents to go in with him because the mother can't lift him.[619]

Once in the city, it was difficult to get funding for appropriate accommodation. Even basic transportation was complicated by the requirement to obtain funding approval before travelling.

I don't know if you're aware they stick them in these boarding homes and these children can't, especially the autistic children, they can't handle the noise....So we've having to pay ... out of our funds to put them in a hotel where we know they're going to be safe. ... When these people go in, like they're on hold for about an hour, two hours, you know, just to get a taxi from point A to point B or a flight. You have to call once you arrive in Winnipeg and say I'm in Winnipeg I need to – I'm here so I need a taxi.[620]

She noted that, as it was possible to drive from her Nation to Winnipeg, she sometimes preferred that Jordan's Principle staff use a van to drive families four and a half hours in order avoid the challenges associated with the medical transportation system.[621]

Another serious challenge for remote communities was the additional expense and complication of acquiring equipment and supplies. A Case Manager speaking during a TAG meeting explained the impact of freight costs on her Nation's Jordan's Principle budget:

That's coming out of our budgets that are for our program where that can be going to a lot of other things and we can be doing for the kids. It costs us $4,000 to bring something up that other communities don't have the issue with because they're driving. It's a barrier.[622]

In the same meeting, another Case Manager talked about the difficulties, due to inaccessible roads, that further exacerbated challenges in meeting deadlines and pressing needs in some First Nation.

Our communities are not accessible by road. A lot of times we have deadlines in terms of getting the equipment for somebody, during one whole year, we have a window of two months for any transportation, any special equipment. For instance, if we wanted to build a fence around a hole for a child, we need to transport it to winter road. We have to submit our winter orders by November or December the latest, then they would be ready to be shipped as soon as the winter road is open. It's very costly to bring anything and a lot of times they might say no when they're trying to transport certain equipment up here on the plane.[623]

Cumulatively, the challenges of service provision in remote, northern First Nations can result in children and families in those Nations receiving a smaller range of, lesser quality in, or less frequent access to services.

5.2.4 Off-reserve First Nation children

A series of orders issued by the CHRT has required the federal government to expand its narrow interpretations of Jordan's Principle eligibility to include: children who live on or off reserve and are registered or eligible for registration through the *Indian Act*; children with a parent/guardian with *Indian Act* status or a parent/guardian who is eligible for status and live on or off reserve; children who are recognized by their Nation and live on or off reserve; and children who are "ordinarily resident on reserve."[624,625,626] Service providers who worked both on and off reserve indicated that, because of the extension of services through Jordan's Principle, there were situations in which services were now more readily available or more easily accessible to First Nation children living on reserve than to off-reserve First Nation children.

One participant in a focus group noted:

I've been with Jordan's Principle for several years, we used to have families begging to come off reserve to receive services. Now we're telling families "stay on reserve." Under Jordan's Principles service agreements [with SSPs.] ... if you look at an off-reserve, we don't have those service providers coming in on a regular basis ...[627]

Another shared a case of a First Nations girl with severe suicidal ideation and self-harming behaviours who lived 10 minutes away from a First Nation in which children could access telehealth services through a SSP. She noted that, because the child was not an acknowledged member of that Nation, she was not able to access services there.

We ended up going back to the first support that was open and offered to the child with just the community mental health. It's an hour and 45 minutes away from the child's community.[628]

It is unknown whether an Off-Reserve Case Manager was involved in the child's case, and might have been able to arrange access

to alternate services. However, the SSP's colleague summarized the situation succinctly, noting that all communities – First Nations and non-First Nations – are underserved when it comes to mental health, but the pathways to accessing services now sometimes seem clearer on reserve.[629]

Other interviewees noted that Off-Reserve Case Managers have not had the resources to do extensive off-reserve education about Jordan's Principle. They also pointed to differences between the way Jordan's Principle funds were allocated on reserve, where the emphasis was on the development or extension of services for groups of children, and off reserve, where funding is primarily allocated to address the identified needs of individual children.[630,631]

In other cases, the limitations on services for off-reserve First Nation families were more explicitly demarcated. A service provider, who had been working with First Nation families both on and off reserve, shared that he had recently been informed that his organization would no longer be funded to provide services to First Nation families living in Winnipeg. He was asked to bring active Winnipeg cases to gradual closure, in accordance with the clinical needs of the children and families, and instructed not to extend services to additional families living in Winnipeg.

> *One of the things that recently got changed is that children and families living in Winnipeg could not receive Jordan's Principle services, but children ... on reserve or off reserve and not living in Winnipeg can receive services ... That's been difficult, because obviously one of the reasons families move to Winnipeg in the first place is to access service, because they don't have services where they live, and now we're telling them that they can't access Jordan's Principle services in the city.*[632]

His organization originally extended services to First Nation children living off-reserve in keeping with their understanding of CHRT rulings on Jordan's Principle eligibility. However, administrators were subsequently informed by the FNIHB regional office that directives from Ottawa provided further guidance that made it more difficult to fund services for off-reserve children. The organization was told that they were to continue providing services to off-reserve First Nation children in rural areas but would no longer receive funding to provide Jordan's Principle services to families in Winnipeg. No clear explanation for this shift in policy was provided.[633]

The challenges that off-reserve First Nation families face in accessing services are compounded by the fact that the provincial government has no mechanisms for addressing First Nation children's needs through Jordan's Principle. A 2018 statement from the Manitoba Departments of Health and Families noted that the departments generally 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."[634] However, the statement also noted that, in cases involving First Nation children living off reserve, "any requests for services or funding are responded to in the same manner as they would for any other child living off reserve."[635] We could find no evidence that this provincial approach to Jordan's Principle has been meaningfully modified.

Cumulatively, observations by study participants raise important questions about whether First Nation children living off reserve are receiving equitable treatment under Jordan's Principle. Some participants pushed this line of inquiry even further and noted the ethical questions they faced around denying services to non-First Nation children who lacked access to needed services that are available to First Nation children through Jordan's Principle. Some service providers noted that the provision of additional services to First Nation children is in keeping with the goal of achieving equity, or equality of outcomes, for First Nation children. Yet, others noted the moral challenge of denying these services to Métis or other children in urgent need of support.[636,637,638]

5.2.5 Mental health services and supports

Participants also pointed to a need for additional mental health supports, noting that the COVID-19 pandemic, and the resulting community lockdowns highlighted and exacerbated the need for more comprehensive, locally based mental health services.[639] First Nations across Canada have called for additional mental health resources, noting that confinement, loss, and disruption of daily patterns of life associated with COVID 19 have exacerbated mental health issues that are rooted in settler colonial injustice.[640] In Manitoba, multiple Nations have recently declared state of emergencies following youth suicides or self-harm incidents.[641,642,643]

Participants noted the severity and complexity of the mental health issues that they face in working in First Nations. For example, one SSP described the case of a young woman who had been referred to her.

> *She had multiple previous suicide attempts prior to involvement with us, ongoing suicide ideation, struggling with some social anxiety in large groups at school, low moods for standard periods of time. And so, after doing our assessment and building a relationship with her, we learned that there was some previous trauma in her life that was disclosed appropriately through CFS. She also doesn't have a relationship with her father, where she has feelings of abandonment and loss that come from that. And there was a period of time where her mother was struggling with substance abuse, so was kind of in and out of her life.*[644]

Reflecting on complex and severe needs faced by some children and families, interviewees and focus group participants noted that much of their work focused on crisis intervention.[645,646]

Discussions of the available mental health services highlighted the ways in which the emphasis on crisis response was shaped by a lack of Nation-based mental health resources. Interviewees noted that long waitlists for off-reserve services persist even though the need for widespread reforms to mental health services in the province has been highlighted for many years, and the Manitoba Advocate for Children and Youth has linked ongoing gaps in services to child deaths.[647,648,649]

On-reserve, the typical allocation of FNIHB funded mental health supports within First Nations is limited to 2-3 days/week of mental health worker time.[650] As one SSP noted, the impact of these limited supports can be undermined by the contract-based structure of the positions and contractor turnover.

> *Each community has the opportunity to have mental health workers through FNIHB, and those are picked up on a contract basis. So let's say we were working with one FNIHB worker for a month and we're emailing back and forth and having a plan in place for the students, we know the following month it can be somebody totally different and then the plan kind of goes out to left field and we have to explain everything again and come up with a way to implement that same plan. So it is kind of a juggling act when it comes to mental health in the community.*[651]

In addition to FNIHB funded mental health workers, basic child and youth focused supports could be provided by school counsellors.

The work of FNIHB mental health workers and school counsellors was supplemented

by the Jordan's Principle funded services provided by SSPs. These supports and services greatly expanded the available mental health resources, however participants noted several factors that limit the ability of SSPs to fully address children and families' mental health needs. SSPs commute into communities for only a few days at a time, sometimes providing telehealth services in between visits. This necessarily limits the extent to which they can respond to emergent issues in real time or engage in ongoing, preventative interventions.

In addition, as will be discussed further in Chapter 7, access to SSP services can be further complicated by long wait lists. Some SSPs noted that, in order to ensure services to those children with the most urgent or severe needs, and prevent the expansion of waitlists, they had to refuse services to children/families with less severe or complex cases. One SSP described criteria that narrowed services to those children with severe or urgent needs.

> *They have to meet the criteria to see us and that criteria is either self-harm, suicidal ideation, suicide attempts, or trauma, complex trauma.*[652]

Another SSP, from the same organization, elaborated.

> *I do have to say no, if they don't meet that criteria, because I have too many files that I can't keep up with. And as soon as I add somebody else to it, it is really taking away from my time and my ability to be there for somebody else who fits that criteria that really needs me.*[653]

The organization worked to extend services to children with less urgent needs whenever possible, while managing high caseloads with limited staff.

In absence of locally based preventative and supportive mental health resources that were sufficient to meet the needs of children and their families, participants noted a damaging approach in which children in some Nations had to be flown out of their communities to access services. This practice is expensive, inconsistent with the spirit of building local capacity to address this issue, and potentially even harmful. One SSP noted:

> *Kids would be sent down, they'd fly down, they'd get better in the air. Why not have them staying home with community services?*[654]

Another SSP expanded on the harmful impact of this pattern.

> *Having kids flown out to Thompson or Winnipeg for crisis, is antithetical to their mental health, and it's a revolving door, it is frustrating for the service providers and the community, it's frustrating for the families, it's exhausting, it's hugely expensive. And it doesn't do what we – it doesn't meet the goal.*[655]

Other interviewees spoke of the trauma that youth could experience when they were rushed out of their Nation in this way, and noted the work needed to help them process the experience afterwards.

Participants recognized the potential for funded mental health initiatives at the Nation level, pointing to examples of some Nations that had developed comprehensive, Jordan's Principle funded approaches.

> *Some communities, they're really strong and the people are very confident and they know how to handle this. And it's only the most sort of severe mental illness that they come to us for and it's, like, "Wow, you guys have everything else, a great, great system."*[656]

However, they also observed that not every Nation currently has the capacity to develop needed mental health services. One SSP pointed to a common trajectory in the development of Jordan's Principle services.

> *I think some of the communities that are still in the early stages of development are more focused on early physical developmental disabilities and not so much mental health, particularly when it comes to teenagers. I think there's still some gaps there in which communities are accessing services for their kids.*[657]

The initial focus on physical and developmental disabilities aligns with a history in which Jordan's Principle was initially focused on children with special healthcare needs and the expansion, to a broader focus on First Nation children, occurred over time.

Interviewees and focus group participants called for additional resources to support the local development of mental health services. They pointed to the need for crisis response teams in each community, a particular need for services for older youth, the incorporation of culture and traditional teachings into these approaches, and the possibility for innovative interventions such as community-based crisis housing which could provide "24 to 36 to 72 hours of settle down, we're going to surround you with love" time for youth, instead of the emergency evacuations that currently take place.[658,659,660,661]

Chapter 6:

Relational & Responsive Approaches to Service Design and Delivery

In interviews and focus groups, Jordan's Principle Case Managers, SSPs and Service Coordinators outlined a shared approach to the design and delivery of services. They noted that work in First Nations requires extensive relationship-building with families. They described the development of trust as a necessary foundation for families to engage with Jordan's Principle services, and for service providers to learn about, and tailor services to, community and family priorities, resources, and needs. They also noted the need to build relationships with local knowledge keepers and Elders, to ensure that services respected local practices and protocols and avoided inadvertently perpetuating harm. Finally, they noted that they must also build relationships with other service providers and Nation leadership in order to ensure coordination of care and support for needed services and programs. The extensive relationship-building requirements described by interviewees and focus group participants expanded service provider roles, requiring them to take on complex responsibilities that extended beyond traditional disciplinary boundaries. The trust built with families, led to a broader scope of practice that sought to respond to each family's

priorities and needs, leading service providers to challenge normative practices as they tailored services.

6.1 A relational approach

Participants identified relationship building as being at the core of their work in First Nations. Their relational approach, centered (re)building relationships with families, relationships within Nations, relationships with Elders and knowledge keepers, and relationships with other service providers and leadership.

6.1.1 (Re)Building relationships with families

Case Managers and SSPs highlighted the foundational role of (re)building trusting relationships with First Nation children and families. A SSP shared a story that clearly demonstrated the central role of relationship building in service delivery. She discussed an interaction at the front desk of an office, after she offered to hold a toddler for a mother who was struggling to complete her business while looking after multiple children.

> *So, I was holding him and she [the mother] was talking to local people in their local language, and she was talking to us, and you could see our cred going way up because, you know, we were… trusted with these kids…next thing I know, after we've given the kids back someone comes out and says, "We need more information from you, come in the office." So, they bring me in the office and they, like, need our address and they're asking all these questions about what we do…And then, the nice man sitting in the corner all this time, eventually, he starts talking, and it turns out he has a…[school aged] son who has never gone to school.*[662]

In talking with the man, the SSP learned that his son had significant developmental issues as a baby and that, for different reasons, multiple attempts to secure services to address his son's needs did not work out. The SSP explained Jordan's Principle and they agreed that she would refer the man and his son to local Jordan's Principle services. The SSP shared that:

> *When finally, the local staff met him, our rehab assistant said, "Oh, that dad has come in three times and picked up a referral form and never brought it back." … He basically was watching everything long enough until he felt safe.*[663]

Participants noted that the work to build trust and relationships did not end once a child or family started receiving services, but continued, with the ability to understand needs and support children and families dependent on the ongoing development of trust. Often, once trust is established, a parent is open to sharing information about and receiving supports for other children who may not have otherwise received any services. One SSP recalled:

> *Over the three years, we have built a lovely relationship with her [a mother] and her family. And just in the past year during COVID, actually, she started asking us about her other kids and had some other concerns. And so, just like those signs of trust that she not only is letting us help with her youngest son who has these really high needs, but her other son that she has questions about.*[664]

Interviewees and focus group members described the need to focus on rebuilding trust with families that have experienced trauma associated with histories of difficulty accessing services inappropriate or damaging services, and inter-generational policies of cultural genocide such as Residential Schools and contemporary CFS.[665,666,667] A Case Manager spoke of the ways in which the ongoing, mass removal of First Nation children by the CFS system shapes families' initial perceptions of Jordan's Principle services and necessitates a relational approach. She described a pattern of interaction in which families reveal strong concerns about engaging with services.

> *OK, just a minute, are you guys CFS? Are you just trying to slip CFS in here?" "No we're not, we're the complete opposite. "Oh OK, no you look like, no I think this is CFS;" so we are having to do that deep healing work with families in order to get in and do the work to develop and build a bridge towards trust. And until we do that, until we are able to engage and have conversation and build that trust we don't get… anywhere. And so we are having to do it, we are having to do that, "How are you?" Just phone and ask, "How are you, how's things going today?" Those very simple and very, really when you think of it very kind of human actions and behaviours, attitudes that, you know, that lead to behaviours of "I care, I care about you."* [668]

The fear of CFS engagement can persist beyond the initial relationship building stage. For instance, in a context in which the rate of First Nation children in out of home care is higher than in any other province, service providers noted that families feared COVID-19 measures could trigger the involvement of the child welfare system and the removal of children from family care.[669] One SSP noted:

> *There was a mom that had a few questions and then eventually felt comfortable enough to ask the question that she really wanted and although it was more of a statement than a question, she said, "My greatest fear that if I keep my children home because they have to quarantine, they [CFS] are going to come and take them away."* [670]

In a context shaped both by the trauma inflicted by colonial interventions, and the enduring strength of First Nations traditions and culture, some interviewees noted that being Indigenous and speaking an Indigenous language can be an asset to building trust. Case Managers and SSPs discussed their First Nations identities as sources of pride, as a way to build trust with children and families, and sources of knowledge that they utilized when implementing Jordan's Principle services.[671,672] One SSP discussed the ways in which her identity complemented her professional training.

> *I guess being an Aboriginal woman, but as well as being a social worker, I look at things from a totally different perspective than from the medical standpoint and a western standpoint. So when I look at the child and I look at the family and I look at the needs, I'm looking at it from a holistic perspective not just a westernized medical perspective. So I'm not just looking at the medical issue, I'm looking at all the other aspects and how it's affecting the family. First of all the child, the family and then the community as a whole.*[673]

SSPs who were not local to the Nations in which they worked noted that being an outsider can also be an asset to building trusting relationships. Children and families sometimes expressed worries about confidentiality within small communities, and hopes that working with someone from outside the Nation would better ensure confidentiality.

6.1.2 Relationships within Nations (being present within the community)

Many interviewees noted the importance of participation in community events and activities that might not be billable under a fee-for-service payment model, but were viewed as being central to the relationship building process. Frontline staff noted that being present for Nation events, such as Pow

Wows, or spending time with school or health centre staff, creates trust. This trust, in turn, encourages communication and engagement from children, families, and local service providers.[674,675] Activities offered through Jordan's Principle funded land-based healing/education programs, provided additional opportunities to spend time together. An SSP explained:

> *One of the biggest things that I see is a success and a strength, particularly when we were able to travel, was the capacity to build relationships within those communities. Because …they love you there as a service provider, but they also love you there as a person. And coming to learn more about their community and their people, and they – I've been asked to participate in all kinds of random stuff. But that provides you an opportunity to build a really strong relationship where people then feel comfortable to call you and [say], "Hey, I have a question that I'm not sure who I should be asking."* [676]

Such opportunities for relationship building were disrupted by the COVID-19 pandemic. Many SSPs and Case Managers had to quickly adapt their practices and daily routines in response to lockdowns, which prevented people from going in or out of the Nation, and stay-at-home orders, which required all services transition to on-line platforms.[677,678,679] SSPs noted that the emergency adaptations made in response to public health measures increased integration of technology in their service delivery practices, increasing the accessibility of some services in some Nations. They also noted that, in some cases, the elimination of travel supported increased efficiency and speed of response to children and families.[680,681] However, they simultaneously pointed important challenges to building initial relationships with children and families, noting that the inability to see people in person made it difficult to forge new relationships and necessitated greater care to avoid miscommunication and to maintain communication.[682] In particular, they expressed "looking forward" to moving back towards in-person service provision and maintaining the online services that could support long-term expansion of service accessibility.[683,684]

6.1.3 Relationships with Elders and local knowledge keepers

Interviewees noted that work in First Nations also required building strong relationships beyond those with the families. Relationships with Elders and local knowledge keepers were identified as being important in order to ensure that service providers understood local histories, practices, and protocols, and could adapt services to avoid inadvertently perpetuating harm. For SSPs coming from outside, taking time to learn about the Nations created an understanding of the diversity across Nations and unique needs that a Nation might have.[685]

> *There's so much diversity within the First Nations population itself that we're trying to bring all of that diversity together in a program that best meets the needs within each of those communities. And we have to be very respectful of the traditions of each of those communities and so that's the challenge, right? It's challenging to bring that diversity together to a common purpose.*[686]

The diversity in contexts translated into a need to tailor and adapt service provision for each family and Nation. One SSP observed:

> *Every day is very different, whereas when I worked in the city, I could look at two schools and say, "Oh, yeah, these two schools are very similar in how they're functioning." There's a lot of different aspects of doing our job in a community. And they're just a lot bigger than just looking at the school functioning. We have to consider the community functioning; we have to consider the politics. There's a lot more to the job than just being a physio.*[687]

Participants also pointed to religion and spirituality as important elements of diversity that must be taken into account in the design and delivery of services. For example, some Nations held strong traditional beliefs across generations, others had a mix of Christian and traditional beliefs, whereas other Nations had generational divides where parents followed Christian traditions yet their children were expressing high interest in traditional teachings through Jordan's Principle programs.[688,689]

Both First Nation and non-First Nation service providers identified the importance of asking questions and listening to children, families, Nation leadership, and the broader community to build shared "points of connection" through mutual understanding and storytelling.[690,691,692] Non-Indigenous service providers discussed the importance of collaboration with Elders to ensure traditional knowledge and culturally informed services were provided across different specializations. A challenge for external SSPs who were working to collaborate with Elders emerged during the COVID-19 pandemic, when travel and on-site service provision was disrupted. Many SSPs expressed hope that the return to travel and reduction in community lockdowns could allow them to revive pre-existing collaborations with Elders.[693] One First Nation service provider also noted that Elders she worked with had identified the importance of supporting non-First Nations co-workers in a process of "knowledge translation" that could provide guidance and mutual aid.[694] Non-Indigenous SSPs also called for increased integration collaboration with Elders and culturally relevant services while recognizing the importance of balancing the diversity between the Nations.

6.1.4 Relationships with other service providers and leadership

Study participants described building relationships with other service providers and with Nation leadership in order to ensure "coordination of care", and a "proactive" approach to "integrated, person-focused" care that was required in order to address children's socially complex needs.[695] For example, one SSP discussed the way in which the implementation of Jordan's Principle has helped facilitate contact between service providers working within the same Nation. When discussing the transition between a service provider working with children aged zero to six and a school-based clinician, she highlighted the importance of collaboration during transition.

