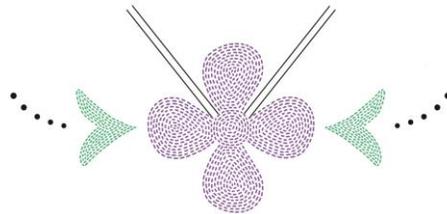


National Inquiry into  
Missing and Murdered  
Indigenous Women and Girls



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

**National Inquiry into Missing and Murdered  
Indigenous Women and Girls  
Truth-Gathering Process  
Part 2 Institutional hearings: “Government Services”  
Sheraton Suites Calgary Eau Claire  
Calgary, Alberta**



**PUBLIC**

**Part 2 Volume 3**

**Wednesday, May 30, 2018**

**Panel 2: “Health Services”**

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

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

**INTERNATIONAL REPORTING INC.**

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

E-mail: [info@irri.net](mailto:info@irri.net) – Phone: 613-748-6043 – Fax: 613-748-8246

## II

### APPEARANCES

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

### III

#### APPEARANCES

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

**IV**

**APPEARANCES**

Ontario Federation of  
Indigenous Friendship Centres

Niki Hashie (Representative)

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

Beth Symes (Legal Counsel)

Regina Treaty Status Indian  
Services, Inc

Erica Beaudin (Representative)

Saskatchewan Association of  
Chiefs of Police

Katrina Swan (Legal Counsel)

Winnipeg Police Service

Kimberly Carswell  
(Legal Counsel)

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Second Chair: Thomas Barnett (Commission Counsel)

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

Counsel: Anne Turley for Government of Canada

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

Counsel: Jennifer Cox (Commission Counsel)

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

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

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

1 Calgary, Alberta

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

3 --- **OPENING COMMENTS**

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

12 **(LAUGHTER)**

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

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

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

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

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

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

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

6 --- DRUMMING CEREMONY

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

9 (APPLAUSE)

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

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

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

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

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

5 --- OPENING PRAYER

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

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

12                   **(APPLAUSE)**

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

17                   **(LAUGHTER)**

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

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

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

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

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

1 a break, so...

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 **VALERIE GIDEON, Affirmed:**

25 **CHIEF COMMISSIONER MARION BULLER:** Thank

1       you, Doctor.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14                   Biography of Valérie Gideon (one page)

15 --- **PIÈCE NO. 24(b):**

16                   Biographie de Valérie Gideon (une page)

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

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

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

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

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

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

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

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

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

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

19          **--- EXHIBIT NO. 25:**

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

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

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

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

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

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

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

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

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

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

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

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

1 course, First Nations and Inuit government.

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

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

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

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

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

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

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

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

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

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

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

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

1 be offered, or delivered by FNIHB?

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

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

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

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

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

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

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

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

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

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

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

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

25 So we've adapted the model to whatever

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

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

1 decision-making at tables.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Alberta to begin that process.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25          --- **EXHIBIT NO. 27:**

1 "Guidelines for the FNIHB eHealth  
2 Infostructure Program (eHIP),"  
3 (March 2016) Health Canada, First  
4 Nations and Inuit Health Branch,  
5 ISBN: 978-1-100-5406401 (28 pages)

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

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

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

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

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

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

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

25 You know, obviously provincial health

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

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

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

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

1 treatment and 90 percent having viral suppression.

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

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

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

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

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

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

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

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

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

1 DR. VALERIE GIDEON: M'hm.

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

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

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

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

12 --- EXHIBIT NO. 28:

13 First Nations Mental Wellness  
14 Continuum Framework (January  
15 2015), Health Canada, ISBN: 978-1-  
16 100-25327-5 (63 pages)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 Indian Residence Schools

1 Resolution Health Support Program  
2 Policy Framework (June 2014),  
3 Health Canada (24 pages)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4           **--- EXHIBIT NO. 30:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25                       Infrastructure also will be a big priority

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

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

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

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

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

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

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

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

7 "Honouring Our Strengths: A Renewed  
8 Framework to Address Substance Use  
9 Issues Among First Nations People in  
10 Canada" (2011), Health Canada, ISBN:  
11 978-1-100-19331-1 (104 pages)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 First Nations and Inuit Component of

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

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

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

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

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

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

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

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

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

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

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

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

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

15 **(LAUGHTER)**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 anything.

2 **JACKIE ANDERSON, Affirmed:**

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

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

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

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

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

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

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

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

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

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

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

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

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

1 also worked for the Province of Manitoba, correct?

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

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

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

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

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

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

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

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

1 people absolutely need.

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

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

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

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

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

25 Tracia's Trust: Manitoba Sexual

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 huge challenge for her.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 work that they're doing?

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

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

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

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

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

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

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

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

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

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

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

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

25                   But Family Group Conferencing within the Ma

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

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

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

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

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

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

1 rebuild their families.

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

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

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

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

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

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

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

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

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

1 for our families.

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

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

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

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

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

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

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

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

25 So Family Group Conferencing, now that it has

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 I just want to really quickly share with

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

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

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

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

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

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

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

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

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

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

23 **CHRISTINE DUMAINE, Affirmed:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25           We continued to drive to Saskatoon, we were

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 **UNIDENTIFIED SPEAKER:** Experiential.

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

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

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

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

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

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

1 who was locked up.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 "No more: Ending Sex-Trafficking in  
10 Canada," Report of the National Task  
11 Force on Sex Trafficking of Women and  
12 Girls in Canada (Fall 2014), Canadian  
13 Women's Foundation (138 pages)

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

19 **VALERIE GIDEON, Previously Affirmed:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 But that being said, sometimes proposals are

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

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

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

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

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

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

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

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

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

1 to access supplementary funding from their funding  
2 agreement.

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

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

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

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

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

1 were speaking about MKO?

2 MR. STUART WUTTKE: Yes.

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

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

24 JACKIE ANDERSON, Previously Affirmed:

25 CROSS-EXAMINATION BY MR. WUTTKE:

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

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

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

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

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

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

1 the funding to receive the services.

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

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

7 **JACKIE ANDERSON, Previously Affirmed:**

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

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

1 strategies for prevention of childhood abuse?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 **VALERIE GIDEON, Previously Affirmed:**

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

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

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

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

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

1 particular for sure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8                   **JACKIE ANDERSON, Previously Affirmed:**

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

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

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

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

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

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

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

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

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

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

25 **MS. JACKIE ANDERSON:** No, they do.

1                   **MS. LISA WEBER:** They do need to?

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

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

12                   **MS. JACKIE ANDERSON:** Yes, I believe so.

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

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

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

1 up those rights?

2 **MS. JACKIE ANDERSON:** Unfortunately --

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

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

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

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

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

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

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

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

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

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

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

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

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

5 **MS. LISA WEBER:** Thank you. One of the  
6 issues that I often hear about, again, in Alberta, and I  
7 would assume it might be similar in Manitoba, is issues  
8 around the fact that there is a publication ban on the  
9 identity of children if they're receiving services, and I'm  
10 just wondering, given the nature of the work and services  
11 that your organization provides, whether or not that's ever  
12 been a -- if it's negatively impacted the ability to  
13 provide needed services or finding individuals who may go  
14 missing, as an example?

15 **MS. JACKIE ANDERSON:** Are you talking about  
16 if a child has gone missing or -- is that what you're  
17 referring to?

18 **MS. LISA WEBER:** Yeah, I'm referring to any  
19 legislative prohibitions on publishing the identity of  
20 person -- individuals, children, under age, and whether  
21 that's negatively impacted your ability to provide  
22 services?

23 **MS. JACKIE ANDERSON:** Not necessarily. I  
24 mean, there's a couple of things that, you know, when  
25 missing persons reports are going out they're identifying

1           them as a vulnerable child and youth. And although it's  
2           important that there's a response to be able to safely  
3           locate and bring our young people home, it's -- it's  
4           socially -- or it's on, you know, social media where  
5           perpetrators are also watching. Is that what you're  
6           referring to or --

7                   **MS. LISA WEBER:** Yeah, whether or not  
8           there -- there has been a negative impact of the inability,  
9           for example, to publish the name or the identity of youth  
10          who may be missing?

11                   **MS. JACKIE ANDERSON:** I don't think so.

12                   **MS. LISA WEBER:** Okay. I know the focus of  
13          the Commission's work and your work is women and girls, and  
14          I am just wondering if you could comment in my closing  
15          question if you have any observations or knowledge about  
16          the situation of boys and men perhaps in your province and  
17          what's being done to address issues that they may be  
18          also --

19                   **MS. JACKIE ANDERSON:** M'hm.

20                   **MS. LISA WEBER:** -- feeling the impact of?

21                   **MS. JENNIFER COX:** Those are -- that's a  
22          question that's sort of beyond the scope of the mandate of  
23          the National Inquiry.

24                   **MS. LISA WEBER:** Okay, so she's not going to  
25          answer that then?

1                   **CHIEF COMMISSIONER MARION BULLER:** Is this  
2 an official objection?

3                   **MS. JENNIFER COX:** I guess it is, yes.

4                   **CHIEF COMMISSIONER MARION BULLER:** Stop the  
5 clock, please, and submissions.

6                   **MS. LISA WEBER:** Thank you very much. Those  
7 are all my questions. Thank you.

8                   **CHIEF COMMISSIONER MARION BULLER:** And for  
9 the record --

10                   **MS. LISA WEBER:** I'm sorry, I forgot to tell  
11 you my name yesterday too. Lisa Weber, counsel for the --

12                   **CHIEF COMMISSIONER MARION BULLER:** That's  
13 okay, you're consistent.

14                   **MS. LISA WEBER:** Thank you.

15                   **COMMISSIONER QAJAQ ROBINSON:** Can we have  
16 that explained a little bit more, why the objection?

17                   **MS. JENNIFER COX:** Why did I object?

18                   **COMMISSIONER QAJAQ ROBINSON:** Yes.

19                   **MS. JENNIFER COX:** Because it's beyond the  
20 scope of the terms --

21                   **COMMISSIONER QAJAQ ROBINSON:** No, I know  
22 how, but she asked how are -- because -- perhaps it was  
23 because I wasn't sure exactly the scope of the question.  
24 I'm just wondering, we've heard about the need to educate  
25 boys, we've heard the needs to include men, so I wasn't

1       sure if your question was about violence that the boys are  
2       experiencing or their role in the situation?

3               **MS. JENNIFER COX:** Yeah, is it a follow-up,  
4       I guess, would be -- yeah, and that would be a proper  
5       question. I wouldn't object to that.

6               **MS. LISA WEBER:** Fair enough. I just  
7       wondered in her experience because Jackie has a wealth of  
8       experience, clearly, and I was just wondering if she had  
9       any closing comments that she might be willing to make just  
10      in regards to boys and men in Manitoba and the experiences  
11      they are having?

12              **MS. JACKIE ANDERSON:** Could I answer?

13              **MS. JENNIFER COX:** Yes.

14              **MS. JACKIE ANDERSON:** Okay, I'm completely  
15      comfortable with answering that as well because often our  
16      little brothers are forgotten, you know, and unfortunately  
17      it is something that we come across every day, where young  
18      boys are also being exploited and being hurt and harmed,  
19      and I think that a lot more work needs to be done to also  
20      be able to address some of the special needs that our  
21      young -- our young men need to have as it relates to the  
22      violence and exploitation they are experiencing.

23                      There was research that was done, and I  
24      can't say what year it is, but it's called Under the Radar,  
25      I believe it is, and it was done by Dr. Sue McIntyre who

1 travelled across Canada and held summits and spoke to boys  
2 and men who were also being affected through exploitation.

3 **MS. LISA WEBER:** Thank you very much. Those  
4 are all my questions. Thank you, Commissioners.

5 **MS. JENNIFER COX:** So the next party is Awo  
6 Tran Healing Lodge Society.

7 **VALERIE GIDEON, Previously Affirmed:**

8 **CROSS-EXAMINATION BY MR. BLAIN:**

9 **MR. DARRIN BLAIN:** Good afternoon, Chief  
10 Commissioner Buller, Commissioners, panelists, my friends  
11 in the legal profession and the people behind me who are  
12 representing parties. My name is Darrin Blain and I'm a  
13 lawyer in private practice here in Calgary. I've just  
14 finished my 800th Indian residential school hearing. And I  
15 don't tell you that to play my violin, I tell you that  
16 because I might be talking about some perspective that I've  
17 gotten from that process.

18 I'm also a proud member of the Peguis First  
19 Nation in Manitoba, which I'm sure a couple of you on  
20 the -- on the board have heard about, so thank you for  
21 having me.

22 To the representative from Health Canada,  
23 good afternoon. Would you agree with this statement: That  
24 the physical, emotional and spiritual health of the  
25 Aboriginal women and girls in this country, and how those

1 are not being met by your agency and other agencies that  
2 are responsible for delivering them, constitute a national  
3 emergency, or they are of national emergent concern?