> *We have transition meetings for those students. But prior to [Jordan's Principle], there was no contact with other SLPs. So it was just, we were pretty much on our own.*[696]

Another SSP spoke to the need for coordination between service providers in order to ensure that appropriate services could be provided. She described the situation of a child with complex medical needs:

> *She's nonverbal, she doesn't walk and she's tube fed, she has a diagnosis that probably will not have her living long into her adulthood. So [I] engaged with her with nursing and dietician and, you know, got some respite going through, this is through one of those little lovely relationships that we have with CFS where they'll support family enhancement. And amazingly we were able to get some respite going for a little bit with a gal who had her tube training, lives in the community and actually we can do the out of home, the coveted out of home respite.*[697]

At the level of work to support individual children and families, collaboration was seen as necessary to ensuring well-coordinated services. Case Managers and Nation-level staff highlighted the importance of collaborating with other programs and service providers working within the Nation. For example, one Health Director described the way that networking meetings and relationships between service providers facilitated service access and prevented service duplication:

> *One of our biggest, our strengths in our community is having that working relationship because you know ... for example our Head Start program that works with children from zero to six, they provide all these different ages and stages. So, if a child has development delays then it's easy for the Aboriginal Head Start coordinators to make a referral to the program ... I think the networking team in our community is one of our biggest strengths to ensure that no child is left behind. And you know, we wanted to continue with that momentum because all these different organizations do work with children and ... not everybody will walk into the health centre, not everybody will walk into the social or education. So this is where we come together, we still meet on a monthly basis to ensure there's no duplication of services and what type of services each child receives.*[698]

In contrast, a SSP pointed out that access to services could also be complicated by silos between organizations working within a Nation.

> *We've experienced where, you know, the nursing station is over here and the community-based services are over here, and they don't like each other. So then Jordan's Principle is trying to walk the balance in between. Or sometimes it's, like, well, oh yeah, they have a holistic team here, but it's only for adults. Okay, so then what do we do with the 13-year-old, right? You know, we need this service for a 13-year-old.*[699]

In this situation, collaboration between Jordan's Principle services and the nursing station, to ensure that the needs of children and families are addressed, might support the extension of existing holistic team services to teens, facilitate the submission of a group request to support expansion of services, or open up other strategies for addressing the identified gap in services.

Another SSP reflected on divisions that can exist between services, identifying Jordan's Principle Case Managers as people who could potentially serve as integral advocates that support the development of collaboration.

> *There's definitely still a divide. Like, we stick with school, we kind of focus in our services on school, our attention to the schools ... But I think of one community in particular where we're actually involved with [the Case Manager] and she is the one that's been pulling us all in, all the service providers, pulling us all into the plan to provide services for the kids. And of all my schools, that's the only one that's doing that. I have no other connection with the Jordan's Principle coordinators.*[700]

SSPs noted that Nations with "strong", local Case Managers tended to have greater engagement from children and families, as well as increased advocacy for services from the Nation's Jordan's Principle program.[701] Participants indicated that Case Managers supported coordination of care by creating common understanding of child and family needs and priorities, identifying resources to meet needs, identifying gaps in resources, and seeking to address gaps in resources.

SSPs also highlighted the ways in which collaboration with Nation-level, Jordan's Principle funded, service providers was essential to maintaining consistent support for children and families. One SSP, for example, described the role of Nation-based therapists, therapy assistants, and child development workers.

> *I have a student [with complex needs]... I deal with all of the needs at school. So that includes adapted equipment, transfers, programming with the teacher. So getting the teacher involved in students programming for physio, and then the community physio deals with any home needs including accessibility, any programming or training was required for...the child development workers going into the home. So the community therapist does all the training for that part...And I think those open lines of communication are key to the functioning of the Jordan's Principle and really wrapping those children in support from all directions.*[702]

Interview and focus group participants also noted that, in some situations, like that of educational assistants (EAs) who work within schools but are hired and supervised by health-based Jordan's Principle programs, necessitated collaboration around day-to-day management and support for Jordan's Principle staff. In these situations, EAs are hired to support children in school, but the effectiveness of their support depends on coordination and collaboration with teachers and other school staff. Those who work alongside an EA, in the school, on a daily basis, are best positioned to provide the EA with feedback based on observation of their work with children. School staff also assume responsibility for ensuring that EAs are incorporated into school activities in a meaningful way, have adequate space to utilize specialized equipment, and have clear channels for communicating and discussing any questions or concerns they have about children's care. When these collaborations were not in place, there was tension, or even conflict, around EA positions.[703,704,705,706]

At the Nation level, interviewees and focus group participants stressed collaboration and coordination with leadership, and between service providers, as key to the effective implementation of services. An interviewee reflected on the critical importance of having the Health or Education Director, as well as Chief and Council's support in the implementation of Jordan's Principle services on-reserve.

> *In order to implement services and provide the services that are required ... the support of your Chief-and-Council and your Health Director are critical. If you are battling that process on a daily basis that makes our job almost impossible.*[707]

SSPs and Case Managers also noted that letters of support from First Nation leadership were important when compiling supporting documentation for Jordan's Principle requests. Supporting leadership to build understanding of Jordan's Principle and the services provided through Jordan's Principle was important to securing this supporting documentation.[708]

When it comes to First Nation children, the need for strong collaboration in order to ensure continuity and coordination of care extends to building connections between on and off-reserve services, and across other jurisdictional boundaries that exist within the systems of services for First Nation children in Manitoba.[709] A SSP working with First Nations schools spoke to the importance of these connections.

> *We are separate from the provincial system, but some fluidity or willingness, again about sharing new information to the school [is needed to ensure] ... appropriate education for First Nations students.* [710]

She noted the potential for duplicated or disrupted assessments in the absence of information sharing:

> *If they're moving into a provincial school division and they've received clinical services from us…that school psychologist may be unknowingly redoing an assessment that was just done.*[711]

6.2 Broad and responsive scope of practice

Participants noted that building relationships with families, and understanding the context in which the families live, broadens the scope of needs they seek to address. Meeting this broader scope of needs requires adaptation of the ways in which they seek to work with and support the family as a whole. Case Managers and SSPS noted that, while families are often expected to fit in with, or adapt to, normative practices in service delivery, a fundamental part of the work they do with children and families involves adapting their services and practices to fit with family needs and contexts.[712] By observing and listening to the needs of children, families, and the broader Nations, they sought to build programs tailored to the self-identified needs of children and families.[713,714]

A SSP noted the ways in which understanding the context in which families live impacted her approach to services:

> *I think sometimes there are bigger things on parents' minds than what I'm suggesting, and it's really hard to say, "Get down on the floor and play with them," if they don't have space on the floor. Or if they don't have toys or books at home because they can't get them at the store.*[715]

A colleague participating in the conversation added on, explicitly linking this example, to a need to focus on the social determinants of health.[a]

> *Yeah, if the floor is too cold to sit on, if you are spending many hours a day figuring out how to get water to your house, if there's big holes in your floor and in your walls and there's, you know, et cetera, there are, you know, the social determinants of health and the – and very basic housing problems in the communities that I go to are a massive, massive problem.*[716]

In some cases, awareness of these challenges led front line workers to support families in seeking out additional supports and services, or in submitting requests for housing renovations through Jordan's Principle. As noted in Chapter 5, the process for requesting housing renovations was complicated and time-consuming, requiring service providers to engage with family contexts in ways that extended beyond the formal, disciplinary boundaries of their training.

Interviewees and focus group participants also described other ways in which a relational approach to practice extended their work far beyond the roles and responsibilities that were part of their formal scope of work. For example, a SSP working in schools described extensive, out of school engagement on behalf of some families.

> *Like for me, I'll just bring up diabetes; it's a big issue and when I leave the community and …[I've] dealt with a couple of families that really, really could use assistance and support in terms of dealing with their children living with diabetes, I can provide as much support as I can. I'm going to try to hook up the families, the community supports once I leave, and so I might find a dietician for that area and Tribal Council, who, you know, is there – and who can make those linkages to Jordan's Principle? Is there, you know, who else is available in the community?* [717]

Another spoke of families calling on her and her colleagues to transport goods that were difficult to find or prohibitively expensive within their Nations. She described responding in to these requests as a way of further developing relationships.

> *With the fly in communities…a lot of times we'll even start getting calls…can you bring me this, can you bring me that, and I certainly don't mind…Even to the point of, like, what I'm packing for food, right? I mean I have a friend who cooks Indian food, right, yeah do you want to try this?* [718]

She noted that she makes a point of bringing diabetic safe food and drinks that are more readily available in southern regions.[719] SSPs also noted broadening their professional roles to provide resource and programming development, emergency childcare, and classroom management, as well as spending significant time on case management tasks that were integral to maintaining their relationships with the children and families.[720,721,722,723]

6.2.1 Questioning normative practice

Interview and focus group participants also noted the ways in which a relational approach to working with families, and the broad and responsive practice that emerged from a relational approach, led them to question normative professional practices. For example, many noted that standard consent forms lacked cultural relevance and called for reforming the documentation for First Nation children and families.[724] SSPs suggested adding First Nations languages, no longer using confusing legal language, changing the concept of guardianship embedded in consent forms to reflect First Nations caregiving traditions, and altering information on the consent forms to avoid Winnipeg or urban-centric language.[725,726]

> *The language of our consents is very legal and confusing. Our consents are organization-wide as opposed to rural and Northern specific, and that's an organizational requirement. But what we're looking at on that form is really Winnipeg-centric, so it's very, I think, quite triggering and overwhelming to families coming in, who their first language isn't even English. And they're being asked to sign something they don't understand, with lots of boxes and lots of whatever, and that, right there, is one of the first things I would attack.*[727]

SSPs emphasized the importance of speaking directly with children and their families to ensure all questions and concerns are addressed in advance of providing services.[728]

> *It's very important to me, too, that we have informed consent. And sometimes it's very difficult, especially in our schools where we don't have good Internet connection, where we don't have good parental engagement. So when I get a guidance counsellor or principal [who] says, "Well, I run into Joe Blow on the street, and I'll just tell him to run in and sign the paper." No, that's not good enough for me. They need to know what they're signing, they need to know who I am and what their child will be doing with me…So, next time I'm in the community, I will go and talk to them and I will explain why their child is going*

a The WHO defines social determinants of health as, "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life." See https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1 for a brief discussion of the social determinants of health.

to see me and if it's OK with them that I see their child.[729]

SSPs also drew attention to the ways in which standard practices around consent were out of step with the family structures and care agreements in First Nations that they worked with. One SSP described the appropriate treatment of family structure and guardianship in consent processes this way:

> *It's recognizing the family structures and valid expertise…recognizing the knowledge and the care of whoever knows that child best, regardless of who's their legal guardian. And that's what I think the policy should do.*[730]

SSPs drew attention to tensions surrounding normative practices around assessment, noting the limited relevance that many assessment frameworks had for First Nation children, and questioning the validity of assessments conducted without consideration for socio-economic factors that can impact assessment outcomes.[731,732,733] They also expressed criticism of the historical role that assessment has played in Nations with limited access to mental health services. Service providers noted exploitive practices by psychologists who would provide costly assessments without follow-up, on-going support, or significant involvement with the child and their family. The lack of provincial regulation around school psychology was also discussed as a concern for SSPs who noted the absence of a professional governing body risked exploitive contracting of services with limited long-term follow-up for children with pressing mental health needs.[734] As one SSP described:

> *Typically, that contract psychologist comes in, meets the student, does an hour's worth of assessment or so, and writes up the report. So with our service being non-contract and coming back for follow up, that seems unfamiliar to them.*[735]

Across interviews and focus groups, participants highlighted the ways in which they were questioning and pushing back against normative practice in use of assessments. They also described adapting assessment methods and documentation so that they were accessible and relevant for First Nation children and families.[736] They noted centering the strengths and self-identified needs of children and families, using these, rather than standardized assessments, as the guiding forces in service planning and provision of supports.[737,738,739] Some service providers continued to utilize assessments, but adopted modified approaches to conducting the assessment, such as removing standardized language that can be accusatory or stigmatizing.[740] They also spoke of a more measured and careful approach, in order to avoid "rushing" into conducting assessments.[741] Finally, they noted the limitations of using standardized assessment that were developed based on 'normative' scales with non-Indigenous populations, describing an adapted approach in which they used assessments as a way to gauge an individual child's baseline and track changes relative to this baseline, rather than comparing children's assessments to normative standards.[742,743,744]

Chapter 7:

Structural factors that constrain the current implementation of Jordan's Principle

In this chapter, we analyze inter-related structural factors that impede the implementation of Jordan's Principle in Manitoba.

- The emergence of high caseloads and growing waitlists – Success in the approach to Jordan's Principle has not been matched with necessary staff expansions. High caseloads and growing waiting lists limit the time that existing Case Managers, Service Coordinators, and SSPs have to engage in relationship building, while also creating stress that may contribute to staff turnover. This, in turn, hinders a relational approach to service implementation and delivery.
- The administrative burden and delays associated with some Jordan's Principle requests – The approach to Jordan's Principle in Manitoba features the transfer of substantial power for decision-making, in regards to individual requests for Jordan's Principle funding, to Service Coordinators (affiliated with Tribal councils or EUTC). However, some categories of requests still assessed by federal government offices, in

Winnipeg or Ottawa, have substantial and burdensome administrative requirements that limit responsiveness, cause delays in service, and strain system resources.

- Inadequate physical infrastructure – Many Nations lack the physical space to host and administer Jordan's Principle programs and the growing range of activities and services to support children's health and wellbeing.
- Inadequate digital infrastructure - Many remote and northern Nations lack the cell phone, Internet, or telehealth connectivity that is needed to improve families' access to services that are not available locally, or to supplement sporadic in-person services.
- Insufficient resources for capacity enhancement initiatives– Organizations involved with Jordan's Principle services in Manitoba have developed a broad range of innovative capacity enhancement initiatives, but they lack the resources needed to sustain, expand, and extend these initiatives to every First Nation in Manitoba.
- Insufficient regional coordination and support – Participants expressed a strong desire for increased data collection and data sharing tools, policies or best practices that support Nations in achieving a common baseline of services, and other supports for coordination and collaboration. However, the funding available to coordinate regional efforts along these dimensions is insufficient and the formal, First Nations led infrastructures for coordination and support remain under resourced and underdeveloped; they cannot currently support the scope of required work.

7.1 Growing caseloads and waitlists

Interviewees and focus group participants indicated that their capacities to meet the needs of First Nation children are increasingly challenged by growing caseloads and waitlists. Figure 20 displays data on the growth in SSP caseloads over time, as well as 2020-21 waitlist totals. It shows that caseloads increased dramatically and extended waitlists developed for three of four SSPs for whom data was available. In some cases, children waited as long as a year before receiving services through a SSP.[745]

Case Managers and SSPs described the rapid growth in caseloads since 2018 as both reflecting the success, and challenging the continued implementation, of a relational approach to services.[746,747,748,749] Interviewees and focus group participants identified a focus on building relationships as the key to engaging families, but they also noted that growing caseloads resulting from a relational approach, a related increase in travel demands, and the complex needs of the children seeking services, limited their ability to continue implementing a relational approach.[750,751] One SSP summarized the situation this way:

> *There's not enough time... there were only two [specialized service providers] and we currently have 1,000 referrals. So it's not enough time... because the travel, it's remote access, and the time it takes to get there and establish yourself. And the unpredictability of, you know, school might not be open because there's no teacher, or there's no water, so there's so many things that get in the way of actually delivering that service. So there does seem to be a big time crunch when we are there, it's go, go, go, go ... I find it high pressure and not enough time to do the things that we want to do.*[752]

Another SSP specified the problem as being a failure to hire enough staff to keep pace with growing caseloads. She also noted that resulting high caseloads compromised ability to engage in necessary relationship building.

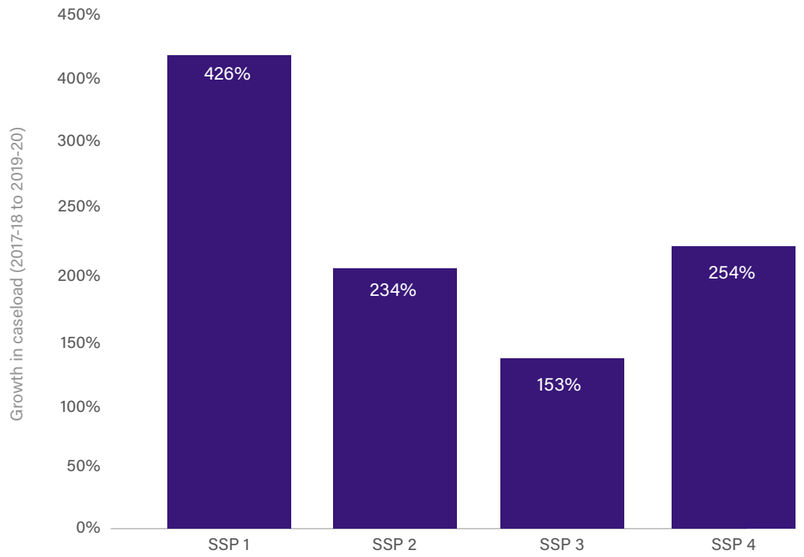
> *We need to do this ongoing relationship building in order for the children to get the services they need. But we are at real risk ...to not be able to do, frankly, what we need to be able to do because our caseloads are so huge.*[759]

Some SSPs who reported difficulty meeting the need for services also indicated that their organizations had been funded for fewer positions than requested or that they were uncertain about the availability of funding for hiring additional staff.[760,761,762] One SSP succinctly summarized the resource challenges to meeting First Nation children's needs.

> *The brute force solution is just to keep hiring more people. But we find that the more ... our partners become familiar with our services, the more referrals we receive ... There are only so many professionals who can deliver these services. So, we're always trying to figure out different ways of delivering services, but, yeah, wait lists are a big, big challenge.*[763]

Further reflecting on the situation, the SSP described one current strategy for dealing with caseloads and waitlists.

Figure 20: Percent growth in SSP caseloads between 2017-18 and 2019-20, and 2020 caseloads and waitlists[753,754,755,756,757,758,a]



	SSP 1	SSP 2	SSP 3	SSP 4
2020 Caseload	721	612	2,668	7,722
2020 Waitlist	375	0	1,546	1,570

a Caseloads and waitlists are calculated differently by each SSP and, in most cases, multiply count children receiving multiple services.

> *We have prioritization systems. Where there's a – especially urgent need, we try to respond more quickly ... there are definitely some ethical trade-offs inherent in this approach. If we have a clinician in a community with a small number of children and more referrals come in from the same community, we will prioritize those because we already have someone there.*[764]

Heavy caseloads and waitlists are not limited to SSPs. TSCs spoke of heavy caseloads, noting that this translated into difficulty meeting the CHRT mandated timelines for responding to Jordan's Principle requests.[765] Case Managers also pointed to the rapid growth in caseloads for services operated at the Nation level. One Case Manager described the situation in her Nation.

> *We have grown, like I said from 91, we are now at 255 children who are in our program, which puts us up around over 1,000 when you include siblings and the family whether they are parents or grandparents or relatives.*[766]

In some Nations, Jordan's Principle Case Managers were able to mitigate some of the wait for certain services by creating locally based services or seeking alternate referrals. However, in other situations, children simply went without services while on waitlists, or received a reduced level of services from providers struggling to meet needs across a heavy case-load.

7.2 Complex responsibilities, stress and turnover

The ballooning caseloads and growing waitlists had a negative impact on Jordan's Principle staff, who sought to manage the pressures of large caseloads on top of the expanded professional responsibilities that came with a broad and responsive approach to service delivery. Many workers reported having administrative and/or clinical responsibilities that entailed the work typically assigned to two or three people.[767,768]

Case Manager roles exemplified the broad range of responsibilities that Jordan's Principle staff took on. The complex responsibilities of Case Managers include, but are not limited to: developing and administering services across the health, education, and social service domains; building and maintaining relationships with Nation leadership, other service providers, and Jordan's Principle workers and administrators; recruiting, hiring, and managing respite workers, child development workers, EAs and other staff; and working directly with children and families whose needs can require extensive knowledge of highly specialized supports and services.[769,770,771] In some instances Jordan's Principle Case Managers are also charged with linking Nation based staff to training programs that fit their professional interests and address needs within their Nations.[772,773,774]

An SSP commented on the complexity of the Case Manager job description. She recalled thinking, "Wow, this is impossible for one person, this is probably a three-person job."[775] Another participant in the same focus group mentioned one strategy that helped to slightly reduce the burden and complexity of the Case Manager role.

> *I think that there have been a couple of communities where they have moved someone from a CDW [child development worker] position to sort of the Assistant Case Manager. So the Case Manager is now only running at 110 kilometers an hour instead of 150, and someone else has taken a little bit of that pressure.*[776]

Asked to describe her position, one Case Manager offered a succinct summary.