4 **DR. VALERIE GIDEON:** So I just wanted to  
5 clarify that I'm not with Health Canada, just for the  
6 record, I'm with the Department of Indigenous Services  
7 Canada under the First Nations Inuit Health Branch.

8 I would say that it wouldn't be for me to  
9 define that, it would be for Aboriginal women and girls to  
10 define that from their own experience with respect  
11 to -- and from the leadership in the communities and First  
12 Nations Inuit and Métis organizations.

13 **MR. DARRIN BLAIN:** So your organization or  
14 who you work for, doesn't -- you wouldn't call that of  
15 national urgent concern?

16 **DR. VALERIE GIDEON:** It would not be for us  
17 to declare an emergency. For instance, in First Nations  
18 communities, First Nations communities have sometimes  
19 declared emergencies due to social crises, it would be up  
20 to them to do that. It wouldn't be something that we would  
21 feel that we would have the mandate to do.

22 **MR. DARRIN BLAIN:** Do you think that this  
23 issue of the health of First Nation women and girls in this  
24 country ought to receive principal discussion by these  
25 Commissioners in their report?

1                   **DR. VALERIE GIDEON:** It isn't for me to say  
2 what the Commissioners should be focussing on in the  
3 report. My job is to provide evidence and advice, if  
4 asked, on specific issues, but I certainly would not  
5 pretend to tell the Commissioners what they should or  
6 should not be focussing on.

7                   **MR. DARRIN BLAIN:** And do you agree with me  
8 that we ought to be hiring more First Nation nurses,  
9 doctors and psychologists in this country?

10                   **DR. VALERIE GIDEON:** Absolutely. I would  
11 agree with that.

12                   **MR. DARRIN BLAIN:** And can we make that a  
13 joint recommendation to the Commission?

14                   **DR. VALERIE GIDEON:** I would certainly --

15                   **MR. DARRIN BLAIN:** Because I agree with it.

16                   **DR. VALERIE GIDEON:** -- support the  
17 recommendation that there needs to be more Indigenous  
18 health human resources. In fact, that's a recommendation  
19 that the Royal Commission on Aboriginal Peoples made in the  
20 '90s -- or, sorry, in 2006, and they actually called for,  
21 if I believe it, 10,000 Indigenous health human resources  
22 professions to be trained by that point in time. They had  
23 specified a target.

24                   **MR. DARRIN BLAIN:** And do you agree with me  
25 that First Nations women and girls represent, in a lot of

1 cases, the most vulnerable segment of our society, and they  
2 really deserve the best care with the most talent? Would  
3 you agree with that?

4 **DR. VALERIE GIDEON:** The evidence definitely  
5 shows that First Nations women and girls are often at risk,  
6 at greater risk, of -- from health conditions to other  
7 social issues and factors, absolutely. There is a growing  
8 body of evidence that demonstrates that.

9 **MR. DARRIN BLAIN:** And to the next part of  
10 that question, would you agree that they deserve the  
11 best -- the best medical talent this country has to offer?

12 **DR. VALERIE GIDEON:** I would agree that  
13 First Nations women and girls absolutely deserve attention  
14 in this country and quality services to address their  
15 needs.

16 **MR. DARRIN BLAIN:** Bear with me, please.  
17 You mentioned a 24/7 help line for people contemplating  
18 suicide that's available in French, English and I think you  
19 mentioned three or four First Nation languages; is that  
20 right?

21 **DR. VALERIE GIDEON:** The same languages that  
22 is -- that are used in the 24/7 line of the Commission.

23 **MR. DARRIN BLAIN:** Could it be a  
24 recommendation to the Commissioners that any 24/7 help line  
25 that is established or continues in this country to help

1 Aboriginal women and children, particularly girls, that are  
2 contemplating suicide be made available in every First  
3 Nation language in this country?

4 **DR. VALERIE GIDEON:** Are you asking me a  
5 question or you're making a recommendation to the  
6 Commission?

7 **MR. DARRIN BLAIN:** I'm asking if you agree  
8 with my recommendation.

9 **DR. VALERIE GIDEON:** I honestly don't know  
10 how feasible it would be for that to happen. But I  
11 certainly believe that in community, it would be -- it is  
12 important for First Nation women and girls to have access  
13 to services in their language to the maximum extent  
14 possible.

15 **MR. DARRIN BLAIN:** All right. Very well.  
16 Time is of the essence this afternoon. I've got some more  
17 questions here. I need to move on to the other presenters.  
18 Thank you for your comments.

19 **JACKIE ANDERSON, Previously Affirmed:**

20 **CROSS-EXAMINATION BY MR. BLAIN:**

21 **MR. DARRIN BLAIN:** Ms. Anderson. Good  
22 afternoon.

23 **MS. JACKIE ANDERSON:** Hi.

24 **MR. DARRIN BLAIN:** I think you know where  
25 I'm from, do you not?

1                   **MS. JACKIE ANDERSON:** Peguis.

2                   **MR. DARRIN BLAIN:** Yeah. Nice to finally  
3 meet you.

4                   **MS. JACKIE ANDERSON:** (Indiscernible).

5                   **MR. DARRIN BLAIN:** Bear with me, please.  
6 Have you attended the funerals of any of your clients that  
7 have slipped through the cracks and not made it through  
8 your program?

9                   **MS. JACKIE ANDERSON:** Yes.

10                  **MR. DARRIN BLAIN:** Do you feel like better  
11 funding and better resources may have prevented that?

12                  **MS. JACKIE ANDERSON:** Absolutely.

13                  **MR. DARRIN BLAIN:** Is that one of the  
14 recommendations to this Commission, that your program and  
15 programs like it receive the maximum funding available, and  
16 that the programs be reviewed and receive principal  
17 consideration by this Commission?

18                  **MS. JACKIE ANDERSON:** I -- I think it needs  
19 to be a priority. We're here today to, you know,  
20 honour -- honour our victims, those that are still being  
21 victimized and those that we have lost. And yes, sadly,  
22 today I -- I sit here, and I've had to, you know, bury  
23 three of our little sisters. And, in fact, behind me on  
24 this wall, some of them are -- are behind us.

25                  **MR. DARRIN BLAIN:** M'hm.

1           **MS. JACKIE ANDERSON:** M'hm.

2           **MR. DARRIN BLAIN:** You mentioned the  
3 effectiveness of something called the National Survivor  
4 Summit?

5           **MS. JACKIE ANDERSON:** Yes.

6           **MR. DARRIN BLAIN:** And is it a  
7 recommendation to the Commission that the National Survivor  
8 Summits be funded by Health Canada or a health agency of  
9 the Government of Canada, and that they receive significant  
10 and fulsome review?

11           **MS. JACKIE ANDERSON:** I can't say who would  
12 be responsible, I guess, for the funding piece of it. But  
13 when you look at, you know, the life of a survivor, the  
14 ongoing, it's -- health is absolutely a number one priority  
15 for the ongoing healing that they need. And in regards to  
16 that summit, that is an absolute need. And not, again,  
17 something that happens once every ten years. I believe it  
18 needs to be happening every year.

19           **MR. DARRIN BLAIN:** Let's make that a  
20 recommendation to the Commission today. Is that all right?

21           **MS. JACKIE ANDERSON:** M'hm.

22           **MR. DARRIN BLAIN:** Okay.

23           **MS. JENNIFER COX:** So for the purposes of  
24 the record, it has to be yes or no.

25           **MR. DARRIN BLAIN:** Oh. Sorry.

1                   **MS. JACKIE ANDERSON:** Yes.

2                   **MR. DARRIN BLAIN:** I have one more question  
3 for you, then I'll move on to Ms. Dumaine. Are you  
4 involved in criminal law. Are you involved in criminal law  
5 reform or are you being asked by the criminal law experts  
6 in this country about criminal law reform, and  
7 specifically, sentencing for these people that are preying  
8 on -- on the women and girls that you see?

9                   **MS. JACKIE ANDERSON:** Not directly involved  
10 at that level. However, my involvement is education and  
11 awareness. As I mentioned earlier, it's important that, in  
12 the work that we do, that there is collaboration with  
13 police and all the different systems that we're needing in  
14 order to share what we're seeing and what we're  
15 experiencing and what needs to happen for our young people.

16                   **MR. DARRIN BLAIN:** Okay.

17 **CHRISTINE DUMAINE, Previously Affirmed:**

18 **CROSS-EXAMINATION BY MR. BLAIN:**

19                   **MR. DARRIN BLAIN:** Okay. Christine, good  
20 afternoon.

21                   **MS. CHRISTINE DUMAINE:** Good afternoon.

22                   **MR. DARRIN BLAIN:** I was impressed by your  
23 testimony, and I'm not sure you noticed this, but when you  
24 were speaking, the room went very quiet. And I think that  
25 everyone that I talked to was remarkably impressed by your

1 testimony.

2 **MS. CHRISTINE DUMAINE:** Thank you.

3 **MR. DARRIN BLAIN:** Thank you for being here.  
4 Thank you for being a survivor. Thank you for being a role  
5 model to the woman who's watching this on the internet  
6 right now from a women's shelter with bruises and a lack of  
7 hope. Thank you for speaking to her today. I appreciate  
8 that, and I'm sure that everyone in this room does.

9 **MS. CHRISTINE DUMAINE:** Thank you.

10 **MR. DARRIN BLAIN:** I had a couple of  
11 questions for you. I think something you said today was  
12 just the most -- the -- I'm going to -- when I -- when I  
13 conclude this week, I'm going to take something that you  
14 said with me that was remarkable. I'm just going to repeat  
15 it. "We need Indigenous-led homes run by people with  
16 experience that are First Nation." Now listen, here's the  
17 important part. "As they are the true experts." I just  
18 love what you said there. And I thought that was really  
19 telling about your own healing, and in many respects,  
20 you're the most important person giving evidence or  
21 comments today.

22 So I take it, then, that if we were to ask  
23 the Commissioners for something out of your testimony, that  
24 we would be asking them for funding or to make it a  
25 principle or a really important part of their report that

1 for women and girls in crisis, like you were, that they  
2 make available or consideration of the availability of  
3 Indigenous-led homes, just like you mentioned, and that  
4 funding ought to come for that so people don't need to  
5 worry about how to pay to get in there and how to run the  
6 organization, and that we source out the best Aboriginal  
7 talent to help people just like you were in their road to  
8 recovery. Are we asking the Commission for that today?

9 **MS. CHRISTINE DUMAINE:** Yes.

10 **MR. DARRIN BLAIN:** Thank you again for being  
11 here. The Commission. Good afternoon. Those are my  
12 questions.

13 **MS. JENNIFER COX:** So the next party with 13  
14 minutes is ITK.

15 **JACKIE ANDERSON, Previously Affirmed:**

16 **CROSS-EXAMINATION BY MS. ZARPA:**

17 **MS. ELIZABETH ZARPA:** Good afternoon. I  
18 want to start -- start off and say I want to thank Treaty 7  
19 Nation for allowing us to be here on their territory again  
20 all throughout the week. The Blackfoot and the Métis,  
21 thank you. And I also want to say thank you, too, for the  
22 wonderful testimony today and the questions. So I'm going  
23 to start -- going to start with you, Ms. Jackie Anderson  
24 and Ms. Christine Duhaine?

25 **MS. CHRISTINE DUMAINE:** Dumaine.

1                   **MS. ELIZABETH ZARPA:** Dumaine. Oh, sorry.  
2                   Okay. I -- I want to highlight a little bit about the  
3                   experience that was expressed by you, Ms. Anderson, around  
4                   Indigenous people who come from sort of rural northern  
5                   areas, and they go into urban settings, and there's  
6                   predators there. I -- I wanted to question whether there  
7                   was any programs or any sort of initiatives that you're  
8                   aware of that seeks to address the predatorial behaviour of  
9                   those individuals that prey on vulnerable and young  
10                  Indigenous women.

11                  **MS. JACKIE ANDERSON:** Programs for the  
12                  perpetrators or programs for the -- the young people coming  
13                  in from rural?

14                  **MS. ELIZABETH ZARPA:** I would like to speak  
15                  to the experience of the predatorial behaviour, like the  
16                  predators somehow being targeted in this experience. Are  
17                  they -- are they targeted for -- to change their  
18                  behaviours?

19                  **MS. JACKIE ANDERSON:** The predators? Sorry.  
20                  I --

21                  **MS. ELIZABETH ZARPA:** Yeah.

22                  **MS. JACKIE ANDERSON:** As -- as far as I  
23                  know, the only program that is for predators or  
24                  perpetrators is john school, and that's based on their  
25                  first arrest. They have an opportunity to go to john

1 school. But there's no actual program specifically  
2 targeting the demand on changing behaviours or -- or  
3 confronting their behaviours and what they're doing to our  
4 young people.