> *I basically just oversee everything and I'm on call all the time. So, I take any client messages and phone calls during the day and after hours.*[777]

The role of TSCs, who were charged with facilitating capacity building for Case Managers, was equally complex. In addition to supporting submission of complex Jordan's Principle requests, and overseeing the entire Jordan's Principle request process (from intake to assessment and approval) for many other types of requests, TSCs were responsible for many other tasks. One coordinator explained:

> *I'm dealing with a lot of administrative tasks as well, identifying training, having that training roll out for our staff, we look at management, management is difficult some days and some days it's rewarding and it's good. We look at advocacy also, not only within our own communities at the grassroots level, but we also look at advocacy at the provincial table as well, and federally. We also look at community engagement, how are we getting the word out of what we are doing and things change so quickly, that we have to adapt to these changes, pretty much overnight...We also provide services for our proposal writing for our programs.*[778]

Across Jordan's Principle positions, the complexity of roles and responsibilities was augmented by the COVID-19 pandemic. Jordan's Principle staff fulfilled new tasks - including the development and implementation of mental and physical wellbeing programming, wellness checks, and the delivery of necessary goods to families and children - alongside pre-existing Jordan's Principle services.[779] Jordan's Principle staff were also frequently reassigned to emergency positions. For example one Nation had four out of six Jordan's Principle staff reassigned, with three positions vacant, and one staff on a medical leave.[780] Some Jordan's Principle staff noted working as much as "11 days, 14 hour days, with no breaks" in response to emergency COVID-19 measures.[781] A Jordan's Principle Case Manager reflected on the stress of the position, which was compounded by the COVID-19 pandemic.

> *I worked in the emergency room [for] years before I started this job and I've never felt the pressure and the stress of all the things that we deal with on a daily basis, Monday to Sunday, weekends, evenings, as I have in this job. It's a great job... we do amazing work and that's what makes it all worth it, but it can be very hard ... and I'm saying that it's really stressful for me right now.*[782]

Citing the stresses created by high caseloads and complex roles, as well as contractual hiring practices, recruitment challenges, limited job onboarding, and inadequate compensation, focus group participants noted high turnover in specialized service provider and Nation-level positions.[783,784,785,786,787] Turnover in any one position negatively impacted abilities to meet child and family needs, disrupting established relationships and continuity of care.[788,789]

7.3 Delays in service – administrative burden for some Jordan's Principle requests

Interview and focus group participants cited the administrative burden of making Jordan's Principle requests as another factor that strained system resources, limiting the time available for relationship building and other tasks. Delays in the provision of services to children were also caused by administrative processes. Participants pointed, in particular to burdensome requirements when requests for Jordan's Principle funding for individual children were assessed by the FNIHB regional office, or by the national Jordan's Principle office in Ottawa, rather than by First Nation Service Coordinators.

In comparison with the other jurisdictions for which detailed descriptions of Jordan's Principle services are available, First Nation organizations in Manitoba have assumed greater responsibilities and decision-making power when it comes to individual Jordan's Principle requests.[790,791] In Manitoba, Services Coordinators have a primary role in assessing and making decisions on many individual Jordan's Principle requests (see Chapter 4). However, administrative requirements for individual requests are still established by FNIHB, which also retains responsibility for assessing some categories of individual requests. The Regional Jordan's Principle Coordinator summarized the current division of responsibilities:

> *Anything to do with community-based needs, we are able monitor community activities with the support of the Tribal Council for affiliated communities, and we only get involved when it is a critical situation.*[792]

The requests assessed by FNIHB include, but are not limited to, those involving dental care, medical equipment, educational supports, or housing.[793,794] Participants indicated that the administrative requirements associated with these requests could be time consuming and burdensome.[795,796] A typical request requires the submission of substantial supporting documentation: an intake form, a service request, an assessment from a health care professional, a letter of recommendation from a different health care professional, a letter justifying the need for the service on the basis of substantive equality, and a detailed quote/cost estimate. Depending on the service being requested, additional requirements can include documentation of denial of services by NIHB, a letter from the school/Education Director/Chief and Council attesting that they cannot fund the requested service, letters of support from Chief and Council or the Health Director, or additional assessments.[797,798,799,800] As discussed in Chapter 5, requests for home modifications were identified as particularly burdensome, sometimes requiring environmental health assessments which were only available 2-3 times annually in remote Nations.[801]

Prior research has detailed the heavy burden that the requirement to justify services on the basis of substantive equality imposes on First Nations, service providers, and families, as well as the ways in which a reliance on focal points' administrative discretion in assessing substantive equality may lead to denials of service and inconsistencies in decision-making.[802] In Manitoba, Case Managers identified strong working relationships with the Regional Jordan's Principle Coordinator as helping to mitigate challenges in regional decision-making. However, they also noted that decisions for some categories of requests were made at the national, rather than the regional level. Prior research indicates that categories of requests for which there are concerns about costs or about overlap with other programs are escalated to the national office for decisions. In keeping with prior research, participants identified concerns about increased denials and long delays when requests were escalated to the national office for approval. Concerns surrounding the national office included limited communication during request processing and a lack of clear explanation of why requests were denied after extended waiting.[803,804,805] Case Managers in Manitoba noted that such service delays are in violation of the spirit and intent of Jordan's Principle.

Prior research has also documented the ways in which burdensome administrative requirements around Jordan's Principle requests can cause substantial delays in service, while still allowing the federal government to claim compliance with CHRT timelines that start from the point that all required documents have been submitted.[806] In addition, recent research documents the potential for delays, within the federal payment system, that result from: federal requirements that vendors/service providers be registered in the federal system, lengthy timelines for payments to vendors, and restrictions on up-front and cross-year payments.[807] Within Manitoba, these delays may occur when Jordan's Principle requests are assessed by the federal government (regionally or nationally), rather than by First Nation Service Coordinators. In these cases, payment for services are made through federal payment systems.

7.3 Inadequate physical infrastructure

Interviewees and focus group participants also stressed the need for further development of physical infrastructure to support Jordan's Principle funded programs and services. As discussed in Chapter 2, the federal decision to classify Jordan's Principle as an initiative, rather than a program, has meant that Jordan's Principle funding cannot be used for capital expenses, such as construction or modification of buildings to house Jordan's Principle programs. Across different forms of data collection, participants stressed the urgent need for adequate and appropriate space for Jordan's Principle programming and administration. Twenty-six out of 31 Case Managers responding to a survey indicated that the space for their Jordan's Principle programming was "insufficient."[808,**b**]

Recent research on Jordan's Principle programming in northern Alberta explored, in detail, the impacts of space limitations on Jordan's Principle services, particularly in rural/remote Nations.[809] Working in shared space within existing health and early education settings facilitated relationship building, but it also complicated the work of the Jordan's Principle service providers, who lacked consistent or appropriate space: to hold confidential meetings with individual clients, store files or supplies, collaborate with colleagues, or carry out group activities. A lack of accommodation space, in which visiting service providers could interact with one another, was also viewed as a lost opportunity to foster coordination and collaboration.[810]

Some Nations in Manitoba were able to front the costs of constructing a Jordan's Principle building, with the expectation that they could amortize the cost by renting the space to the Jordan's Principle program, or to repurpose existing buildings. One Case Manager described the ways in which a new space, which her program moved into a year ago, facilitated relationship building.[811]

> *It has five offices and a rehab room, a board room. And you know, a comfortable living space, a nice kitchen ... They [children] come in and they see their little living room with all the stuff that they can sit there and just engage in right away. You know. So we've made it fit, like the colour on the wall is not so white and whatever. It's all – you know, it's all fit to welcome the child into the building, and even the kitchen, like we've had so many of our teenagers just drop in and you know, just come in, heat up a pizza, pop, or say "Hi." It has that welcoming effect, and I think that's what makes a difference is they know there's a place that they can go to, even the parents that'll drop by [and say], "I need some Pampers," and we have those on stock so they know they can come there and get what they need, even wipes.*

b The CHRT recently clarified that the federal government has an obligation to fund capital expenses that are necessary to "support the delivery of Jordan's Principle services to children on-reserve" and ordered the federal government to provide funding to "FNCFS agencies, including small agencies and First Nations" for these expenses. The details of this funding are not yet available in Manitoba. *First Nations Child and Family Caring Society of Canada et al. v Attorney General of Canada* (for the Minister of Indian and Northern Affairs Canada): 2021, CHRT 41, s532

You know, whatever their needs are we have to make sure that we have those things available for them.[812]

Meantime, in a Nation that has not been able to support construction of a Jordan's Principle building, a Case Manager spoke with visceral longing about her vision for the children and families in her Nation to have access to a strikingly similar Jordan's Principle space.

One of the things that we've been asking for, for a long time is our own space, our own building…I'm giving myself goosebumps talking about it because it hasn't happened yet. But having our own place where people can go to and they're not pushed out of it, they're not rushed through it. They're not turned away from it. But they can come there with their kids, they can be there if they need to be … There's a room for kids to play in. there's a kitchen for us to teach cooking or provide food for families. There's assessment space …[813]

She continued, describing the inadequacy of the current physical infrastructure.

Part of our team got moved to a new building. There's no assessment space in that new space … There is no way we can take a kid in there that has ADHD, autism, FASD attention issues, sensory issues, there's absolutely no way we can do therapy in that space … Families do not want child development workers and therapists coming to their house. There's so much shame about it. There's judgment that they feel. There's - they just don't want it. They want to be able to go somewhere and have the appointment, learn what they need to learn, and then take it back to their house. I really think that it could be a community hub for many different places.[814]

In recognition of the infrastructure challenges that Nations continue to encounter, the AMC Executive Council of Chiefs passed a resolution in support of Nations utilizing Jordan's Principle funding for infrastructure and capital costs.[815]

7.4 Inadequate digital infrastructure

In addition to the need for physical infrastructure, evaluation participants highlighted a critical need for digital infrastructure. Interview and focus group participants identified improved, universal Internet, cell phone and telehealth access as key to delivering more efficient and consistent services moving forward. One SSP, who expressed a strong desire to return to in-person service delivery, also discussed the potential for remote service provision to play a crucial role, even once in-person services resume.

One of the things that we have learned or had to learn with COVID, is that there is room for technology in the services that we provide and ways that we can incorporate it that can be helpful. You know, a lot of the families that we provide services to … don't have access to phone or access to Internet, or at least reliable versions of that. And so, you know, when it comes to doing in person services again, number one, we're going to be able to consistently see those families and those clients again. But also understanding that virtual services can sometimes be faster and more efficient … And now hopefully by the end of the pandemic, communities will be a little bit more open to it and receptive to trying to do those things.[816]

Another SSP highlighted the potential for remote services to allow for more continuity in services than is possible in-person when service providers travel between multiple communities.

If all the communities could have really good Internet, that would be great. Internet access is a huge, obviously, over the past year, has been a huge challenge in providing better virtual services. That being said, the one thing that we've learned is that for the few kids that we have been able to connect with virtually is that this is an option to fill in between visits as well. Being able to provide those virtual kinds of appointments in between our four to six, sometimes eight week visits. So communities need and deserve Internet access.[817]

Other SSPs noted that digital platforms can mitigate disruptive travel and time away from home by supporting immediate access to specialized supports when crises, such as urgent mental health needs, emerge.[818] These findings are consistent with previous research, in Manitoba, that highlighted the potential of using technology as an additional form of service delivery with children and families in rural and remote communities.[819]

The long-term failures to support digital infrastructure development across First Nations have amplified the harm caused by the COVID-19 pandemic. For example, a SSP noted that he knew of only a couple schools, out of over 50 served by his organization, which had access to the digital infrastructure needed to support remote schooling. As a result, children in many Nations missed out on an entire year of instruction.[820] In recent months, increased awareness and growing pressure resulted in both the federal and provincial governments announcing projects to improve digital infrastructure in rural and remote First Nations. The federal government announced funding for high speed Internet in 11 First Nations in Manitoba. The provincial government announced plans to extend high speed Internet to 30 First Nations, but First Nations were not consulted/engaged in the process of deciding on a service provider in this project, and the AMC has objected to the lack of transparency and inclusion in the decision-making process.[821,822,823,824]

7.5 Insufficient capacity enhancement resources

Interviewees and focus group participants identified the need for increased, long-term funding to support sustained capacity enhancement initiatives, and to expand existing initiatives to meet capacity enhancement needs in every First Nation in Manitoba. They discussed a need for short-term capacity enhancement efforts to ensure that Jordan's Principle staff were equipped with the skills and knowledge to carry out their complex roles and meet the needs of children and families. They also identified a need for, and discussed initiatives designed to support development of, a cadre of First Nations service specialists, equipped with the credentials to lead and staff a First Nations system of specialized services.

As noted in prior studies, Jordan's Principle was rolled out rapidly, with little time for planning or preparation.[825] Many Nations and service organizations found themselves simultaneously implementing services, recruiting and training staff, and conducting outreach to children and families. Case Managers had diverse educational backgrounds and, at times, hired Nation members with minimal professional experience, with an understanding that they would receive professional development and training, for additional Jordan's Principle roles.[826,827,828]

Case Managers described feeling rushed, and having minimal guidance. A Case Manager hired almost two years after the beginning of Jordan's Principle implementation described her introduction to her position.

I wasn't really given any details about it [Jordan's Principle]. I didn't actually really know what it was about when I came into it so I did my own research

> *and discovered it was bridging the gaps for any child, at that time 19 and under. So whether it be in health, education, social, or cultural, bringing all the resources together to help the child get, to like overcome their gap I guess.*[829]

She noted that her onboarding consisted of a half-day training in Winnipeg, and a second half-day workshop, in which participants were walked through the forms in a new 'toolkit' of government-produced intake and tracking forms.[830] These one-time trainings were insufficient to support Case Managers in keeping abreast of constantly shifting Jordan's Principle policies and procedures, the implications of new CHRT rulings, and provincial-level developments in health, education, and social services.

A SSP pointed to the need for ongoing supports and systems for sharing information with new Case Managers. She noted that people taking on the role of Case Managers in 2021 may have access to even fewer supports and information sources than those who were hired earlier, when there was a more concerted effort to disseminate information about the SSP system to Case Managers and Nation-level Jordan's Principle staff.

> *When Jordan's Principle was first rolling out, there was a lot of initial training offered for Case Managers and CDWs [child development workers] and coming together with the specialized service providers and helping them understand what each of the different programs could offer and how they could work with their community... [Now,] I don't know that the new Case Managers get that information clearly.*[831]

Among the trainings that were available to Case Managers and Nation-level staff in 2018 was a five-day training, delivered over the course of two weeks, that featured educators from St. Amant, MATC, and the RCC, working in partnership with TSCs, to offer fundamental information about allied health, mental health/wellness, and other services. The training was offered to hundreds of people. The intention was to establish this training as a permanent, ongoing service. However, staff turnover within the federal government and at the Nation level disrupted these plans. SSPs continue to provide other trainings, but this comprehensive introductory training is no longer available.[832]

The limitations on needed capacity enhancement constrained the roles and responsibilities of Nation-level staff. For instance, a SSP highlighted the critical importance of capacity building using the example of therapy assistants working on reserve. Delegation of day-to-day work, from SSPs to local therapy assistants or other Nation-level facilitators, has the potential to expand the reach of and access to limited specialized therapy services.[833,834] However, in the absence of well structured, easily accessible, and consistent capacity building, the therapy assistant role was often reduced to something much more administrative. One SSP noted:

> *Each community, for the most part, does have a rehab aid [therapy assistant] now identified. And so, that looks different depending on the program, but typically ... that person would be in charge of, like, communicating with us and helping us and ... making our schedule. They usually get tied up more with administrative tasks than actual hands-on rehab aid sort of things.*[835]

Participants identified the development of First Nation capacity to provide and manage clinical services as being essential to the development of a First Nation led and run system of services.[836,837,838] SSPs generally portrayed their role in First Nations as being provisional, and committed to supporting the development of and transfer of responsibility to First Nations led and run services.[839,840,841] However, they also highlighted the need for substantial capacity enhancement in order to reach a point at which transfer across service domains was possible.

In Manitoba, the MFNERC has played a leading role in innovating and implementing programs to build credentialed, clinical capacity within First Nations. MFNERC's current capacity development efforts focus on training cohorts of First Nations allied and mental health clinicians, resource teachers, education assistants, special education assistants, and therapy assistants. These capacity building and training opportunities are funded through a complex mix of funding sources that have changed over time; each funder has separate requirements and stipulations around the types of training/services to be provided and the Nations to be supported. These funding sources include Jordan's Principle funding, a five-year ISC training grant, and high cost special education funding.[842,843]

In the fifth year of the ISC training grant, MFNERC reported a cohort of 12 graduating psychologists, 25 First Nation literacy specialists, 6 speech therapists, 5 occupational therapists, 1 physiotherapist, 110 First Nations resource teachers, and 120 people participating in therapy assistant training to become SLP, OT or PT assistants.[844,845] A graduate of one of the MFNERC training initiatives spoke to the long-term investment and network of relationships that enable this type of capacity building.

> *One of the things that I wanted to comment, too, was I grew up in the reserves, in the community. And honest to God, I didn't even know SLPs existed. I didn't know OT and PT existed. None of that. I've never seen any of that growing up there. Because I was a classroom teacher prior coming over here. MFNERC had posted this ad for a training opportunity.*[846]

She credited MFNERC staff with helping her obtain her current position.

> *It was [the Manager of Clinical Services] that always told me, "We have to do this, we have to do this." It was his vision. I couldn't have those dreams, because I never knew such things existed, right?*[847]

Long-term capacity building processes can increase the numbers of First Nations service providers. This, in turn, can promote the development of organizational mandates and reforms that support service approaches that are grounded in First Nations world views and contexts. An MFNERC staff member pointed to the transformative impact of capacity enhancement, noting that his organization has hired over 50 full time, First Nation staff over five years. He described a shift in the organization's approach to services that resulted from having 2/3 of their positions filled by First Nation people.

> *[We have been] moving away from a western medical model and moving to a First Nation world view of inclusion. So we've undergone a big paradigm shift ... to a more rights based approach, reflecting First Nations world view.*[848]

This type of transformation in the makeup of service providers calls for long-term, intensive investment in education and mentoring. Diverse training programs across levels of education, staff positions, and service domains are essential to facilitating these changes, and are integral to the long-term success of Jordan's Principle.

Currently, the uncertainty, complexity, and short-term nature of capacity enhancement funding make it difficult to extend needed training and education opportunities to all First Nations. Working with a combination of ISC and Jordan's Principle Funds, MFNERC has been required to restrict some training opportunities to Nations that are members of the MFNSS or Nations in which MFNERC is supporting special education services. A

system in which only some Nations have access to important capacity enhancement initiatives adds to existing inequalities and to tensions across Nation; these inequalities and tension perpetuate the inequities in access to services that Jordan's Principle is meant to address. Equitable, long-term funding to support capacity enhancement across Nations is required.

7.6 Insufficient regional coordination

Finally, study participants highlighted the need for additional, regional structures to support the coordination needed to establish a common baseline of services across all First Nations in Manitoba. Pointing to tensions around some elements of variation in services across First Nations, participants called for additional policies and/or widely disseminated information about promising practices to help ensure equitable services for First Nation children throughout the Manitoba region.[849,850] As discussed in Chapter 2, AMC has approved plans for a Jordan's Principle Equity Roundtable and proposed the establishment of a Capacity Enhancement Center (CEC). However, work on establishing these structures has been slowed by COVID-19, staff turnover, and a lack of federal funding. In the interim, responsibility for regional coordination has been unclear. Study participants pointed to important advancements in regional coordination, but they also highlighted the ways in which the absence of sufficient regional supports impacted their abilities to ensure equitable services.

Some participants made explicit calls for regional coordination around policies and promising practices, being careful to note that any policies or promising practices should respect the self-determination of Nations. For example, one SSP called for:

> *Striking the balance between the sort of very unique Manitoba model that we have, which is very decentralized, maintaining that autonomy, community to community, to do what it needs to do, but also, have some means of sharing best practices.*[851]

Another interviewee explicitly noted a preference for dissemination of promising practices, rather than establishment of policy, in order to strike this balance, noting "I think it'll be hard to have one overarching policy of Jordan's Principle for all of the programs." [852]

The clearest calls for definition of a policy framework were related to respite care.[853,854,855] Respite care was a focus of the initial implementation of Jordan's Principle in Manitoba and is currently the Jordan's Principle service most commonly offered across First Nations.[856,857] The development of respite care has been carried out on a Nation-by-Nation basis, but programs share some basic elements. Jordan's Principle Case Managers assess families' and children's needs in order to determine the hours and details of, as well as the compensation for, respite services.[858] Some Nations provide respite workers for families, other Nations allow families to choose a trusted caregiver who is already known to the child, and some Nations utilize a hybrid model.[859]

No guidelines or standards for respite programming were circulated when Nations were developing Jordan's Principle funded respite care services. Pinaymootang First Nation, which had developed a respite care program prior to the introduction of the Jordan's Principle CFI funding, provided basic support for many Nations establishing respite care programs. However, program and policy development was left to Case Managers, many of whom may never have had prior experience with respite care.[860,861,862] A participant in a TAG meeting highlighted the complexities of establishing a respite care program, asking:

> *When you said about funding for respite, is there a protocol? Are there forms? Is there an amount that you should be paying the family? How do I know that they're actually doing what they're supposed to be doing? How do I monitor that?* [863]

The allocation of respite care hours, as well as the approach to caregiver selection and payment, vary across Nations. Study participants indicated that the variation in approaches to respite care was a source of tension; families were aware of the differences across Nations/organizations and would appeal directly to the Regional Coordinator if there was disagreement on the hours or wages provided for respite services.[864,865,866]

Interviewees pointed to informal information sharing as a primary support for the development of more unified respite care policies; they also indicated that some TSCs may have developed respite care policies for/with Case Managers in member Nations.[867] But, as of early 2021, more than four years into the current implementation of Jordan's Principle, there were no guidelines or policies to support the development of a consistent baseline of respite care across all First Nations in Manitoba. Responding to a request from Off-Reserve Service Coordinators, the AMC worked with Case Managers attending TAG meetings to develop a common intake and assessment tool that includes a scoring system to support Case Managers in making respite care allocations based on children's needs (see Appendix 7). The policy is now awaiting formal approval by the AMC Women's Council.[868,869]

Data sharing protocols are another example of policies, or tools for supporting promising practices, that may foster the development of a baseline of equitable services across service providers and Nations. Participants highlighted the ways in a lack of clear protocols around data sharing posed challenges to work with children with complex needs. They noted that, when organizations working with a family failed to share information, the results could include:

- Unnecessary burden on children and families as a result of duplication of diagnostic or intake processes,
- Delays in establishment of appropriate service plans as independent service providers worked to understand and make sense of the alternate supports and services that a child was receiving.
- Receipt of services based on conflicting or misaligned intervention strategies.