5 **MS. ELIZABETH ZARPA:** And upon entering into  
6 this john school, are -- is there a -- criminal charged, or  
7 that you're aware of, or if you're not aware of that?

8 **MS. JACKIE ANDERSON:** I'm not totally sure.  
9 But I do know that if it's your first charge, you have the  
10 opportunity to pay a fine or go to john school. You also do  
11 have to pay for the -- the john school yourself.

12 **MS. ELIZABETH ZARPA:** And it's mandatory?

13 **MS. JACKIE ANDERSON:** Yes.

14 **MS. ELIZABETH ZARPA:** And is that, sort of,  
15 experience of looking, seeking of johns, is that something  
16 that's used extensively, say, in Winnipeg, around the place  
17 that you mentioned? Like, the areas where young Indigenous  
18 people hangout?

19 **MS. JACKIE ANDERSON:** M'hm.

20 **MS. ELIZABETH ZARPA:** Are -- is that, sort  
21 of, monitored to make sure that johns are not praying on  
22 young Indigenous women?

23 **MS. JACKIE ANDERSON:** I'm sorry. I don't  
24 know what your -- understand your question.

25 **MS. ELIZABETH ZARPA:** So is -- how do you --

1           how -- how -- in your experience --

2                   **MS. JACKIE ANDERSON:** M'hm.

3                   **MS. ELIZABETH ZARPA:** -- are johns, sort of,  
4           sought out? Are they --

5                   **MS. JACKIE ANDERSON:** Being identified?

6                   **MS. ELIZABETH ZARPA:** -- policed? Yeah.

7                   **MS. JACKIE ANDERSON:** Oh, okay. Again, we  
8           have some very, very strong community outreach teams working  
9           on the front lines and working on the streets. And it's a  
10          collaborative approach of multiple organizations that are  
11          going in different areas within our city that we know are  
12          identified stroll areas that perpetrators are out seeking.  
13          So there's that collaborated, coordinated approach where  
14          licence plates of -- of vehicles that are coming into our  
15          communities that we know have no other reason why they  
16          should be in that community. We're tracking, we're doing  
17          suspect trafficking forms, and they are meeting weekly,  
18          these teams, and -- and giving this information over to the  
19          police.

20                   **MS. ELIZABETH ZARPA:** Okay. And are -- are  
21          those -- are those volunteer, or are they funded?

22                   **MS. JACKIE ANDERSON:** The outreach teams?

23                   **MS. ELIZABETH ZARPA:** Yes.

24                   **MS. JACKIE ANDERSON:** They are -- they are  
25          funded within different organizations.

1                   **MS. ELIZABETH ZARPA:** Okay. Great. And you  
2 mentioned that some of the most vulnerable people are the  
3 ones who come from the north.

4                   **MS. JACKIE ANDERSON:** M'hm.

5                   **MS. ELIZABETH ZARPA:** And would you classify  
6 Inuit who travel to Winnipeg, they -- they're from the  
7 north?

8                   **MS. JACKIE ANDERSON:** Pardon me? Who?

9                   **MS. ELIZABETH ZARPA:** Inuit.

10                  **MS. JACKIE ANDERSON:** Inuit. Yes.

11                  **MS. ELIZABETH ZARPA:** Okay. And do you know  
12 if there is any specific programming for young Inuit women  
13 who go to Winnipeg who, say, are vulnerable as well? Or  
14 getting caught up in the systems?

15                  **MS. JACKIE ANDERSON:** I do know that they do  
16 have a community centre specifically for Inuit families that  
17 are coming in. Our programs are -- are open to all  
18 Indigenous peoples.

19                  **MS. ELIZABETH ZARPA:** Okay. Thank you so  
20 much.

21                  **MS. JACKIE ANDERSON:** Thank you.

22 **VALERIE GIDEON, Previously Affirmed:**

23 **CROSS-EXAMINATION BY MS. ZARPA:**

24                  **MS. ELIZABETH ZARPA:** Okay. So my next  
25 questions are for Ms. Gideon. So you mentioned that First

1 Nations and Inuit Health Branch includes First Nations and  
2 Inuit. Could you please elaborate to me what -- what that  
3 means? Who -- who classifies as Inuit?

4 **DR. VALERIE GIDEON:** Well, our mandate does  
5 include providing a number of programs and services to  
6 Inuit. It does work differently in the Inuit context  
7 because of Inuit land claim agreements, and the role of  
8 territorial governments. However, we do provide funding  
9 specific to Inuit for a variety of community health programs  
10 in the area of mental health, and the area of a -- a healthy  
11 child development, home and community care, and as well,  
12 Inuit have coverage for non-insured benefits regardless of  
13 where they live in Canada.

14 We have an Inuit health approach specifically  
15 within the First Nations Inuit Health Branch that we  
16 developed with ITK and the National Inuit Committee on  
17 Health in 2014 that spells out how we work collaboratively  
18 with Inuit land claim organizations across the country. And  
19 when we receive new investments, we work with the National  
20 Inuit Committee on Health and each of the individual land  
21 claim organizations to discuss how those resources would be  
22 best invested.

23 In Nunavut, we have a tripartite partnership  
24 table, so that NTI, the Government of Nunavut, and  
25 ourselves, discuss very openly working together to address

1 needs of -- of Inuit. In Nunavut, specifically, there is a  
2 tripartite MOU that was signed to support a ten-year funding  
3 agreement --

4 **MS. ELIZABETH ZARPA:** Right.

5 **DR. VALERIE GIDEON:** -- for Nunavut.

6 **MS. ELIZABETH ZARPA:** M'hm.

7 **DR. VALERIE GIDEON:** Which includes a lot of  
8 these programs and initiatives that I mentioned.

9 **MS. ELIZABETH ZARPA:** Okay. Wonderful. So  
10 with all of these different agreements, and these different  
11 strategies, and these different guidelines, and these  
12 different meetings, are there Inuit doctors that you're  
13 aware of?

14 **DR. VALERIE GIDEON:** I believe that there are  
15 a few. We do not employ physicians specifically that work  
16 in Inuit Nunangat. It's done through either a provincial,  
17 territorial, or an Inuit government. So my knowledge is  
18 more superficial with respect to who is providing direct  
19 service delivery in Inuit communities. But, I think, health  
20 human resources is a significant priority --

21 **MS. ELIZABETH ZARPA:** And --

22 **DR. VALERIE GIDEON:** -- within the context of  
23 Inuit Nunangat.

24 **MS. ELIZABETH ZARPA:** And would you agree  
25 that having individuals who have lived experiences in

1 northern regions, such as Inuit communities, are best  
2 equipped to deal with in the health system -- the population  
3 in which they're serving?

4 **DR. VALERIE GIDEON:** Hundred percent.

5 **MS. ELIZABETH ZARPA:** Right.

6 **DR. VALERIE GIDEON:** Especially, even just  
7 from the perspective of language.

8 **MS. ELIZABETH ZARPA:** Great. And are you  
9 aware of -- are there hospitals in Nunatsiavut?

10 **DR. VALERIE GIDEON:** There's not a hospital  
11 in Nunatsiavut. They have health centres, primary  
12 healthcare clinics, and -- that are -- that are run in  
13 partnership between the Nunatsiavut Government and the  
14 provincial government.

15 **MS. ELIZABETH ZARPA:** Okay. I'm actually  
16 going to ask if I can have a CBC news article entitled,  
17 "Montreal Boarding Home for Nunavik Medical Patients Over  
18 Capacity Since Opening." It's a CBC News article that was  
19 posted in July 2000 [sic] -- 2017. Have you seen this?

20 **DR. VALERIE GIDEON:** I only saw it today when  
21 it was handed to me.

22 **MS. ELIZABETH ZARPA:** Okay. I'm going to ask  
23 the Commissioners and counsel whether I can enter this as an  
24 exhibit?

25 **CHIEF COMMISSIONER MARION BULLER:** Is this by

1 consent?

2 **MS. ANNE TURLEY:** It's by consent.

3 **CHIEF COMMISSIONER MARION BULLER:** It is.

4 Okay. Then the CBC article, "Montreal Boarding Home for  
5 Nunavik Medical Patients Over Capacity Since Opening," post  
6 July 25th, 2017 will be the next exhibit, which is, sorry,  
7 number 36. And while I have the mic, counsel's name for the  
8 record, please?

9 **MS. ELIZABETH ZARPA:** My name is Elizabeth  
10 Zarpa. Thank you.

11 --- **EXHIBIT NO. 36:**

12 "Montreal boarding home for Nunavik  
13 medical patients over capacity since  
14 opening," CBC News, posted July 25, 2017  
15 12:25 CT, last updated July 25, 2017  
16 (three pages)

17 **MS. ELIZABETH ZARPA:** So I'm going to quote  
18 on the last part. I'm just going to quote a couple of  
19 things from the article. And it says, Nunavik director sees  
20 load is, "Not sustainable." "Would like to see hospital  
21 built in Nunavik."

22 The idea of having a regional hospital  
23 in Nunavik is a must - it's a  
24 necessity -- because unless certain  
25 specialties are repatriated back to

1                   Nunavik in a regional hospital, the  
2                   number of our clients arriving will only  
3                   be increasing.

4                   I'm not entirely sure whether if the First  
5                   Nations and Inuit Health branch deals directly with this;  
6                   does it?

7                   **DR. VALERIE GIDEON:** So Nunavik is under a  
8                   land claim agreement. The Nunavik Health and Social  
9                   Services Board is part of the provincial health system. So  
10                  it is not directly related to the First Nations and Inuit  
11                  Health Branch. The only thing that I would say is that  
12                  boarding home capacity is a national issue.

13                  With respect to patients coming from Inuit  
14                  Nunangat, particularly with the high birth rate and prenatal  
15                  escorts also requiring a lot of accommodation in urban  
16                  centres. So I would say that we're aware of the needs for  
17                  more accommodation for Inuit patients coming south or in  
18                  Iqualuit for services, but we're not directly related to --  
19                  we're not directly linked to the care system in Nunavik  
20                  because it's governed under the land claim agreement.

21                  **MS. ELIZABETH ZARPA:** So because it's  
22                  governed under the land claim agreement in its provincial  
23                  jurisdiction, in order for them to put a hospital in, say,  
24                  Kuuujuaq?

25                  **DR. VALERIE GIDEON:** That's right. But we do

1 meet with them regularly to talk about what we can do to  
2 help support their needs in a partnership model. So we meet  
3 with Minnie Grey, the Executive Director of the Nunavik  
4 Health and Social Services Board. And I'm sure that we  
5 would be open to speaking with her about what her thoughts  
6 are on this matter.

7 **MS. ELIZABETH ZARPA:** And would you -- would  
8 you provide any suggestion in terms of how to make this  
9 process a little less administratively challenging for Inuit  
10 who want to build a hospital in Nunavik?

11 **DR. VALERIE GIDEON:** I mean, they are -- they  
12 are governing the health services in their particular  
13 territory under the land claim agreement, so I -- I just  
14 don't feel like I could provide or impose my advice to them.

15 **MS. ELIZABETH ZARPA:** And is it common in  
16 your experience that Inuit travel from, say, Iqualuit or  
17 Inuvialuit to go down south to go to the hospitals?

18 **DR. VALERIE GIDEON:** Absolutely.

19 **MS. ELIZABETH ZARPA:** So this experience in  
20 the CBC news article is something that's very common?

21 **DR. VALERIE GIDEON:** It is common, yes.

22 **MS. ELIZABETH ZARPA:** And it's not the  
23 jurisdiction of the First Nations or First Nations Inuit  
24 Health Branch to deal with this?

25 **DR. VALERIE GIDEON:** That's right. Not

1 specifically, no.

2 **MS. ELIZABETH ZARPA:** Okay. Thank you so  
3 much. That's all the questions I have today.

4 **MS. JENNIFER COX:** The next party is  
5 Independent First Nations and they have 17 minutes.

6 **VALERIE GIDEON, Previously Affirmed:**

7 **CROSS-EXAMINATION BY MS. BEAMISH:**

8 **MS. SARAH BEAMISH:** Hello, my name is Sarah  
9 Beamish, I'm counsel for Independent First Nations, which  
10 is a group of 12 Anishinaabe, Haudenosaunee and Oji-Cree  
11 First Nations. Thank you all for your testimony today.

12 I'd like to start with a few questions for  
13 Dr. Gideon. So, firstly, the projects about digital health  
14 technology, I think there's a lot of promising stuff in  
15 there, but from an IFN perspective there's one -- at least  
16 one barrier to implementing them that I want to ask you  
17 about.

18 So in some of the IFN communities a major  
19 barrier would be electricity. Some of these communities'  
20 electricity grids are basically maxed out, such that they  
21 can't even be building new houses at this point, so any new  
22 programs or services that would put significant demand in  
23 terms of electricity would be a problem.

24 So my question for you is whether the plans  
25 and efforts regarding digital health technologies have

1 anticipated this problem and whether there are any plans to  
2 deal with it?