Data sharing protocols may help to eliminate the possibility of delays and disruptions in service that can occur when service providers have not established strong, informal systems of collaboration and coordination. In interviews and focus groups, participants highlighted protocols and systems to facilitate the sharing of case files and information as being an essential component of meaningful collaboration. In the long term, a shared database could also potentially support the assessment of the impact of Jordan's Principle services on the health and wellbeing of First Nation children and families. This impact should be the ultimate test of Jordan's Principle implementation.

Initial efforts to develop a shared database have been slowed, by COVID-19 related restrictions and responsibilities, but also by questions about: data sovereignty, who should lead the database development project, and how to select a database contractor to carry out the technical aspect of database development.[870] The FNIHB regional office initially awarded South East Regional Development Corporation (SERDC) funding to develop a shared, regional Jordan's Principle database.[871] No request for proposals was circulated and the development of database plans took place primarily in partnership with a TSC/ISC/SSP working group that, at that time, did not include representatives from the FNHSSM, AMC or other groups with long-term, region wide knowledge. One interviewee

noted that, when SERDC presented a database plan based on their existing database to Case Managers and others there was "pushback." Case Managers wanted to know why SERDC got the database contract, who made the decision and why database companies working with other First Nations/First Nation organizations were not considered for the Jordan's Principle database.[872] Database development was put on hold due to the tensions around the project and COVID-19 related work and restrictions.[873,874]

Time, additional resources, and greater regional coordination are needed to support the development and effective implementation of such a database. The required resources include not only those to support database construction, but those needed to develop, disseminate, and provide ongoing training around data sharing protocols. Resources to develop, disseminate, and provide ongoing training around standards of data entry will also be needed in order to ensure that the data collected is complete and consistent enough to support rigorous analysis.[875,876,877]

While respite care policies and data sharing protocols were among the most commonly mentioned areas in which participants noted a need for best practices, they also pointed to other areas and noted that some ongoing initiatives to support promising practices and policy development are already underway. For example, one interviewee indicated that the TSC/ISC/SSP group was working on a promising practices module that could be gifted to communities, and that the Interlake Reserves Tribal Council was also funded to develop Jordan's Principle policies and procedure.[878] The emergence of both formal policies, developed in consultation with Case Managers, and flexible tool kits to support promising practices that can be modified and adapted for unique Nation contexts, are important steps forward in the implementation of Jordan's Principle in Manitoba. However, consideration of the ongoing utility of these policies and tools raises many questions around collaboration and coordination: Which organizations have the mandate to ensure that newly hired Case Managers receive best practice manuals and tool kits? Which organization has responsibility for informing new Case Managers about existing policies? Is there a mechanism for monitoring compliance with policies and is such a mechanism necessary? How will new tools and policies link with and build on those already developed? Who will ensure that tools and policies are updated over time?

Chapter 8:

Recommendations

We began this report by outlining the loose patchwork of services for First Nation children that existed prior to the implementation of Jordan's Principle. Within this complicated patchwork of services, First Nation children encountered gaps in needed services, as well as service denials, delays, and disruptions. The implementation of Jordan's Principle in Manitoba added important new patches to the pre-existing patchwork, extending needed new services to First Nation children and families. However, important gaps in services remain, and the efforts to ensure a strong system of services for all First Nation children has been undermined by short term, demand driven funding, reliance on administrative discretion, and failure to support regional coordination structure.

Moreover, findings presented in this report point to substantial variation across Nations in terms of the context of, approach to, and progress towards establishing Jordan's Principle services. Some of this variation results from a relational and responsive approach to service design and delivery that tailors services to meet the specific needs of children and families within unique, Nation-level contexts. However, as evinced by the case studies presented in Chapter 4, other elements of variation seemed to reflect pre-

existing inequities in infrastructure, services, and capacity. This type of variation represents inequities in the benefits that different Nations, and children and families within those Nations, have been able to secure through Jordan's Principle.

Pre-existing inequities in infrastructure, services, and capacities present a complex challenge to implementing Jordan's Principle in accordance with CHRT orders: Jordan's Principles funding, services, and supports must be provided in a way, and at a level, that does not compound pre-existing service inequities. Layered on top of this challenge are commitments and obligations to respect self-determination and to support First Nations in creating self-determined systems of services.

First Nations in Manitoba have long advocated for both self determination in services and a systemic approach to services. A Case Manager summarized the ideal balance between self-determination and ensuring equity, in services.

> *We need to be ensuring that we are all on the same baseline and then you can do whatever you want with your program ... And I think that's really important for this to be successful. Because when families transition between communities, they need to feel secure enough to know that their child is still going to receive those same services when they go from Community A to Community B.*[879]

Taken together, the recommendations put forward in this report outline a plan for moving from the current patchwork of services for First Nation children to a well-designed service quilt in which there are no more gaps in services for First Nation children. They point to a revised approach to the implementation of Jordan's Principle in which each Nation would have access to the resources and supports to create a block of services that reflects its unique context, strengths, culture, needs. These Nation-level service blocks would be the reinforced by a strong regional backing and bound to a broader system of services with durable seams of relationships, neatly executed and well maintained in order to ensure that First Nation children receive timely services to address their needs.

We recommend that the federal government:

1. **Commit funding and other resources to ensure adequate housing and clean water for every First Nation child.** We cannot speak of meeting the needs and best interests of First Nation children who do not have safe housing and clean water. In particular, the federal government must work with First Nations to determine and implement:
    a. The policy changes and resource allocation needed to immediately address housing shortages and overcrowding, as well as problems with the condition/repair of housing that affect the health and safety of on-reserve children. Study participants noted that Jordan's Principle housing renovation funds are current restricted to situations in which housing needs are directly linked to disability. This restriction is not in keeping with the broad application of Jordan's Principle outlined by the CHRT.
    b. Policy changes and resource allocation to immediately ensure all First Nations have consistent access to clean water. The Auditor General of Canada has recently highlighted Canada's failure to meet clean water goals and the need to revise funding and planning models in order to meet the evolving water needs of First Nations. The federal government must work in full partnership with First Nations to ensure all Nations have access to clean water and to develop and implement plans for ongoing maintenance, repair, and expansion to meet First Nations' water needs.[880,881]
2. **Extend eligibility for Jordan's Principle through age 21.** This is essential in order to eliminate situations in which families are forced to rely on CFS in order to access services for youth in the transition to adulthood. It is also necessary to ensure that First Nation youth, living on reserve, have access to equitable services that meet their needs. The federal government must also commit to funding and supporting the development of equitable disability services across the life course – disabilities do not end at 18, or at 21.
3. **Commit to working with First Nations to analyze and extend funds to cover the real costs of implementing Jordan's Principle in remote, northern Nations.** Failure to fully fund the real costs of Jordan's Principle services and supports exacerbates inequities between First Nations, making it impossible to achieve the equitable services. The costs of providing Jordan's Principle services in remote Nations include, but are not limited to, the extra costs of: purchasing/shipping both basic necessities, such as groceries, and more specialized equipment; recruiting and retaining qualified staff; ensuring equitable in-community time for service providers who commute to remote Nations; and providing medical transportation that meets the needs of children and families. Existing research on the real cost of child welfare services in remote Nations may serve as a starting place for this work.
4. **Commit to funding and supporting the development of dedicated, physical space for Jordan's Principle programs and services in each Nation.** The CHRT recently clarified that the federal government has an obligation to fund capital expenses that are necessary to "support the delivery of Jordan's Principle services to children on-reserve" and ordered the federal government to provide funding to "FNCFS agencies, including small agencies and First Nations" for these expenses.[882] The details of this funding are not yet available in Manitoba. Capital funds should be allocated to and overseen by the department/unit that coordinates Jordan's Principle services within each Nation. In planning for and proposing funding for capital expenses, First Nations should be supported in considering the full and future needs of their Jordan's Principle programs, as well as the diverse family needs and multiple modes of practice supported through Jordan's Principle. Depending on the needs and existing infrastructure within a Nation, features of the Jordan's Principle spaces might include, but should not be limited to: rooms for private consultation and meetings with families, recreational space for group activities, community kitchen and gathering space, classroom space for workshops and tutoring, spaces designed for out-of-home respite care, space for sensory toys or other PT/OT equipment, dedicated space for telehealth/online services, office space for Jordan's Principle staff, office/meeting space and accommodation for visiting service providers.
5. **Commit to funding and supporting the development of the digital infrastructure required to support a responsive, relational approach to the development and provision of Jordan's Principle services. Every Nation needs reliable cell phone, Internet, and telehealth service.** Both provincial and federal governments have recently announced initiatives to improve digital infrastructure. These initiatives should be implemented in full partnership with First Nations.
6. **Commit to funding and supporting**

the development of communities of practice that provide space for Case Managers, Service Coordinators, and SSPs to share strategies and successes, discuss challenges, and connect to resources that may support ongoing service development. These communities of practice should be mandated by First Nations, but function at arm's-length from all governments in order to provide space to discuss practice issues, program development, and innovations without concern for politicization.

7. **Allocate long-term Jordan's Principle funding that is flexible enough to enable First Nations to develop services in accordance with their priorities and members' needs.** Ongoing collaboration and discussion between First Nations and federal and provincial authorities is needed to specify the details of this funding. Key issues that must be addressed include (but are not limited to):
    a. The structure of Jordan's Principle funding;
    b. The coordination of Jordan's Principle funding with other funding sources;
    c. The provincial relationship to Jordan's Principle.

    Analysis of the variation, across regions and First Nations, in existing structures for Jordan's Principle may inform discussion of these issues.
8. **Commit to a systemic approach to Jordan's Principle funding that actively extends the resources needed to establish an equitable baseline of services in each First Nation.** Currently, the normative approach to Jordan's Principle funding is demand-driven. First Nations must request funding, and they must do so with very little access to information about what has been funded in other Nations, or what can be funded through Jordan's Principle. Every First Nation should be ensured equitable, flexible, long-term funding for a common baseline of services. First Nations must have consistent, ongoing access to clear and transparent information about the scope of Jordan's Principle funding that is available. They must have ongoing access to supports for visioning and making sense of the ways in which the full scope of this funding can be utilized in their Nations. They must also have access to ongoing supports for revising/adapting funding as service capacities or contexts change. Demand-driven funding should also exist to support innovation and adaptation of services.
9. **Commit to establishing clear and consistent paths for communicating policy information to every First Nation and for engaging First Nations in policy development and decision-making processes.** At the National level, this includes ensuring that First Nations receive regular updates on the work of the Jordan's Principle Technical Advisory Group, the Jordan's Principle Organizing Committee, and other working groups focused on services for First Nation people. At the regional level, this includes ensuring that all First Nations receive regular updates from the FNIHB/ISC regional office. The FNIHB/ISC regional office must also work with First Nations to establish formal structures for engaging First Nations in decision-making around Jordan's Principle.
10. **Allocate long-term funding and other resources for capacity enhancement initiatives that support every First Nation in Manitoba in moving towards a self-determined system of services.** Diverse forms of education and training are needed in order to support First Nation people in assuming all Jordan's Principle roles across service domains and levels of education. Many innovative capacity enhancement initiatives within Manitoba have lapsed because of short-term funding or have not been supported with resources to reach every Nation. For example, MFNERC has lacked the funding to extend some of its initiatives to support First Nations in obtaining clinical degrees to all Nations in Manitoba. In addition, funding lapsed for five-day, SSP provided workshop on allied health, mental health/wellness and other services. The FNIHB/ISC regional office should work with First Nations to survey First Nations and SSPs in order to learn about successful capacity enhancement initiatives, as well as gaps in capacity enhancement. The results of this survey should support assessment of the funding and other resources needed to revive, scale-up, and fill gaps in capacity enhancement initiatives. Based on this assessment, the federal government should commit to long-term funding that supports diverse capacity enhancement initiatives that reach every First Nation.
11. **Work with SSPs and First Nations to restructure Jordan's Principle funding in ways that support First Nations in taking on specific services/responsibilities in accordance with a self-determined pacing and sequence.** First Nations currently face difficult choices between local control of self-determined services on one hand and access to the resources, multi-disciplinary expertise, and other benefits of economies of scale provided by SSPs on the other. These choices can be complicated by an all-or-nothing approach in which First Nations must opt in or out of a bundle of services provided by SSPs. Instead, First Nations should be able to choose specific services that are tailored to their contexts and capacities. Shifting to a more flexible model will support self-determination in services, but will also require ongoing collaboration and allocation of resources to support coordination of services across various models and configurations. In addition, in asserting self-determination and assuming local control of services, First Nations may lose some of the cost benefits associated with economies of scale; in keeping with commitments to honour Indigenous self-determination, the federal government must be prepared to provide increased funding that enables First Nations to provide equitable services.
12. **Support the development of formal, First Nations led structures to facilitate coordination and collaboration around Jordan's Principle.** Regional coordination is essential to a systemic approach to services. Development of policy, promising practices, data collection and sharing systems, and additional research are among the tasks that require substantial and sustained regional coordination. Regional coordination in Manitoba has been underfunded from the start, and further fragmented/underdeveloped by COVID-19 related resource strains, as well as competition between groups and initiatives. AMC has put forward the most comprehensive plan for regional coordination in the form of its proposals for an Equity Roundtable and a Capacity Enhancement Centre. The federal government should commit to funding AMC to conduct regional engagement – with Case Managers, Service Coordinators, SSPs and regional First Nation organizations -focused on developing timelines and work plans for establishing the regional coordination structures outlined in those proposals. The federal government should fully fund the work plans that emerge from engagement processes.
13. **Commit to funding a First Nations owned and controlled program of research to support the further implementation of Jordan's Principle.** Through Jordan's

Principle, First Nations are working to develop self-determined systems of culturally grounded, innovative services for children and families. However, they are doing so in a context that has been shaped by: long-standing federal and provincial neglect of the needs of First Nations, limited time to develop new models of care, dependence on western-trained service providers, and a colonial policy structure. Transformative research can help support First Nations in developing new systems of care. Descriptive studies like this one, that document the implementation of Jordan's Principle across different contexts are an important initial step. Further research may address issues such as:

a. Calculating the true cost of service in remote Northern First Nations – Building on CHRT ordered work to asses child welfare costs, such research might detail Case Manager and Service Provider accounts of the extra cost of services in remote Nations and seek to compare these costs with data on the budgets for Jordan's Principle services in urban, rural, and remote Nations.

b. The development of First Nations models of service/care – Focusing on specific Nations or organizations, such research might seek to identify the core elements of First Nations service models, as well as success in and challenges to model development and implementation.

c. The development of First Nations service systems equipped to respond to emergencies and crisis – Using the provision of services during the global COVID-19 pandemic as a case study, such research might identify the types of additional services and supports required to meet First Nation needs during public health emergencies and estimate the cost of these types of services and supports. Assessment of needs and costs associated with COVID could support analysis of the work needed to develop a robust and flexible service system equipped to respond to other emergency situations such as fires, floods, or other disease outbreaks.

Appendices:

Appendix 1: Research Team

Dr. Vandna Sinha is an associate research professor in the School of Education at the University of Colorado, Boulder. She joined the University of Colorado in 2019, after spending 13 years in the School of Social Work at McGill University. Vandna has 18 years of experience conducting interdisciplinary, mixed-methods, research in partnership with child welfare, health, social service, and child/youth advocacy organizations. Her research focuses on the ways that social policies impact children's access to services and on the abilities of marginalized families and communities to care for children. Many of her projects have focused on understanding service disparities and barriers to the provision of equitable services for First Nation children in Canada. Vandna was the Principal Investigator for the First Nations Incidence Study of Reported Child Abuse and Neglect 2008 (FNIS-2008) and she led the development of and planning for a follow up to the FNIS-2008. She has also led multiple other child welfare focused projects. Vandna coordinated the national Jordan's Principle Working Group (2012-2016) and has led studies on the development of Jordan's Principle funded services in Pinaymootang First Nation (Manitoba) and in Alberta. She holds a PhD and Masters in Human Development and

Social Policy from Northwestern University and undergraduate degrees in Economics and Community Action from the University of Utah.

Meghan Sangster completed her Masters of Social Work at McGill University. She has worked as a research associate for the Children's Services Policy Research Group since August of 2018 and has participated in research projects documenting the implementation of Jordan's Principle in Alberta for 3 years. Meghan obtained her Bachelor of Arts Honours in political science and philosophy and a Certificate in Sexual and Gender Diversity from Queen's University followed by a Master's of Education at York University. She has also supported the completion of a private contract with the Child and Family Caring Society in partnership with the University of Toronto Policy Bench. In addition to her research Meghan conducted clinical harm reduction work for over 2 years to provide support to people experiencing homelessness and people who use drugs in out-patient and drop-in settings.

Dr. Alison J. Gerlach is an assistant professor who joined the School of Child and Youth Care at the University of Victoria in August 2018. She holds a research associate position at the Research in Health and Health Care Inequities research unit at the University of British Columbia School of Nursing and a research associate position with the Human Early Learning Partnership research network at the University of British Columbia School of Population Health. Alison's current program of research and scholarship focuses on informing systems change for equity-oriented, child- and family-centred care in diverse early years and healthcare contexts with Indigenous and non-Indigenous families and children who experience structural forms of marginalization and a greater risk of health inequities.

Alison's work draws on 25 years of providing occupational therapy with dis/abled children in diverse community and family contexts, and in partnership with Indigenous organizations and First Nations in British Columbia. Alison's research focuses on the continuities between children's early experiences of adversity, dis/ability, and health inequities and the development of inclusive, responsive, and equity-oriented structural, organizational, and practice level approaches. Alison recently led two policy impact forums with Ministry of Child and Family Development policy stakeholders to support the mobilization of a provincial study on how structural factors influence the capacity of early child development programs and agencies to implement trauma- and violence-informed care in the services with Indigenous communities and families.

Dr. Marlyn Bennett is from Sandy Bay Ojibway First Nation and a 60s Scoop Survivor. Marlyn is an assistant professor with the Faculty of Social Work at the University of Manitoba. She has been the Director of the Master of Social Work based in Indigenous Knowledges Program for the past five years. She is a senior researcher with over 20 years of experience working within Indigenous communities, non-Indigenous organizations, and governments. Marlyn's program of research maintains a national purview and utilizes qualitative research methodologies with an interdisciplinary focus on Indigenous health outcomes. Her program of research also focuses on the experiences of Indigenous women and youth with the child welfare system and in reforming social, health, and child welfare services to integrate cultural safety into services for Indigenous women and girls who experience sexual violence.

Marlyn has experience as a policy analyst overseeing the development of self-government for First Nation child welfare as part of the Framework Agreement in Manitoba. She has also been involved in the devolution of Indigenous child welfare in Manitoba through the Aboriginal Justice Inquiry Child Welfare Initiative. Marlyn has worked for the First Nations Child and Family Caring Society of Canada as the Director of Research, and in that role, she served as the first Editor-in-Chief of the First Peoples Child & Family Review, an online journal published through the Caring Society. She has proven experience with Indigenous child welfare board administration, regulatory experience as a public representative overseeing the social work profession in Manitoba and is a member of the Canadian Association of Social Work Educators. Marlyn is currently a member of the University of Manitoba Faculty of Graduate Studies' Research Ethics Board committee and is a recent appointee to a CFS panel review with the Province of Manitoba's Department of Families. Marlyn has also been a member of the Indigenous Advisory Committee to the First Nations component of the Canadian Incidence Study of Reported Child Abuse and Neglect for over 15 years which has required critical oversight of national research implementation including quantitative methodologies, inter-governmental engagement, and First Nations oversight.

Dr. Josée G. Lavoie is a professor with the Department of Community Health Sciences, Faculty of Health Sciences, College of Medicine, University of Manitoba, and Director of Ongomiizwin Research at the University of Manitoba. Josée holds a BSc in Dietetics & Nutrition (1986); a MA in Medical Anthropology from McGill University (1993); and a PhD in Health Policy and Financing (2005) from the London School of Hygiene and Tropical Medicine, UK. Before beginning her research career, Josée spent 10 years working in Indigenous controlled health services in Nunavik, Nunavut and Northern Saskatchewan. She is a member of the board for the Canadian Society for Circumpolar Health. Josée's program of research is located at the interface between policy and Indigenous health services, with a focus on contracting, accountability and responsiveness.

Dr. Lucyna Lach is an associate professor in the School of Social Work and an associate member of the Departments of Pediatrics, Neurology and Neurosurgery, Faculty of Medicine, McGill University. Her program of research focuses on the well-being of children with neurodisabilities and their caregivers (i.e. caregiver health, and parenting). Dr. Lach's current projects address social determinants of health of children with neurodisabilties. She is co-leading a team of researchers and trainees whose projects have been funded by Kids Brain Health Network (KBHN) and the Social Sciences and Humanities Research Council (SSHRC) to document determinants such as income, service use, educational outcomes, and uptake of income supports such as the Disability Tax Credit using population-based as well as administrative and clinical databases. She is also collaborating with Dr. David Nicholas to increase capacity in navigation systems that support families of children with neurodisabilities in Vancouver, Edmonton and Yellowknife. In addition, she is part of a Strategic Patient-Oriented Research (SPOR) Team entitled CHILDBRIGHT, and is co-leading (along with Dr. Patrick McGrath) development and implementation of a randomized control trial entitled Strongest Families – Neurodevelopment. This project is evaluating a web-based program that combines group coaching and educational modules, with parent-to-parent support for parents whose children have a neurodisability and mental health concerns. Dr. Lach is a peer-reviewer for numerous journals and organizations who provide funding in this area of research.

Marcel Balfour is a Norway House Cree Nation citizen and a 60s Scoop Survivor. He has an undergraduate degree in anthropology from the University of Winnipeg and a law degree from the University of Ottawa. He articled at the Ontario Human Rights Commission (Toronto) and was called to the Ontario Bar.

Marcel assumed a senior management position with Norway House Cree Nation in 2002, serving as Executive Director to the Chief and Council. He has worked at the international level

with the United Nations Education and Scientific and Cultural Organization in Paris, France. He also worked at the national level in Canada to assist in developing the National Aboriginal Health Organization (NAHO) in Ottawa. In 2002 he was elected to a four-year term as Councilor. He was elected Chief of Norway House Cree Nation in 2006 and served a four-year term in that position. As both a staff member and an elected leader of Norway House Cree Nation, he engaged with issues related to on and off-reserve access to services for First Nation children. He also participated in and supported discussion and advocacy around Jordan's Principle at regional and national levels in these positions.

Marcel began participating in Assembly of Manitoba Chiefs (AMC) work while Chief of Norway House Cree Nation. Among other roles, he participated in the AMC Chiefs Task Force on Health which was the AMC Chief's committee responsible for the regional implementation of Jordan's Principle. He was also the health portfolio holder for the Chiefs Committee on Health for the Manitoba Keewatinowi Okimakanak. Marcel began working for the AMC Secretariat in 2010 and has held diverse roles, including Special Advisor to the Executive Director and Acting Executive Director. Marcel currently serves as a Senior Policy Analyst, leading the Jordan's Principle Service Coordination Unit (JPSC).

Through his work with Norway House Cree Nation and AMC, Marcel has worked with First Nations leadership, including the AMC Grand Chief and Chiefs, First Nations technicians, other First Nation organizations at both the regional and national levels, and federal and provincial governments to support the development and implementation of an approach to Jordan's Principle that is designed and led by First Nations and meets the needs of First Nation children and families in Manitoba. During his tenure at the AMC, the JPSC has worked in close partnership with the AMC Grand Chief's Office, the AMC Women's Council, the First Nations Family Advocate office and Eagle Urban Transition Centre, as well as with other groups to engage First Nations leadership, First Nations health and education directors, First Nations social development advisors technical group, and other First Nations representatives in visioning and guiding the development of a Manitoba-specific approach to Jordan's Principle. The JPSC has organized Jordan's Principle focused regional gatherings and meetings, supported the development and passage of AMC Chiefs-in-Assembly resolutions on Jordan's Principle, and engaged with national-level legal and policy-making processes related to Jordan's Principle.

My name is **Samantha Folster**, a Cree indigenous woman from Norway House, Manitoba. My spirit name is South wind Thunder bird Woman. I am 47 years old and a member of the Norway House Cree Nation. I have a Social Work Degree with the University of Manitoba and a Master's Degree in Public Administration with the University of Manitoba/University of Winnipeg. I have worked in Social work for 20+ years working with families and children in various programs and services. These include Child and Family Services, Education, Social Services, Health, Mediation and Children's Special Services. The opportunity to be a leader in my community for one term in 2014-2018 has expedited my vision in policy development and provided insight in community development as a whole. During my lifetime, career board governance experience provided many decision-making opportunities at a community, regional, and national level.

During the conception of Jordan's Principle it was our community that began the process of advocacy for Jordan's Principle as Jordan River Anderson was from Norway House Cree Nation. It was an experiential time in my career to witness the fruition of this program and service for our families and children. As a policy analyst for Jordan's Principle for Assembly of Manitoba Chiefs, it is a role that continues to be a strong voice for children and families in all first Nations across this province.

Appendix 2: Study approach and methods

The study drew on diverse sources of information and included multiple methods of data collection. These included:

- Literature review,
- Content analysis of policy documents,
- Individual and group interviews,
- Focus groups,
- A survey of Nation-level service directors and Case Managers, and
- Participant observation in Jordan's Principle Technical Advisory Group (TAG) meetings, which bring Jordan's Principle Case Managers together to share experiences, questions and issues of concern.

Two anonymized case studies integrate information from interviews and literature/media focused on a single Nation. However, in order to preserve anonymity, we have drawn from study data on other Nations to modify potentially identifying details.

Interviews and focus groups were recorded and transcribed. These transcripts, as well as meeting notes, were systematically analyzed. We first reviewed the transcripts and notes to identify recurring themes, then compiled the segments of each transcript and set of meeting notes that related to each theme. Based on these compiled quotations, we created memos that provided brief summaries of key patterns in the data for each theme. These memos formed the core of our analysis. Data from other sources were combined in order to complement and add additional detail to the information in the memos. In addition, policy documents and a literature review were used to detail the historical and policy context for data on the current implementation of Jordan's Principle.

We engaged in multiple methods of verification of our analyses, including:

- Asking Advisory Committee members and other key stakeholders to review drafts of the reports;
- Sharing quotations and contextualizing sentences with focus group and interview participants, along with a request for feedback; and
- Asking organizations that provide Jordan's Principle funded services to review and offer feedback on descriptions of the services provided by their organizations.

Data collection methods and the data collected are summarized in Appendix Table 1. A key goal in analyzing and writing about this information was to ensure that we placed study findings in appropriate historical and policy context. Contextualizing study findings supports an examination of the ways in which the current implementation of Jordan's Principle is shaped by and replicates - as well as the way it diverges from - the policies, practices and power dynamics that have served to disempower and disadvantage First Nation people in the past and in the present day.

The recommendations included in this report were developed through an iterative process involving multiple steps. We generated an initial list of potential recommendations based on the findings presented in the interim report, distinguishing between challenges for which specific solutions were clearly outlined in the interim report and those areas in which proposed solutions were not as clearly defined. These initial proposals were discussed with the project advisory committee and revised/refined based on that discussion. A second discussion was held representatives of regional First Nation organizations and recommendations were again revised/refined based on this discussion. Additional discussions with the advisory committee and the AMC Women's Council informed the final version of the recommendations presented in this report.

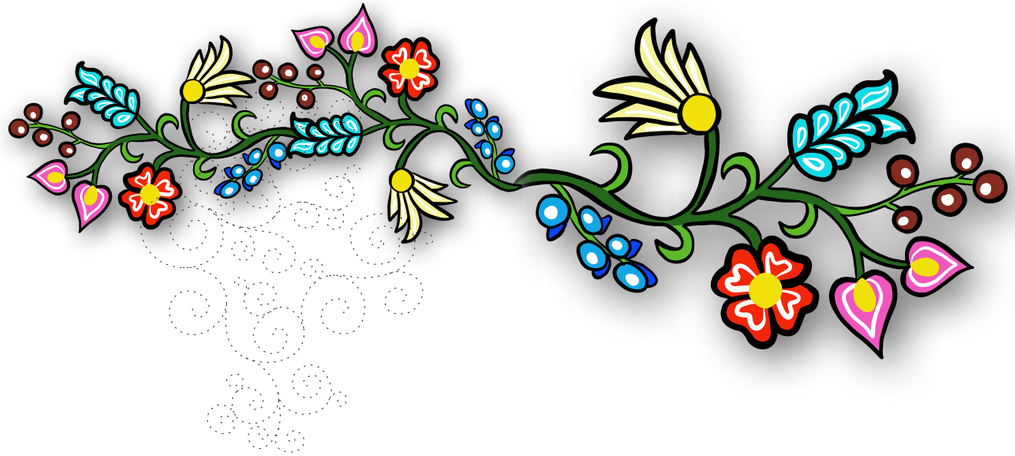
Appendix Table 1: Data collection methods and sample summary

Approach to Information Gathering	Focus of Information Gathering	Information Obtained
Document Review	Publicly available policy documents, presentations, reports, and research summaries	AMC resolutions, CHRT rulings, and orders, Manitoba focused reports, Jordan's Principle policy documents, presentations at Jordan's Principle events, parliamentary Hansard
	Internal documents provided by the AMC	Jordan's Principle engagement reports, terms of reference, briefing notes, information sheets, and meeting minutes from different Jordan's Principle focused events
	Prior research	Research on policy guiding services for First Nations, accessibility of services, and outcomes for First Nation children. In addition, we draw on prior research on Jordan's Principle in Manitoba
Individual/group interviews and focus groups	28 Interviews/consultations with Nation and regional level Service Coordinators, Case Managers, administrators and policy specialists	▪ Seven Jordan's Principle Case Managers ▪ 14 regional level technicians, service providers, and policy specialists including AMC, Eagle Urban Transition Centre (EUTC), Special Needs Advocate Office, Indigenous Services Canada (ISC) ▪ Seven Specialized Service Provider (SSP) administrators ▪ Seven Tribal Council Service Coordinators (TSC) or Jordan's Principle at regional leadership organizations
	Five focus groups and three interviews with over 20 front line service providers	More than 20 frontline staff and Specialized Service providers including Manitoba Adolescent Treatment Centre (MATC), St. Amant, Rehabilitation Centre for Children (RCC), Manitoba First Nations Education Resource Centre (MFNERC), Frontier School Division (FSD)
Participant Observation	Jordan's Principle TAG meetings	Field notes and minutes, April 2020-April 2021
Administrative Data	National and regional level data	Data on the number of children served and services provided by service domain, region, and year
Survey Data	Jordan's Principle Case Manager, Health Director, and Education Director perspectives on access to services	Data on the range of services provided through Jordan's Principle and available through other sources
Case Studies	Details of Jordan's Principle services and implementation processes in two First Nations	Interviews and discussion with Jordan's Principle Case Managers and/or others central to Jordan's Principle in the Nation

The context of data collection

Discussions around this study began in the fall of 2018, and an initial research agreement was drafted in March of 2019, after navigating complex administrative processes. A research agreement was finalized in April 2020. The Health Information Research Governance Committee (HIRGC) and university ethics boards concluded consideration of ethics applications by October 2020.

Data collection was deeply affected by COVID-19 related travel restrictions and by the situations in First Nations in Manitoba. Research proceeded despite the growing impact of the COVID-19 pandemic. All interviews, focus groups, and meetings took place virtually. Service providers, coordinators and Case Managers affiliated with Jordan's Principle faced incredible challenges during this period. They worked to sustain essential supports and services, while also extending new services and supports to meet the needs of children and families through extended periods of lockdown and other COVID-19 restrictions. Many were on the front lines of COVID-19 response efforts. Thus, data collection for this report took place in a context in which study participants were carrying heavy burdens. We are grateful for their willingness to share their experiences and knowledge during this complicated time.



Appendix 3: Off-reserve services and programs for children with disabilities

Information for Manitobans with Disabilities

Services and Programs for Children

My child has unique needs. Can she attend licensed child care? How will her needs be met?

Supports are available to help licensed non-profit child care centres and licensed home providers meet your child's unique needs. Based on specific eligibility criteria, licensed child care facilities may apply and qualify for:

- financial help for support staff
- grants for specialized equipment or adaptations to equipment
- staff training

Child care providers will work with you and other professionals. Together, you will share information to help develop goals for your child. For more information, please see the Guide to the Inclusion Support Program at:

www.manitoba.ca/fs/childcare/resources/pubs/inclusion_support_program_guide.pdf

How do we find a licensed child care centre or child care home?

Use the Online Child Care Registry to register your child for a space at multiple licensed facilities at one time. When a space at one of the facilities you have selected becomes available, the facility will contact you. You can visit the registry at:

www.manitoba.ca/onlinechildcareregistry

Please check off the "special requirements" box when you register your child. After adding your child to the Online Child Care Registry, you may also want to contact facilities directly to confirm your child care needs.

Manitoba

What questions should I ask a child care provider?

You can find helpful questions to ask a potential child care provider in the document, *A Guide to Child Care in Manitoba*. The guide contains questions about:

- the daily program
- health, nutrition and safety
- furnishings and equipment
- staff training and staff-to-child ratios
- administrative policies

You can view the guide at:

www.manitoba.ca/fs/childcare/quality_child_care.html

How long will I need to wait for licensed child care?

The waiting period for a space will depend on the facility and where you live in Manitoba. Some facilities may have spaces available immediately, while others may have a waiting list. It is recommended that you register at more than one facility and consider other areas if waiting lists are long.

What type of funding assistance is available for families with a child enrolled in licensed child care or who have a child attending nursery school?

Subsidies for child care

For families that apply and qualify, the province may provide a **subsidy** for the maximum daily child care fees. Subsidy for child care fees is based on family income. To qualify for a subsidy, you need to be:

- working
- looking for work
- going to school
- have another specific reason

Subsidies for nursery school

A subsidy for families using nursery schools, including those with a stay-at-home parent, is now available. This can help provide a stimulating experience for your child in one of Manitoba's nearly 200 licensed nursery school programs. Parents do not need to be working or going to school to apply.

You can apply for a child care subsidy and use the Subsidy Eligibility Estimator (SEE) to find out how much you would be eligible for at:

www.manitoba.ca/childcare

To speak with someone about subsidies, call the Subsidy Information Services line at:

Winnipeg: 204-945-8195

Toll free: 1-877-587-6224

Subsidies are a type of financial assistance from government. There are subsidies that are available to help families pay for the cost of child care. Payment is made directly to the child care centre on behalf of the family.

I have questions about child care. Who do I contact?

You can contact Child Care Information Services at:

Winnipeg: 204-945-0776
Toll free: 1-888-213-4754 or
Email: cdcinfo@gov.mb.ca

You can also visit the website:

www.manitoba.ca/childcare

I have a concern about my licensed centre or home. What do I do?

If you have a concern about your child care centre, contact Child Care Information Services at:

Winnipeg: 204-945-0776
Toll free: 1-888-213-4754 or
Email: cdcinfo@gov.mb.ca

A staff member from Manitoba Early Learning and Child Care is available to answer your questions or write down the details of a concern or complaint. The staff will also help to ensure appropriate follow-up. All concerns are investigated by licensing staff.

What should I do if I'm concerned that my child may have a disability or developmental delay?

Children develop in the same basic ways and at different rates. If you are worried about your child's development, visit your family doctor or your child's doctor and explain your concerns. Your concerns may come from your own observations or from others (such as family members, friends or staff at the child care centre or school). Based on your information and an examination, your doctor may make a referral for an assessment to a health professional.

For more information on how to get an assessment and a diagnosis for your child, visit the Information for Manitobans with Disabilities section, *A Young Child's Assessment and Diagnosis*.

What is the Children's disABILITY Services program?

This program, provided through Manitoba Family Services, supports families who are raising a child (or children) with developmental or physical disabilities, to meet the additional needs they may have. Children's disABILITY Services offers a variety of resources and supports to parents to assist them to care for their children at home in their own communities, where children grow and thrive.

Does my child qualify for Children's disABILITY Services?

To be eligible for CDS, children must:

- be under the age of 18
- be living in Manitoba with their birth, adoptive or extended families
- have a medical diagnosis confirming they have one or more of the following conditions:
  - intellectual disability
  - developmental delay
  - autism spectrum disorder
  - lifelong physical disability
  - a high probability of developmental delay due to a pre-existing condition

Are we eligible for Children's disABILITY Services?

ServiceLink
Connecting you to services you need

Through the Manitoba government's **ServiceLink**, you can learn more about the services that may be available to your family from Children's disABILITY Services. This on-line tool will take you through a series of basic questions and provide a results page containing services that you may be eligible for, links to related websites and contact information.
www.manitoba.ca/servicelink

What services are provided by the Children's disABILITY Services program?

The CDS program offers a wide range of services for children with disabilities and their families. The specific services that each child and their family receive are based on individual assessment and available financial and human resources. Services may include:

Service	Description	Preschool (birth to age 6)	Children (age 6-12)	Youth (age 13-17)
Child Development Program	The Child Development Program provides early intervention services for children who have a developmental delay or disability. This service helps children develop in five areas: self-help, motor skills, socialization, communication and cognition. Child Development staff work with parents to identify their child's strengths and goals. Staff teach parents and caregivers ways to help the child develop and learn new skills.	•	• (up to school entry)	
Therapy	Therapies that may be available are occupational therapy, physiotherapy, speech and language therapy and audiology. Children who need therapy services will be referred to their regional central intake for the Children's Therapy Initiative (CTI). Please see further information on *therapy for children* in this section.	•	•	•
Autism Services – Autism Outreach	This program teaches parents and caregivers autism intervention methods that are personalized and flexible. Autism specialists work closely with child-development staff to deliver the services.	•	• (up to school entry)	•
Autism Services - Applied Behavioural Analysis (ABA)	Programming based on the principles of ABA is available for children diagnosed with autism spectrum disorder. Programs are personalized and use behavioural strategies to teach skills across a number of areas.	• (up to 3 years or until eligible for school entry)	• (for children who have participated in the early learning program - one year of school age programming, followed by consultative supports)	• (Consultative supports are available upon referral until high school graduation)
Summer Skills Programming	Children's disABILITY Services can help school-age children maintain their skills during the summer months. This is done by providing supports children need to access programs and activities that promote what they have learned during the school year.		•	•

Service	Description	Preschool (birth to age 6)	Children (age 6-12)	Youth (age 13-17)
Behavioural Services	Behavioural specialists may assess a child's challenging behaviours, and together with the family, develop a plan that addresses the child's needs.	•	•	•
After School Care for Adolescents	After school care may be available for adolescents who can no longer access child care, but still need to be looked after and supervised outside school hours, while their parents are at work.		• (may start at age 12)	
Respite	Respite is a break from the very unique demands of caring for a child with disabilities. Respite can be provided in or outside the child's home for parents who need a short-term break. The amount and type of respite families receive is based on the circumstances of each family. For children who have lifelong, complex medical needs, respite can be provided by a registered nurse through the local regional health authority.	•	•	•
Supplies, Equipment and Home/Vehicle Modifications	Children's disABILITY Services may provide funding for certain supplies, equipment and home or van modifications at a basic level. These supports are provided through the Disability and Health Supports Unit. For more information on what's available, visit www.manitoba.ca/fs/dhsu .	•	•	•
Transportation Costs to and from Medical Appointments	Assistance may be available for families who need financial support to cover the costs of transportation to and from medical appointment and specialized services for their child with disabilities. This support is mainly for families in rural and northern regions.	•	•	•

How do I contact the Children's disABILITY Services Program?

Call your regional or community area office. The locations and phone numbers can be found at:
www.gov.mb.ca/fs/cds/index.html

When calling the regional or community area office, you will be asked for basic information, including your name, address and telephone number. You will also be asked for information about your child, including diagnostic information, if known. You will be asked what type of help you are looking for. This information will be used to begin the process of determining eligibility for CDS. A CDS staff person will contact you and advise you of next steps in the process.

What if my child already has a diagnosis and I have the assessment information?

Check with the professional who made the diagnosis to see if a referral to CDS has been made. If it has, call your regional or community area office to check on the status of your child's referral. If a referral has not occurred, call your regional or community area office to get a referral. You can find contact information for your regional or community area office at www.gov.mb.ca/fs/cds/locations.html

I recently moved, or I am thinking of moving, to Manitoba. Who do I call and what information will I need?

Call the *regional or community area* that you have moved to or plan to move to. You will be asked for some basic information including your name, address and telephone number. You may also be asked to complete a referral form. As part of the referral process, you may be asked to provide documentation from a qualified professional about your child's diagnosis.

If you have a school age child, the *Transitioning Through School* section will provide information on creating a smooth transition to a new school.

What other services and supports may be available for my child with disabilities?

- Canadian National Institute for the Blind (CNIB)
  www.cnib.ca/en/mb-sk/Pages/default.aspx
- Central Speech and Hearing Clinic
  www.centralspeech.ca
- Family Dynamics (formerly called the Family Centre of Winnipeg)
  www.familydynamics.ca/about/
- Manitoba Adolescent Treatment Centre (MATC)
  www.matc.ca/index.html

- Regional Health Authorities in Manitoba
  www.gov.mb.ca/health/rha/contact.html
- Rehabilitation Centre for Children
  www.rccinc.ca/programs-services
- Society for Manitobans with Disabilities
  www.smd.mb.ca/childrens_services.aspx
- Specialized Services for Children and Youth (SSCY)
  www.sscy.ca

My child has been assessed and now needs therapy. Who do I contact to get service?

Children's Therapy Initiative

The Children's Therapy Initiative provides service to children from birth to 21 years of age who require audiology, occupational therapy, physiotherapy and/or speech-language pathology services.

Children's Therapy Initiative provides co-ordinated, regionally based services that allow children to get the therapy services they need in their own communities.

- **Service for Preschool Aged Children**
  In many areas of the province, therapy services for preschool aged children are co-ordinated through a central intake. Your child may be referred for therapy by a specialist or your family can contact the program directly.

  Referrals are reviewed to determine if therapy services are needed. Families may be asked to give additional information before a therapist is assigned.

  Some preschool age children may receive therapy at home or in a child care setting.

  For more information about preschool therapy in your area, including contact information to each regional Children's Therapy Initiative, please visit:

  www.sscy.ca/childrens-therapy-initiative

- **School Aged Children and Youth**
  School aged children and youth who require therapy may receive these services through their school division. Parents should contact their local school for more information on therapy services. The link below provides a listing of all schools in Manitoba and their contact information:
  www.edu.gov.mb.ca/k12/schools/2015_mb_schools_book.pdf

Private Therapy Services

You may have access to therapy services through individual or group insurance. For example, many workplaces offer insurance plans for employees to purchase therapy services. Although each workplace has a different plan, some therapy services may be included.

What areas do different types of therapists support?