3 **DR. VALERIE GIDEON:** So absolutely when we  
4 look at community infrastructure requirements, it  
5 absolutely is a consideration, and it's not just with  
6 respect to digital technologies, it's also with respect to  
7 construction of new health facilities, right? You also  
8 have to make sure that they -- the water plant, the waste  
9 water system, all of those elements of community  
10 infrastructure can sustain a new health facility,  
11 particularly if the capacity is maximized.

12 So, you know, it's -- within the context of  
13 Ontario, however, we have been successful, as I noted  
14 earlier, in terms of being able to make investments to  
15 increase connectivity through the fiber optic network, and  
16 that has seemed to work well for a number of northern and  
17 isolated communities across Ontario. But, of course, I'm  
18 not familiar with each situation of each of the Independent  
19 First Nations, but I recognize that community  
20 infrastructure is part of the -- could be part of the  
21 barriers to access for greater health care services, not  
22 just digital, but also new health care infrastructure in  
23 general.

24 **MS. SARAH BEAMISH:** Okay. So my next  
25 question is about dental care. I notice that in the

1 Exhibit 25 about the Non-Insured Health Benefits Program,  
2 it talked about providing coverage for medically necessary  
3 dental care. And in the Independent First Nations there  
4 are women who have had their teeth damaged or lost because  
5 of violence, and it affects their self-esteem and dignity,  
6 it affects their sense of wellbeing, it sometimes affects  
7 their ability to get employment.

8 They experience it as a major impact of  
9 violence on them and one that potentially increases their  
10 vulnerability to future violence, but they  
11 experience -- their experience in trying to get dental care  
12 in these situations has sometimes been that they can't get  
13 coverage for it because it's deemed to be a cosmetic issue  
14 rather than a medically necessary issue. So my question is  
15 whether currently you know if the -- if this health  
16 benefits program would fund repair or replacement in a  
17 situation where it was only deemed to be cosmetic?

18 **DR. VALERIE GIDEON:** The program that we  
19 have with respect to orthodontics I think is what you're  
20 referring to specifically, it absolutely is based on severe  
21 and functionally handicapped malocclusion. With respect to  
22 general oral health care services though, there are a  
23 number of dental services that are available, as well as  
24 preventative services, such as fluoride varnishes and a lot  
25 of sort of very basic accesses to dental services. 97

1 percent of the dental benefit doesn't require any  
2 predetermination whatsoever, and so it would -- I think  
3 that what would probably be the barrier that you're  
4 referring to would be in the case of orthodontic coverage,  
5 so it is based on medically required services.

6 **MS. SARAH BEAMISH:** Okay. Would you agree  
7 that coverage for tooth repair or replacement in the kind  
8 of situation I'm talking about, where there is -- where it  
9 is maybe a cosmetic issue, is -- would still be beneficial  
10 for Indigenous women's overall health and wellbeing?

11 **DR. VALERIE GIDEON:** I mean, the mandate of  
12 the program is based on medical necessity. The mandate of  
13 the program dates back to 1997 and -- and we used clinical  
14 criteria based on evidenced best practices. We have a  
15 national oral health advisory committee made up of  
16 independent experts that advise us with respect to coverage  
17 within the context of the benefit, so it really isn't about  
18 sort of my opinion, it really is on the basis of research  
19 evidence, evidence-based practice and independent advice  
20 from oral health experts, of which I am not one.

21 **MS. SARAH BEAMISH:** Okay. All right, I hope  
22 you can answer this next question, it's about sort of  
23 cooperation between the health care agencies and other  
24 parts of government. So as some background of what  
25 I'm -- to my question, in some IFN communities they see

1 that what appear to be non-health related decisions by  
2 other parts of government have significant health impacts  
3 that the health system is not always sort of prepared to  
4 address. So as one example of where that has happened,  
5 there was one remote IFN community where there was a high  
6 rate of use of an addictive drug by the residents there,  
7 and there was a bust by the police that abruptly shut down  
8 the communities sources of that drug, and as a result in  
9 the following days and weeks there was a sudden unplanned  
10 widespread experience of going through withdrawal --

11 **DR. VALERIE GIDEON:** M'hm.

12 **MS. SARAH BEAMISH:** -- and there weren't  
13 appropriate detox or other support services for the people  
14 there. And so their experience with this was that  
15 this -- this police intervention had caused a health crisis  
16 and had actually increased safety risks in the community.

17 So in that kind of situation, if the police  
18 had contacted health care officials in your agency or  
19 another federal agency, do you think that it's possible  
20 that a plan could have been made to proactively address  
21 those foreseeable health risks?

22 **DR. VALERIE GIDEON:** Absolutely. And, in  
23 fact, my experience early in my days at what was Health  
24 Canada -- we were part of Health Canada at the time, I ran  
25 the Ontario region with respect to First Nations Inuit

1 Health Branch, and in that period of time prescription drug  
2 abuse was extremely common, the use of Oxycontin in  
3 communities illegally, and we worked together with  
4 Nishnawbe Aski Nation police services in order to be able  
5 to ensure that we were providing community safety plans and  
6 the use of harm reduction measures, such as Suboxone, which  
7 is an opioid agonist treatment, available to support  
8 individuals to manage through their symptoms of withdrawal  
9 and also to manage their addiction and provide a safer  
10 environment for communities. And we were able to do that  
11 in a number of communities, isolated communities in  
12 northern Ontario that were affected so that we would  
13 prevent these types of measures.

14 I would absolutely agree that collaboration  
15 between multiple Federal, or Federal and provincial, or  
16 Federal provincial First Nations agencies is extremely  
17 important to ensure that community safety planning and  
18 community wellness planning is -- is in place.

19 **MS. SARAH BEAMISH:** Okay. So you would  
20 recommend a more systemic approach to that kind of thing  
21 then?

22 **DR. VALERIE GIDEON:** Yeah, we actually set  
23 up community wellness development teams during that time  
24 that are still available and resourced federally and  
25 provincially in order to support communities to develop

1 this type of plan.

2 **MS. SARAH BEAMISH:** Okay.

3 **DR. VALERIE GIDEON:** And to invest in some  
4 targeted interventions and measures.

5 **MS. SARAH BEAMISH:** Okay, thank you. I may  
6 just ask you one or two more questions. My next one is  
7 about ID. In some of the -- in some of the Independent  
8 First Nations, girls and women have had difficulty  
9 accessing health care services when they don't have the  
10 proper ID for whatever reason, and sometimes, as a result,  
11 they don't seek out health care that they need because they  
12 anticipate having -- having issues with ID. Is it right  
13 that Indigenous people often need to present ID to receive  
14 the health services through the programs that you've  
15 discussed today and the ones that are discussed in your  
16 materials?