Therapies for children include physiotherapy, occupational therapy, speech-language therapy and audiology. The following chart shows some of the areas that are addressed by audiologists, occupational therapists, physiotherapists and speech language pathologists.

Speech-Language Pathologists

- speech sounds
- using and understanding language
- social language skills
- voice quality
- oral motor control
- stuttering

Physiotherapists

- motor skills (rolling, sitting, crawling, walking and running)
- joint motion and muscle strength
- balance and coordination
- moving with equipment (bikes, walkers)
- sports and activities

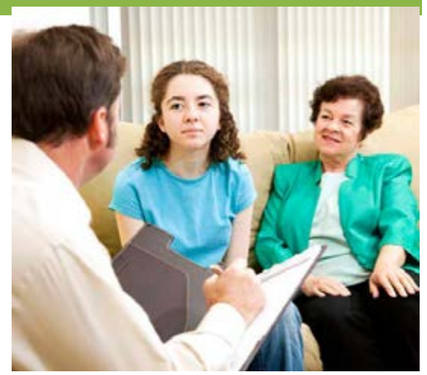
Occupational Therapists

- fine motor skills
- feeding and oral motor skills
- sensory processing
- cognitive/perceptual skills
- social skills
- self-care skills
- play skills
- vision

Audiologists

- hearing
- fitting hearing aids and other devices
- understanding hearing loss
- auditory processing

What types of mental health services are available in Manitoba?



Manitoba has a range of mental health services for children and adolescents provided in community, hospital and school settings.

Regional Health Authorities deliver the majority of child and adolescent mental health services in community and hospital settings. Services are typically provided by **multi-disciplinary teams**, in partnership with families. Team members may include child and adolescent psychiatrists, community mental health workers, clinical psychologists, nurses and social workers and other specialized professionals.

Check with your Regional Health Authority to find out which services are available in your area. For information on Telehealth, community-based services, hospital services and mental health contacts for each Regional Health Authority, please visit:

www.gov.mb.ca/health/mh/region.html

A **multi-disciplinary team** is a group of professionals with different areas of expertise who come together to provide treatment and care for a person with mental health issues.

Community Services

Child/Adolescent Community Mental Health Workers

- assessment and treatment planning in collaboration with family
- consultation services
- education for clients, family members, care providers and the community
- crisis response
- goal oriented treatment

Rural and Northern Telehealth Service

Psychiatrists, based in Winnipeg, are available to provide psychiatric assessment and consultation services to rural and northern Regional Health Authorities.

Specialized Services

Some RHAs may provide a variety of specialized programs and services. These may include:

- Early Psychosis Prevention Programs: provide assessment, identification and treatment supports for people between the ages of 15 to 35 years who may be experiencing or recovering from a first episode of psychosis.
- Youth Forensic Services: provides psychiatric and psychological assessments and brief treatment services for youth involved with the Youth Justice System.

Other Community Based Services

- Self Help and Family Supports: provided through support networks of people, many of whom are either living with a mental illness or have a family member with a mental illness. Self help activities include mutual support, public education, advocacy and recovery-oriented services that promote the needs and priorities of people with mental health problems and illnesses.
- The Mental Health Education Resource Centre of Manitoba: a lending library providing information to service providers, people with mental health problems, families, teachers and the general public.

Hospital Services

Child and Adolescent Psychiatry – Health Sciences Centre: provides comprehensive multi-disciplinary assessment and crisis stabilization for children and adolescents under the age of 18 from the province of Manitoba and parts of Nunavut in accordance with the *Mental Health Act* of Manitoba.

School Based Services

School divisions across Manitoba provide a variety of mental health related services and programming. Services may be provided by school psychologists, clinical psychologists, guidance counsellors, classroom teachers and other specialized professionals.

Check with your child's school to find out what services are available in your school. The link below provides a listing of all schools in Manitoba and their contact information:

www.edu.gov.mb.ca/k12/schools/2015_mb_schools_book.pdf

Stresshacks

This on-line resource provides information about general mental health, tools to manage stress, links, resources and an interactive map of Manitoba that locates resources in your area. This website is designed for youth, parents and professionals/educators and can be viewed at:

www.stresshacks.ca

Who is eligible for child and adolescent mental health services?

Mental health services are available for:

- children and adolescents with mental health problems as well as symptoms of mental illness
- parents, families or caregivers seeking consultation and support services

How are mental health services accessed?

Mental health services can be accessed through your family doctor or other healthcare professional or by calling directly to the mental health services of your local Regional Health Authority. For a list of the Regional Health Authorities in Manitoba and contact information for their mental health programs, visit:

www.gov.mb.ca/health/mh/region.html

Your community may have other types of mental health supports available to children and youth. You may also have access to private services through your workplace Employment Assistance Program or private insurance (such as Blue Cross).

In Winnipeg

The centralized intake for the Child and Adolescent Mental Health Program provides a single point of entry in Winnipeg for children and adolescents experiencing emotional or behavioural concerns as well as symptoms of mental illness.

The centralized intake phone number is **204-958-9660** Monday to Friday 9 a.m. to 5 p.m. Parents, caregivers, doctors and/or counsellors can make referrals. Self-referrals can also be made.

In Winnipeg, the Youth Emergency Crisis Stabilization System is available at **204-949-4777** or toll free at **1-888-383-2776**.

Rural and Northern Regional Health Authorities

For a list of the Regional Health Authorities in Manitoba and the intake numbers for their mental health programs see:

www.gov.mb.ca/health/mh/region.html

Stresshacks

This on-line resource includes an interactive map of Manitoba that locates resources in your area. It can be viewed at:

www.stresshacks.ca

Crisis Services (Outside of Winnipeg)

Child and Adolescent Treatment Centre – Crisis Stabilization Unit (CSU) provides 24-hour care to children and adolescents in crisis from Brandon, Assiniboine, Central and Parkland RHAs. Treatment focuses on stopping the crisis and returning the client to the community. Services provided include: multi-disciplinary team assessments, individual treatment, group and family therapy, community transition and consultation with community resources.

If you are in crisis or cannot wait for an appointment, you can call your local crisis line. For a listing of crisis services and contact information please visit:

www.gov.mb.ca/health/mh/region.html

or refer to your local phone directory.

What is home care? What services and supports can I access from home care?

Home care services within Manitoba are provided through the Regional Health Authorities (RHA's). It is a community-based program that provides home support to any eligible Manitoban, regardless of age, who requires health services or assistance with daily living activities. Services may include:

- personal care assistance (for example, bathing, dressing, toileting)
- home support
- health care (nursing, therapy)
- in-home relief to caregivers
- respite care services in alternative settings
- some supplies and equipment
- volunteer services
- access to alternate care settings
- assessment and facilitation of alternate care placement

Home care services may be provided for your child in your home, educational setting or workplace, based on assessed needs. Under special agreement with the RHA, home care may provide services at an alternate site.

Families may have the opportunity to manage their child's own home care services through family-managed care options.

For a general overview of Manitoba's Home Care Program, see:
www.gov.mb.ca/health/homecare/guide.pdf

Home care services are accessed through your Regional Health Authority. Not all services are available in all regions. Contact your Regional Health Authority for detailed information about home care services, eligibility, or to arrange for a home care assessment with a case co-ordinator. For Regional Health Authority contact information, see:

www.gov.mb.ca/health/rha/contact.html

Who is eligible for home care?

To be eligible for home care, your child must be a Manitoba resident and registered with Manitoba Health. Eligibility is based on an assessment of your child's individual needs. To find out if your child is eligible for home care services, a case co-ordinator will meet with you and complete the assessment. Case co-ordinators are health professionals who are qualified to assess your child's home care needs. When assessing your child's needs, the case co-ordinator will consider the supports that you already have in place as well as other community resources available to you and your child.

There is an appeal process if you disagree with the final decision about eligibility for home care, type of service or level of service. Contact the Manitoba Health Appeal Board at:

Winnipeg: 204-945-5408
Toll free: 1-866-744-3257
Email: appeals@gov.mb.ca

Are there different levels of service that people receive?

Yes, there are different levels of home care service. The level of service provided is based on the assessment process and the mutually agreed upon individual care plan developed with you and the case coordinator for your child.

Where can I learn more about a specific disability?

There are many reliable informational sources for specific disabilities.

- **Consult your doctor:** The diagnosing physician can provide information on the disability and refer you to other information sources.
- **Online resources:** You can search on the internet for information on a specific disability. Some helpful websites may include:
  www.webmd.com/a-to-z-guides/health-topics/ak-ao.htm
  www.mayoclinic.org/diseases-conditions
  www.disabled-world.com/
  www.rarediseases.org/

  Note: It is important to check for reliability when researching online.
- **Local associations:** There may be associations in your community that provide information for people with disabilities. To search for community services, please visit the following website:
  www.contactmb.org/

How can I find a family doctor?

The Family Doctor Connection line, through Manitoba Health, provides people with a listing of doctors in their community who are accepting new patients. To access the listing of available doctors and how to contact them, call:

Winnipeg: 204-786-7111
Toll free: 1-866-690-8260
TTY/TDD: 204-774-8618
Manitoba Relay Service: 1-800-855-0511

For more information on health services in Manitoba, and how to access these services, visit Manitoba Health's info health guide, at:

www.gov.mb.ca/health/guide/4.html

Appendix 4: Off-reserve services and programs for adults with disabilities

Information for Manitobans with Disabilities

Services and Programs for Adults

There are a range of generic and specialized services for adults with disabilities. Services are based on each person's unique needs.

What therapy services are available for adults with a disability? Do adults receive therapy services from a specific agency or through private practice?

There are many therapy services available including physiotherapy, occupational therapy, speech language pathology and audiology. Therapy services for adults are delivered by Regional Health Authorities and other service providers in hospital and community settings. Hospital-based therapy services are funded by Manitoba Health as an insured health benefit. Many community-based therapy services are also fully funded. A referral from a physician or other health professional may be required for community-based services. Contact your Regional Health Authority for details of services available in your region at:

www.gov.mb.ca/health/rha/contact.html

Manitoba

Coverage for Injury

There may be coverage for therapy from specific organizations or programs. For example, Manitoba Public Insurance may provide coverage for specific types of therapy if your injury was caused by a motor vehicle accident. The following chart shows examples of organizations that may provide coverage for therapy:

How Injury or Disability was Acquired	Organization	For More Information
Motor Vehicle Accident	Manitoba Public Insurance	www.mpi.mb.ca
Workplace Injury	Workers' Compensation Board	www.wcb.mb.ca/#
Victim of Crime	Victim Service	www.gov.mb.ca/justice/victims/compensation.html

Private or Employer-Based Insurance

You may have full or partial coverage for therapy services through private or employer-based extended health care insurance (ex: Manitoba Blue Cross). Check with your insurer or employer about coverage and eligibility. A referral from a physician or other health care professional may be required.

Private Practice Therapy

If you are not eligible for coverage through any of the options listed above, or have reached maximum coverage from an organization, you may choose to pay for therapy services. Many therapists also provide services in private practice. The following professional associations provide information on therapy services and how to find a private practice therapist:

- Manitoba Speech and Hearing Association: www.msha.ca/
- Manitoba Branch, Canadian Physiotherapy Association: www.mbphysio.org/
- Manitoba Society of Occupational Therapists: www.msot.mb.ca/

What is home care? What services and supports can I access from home care?

Home care is a community-based program that provides home support to any eligible Manitoban, regardless of age, who requires health services or help with daily living activities. Home care services within Manitoba are provided through the Regional Health Authorities (RHA's). Services may include:

- personal care (for example bathing, dressing, toileting)
- home support (for example cleaning, laundry, meals)
- health care (nursing, therapy)
- in-home relief to caregivers
- respite care services in alternative settings
- some supplies and equipment
- volunteer services
- community housing with supports
- adult day programs
- access to alternate care settings (ex: personal care homes)
- assessment and facilitation of alternate care placement

Home care services may be provided in your home, educational setting or workplace, based on assessed needs. Under special agreement with the RHA, home care may provide services at an alternate site.

Families or individuals may have the opportunity to manage their own home care services through family-managed or self-managed care options.

For a general overview of home care services in Manitoba, visit:
www.gov.mb.ca/health/homecare/guide.pdf

Home care services are accessed through your Regional Health Authority. Not all services are available in all regions. Contact your Regional Health Authority for detailed information about home care services, eligibility, or to arrange for a home care assessment with a case co-ordinator. For Regional Health Authority contact information, visit:
www.gov.mb.ca/health/rha/contact.html

Who is eligible for home care?

To be eligible for home care services, you must be a Manitoba resident and registered With Manitoba Health. Eligibility is based on an assessment of your individual needs. To find out if you are eligible, a case co-ordinator will meet with you and complete the assessment. Case co-ordinators are health professionals who are qualified to assess your home care needs. When assessing your needs, the case co-ordinator will consider the supports that you already have in place as well as other community resources available to you.

There is an appeal process if you disagree with the final decision about eligibility for home care, type of service, level of service or personal care home admission decisions. Contact the Manitoba Health Appeal Board at:

Winnipeg: 204-945-5408
Toll free: 1-866-744-3257
Email: appeals@gov.mb.ca

Are there different levels of service?

Yes, there are different levels of home care service. The level of service provided is based on the assessment process and the mutually agreed upon, individual care plan developed with you and the case co-ordinator.

What types of mental health services are in Manitoba?

Manitoba has a range of mental health services for adults provided in community and hospital settings. The list below provides an overview of services available across Manitoba. The majority of mental health services are delivered by the five Regional Health Authorities with some community-based mental health services provided by self help and advocacy organizations. Not all services are available in all regions. Check with your Regional Health Authority to find out which services are available.

The following link provides a list of mental health contacts in each Regional Health Authority:
www.gov.mb.ca/health/mh/region.html

Community Based Mental Health Services

- The **Family Physician** is often the first point of access for a mental health concern. The physician may refer an individual to specialized mental health services for consultation, assessment or treatment, depending on the needs of the individual.
- **Regional Health Authority Community Mental Health Services** are programs and services provided by Regional Health Authorities that may include case management services, crisis services, and other specialized programs.
  - **Community Mental Health Workers** provide case management, assessment, consultation, supportive counselling and crisis response services. This service is available in all Regional Health Authorities.
- **Intensive Case Management Program** provides a higher level of intensity for individuals with the ability to work on goals related to school, work or social life. There is a strong focus on psychosocial rehabilitation.
- **Mobile Crisis Services** provide a multi-disciplinary team approach to mental health assessment, crisis intervention and short term follow-up for adults dealing with a mental health related crisis. Individuals, family members and service providers can call for assistance. Check with your Regional Health Authority for hours of operation.
- **Crisis Stabilization Units** are short-term, community-based settings that provide mental health intervention to people in mental health crises who require specialized mental health support but not hospitalization.
- **Housing and Supported Employment Services** may be provided by Regional Health Authorities. Housing models may range from supervised group home settings to supported independent housing options. A range of employment support models may also be available.

Other Community Based Mental Health Services

- **Crisis Lines** provide telephone crisis intervention and suicide prevention services by trained volunteers and staff.
- **Self-Help and Family Supports** are provided through support networks of people, many of whom are either living with a mental illness or have a family member with a mental illness. Self-help activities include mutual support, public education, advocacy and recovery-oriented services that promote the needs and priorities of people with mental health problems and illnesses.
- **The Mental Health Education Resource Centre of Manitoba** is a lending library that provides information to service providers, individuals with mental health problems, families, educators and the general public.

Hospital Based Mental Health Services

- **In-patient Psychiatric Units** provide psychiatric care and treatment in hospitals operated by Regional Health Authorities.
- **Out-patient Services** are provided at many community hospitals. These services include assessment, treatment and case management services for people with mental health difficulties.
- **The Selkirk Mental Health Centre** is the provincial psychiatric facility that provides acute and long-term in-patient psychiatric treatment and rehabilitation services to Manitobans whose challenging needs cannot be met elsewhere in the provincial health care system.

Specialized Services

Some Regional Health Authorities may provide a variety of specialized programs and services. These may include:

- **Programs for Assertive Community Treatment (PACT).** This is a multi-disciplinary team of mental health professionals including a psychiatrist, nurses, social workers, occupational therapists, mental health specialists, addiction specialists and vocational rehabilitation specialists. PACT services are provided with a low staff to client ratio using a team approach and shared caseloads. Each client has an individualized recovery plan, receives outreach and can expect continuous service over the years.

- **Early Psychosis Prevention and Intervention Services (EPPIS).** This is an early identification and intervention service designed for individuals experiencing their first episode of psychosis. Services are provided by a community-based multidisciplinary team that emphasizes a multi-modal treatment plan. The team promotes strategies that allow for early case detection and intervention.

- **Co-Occurring Mental Health and Substance Use Disorders (CODI) Outreach Program.** This is delivered by the Winnipeg Regional Health Authority and provides rehabilitation-oriented case management service that combine substance abuse services with mental health services. It is for individuals who have complex mental health and substance use needs.

- **Mental health promotion activities.** Many Regional Health Authorities undertake activities and participate in initiatives that promote positive mental health as part of overall health.

For an overview of Manitoba's Mental Health system, please visit:
www.gov.mb.ca/healthyliving/mh/system.html

Who are these services for?

These mental health services are available for:

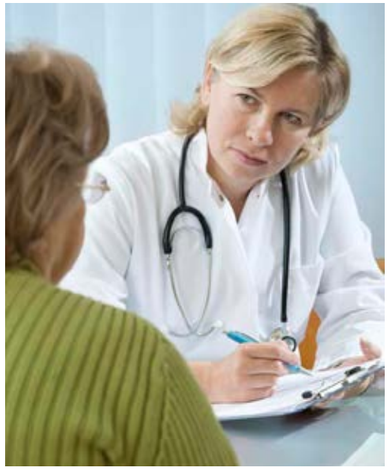
- Individuals experiencing difficulties with their mental health or symptoms of mental illness.
- Families or natural supports seeking consultation and support services (note: health privacy legislation ensures that families or friends cannot get private health information unless there is consent).

How are mental health services accessed?

Mental health services can be accessed through your family doctor or other healthcare professional, or by calling directly to mental health services of your local Regional Health Authority. For a list of the Regional Health Authorities in Manitoba and contact information for their mental health programs, visit:
www.gov.mb.ca/health/mh/region.html

If you are in a mental health crisis or cannot wait for an appointment, you can call your local crisis line or Mobile Crisis Service. The phone number can be found in your local phone book or visit:
www.gov.mb.ca/health/mh/crisis.html

There may be other mental health supports available in your community. To search for community services throughout Manitoba, visit:
www.contactmb.org/



You may have access to private services through your workplace. If your organization has private insurance (for example, Blue Cross), ask about whether mental health supports are included.

What is the market*Abilities* Program?

The market*Abilities* Program offers a wide range of employment-focused services to assist adults with disabilities to:

- prepare for work
- get a job
- maintain employment

Who is eligible for the market*Abilities* Program?

To receive services from the market*Abilities* Program in Manitoba, applicants must:

- be a resident of Manitoba living with an intellectual, physical, psychiatric, vision, hearing or learning disability
- be 16 years of age or older
- be legally entitled to work in Manitoba
- show a willingness to prepare for, obtain and maintain employment

What services are provided through the market*Abilities* Program?

There are a wide range of services available through the market*Abilities* Program. The services that each person receives is tailored to their unique needs and based on available financial and human resources.

- **Vocational Counselling:** Vocational counsellors work with people to explore their employment goals. To develop these goals, counsellors will talk with participants about their interests, abilities and skills.
- **Assessment:** Specialized vocational assessments may be completed to help find appropriate employment options and supports.

A vocation relates to employment or an occupation.

- **Vocational Planning:** Planning is done on an individual basis to address each person's unique training or employment support needs. It may involve a:
  - **Single service:** for example, arranging for equipment or conducting an assessment.
  - **Multi-year training plan that includes a variety of supports:** a variety of supports may be available during the completion of an educational program. Examples include tuition, books, note-takers and tutors. Supports are determined on a case-by-case basis.
- **Vocational Training:** Vocational training may include specific job development and/or post-secondary or other adult education courses. This training can be in the form of work experiences, college, university or certificate programs.
- **Support Services:** Support services may be provided to accommodate disability-related barriers to employment and may provide:
  - supported employment
  - disability-related education expenses
  - sign language interpreting
  - technical equipment
  - building or vehicle modifications
- **Direct Employment Services:** At this stage, the participant is ready for employment. Direct employment services may include:
  - job search
  - résumé preparation
  - establishment of contacts with job placement agencies
  - job referral
  - on-the-job training
  - supports required to obtain or maintain employment

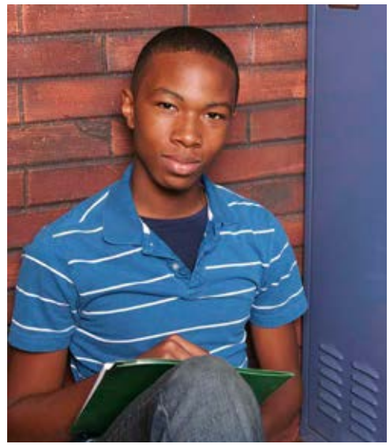
Are there options for self-directed service delivery within the market*Abilities* Program?

Yes. The self-directed option provides people with disabilities a choice in how they can apply for market*Abilities* Program funding. Eligible participants who do not want, or need, assistance from a vocational counsellor can submit a request for funding assistance and manage their own plan. A *Self-Directed* market*Abilities Program Handbook for Applicants* is available to help applicants.

The following website has links to both the handbook and application form:

http://www.gov.mb.ca/jec/eia/marketAbilities/vrmanual/xvii.html

Does the market*Abilities* Program provide services to youth transitioning from school to the community?



For students whose main goal is to gain competitive employment when they leave school, the market*Abilities* Program may play a central role. The marketAbilities Program is one of several partners in *Bridging to Adulthood: A Protocol for Transitioning Students with Exceptional Needs from School to Community.* The market*Abilities* Program provides a wide range of services and supports to assist eligible people prepare for, obtain and maintain employment.

For more information on the market*Abilities* Program please visit:

www.gov.mb.ca/jec/eia/marketAbilities/index.html

What support does the market*Abilities* Program provide after a participant gets a job?

When a market*Abilities* Program participant gets a job, there are supports available to help them keep it.

Monitoring and Follow Up

The Vocational Counsellor will maintain, or arrange for regular contact with, both the participant and the employer to:

- provide counselling support and encouragement to the participant
- act as a resource to the employer if a problem comes up

If the participant needs intensive support to maintain their employment, Employment Supports may be provided for up to 36 months after employment has started. Employment Support provides ongoing support and assistance to participants. The focus is mainly on supports that are directly related to employment. Assistance may also be provided to address or assist with non-employment related issues that affect the person's ability to maintain employment.

Vocational Crisis

Vocational Crisis Services are disability-related supports provided to prevent job loss. If a person is at risk of losing their job, Vocational Crisis Services funding is available on a priority basis to help the person maintain their job. Vocational Crisis is different from Employment Supports. A vocational crisis is short-term, emergency-related and is required to save or retain a job.

Where do I go to apply for services from the market*Abilities* Program?

The market*Abilities* Program's services are available from various service providers, depending on the disability a person has:

- **For people with an intellectual, psychiatric or learning disability, contact: market*Abilities* Program**
  To find the location in your area, visit the following websites:
  Winnipeg service centres:
  www.gov.mb.ca/fs/misc/loc/winnipeg.html
  Rural and Northern services centres:
  www.gov.mb.ca/fs/misc/loc/ruralnorthern.html

- **People with a vision related disability can contact:**
  Canadian National Institute for the Blind
  Manitoba Division
  1080 Portage Avenue
  Winnipeg, Manitoba R3G 3M3
  Phone: 204-774-5421 in Winnipeg
  Toll free: 1-800-552-4893
  TTY deaf access line: 204-775-9802
  Fax: 204-775-5090

- **People with a spinal cord injury can contact:**
  Canadian Paraplegic Association
  Manitoba Division
  825 Sherbrook Street
  Winnipeg, Manitoba R3A 1M5
  Phone: 204-786-4753 in Winnipeg
  Toll free: 1-800-720-4933
  Fax: 204-786-1140

- **People with a physical disability, including the Deaf or hard of hearing, can contact:**
  Society for Manitobans with Disabilities
  825 Sherbrook Street
  Winnipeg, Manitoba R3A 1M5
  Phone: 204-975-3010 in Winnipeg
  Toll free: 1-866-282-8041
  TTY deaf access: 204-975-3012
  TTY toll free: 1-800-225-9108
  TTY deaf services: 204-975-3083
  Fax: 204-975-3073

What is Supported Employment?

Through Supported Employment, people with disabilities have supports to acquire and maintain a job. The goals of the Supported Employment program are:

- to provide employment opportunities for people with disabilities in competitive employment settings
- to allow workers with disabilities to receive supports necessary to maintain employment

The Manitoba Supported Employment Network website provides information for educators, employers and job seekers. For more information, visit:

msen.mb.ca/wordpress/

The Manitoba Supported Employment Network website contains a listing of organizations that provide information and/or services for supported employment. For more information, visit:

http://msen.mb.ca/wordpress/membership-list/

I have been working in my career for many years. I have recently acquired a disability and can no longer perform my job functions. What do I do?

The answer depends, in part, on how your disability was acquired. If it was a motor vehicle accident, contact Manitoba Public Insurance for information on the supports and services that may be available to you. If it was a workplace injury, contact the Workers Compensation Board of Manitoba. Many employers also have long term disability insurance. Ask your employer what is available to you.

For someone who is currently employed and facing a potential job loss due to a vocational crisis, the provincial market*Abilities* Program may also be able to assist. If you are eligible, services may include:

- working with you and your employer to modify certain tasks, or your position description, to accommodate your disability
- exploring the use of technical aids and devices to allow you to carry out the tasks of your current position
- receiving financial assistance to purchase/lease appropriate technical aids or devices
- getting training in the use of technical aids and devices

Do I need to tell my employer about my disability?

You are not required to disclose a disability. However, there are many things to consider when deciding if, and when, you tell your employer. For more information please refer to the section on Human Rights and Reasonable Accommodations.

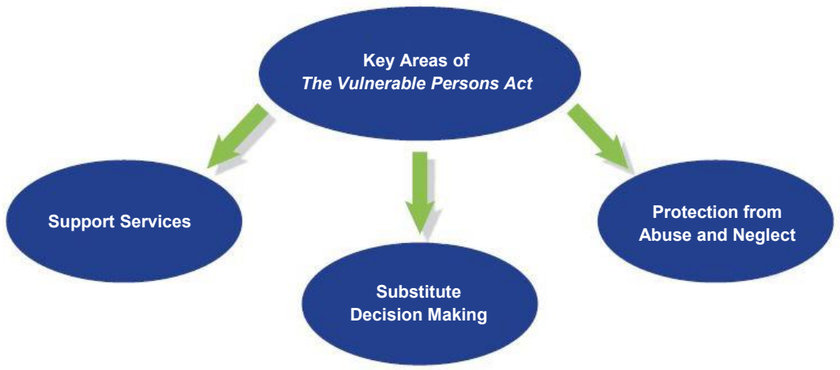
What is The Vulnerable Persons Act?

On October 4, 1996, a law called *The Vulnerable Persons Living with a Mental Disability Act* was introduced in Manitoba. It is often called *The Vulnerable Persons Act*.

This act was developed to promote and protect the rights of adults living with a mental disability who need assistance to meet their basic needs. The legislation recognizes these Manitobans as vulnerable persons.

The act defines a vulnerable person as “an adult living with a mental disability who is in need of assistance to meet his or her basic needs with regard to personal care and/or management of his or her property.”

There are three key areas of *The Vulnerable Persons Act*:



In *The Vulnerable Persons Act*, three key areas are described:

- **Support Services:** Manitoba Family Services may provide support services for a vulnerable person through the Community Living disABILITY Services Program (more information on this program is provided below). For each person who receives services, an individual plan will be developed. Examples of support services are:
  - residential services
  - counselling
  - vocational training
  - life skills programs
- **Protection from Abuse and Neglect:** Through the Act, vulnerable persons are protected from abuse or neglect. If there are reasonable grounds to believe that a vulnerable person is, or is likely to be, abused or neglected, anyone who provides a service to this person must report these suspicions to Manitoba Family Services.

  More information on the protection provisions of the Act can be found at:
  gov.mb.ca/fs/pwd/vpact_protection.html

  For information on reporting, please visit: *Protecting Vulnerable Persons from Abuse and Neglect: Reporting Requirements for Direct Service Providers* at:
  www.gov.mb.ca/fs/pwd/pubs/spl_for_service_providers.pdf

  To view a poster that outlines the steps involved in reporting abuse, visit:
  www.gov.mb.ca/fs/pwd/pubs/spl_for_service_providers_handout.pdf

  For more information on the act, go to:
  www.gov.mb.ca/fs/vpco
- **Substitute Decision Making:** If a vulnerable person is not able to make decisions, even with help, a person known as a **substitute decision maker** may be appointed to make decisions on their behalf in the areas of personal care or property or both. Substitute decision makers are appointed by the Vulnerable Persons’ Commissioner. The Commissioner determines the legal decision making authority of a substitute decision maker. The scope of decision making is limited to those areas where:
  - the vulnerable person is incapable
  - there are decisions to be made

  For more information on substitute decision makers, go to:
  www.gov.mb.ca/fs/vpco

The decision making authority of the **substitute decision maker** is only for the specified period of time required (maximum of five years).

What is the Community Living disABILITY Services Program?

The Community Living disABILITY Services program is a provincial government program that provides a range of support services for families and Manitobans living with a mental disability. The program supports eligible adults to live safely and participate fully in the community. Services are based on the belief that people living with a mental disability should have the opportunity to:

- lead satisfying, productive lives in their communities
- make their own decisions and direct their own lives, with support if necessary
- maintain family bonds
- develop friendships and other relationships that are a natural part of living in the community

Who is eligible?

To be eligible for the Community Living disABILITY Services program, a person must:

- have significantly impaired intellectual functioning accompanied by impaired adaptive behaviour, existing prior to the age of 18
- be 18 years of age or older
- be a Canadian citizen or adult legally entitled to remain and work in Canada on a permanent basis, and a resident of Manitoba

For more information on eligibility please visit:
www.gov.mb.ca/fs/pwd/supported_living

Are you eligible for the Community Living disABILITY Services program?

Through the Manitoba government's **ServiceLink**, you can learn more about the services that may be available for you or your family member through the Community Living disABILITY Services program. This on-line tool will take you through a series of basic questions. A results page will display services that you may be eligible for, links to related websites and contact information. For more information, visit:

web22.gov.mb.ca/ServiceLink/en

What services are available through the Community Living disability Services program?

Service options may include:

- assessment, case co-ordination, planning, resource development and counselling
- residential supports to assist adults to live in the community
- day services, including supported employment and follow-up services, vocational training and individualized development services
- support services such as transportation to and from day programs, respite, crisis intervention and clinical services

Services are co-ordinated through community service workers and are planned on a person-centered basis to meet the unique needs of each individual. Supports and services are available through regional offices located throughout the province. Services are provided depending on the availability of resources, the assessed needs of the person and the urgency of the need for service.

Residential Services

Residential services include a range of supports to assist people to live in the community. Options may include:

- **Independent living with supports:** skill development and supports are provided to assist adults to live on their own.
- **Family home:** supports are provided so a person may live with parents or extended family.
- **Residential care facilities:** accommodation, care and support consistent with individual needs are provided at a facility operated by an agency or a private provider.
- **Adult home share:** care and accommodation is provided by an individual or a couple in their own home

Day Services

Day services may include a range of supports and training to help people participate in the community through one or more of the following activities:

- **Supported employment and follow-up services:** provides supports to individuals to assist in getting and keeping paid jobs in community settings.
- **Vocationally-focused services:** supports individuals to develop, maintain and enhance vocational and employment readiness skills. These services may be provided in a day service facility or in a community setting.
- **Personal development services:** develops, maintains and enhances an individual's personal care, social skills, emotional growth, physical development and community skills.

Support Services

Support services available to assist people and their families may include:

- **Respite:** offers families short-term alternative care for adults living with a mental disability.
- **Day service transportation:** may be provided through public or specialized transportation services for people attending approved day services.
- **Crisis intervention:** ensures the immediate physical safety and well-being of people in crisis while long-term plans are developed.
- **Clinical services:** provide a range of behavioural and psychological supports, including clinical assessment, therapy and consultation with community programs.

Are there options for self-directed service delivery within the Community Living disABILITY Services program?

The Community Living disABILITY Services program does have a self-directed program option. The program, In the Company of Friends, supports participants to manage their own services with the assistance of the individual's support network.

Where can I learn more about a specific disability?

There are many reliable information sources for specific disabilities.

- **Consult your doctor:** The diagnosing physician can provide information on disability and refer you to other information sources.
- **On-line information sources:**
  www.medmatrix.org/_SPages/Patient_Education.asp
  www.mayoclinic.org/patient-care-and-health-information
  (Always check for reliability when researching online.)
- **Local associations:** There may be associations in your community that provide information for people with disabilities. To search for community services, please visit the following website:
  http://www.contactmb.org/

How can I find a family doctor?

The Family Doctor Connection line through Manitoba Health provides a list of doctors who are accepting new patients. To access the list of available doctors and how to contact them, call:

Winnipeg: 204-786-7111
Toll free: 1-866-690-8260
TTY/TDD: 204-774-8618
Manitoba relay service: 1-800-855-0511

For more information on health services in Manitoba and how to access these services, visit Manitoba Health's info health guide online:
www.gov.mb.ca/health/guide/4.html

Appendix 5: First Nations advocacy for a systemic approach & federal response – Three case studies

Awasis Agency – Children with lifelong complex, medical needs

In 1996, MKO requested the formation of a tripartite working group to examine 16 cases in which children from MKO member Nations were placed in the care of Awasis CFS Agency, and in specialized care situations, away from their home Nations, because of complex health care needs that required extensive care. The committee found that 11 of the 16 children required services similar to those provided through the provincial Children Special Services program, which served off-reserve children across the province. The committee concluded that, "many of these children could remain in their home communities with their family" if Children Special Services were available on-reserve.[883] Based on the working group's recommendations, Awasis Agency secured funding for an 18-month pilot project to support the repatriation of children who were residing outside their home Nations due to lifelong complex medical needs. Project funding was subsequently extended for an additional year.

An evaluation of the pilot program found promising results, including: the extension of specialized services to First Nation children and families who would not otherwise have had them, the repatriation of some medically complex children within their Nations, the development of multidisciplinary service teams at the Nation level, and increased family and community engagement with medically complex children. However, it also identified significant weaknesses and subsequently made multiple recommendations for expansion of the program and for policies to better serve First Nation children. The recommendations included the following:

- Address historical gaps in the Nation-level services for First Nation children with complex medical and/or special needs.
- Resolve ongoing jurisdictional debates over which government/government department is fiscally responsible for required medical and therapeutic services to on-reserve children and families.
- Expand the target group beyond children in care to include all children with multiple medical and special needs residing in First Nations.
- Expand the project mandate to include: a mobile, interdisciplinary therapy team; education for families, community service providers and Nation members regarding children with complex and special medical needs; extended case management to serve a larger number of children.
- Provide additional funding to First Nations CFS agencies to support services to children with complex medical and special needs.
- Partner with educational and accreditation units to address the need for trained and experienced First Nations rehabilitation therapists and para-professionals at the Nation level.[884]

Despite these findings and recommendations, FNIHB only funded the pilot project between 1999 and 2001. Awasis Agency was informed that negotiations for a new program would be required in order for the pilot project to continue. Continued funding for the individual children involved in the pilot project was provided on a case-by-case basis.[885] Based on the pilot project experience and the evaluation results, Awasis Agency proposed a more comprehensive program in 2007.[886] This proposal was never funded. The Awasis Agency 2012-13 annual report noted that the last two children who participated in the pilot program would turn 18 in 2014 and 2015, bringing the follow-up funding for participants to an end. A 2016 AMC resolution on Jordan's Principle called for re-establishment of the Awasis Agency program.[887,888]

AMC proposal for a region-wide service delivery model

A 2007 AMC proposal outlined a service delivery model that would address gaps in services for First Nation children with disabilities and their families.[889] The proposal emerged from the work of the Manitoba First Nations Disability Multi-Sectoral Working Group, which included federal and provincial representatives and was established by AMC and the MFNERC in 2006.[890] The proposal outlined a flexible, evolving First Nations service delivery system that would be coordinated by a central service centre. The central service centre would work in close partnership with regional centres charged with coordinating mobile therapy units. These therapy units would provide allied health services as well as community-based vision and hearing supports. The proposal outlined guiding principles that were central to the service delivery system. These included:

- First Nations jurisdiction and control – A focus on promoting leadership, control, ownership, and participation at the community level.
- A holistic approach – A focus on the relationship between physical, emotional, mental, and spiritual wellbeing as well as family and community relationships.
- A community-based service delivery structure – A focus on delivering services at the community level whenever possible.
- A shift out of assessment phase into implementation phase – A focus on ensuring action to implement services and supports that address children's long-term needs in addition to providing short-term diagnosis and assessment.
- First Nations capacity and leadership in service delivery – A focus on supporting the training and study needed to develop a system that engages First Nations professionals, volunteers, and service providers.

None of the participants in or contributors to this study were able to definitively confirm the outcome of this proposal and we found no evidence that the proposed service delivery model was ever implemented.

The Niniijaanis Nide (My Child, My Heart) Program in Pinaymootang First Nation[891]

In 2010, the Sumner-Pruden family from Pinaymootang First Nation filed complaints with the Manitoba and Canadian Human Rights Commissions because the services required to address the complex healthcare needs of their son, Dewey, were not available in their Nation. The case led Health Canada to contact the Pinaymootang Health Centre, to enquire about the costs of additional services to meet Dewey's needs. The Pinaymootang Health Director responded with a proposal for funding to address the unmet needs of 11 Pinaymootang families. She stated that it would be "unconscionable to advocate and provide services to one child, when there are numerous children and families within the community that are entitled to health care services and supports." [892]

Throughout 2014 and 2015, the health centre was directed by FNIHB/ISC officials to submit proposals for a program to meet the needs of children in Pinaymootang to three separate funding opportunities: two unsuccessful applications were submitted to Health Canada's First Nations and Inuit Health Branch's Home and Community Care Program

and First Nations Chronic Disease Prevention and Management Framework, and a successful application was made to the federal Health Service Integration Fund. The health centre received no news for several months after submitting a grant application and did not have a direct line of communication to Health Canada staff. Different representatives from Health Canada made sporadic contact with the health centre and it was unclear if each representative was aware of the other communications taking place between the Ministry and local service providers.

Pinaymootang eventually received temporary Health Service Integration Fund funding for the My Child, My Heart program. Initial funding was granted for four months (December 2015 to April 2016). The health centre set about building a new program, with no specialized services providers to support them and limited time to demonstrate program effectiveness in order to secure additional funding. The services provided through the My Child, My Heart program combined assessment and care practices from several different disciplines that were each normally the responsibility of a specialist. This placed enormous pressure on the program's child development workers, Case Manager, and health centre director, who were responsible for meeting the needs of the children and their families, following best practices, and ensuring safe and appropriate service delivery.

The burdens of service delivery were amplified by a short-term funding model. The My Child, My Heart program was granted an additional year of funding through the newly established Jordan's Principle program, and funding has subsequently been renewed annually.[893] Annual funding allocation meant that the program's sustainability was not guaranteed; it depended on unilateral funding renewal decisions made by FNIHB/ISC. Accordingly, needed services could be discontinued if budget priorities changed. Gaining the trust of families in need, only to become the bearers of bad news if funding was not renewed had the potential to damage ongoing relationships between service providers and community members. Child development workers hired for the program risked being left jobless if funding was discontinued. For families, establishing new routines and getting used to a new standard of care only to see it taken away posed a huge risk to the health and wellbeing of their vulnerable children.

Currently the My Child My Heart program offers a broad range of supports to the families of 151 children. The services provided include respite care, support groups, land based activities, an early childhood development program run through a local preschool, rehabilitation assistance, and American Sign Language training and supports.[894, 895]

Appendix 6: Specialized Service Providers[a]

Rehabilitation Centre for Children (RCC)

The RCC's mission is to support "excellence in children's rehabilitation and developmental pediatrics through innovative clinical service, education, research and technologies."[896] RCC's strategic plan is built around three main themes: Theme one: Children, Youth, and Families – Family Centered / Culturally Safe Integrated Services; Theme two: Service Excellence – Knowledge Generation & Evidence Informed Practice; and Theme three: Organizational Effectiveness.[897] 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.[898]

Located in the Specialized Services for Children and Youth Centre in Winnipeg, RCC has three departments that provide clinical services. Neurodevelopmental services incorporate child development and fetal alcohol spectrum disorders (FASD) clinics as well as neonatal newborn follow up. Clinical and Rehabilitation Services provide prosthetics, orthotics, and mechanical design services as well as multidisciplinary clinics —such as feeding, orthopedics, muscular dystrophy, and others— and complementary therapy services for children from birth to school entry at its Winnipeg centre. The Outreach Therapy Department provides OT and PT services to off-reserve children across Manitoba, through its school therapy services and children's therapy initiative, and to on-reserve children through Jordan's Principle.[899, 900, 901]

RCC first received provincial funding to provide outreach services to rural Manitoba communities in 1987. It has long served First Nation children accessing services off reserve, in rural Manitoba communities, and in its Winnipeg office. Federal Jordan's Principle funding allowed RCC to extend its services directly in First Nations.[902] RCC currently delivers services in 63 First Nations in partnership with other agencies. RCC provides home and community-based OT, PT, SLP and audiology services for children from birth to school entry. The organization also provides child development, FASD and assistive technology clinics in First Nations.[903, 904, 905] Through its collaborations with MFNERC, RCC supports school transition for both the child and family during the kindergarten year.[906]

St. Amant

Located in Winnipeg, St. Amant is an independent not-for-profit that receives funding from the Manitoba Departments of Health and Families and Health Canada. It provides a wide range of programs and services to adults and children with intellectual or developmental disabilities, acquired brain injury, or other conditions necessitating similar supports; it also provides supports for their families.[907] St. Amant operates a large residence for complex-care, more than 100 community sites and homes, a research centre, a school, and two child-care centres.[908]

St. Amant's core values are collaboration, hospitality, excellence and respect. Their vision is one of freeing the spirit and fulfilling potential together. The organization's strategic plan is organized around a human rights and advocacy framework, which also focuses on creating an accessible environment. St. Amant

a SSP descriptions are primarily based on information that was gathered prior to summer of 2021 and do not necessarily reflect changes in SSP services or structure that occurred in the last half of 2021.

takes a holistic approach to services and provides services to support people's spiritual, physical, emotional, and mental health. St. Amant clinical services include OT, PT, SLP, spiritual health, dietician services, social work, counselling, community nurse consultants, and music therapy.[909]

St. Amant takes a lifespan approach to providing disability services. Through its preschool outreach therapy services, the organization provides OT, PT, and SLP services to infants and young children; it also has a program that supports preschool and school-age children with autism. St. Amant also has a school that provides short-term residential support for children who have complex and challenging behavioural and/or other needs. It provides interim supports to children until they can be reintegrated into their on-reserve schools. St. Amant has an intensive and voluntary social work program called the Family Care Program, designed to prevent families with a child or an adult with disability, from experiencing breakdown and crisis.[910] In addition, St. Amant has clinicians supporting adults with disabilities, in a range of environments, to comprehensively address end of life care and diverse needs surrounding dementia. St. Amant currently supports an estimated 170 First Nations adults with health transition services, providing short-term access to behaviour stabilization supports and medical assistance prior to return to their Nations. In addition, St. Amant has supported independent living for adults who need some day-to-day assistance in their lives.[911]

St. Amant has supported individual First Nation people accessing clinical services off reserve for decades. Federal Jordan's Principle funding has allowed St. Amant to extend a broad range of services on reserve.[912] The organization was first approached by the federal government in 2017 and asked to submit a proposal to provide services on reserve. Administrators felt a responsibility, and accepted the opportunity, to help because there was an unmet need and no other organization – Indigenous or government sponsored – was in a position to provide the services offered through St. Amant. The organization started taking on-reserve referrals in the summer of 2017, extending some of the key services offered through their provincially funded programs.[913] Since the first pilot year, they have been constantly expanding. The staff increased from six in 2017, to over 40 in 2020; these staff members support nearly 600 children in 52 First Nations, often providing multiple services to a child.[914,915]

On reserve, St. Amant provides services for children and youth with challenging behaviours, as defined by the family and care givers. These services aim to increase positive behaviors; promote independence, inclusion, and participation; improve quality of life for children/youth and caregivers; and reduce stigma.[916] The services offered in First Nations include psychological supports to address behavioural challenges identified by family members or care givers 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. In addition, it provides psychometric testing to youth in care in order to assess eligibility for provincially funded adult disability services.[917,918] St. Amant strives to support other service providers in leaning about adults and children with disabilities. It has provided close to 200 workshops to families and staff of Jordan's Principle, schools, daycares, and CFS. Common workshop topics include understanding autism, understanding the impact of intellectual disability on daily life, coping strategies for caregivers, and supporting children who have challenging behaviours in a dignified and positive way.[919]

Manitoba First Nations Education Resource Centre (MFNERC)

The AMC founded MFNERC in 1988 to provide "education, administration, technology, language, and culture services to First Nations schools in Manitoba."[920] MFNERC now provides services to 58 First Nations schools in 49 First Nations,[b] with a combined student population of more than 15, 500 children and adolescents.[921,922] The organization 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.[923] A collaborative approach is taken to service delivery in which extensive consultation and coordination with First Nations leadership, Elders, schools, and children and families guides the identification of needs and the implementation of services.[924] MFNERC has also developed partnerships with universities in order to support the development of First Nations capacity to provide clinical services for First Nation children.[925]

Federal Jordan's Principle funding, combined with increases in MFNERC's other federal funding, has enabled MFNERC to expand and enhance the special education services it provides to First Nations schools across Manitoba. MFNERC's funding for special education increased dramatically in 2016, when the federal government increased investment in ISC's High Cost Special Education program.[926] Jordan's Principle funding added to MFNERC's special education funding. Jordan's Principle funding supports provision of clinical services in all schools supported by MFNERC. These services are provided by a team of 80 staff across 10 disciplines, including OT, PT, SLP, school psychology, mental health and wellness, deaf and hard of hearing and American Sign Language instruction, intergenerational trauma supports, respiratory therapy, and nursing services.[927,928,929]

The organization has prioritized hiring First Nation people, which allows services to be provided in Nehetho/Ininew (Cree), Denesuline (Dene), Anishininew (Oji-Cree), and English.[930] MFNERC has also utilized a grant provided by ISC funding to support the implementation of training programs for First Nations resource teachers, rehabilitation assistants, and school psychologists in order to support First Nations capacity to implement clinical programming.[931] Focusing resources on capacity building as identified as a long-term organizational objective that supported on-reserve provision of specialized services, retention of staff, and the implementation of culturally relevant services guided by the self-identified needs of First Nations.[932] A long-term goal of MFNERC is to support First Nations self-determination in service delivery, which can entail stepping back as Nations develop their respective capacities for specialized service provision.[933]

Manitoba Adolescent Treatment Centre (MATC)

MATC is governed by a provincially appointed board of directors and falls under the jurisdiction of the Winnipeg Regional Health Authority Mental Health Program.[934] MATC first opened in 1984; the organization provides mental health services to children and adolescents, aged three-18, using hospital and community-based programs. Long-term and brief interventions are provided to address the psychiatric and emotional needs of people in services.[935] Services include assessment, consultation, inpatient treatment, individual and group therapy, family therapy, pharmacological

b A November 2021 presentation indicates some changes in these numbers.

therapy, psycho-educational supports, and consultation and referrals for substance use.[936] Training services are also offered through MATC to support the professional development of mental health professionals across Manitoba.[937] On-site and telehealth services are provided by a diverse inter-professional team that emphasizes accessible cross-cultural services, relationship building, trust, and accessibility for children and families.[938]

Federal Jordan's Principle funding allowed MATC to extend and expand on a pre-existing psychiatric telehealth service, which was designed to fill gaps in services by providing consultation with child and adolescent psychiatrists through rural health authorities. The telehealth service originated as a provincially funded service; people living in First Nations could only access the service through off-reserve community mental health workers. 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, with strategic provision of services to Nations that were overrepresented in emergency room visits. The service moved beyond a tele-psychiatry model to include ongoing therapeutic support from child and adolescent mental health clinicians.[939] The program won a Manitoba award for its innovative partnership between First Nations, and provincial and federal governments.[940]

A significant portion of MATC's work is geared towards ensuring complex mental health needs are addressed through long-term supports. Cases can include, but are not limited to, addressing complex trauma, providing on-going supports for mental health diagnosis such as schizophrenia and developmental delays, and offering crisis and long-term support for youth experiencing suicidality.[941] MATC workers also 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. Provision of follow-up and ongoing therapy through telehealth ensures cost effective accessibility and continuity of care. In addition, the presence of Jordan's Principle Case Managers and respite workers in First Nations has allowed MATC to establish more consistent and active partnerships that support the identification of children with psychiatric needs. At the start of 2017 three MATC clinicians provided services in 15 First Nations. With the support of Jordan's Principle funding, services have expanded to a team of 12 clinicians, with diverse professional specialties, providing services to 63 First Nations across Manitoba.[942,943,944]

Since receiving Jordan's Principle funding MATC has observed a significant increase in demand for services which has required hiring additional staff to meet the needs of First Nation children and adolescents.[945] MATC currently provides services with an awareness that First Nations capacity to design, implement, and provide mental health services for children and adolescents is developing. A long-term aim of MATC is to provide services up until First Nations programs can independently meet the mental health needs of children and adolescents.[946]

Frontier School Division (FSD)

FSD was created by a Ministerial order, in 1965, with a mandate of providing educational services to Métis and northern students based on the provincial curriculum. FSD currently administers services in 41 schools and has education agreements with 15 First Nations for administration of on-reserve schools. The geographic area of service provision is organized within five "areas" extending across a northern region that includes 75% of the landmass in Manitoba.[947,948] These schools serve 6,305 students from kindergarten to grade 12, many of whom are First Nations.[949,950,951] For example area four schools provides services to an estimated 1,200 students, 83% of whom are First Nations or Métis. Within area four, Frontier Mosakahikan School has a student population that is 100% First Nations or Métis for its kindergarten to grade 12 programming. In addition, 78% of students attending the Frontier Collegiate Institute, which provides education services for grades nine-12, are First Nation or Métis.[952] In the 2019-20 school year FSD received 60% of its funding from Indigenous Services Canada, 35% of funding from the province of Manitoba, and roughly 2% of its funding from municipal sources.[953] Over time, the programs and services offered by FSD have been tailored and expanded to include programs like: Career Education, Fine Arts, Character Education and First Nations Languages.[954]

FSD sought Jordan's Principle funding in order to serve a high percentage of First Nation children who were identified as having at least "one languishing mental health factor" in a study conducted by FSD. In cooperation with clinical psychologists and psychiatrists, FSD designed and delivered a mental health diagnostic assessment for children in their schools. In the schools within area one, about 22% of the student were identified as having at least one "languishing mental health factors", which the report identified as including self-harm, suicide ideation, trauma, rape, sexual abuse, physical violence. FSD requested Jordan's Principle funding in order to meet mental health needs, among its First Nations students, that were more significant than its regular in school counsellors could support. Jordan's Principle provided funding for seven wellness workers to address these mental health needs.[955,956]

FSD outlined four main objectives for services funded through Jordan's Principle: a wellness portfolio, telehealth services, an Elder's program, and wellness activities. The established wellness portfolio includes seven wellness workers; one for each area within Frontier School Division, and an additional worker, based on need, in two areas. The second objective of developing a telehealth service was to address the challenges that FSD faces in serving one of the largest geographic areas of any school board in Canada. Telehealth would facilitate provision of immediate supports to students in crisis, even when travel and weather conditions slow the provision of in-person services. Out of 15 sites identified as having a priority need for telehealth, 11 have all the hardware and software in place to begin telehealth services. The third goal was to develop an Elder's program that includes Elders in the therapy plans of children in crisis. Development of this program requires recognition of the diversity of traditions within the Nations served by FSD and incorporation of the flexibility to serve both those families that follow traditional teachings and those that embrace Christianity, while also supporting revival of a Nations' Indigenous languages and cultures. Implementation of the Elder's program has been delayed due to lack of funding and coordination. Finally, as wellness workers are able to expand beyond responding to immediate crises, FSD seeks to develop an expanded range of wellness activities that create spaces for children and youth to share their concerns openly, in order to prevent crisis.[957]

Appendix 7: AMC Draft Respite Care Policy

First Nation Home Respite Assessment

Date: _____

Child Name:_____Childs Date of Birth:_____

Parent / Guardian:_____Band and Treaty Number:_____

Contact Information:

Cell:_____Home:_____Work:_____Other: _____

Indigenous Respite Care for Jordan's Principle

Respite care will be provided to clients who receive extensive care from family/community members. The goal of respite care is to provide respite time to improve outcomes for families in a balanced model of spiritual, emotional, mental and physical. The role of respite will determine a comprehensive caregiver support initiative and to identify improved access to services. The service provided is to offer families and children a balanced structure which is planned and provided to a child with special needs. The hours for care will depend on the assessed need. Child responsibility will be defined by the family and the respite service will work accordingly to the families care routine and care plan. Respite services that have been identified to provide support include:

- ***Group Respite:*** this includes the land based support and scheduled events and services in a group setting
- ***Home Respite:*** support is provided to the caregivers needs in developing a in home care plan depending on the needs of the family and child
- ***Individual Respite:*** A one-on-one respite for the child in educational, emotional, mental, spiritual or physical need of the child.
- ***Emergency Respite:*** a service provided under a crisis situation which requires immediate response to fill in the gap of service delivery.

Jordan's Principle Fully Acknowledge and Support Culturally Appropriate Services Which Include Language, Spirituality and Connection to the Land

Culture

First Nations teaching cannot be truly embraced without a foundational philosophy of First Nations culture and love of the Creator/god. First Nations culture provides a rich essence that is intrinsically woven by the supportive threads of relationship: with one other, with the Great Spirit, and with the Earth. This is the kernel ofFirst Nations wisdom, and the core value from which all expressions of culture evolved - whether ritual, artefact, or ceremonial practice. Relationship, often expressed best (in the English language anyway), as ***"All My Relations"*** guides the development of all cultural components, including language, oral teachings, prayer from all denominations, music, dance, spiritual and social gatherings, rites of passage, housing, even clothing, adornment, art, tools, and object creation.

Dynamic Culture

It is impossible to describe a common cultural reality for all First Nations people. The various nations traditionally manifested cultural practices, symbols, and belief systems coloured by their unique experiences onthe land and with each other, always conscious and connected with the Spirit world. Still, all First Nations people from all over Mother Earth share the critical tenet of Relationship as central to their expressions of culture.

Intake Process: Development of Care Plans Policy

1. ***Does Special Needs of Family Require:***

	Long Term __	**Short Term __**	**One time __**	**Emergency __**	
Timeframe of Service:	**3 months __**	**6 months __**	**9 months __**	**12 months __**	**Other __**

2. ***The care plan will specify:***
   a. ***the type and frequency of service the client needs and will receive;***
   b. ***the client-centered goals of the service with a target date;***
   c. ***goals that should be individualized, measurable and achievable;***
   d. ***the date that service will commence;***
   e. ***referrals to be made;***
   f. ***the role of the client in self-care;***
   g. ***Services to be carried out by:***
   h. ***Informal caregivers support network;***
   i. ***Other organizations or agencies;***
   j. ***Service review date.***
3. ***The plan should include:***
   a. ***Health promotion;***
   b. ***Illness prevention;***
   c. ***Emotional support and counseling;***
   d. ***Education to promote self-care and independence; and,***
   e. ***Transition/discharge.***
4. ***The care plan must be updated on an ongoing basis to reflect changing needs, met or changed goals, altered service or support.***

DIET			
Child eats appropriately. No emotional issues related to food/eating.	Child has difficult in feeding self or requires restrictive diet due to diagnosed medical condition.	Disability prevents child from consistently self-feeding.	Disability prevents child from self-feeding.
Caregiver provides normal care and assistance.	Caregiver provides assistance behond what is age appropriate.	Caregiver provides feeding assistance with normal feeding utensils and/or requires extensive time to feed child.	Caregiver provides total assistance involving medical procedure in order to eat (e.g., tube feeding).
☐ 1	☐ 2	☐ 3	☐ 4
Comments:			
Spiritual:			
Mental:			
Emotional:			
Physical:			
PERSONAL CARE AND HYGEINE			
Child handles own self-care, but may require routine prompts and guidance. Self-care seen as age appropriate.	Child lacks skills to complete age appropriate care.	Child requires assistance with activities of daily living due to disability or life long medical condition and/or the child requires total physical care due to condition.	Behaviour: Child is unwilling or resistant in completing own self-care.
Caregiver provides normal mentoring, support and guidance.	Caregiver does extra work due to child's inability to complete age appropriate needs.	Caregiver does additional work due to wetting and soiling (3-4 times per week).	Caregiver required to be skilled and patient who can proactively and non-punitively handle the child's care needs.
☐ 1	☐ 2	☐ 3	☐ 4
Comments:			
Spiritual:			
Mental:			
Emotional:			
Physical:			
SOCIAL NEEDS			
Child's social and wellness needs are met.	Child social needs are not met and requires supports.	Child struggles with social and wellness which requires support and experiences social isolation. Lacks self-esteem and has tendency to self-harm and homelessness.	Child's social needs are at high risk in social interaction. They put themselves at risk and/or others. Due to cognitive and developmental challenges.
Caregiver provides social needs with support and guidance.	Caregiver does best to meet the social needs but requires extra support.	Caregiver experiences difficulty in meeting the needs of the child. An identity issue is of concern and does not provide guidance required for child.	Caregiver does not have the skills to provide the support of the child. Provides best to their ability. Requires support.
☐ 1	☐ 2	☐ 3	☐ 4
Comments:			
Spiritual:			
Mental:			
Emotional:			
Physical:			

MENTAL HEALTH			
Child's mental health has not been identified as a concern.	Child as diagnosed mental health condition/mental disability.	Child has mental health diagnosid condition or a mental disability. Child may be on medication prescribed by an MD or psychiatrist.	Child has a mental health diagnosis/disability. Child receives direct therapy from a mental health professional.
Caregiver parent does not identify any mental health issue that is significantly affecting daily living.	Caregiver follows the recommendation of a mental health professional but no medication prescribed. Child needs structure and supervision.	Caregiver has regular consultations with a mental health professional with respect to assisting the child.	Caregiver is directly involved in the implementation of a treatment plan.
☐ 1	☐ 2	☐ 3	☐ 4
Comments:			
Spiritual:			
Mental:			
Emotional:			
Physical:			
BOUNDARIES			
Child's behaviour is appropriate.	Child puts self or others at risk situationally. Behaviour may also be disruptive and/or aggressive.	Child puts others and/or self at risk on a daily basis or child has no boundaries due to medical or mental health condition.	Child lacks impulse control and puts self and/or others at risk constantly. Child is resistant to care (lifestyle).
Caregiver provides age appropriate direction, monitoring and guidance.	Caregiver provides increased supervision and guidance in these situations.	Caregiver provides daily supervision, but there are times during the day when child can be left unspervised for brief periods of time.	Caregiver provides 24 hour supervision in all areas of daily living. Caregiver may require a safety plan due to risky behavious of the child (e.g., gang threats, dangerous behaviours).
☐ 1	☐ 2	☐ 3	☐ 4
Comments:			
Spiritual:			
Mental:			
Emotional:			
Physical:			
SCHOOL EDUCATION PROGRAMS	**IN SCHOOL SUPPORT REQUIRED** ☐ **YES** ☐ **NO**		
Child participants in regular school/day programs with few problems.	Child experiences some difficulties in school/day programs behaviourally or academically.	Child has behavioural/ academic problems at school/ day program.	Child unable or unwilling to participate in regular or modified school/day programming.
Support provides normal encouragement	Support provides additional support, daily communication between home and school, homework assistance and weekly or monthly meetings. School providing support such as resource supports.	School participants in multi-system planning process. School received Level II or III education funding to participate in school programs (i.e., special or modified day programs).	Support provides alternative structure of school/day program that involved home schooling with/without educational assistance.
☐ 4	☐ 4	☐ 4	☐ 4
Spiritual:			
Mental:			
Emotional:			
Physical:			

SUMMARY AND EVALUATION

Level 1, Level 2, Level 3, Level 4

NEED	POINTS			
DIET	☐	☐	☐	☐
PERSONAL CARE AND HYGEINE	☐	☐	☐	☐
SOCIAL NEEDS	☐	☐	☐	☐
MENTAL HEALTH	☐	☐	☐	☐
BOUNDARIES	☐	☐	☐	☐
SCHOOL/DAY PROGRAM	☐	☐	☐	☐
			TOTAL SCORE:	

POINTS CHART AND SUMMARY

25 Points	80 hours monthly
20-24 Points	80-60 hours monthly
15-19 Points	60-40 hours monthly
10-14 Points	40-20 hours monthly
1-10 Points	15-20 hours monthly
*Includes ONLY in home support and one-on-one respite	

RESPITE PLAN	**Respite submission (breakdown of hours & pay amounts)**

I/we have read, discussed and undersand that this is the special rate being recommended and is based on the needs of the child and my/our tasks/responsibilities as detailed in this form.

_____ _____

Parent/Guardian Name ***Signature and Date***

_____ _____

Child Development Worker Name ***Signature and Date***

MEDICAL HEALTH (See Unified Referral Intake System (URIS) to Evaluate)			
***ONLY USED BY URIS NURSE IF APPLICABLE TO YOUR FIRST NATION**	Child has a disability and/or a life long medical condition requiring assistance (e.g., basic operation of a wheelchair, administration of pre-measured oral medications). **URIS C**	Child requires health care routine due to disability and/or life long condition. **URIS B**	Child's health condition includes complex medical care needs. **URIS A**
	Caregiver assists with medically related equipment and/or pre-measured medications due to the child's health condition.	**Caregiver** is trained in specific care procedures, including OT/PT, due to the child's health condition.	**Caregiver** is trained in technology required by child. When primary caregiver is away, professional care is required.
☐	☐	☐	☐
Unified Referral Intake System (URIS):	Group A	Group B	Group C

Unified Referral Intake System (URIS)

Group A	Group B	Group C
Complex Health Care ▪ Complex health care procedure requiring the clinical skill and judgment of a registered nurse.	**Health Care Routines** ▪ Health care routines that may be safely delegated to non-health care personnel who receive training and ongoing monitoring by a registered nurse.	**Activities of Daily Living** ▪ Activities of daily living are identified to provide a sense of the overall care needs that the children may have while participating in the program
Procedures ▪ Ventilator care ▪ Tracheotomy care ▪ Suctioning (tracheal/pharyngeal) ▪ Nasogastric tube care and/or feeding ▪ Complex administration of ▪ medication – i.e. via infusion pump, continued ▪ nasogastric tube, or injection (other than Auto-injector) ▪ Central or peripheral venous line intervention ▪ Other clinical interventions requiring judgments and decision making by a medical or nursing professional.	**Procedures** ▪ Clean intermittent catheterization ▪ Condom application for urinary drainage ▪ Gastrostomy care and feeding ▪ Emptying an ostomy bag and/or changing an established appliance ▪ Administration of medications by: ▪ oral route (requiring measurement) ▪ instillation (i.e., eye/ear drops) ▪ topical (i.e., ointment, therapeutic dressing) ▪ inhalation (i.e., bronchodilators) ▪ gastrostomy ▪ Suctioning (oral or nasal) ▪ Responding to seizures when specific skills are required ▪ Administration of sublingual lorazepam ▪ Assistance with blood glucose monitoring requiring specific action based on results. ▪ Responding to low blood sugar emergencies ▪ Administration of pre-set oxygen ▪ Administration of adrenaline auto-injector	**Procedure** ▪ Passive range of motion/stretching exercises; ▪ Exercises for strength and mobility; ▪ Application of orthotics and prosthetics; ▪ Oral feeding when specific skills are required; (continued) ▪ Assistance with mobility when specific skills are required; ▪ Chest pummeling and postural drainage; ▪ Assistance with: ▪ Oral hygiene and cleanliness of hands/face, ▪ Dressing, ▪ Toileting and/or diapering, ▪ Oral feeding, ▪ Walking; ▪ Basic operation of a wheelchair; ▪ Assistance with symptoms of common maladies (e.g., coughing, vomiting, diarrhea); and ▪ Assistance with administration of pre- measured oral m

Endnotes:

Endnotes

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