17 **DR. VALERIE GIDEON:** So within the context  
18 of the provincial health system, I'm not sure what the  
19 province would do if someone didn't have an OHIP card. I  
20 mean, I know that in the nursing station or health centre  
21 context people are not asked for their status card when  
22 they walk through the door, they are served by nurses.  
23 Regardless of whether or not the health facility is run by  
24 the Federal Government or operated by Federal Government  
25 employees or by First Nation employees, the services are

1 provided. Emergency health services in the province will  
2 be provided to people who need it.

3           Within the context of the Non-Insured Health  
4 Benefits Program, you know, I think that we've not seen  
5 that as a major barrier to access that I'm aware of in all  
6 of my years. But we have intervened in cases where we've  
7 had First Nation women that lost their ID or couldn't find  
8 their ID in order to contact the office of the Indian  
9 Registrar to do an emergency issuance of a letter that  
10 actually just validates that they do have status in  
11 that -- but that is for transportation purposes, in the  
12 sense of them being able to -- if they need air travel to  
13 return home or whichever, we've been able to do that. The  
14 Office of the Indian Registrar will work collaboratively  
15 with us to issue emergency validation of identification if  
16 it -- particularly if it's an urgent situation or if -- if  
17 it's a woman who's at risk or finds herself in a situation  
18 where she can't access service.

19           **MS. SARAH BEAMISH:** Okay. My next question  
20 is about childhood sexual abuse. Do any of the Federal  
21 programs -- health programs for Indigenous people directly  
22 address childhood sexual abuse as a health issue, as far as  
23 you know?

24           **DR. VALERIE GIDEON:** Well, our clinical  
25 practice guidelines include that aspect of it. In fact,

1 we're right now in the process of updating the pre-pubertal  
2 -- sorry, my French sometimes comes out -- child abuse  
3 guidelines specifically. We -- again, we offer a lot of  
4 flexibility with respect to the parameters of community-  
5 based programming so that they can identify their  
6 priorities. The Chiefs of Ontario recently contacted us  
7 because they are setting up a task force specific to child  
8 abuse and also Nishnawbe Aski Nation has done the same thing  
9 in order to be able to develop some more targeted  
10 interventions to address the issue in community. So we  
11 absolutely fund that and support those types of initiatives  
12 initiated by First Nations.

13 And I think, you know, the increase in amount  
14 of resources and services available within the context of  
15 mental wellness broadly, regardless of, you know, what is  
16 the need of the child, which is not for the Federal  
17 Government to -- to know about, but is just something that  
18 is supported. I mean, all those services are available to  
19 children that have experienced sexual abuse.

20 **MS. SARAH BEAMISH:** Okay. Are any of the --  
21 the services you're talking about -- do any of them take a  
22 proactive prevention approach to childhood sexual abuse, or  
23 are they responding after the fact?

24 **DR. VALERIE GIDEON:** Our clinical practice  
25 guidelines for frontline nursing staff absolutely do talk

1 about detection and identifying, really, risk factors within  
2 that context. We also have the Maternal Child Health  
3 Program, as an example, which includes the supports for home  
4 visiting. Home visiting has actually been demonstrated as  
5 an effective practice for community health professionals to  
6 -- or health workers to come into communities and be able to  
7 build that trust relationship with families early on, from  
8 birth until early childhood. The Aboriginal Head Start  
9 program also is a program that's widely utilized in  
10 communities to help support preschool children.

11 And within the context of those guidelines,  
12 there's also, you know, identifying risk factors and also  
13 having provincial -- parental involvement and parental  
14 engagement in the child's development at an early age. So  
15 there are a number of healthy child development type of  
16 initiatives where proactivity is encouraged, absolutely.

17 **MS. SARAH BEAMISH:** Okay. I do have more  
18 questions, but I think I'd like to leave a few minutes for  
19 -- for the next witness, so thank you for your answers.

20 **JACKIE ANDERSON, Previously Affirmed:**

21 **CROSS-EXAMINATION BY MS. BEAMISH:**

22 **MS. SARAH BEAMISH:** All right. So, Ms.  
23 Anderson, first, I just want to say I was moved to hear of  
24 the Centre's relationship with Maori people in developing  
25 your services. I belong to the Ngāruahine Maori people, and

1 so I am sure they would support me in bringing special  
2 greetings to you and the Centre on their behalf.

3 I just -- I think I only have two questions  
4 for you.

5 **MS. JACKIE ANDERSON:** Yeah.

6 **MS. SARAH BEAMISH:** My first one is, in your  
7 experience, would you say that childhood sexual abuse at the  
8 community level, including by family members, is a common  
9 and significant risk factor related to Indigenous girls and  
10 women ending up in situations of sex trafficking and  
11 exploitation?

12 **MS. JACKIE ANDERSON:** Yes.

13 **MS. SARAH BEAMISH:** Yes?

14 **MS. JACKIE ANDERSON:** Absolutely. A very  
15 high number of our children have experienced that child --  
16 that childhood -- child abuse, all forms of child abuse.  
17 That absolutely has an effect on their vulnerability.

18 **MS. SARAH BEAMISH:** Yeah. Okay. Well, I  
19 think -- I would just like to leave a few minutes, because I  
20 wanted to ask you your recommendations to the Commission on  
21 this issue specifically, on the issue of childhood sexual  
22 abuse at the community level, including by family members,  
23 and its connection to violence, other violence, later on in  
24 -- in -- in people's lives. If you want to take a few  
25 minutes to talk about any recommendations you have about

1 addressing this.

2 **MS. JACKIE ANDERSON:** About -- sorry?

3 **MS. SARAH BEAMISH:** About childhood sexual  
4 abuse.

5 **MS. JACKIE ANDERSON:** Well, again, I think it  
6 really has to -- to go with creating that awareness and  
7 education and supporting, you know, our young people with  
8 being able to deal with that trauma and being able to create  
9 safe environments for when children are disclosing or  
10 talking about, you know, experiences that they have  
11 experienced and not re-victimizing them by having to  
12 continuously tell their story of what's going on or what's  
13 happened to them. I think that's very important.

14 **MS. SARAH BEAMISH:** Okay. All right. Well,  
15 I think that's all -- those are all my questions for you,  
16 then. Thank you. So did we want to have a break?

17 **CHIEF COMMISSIONER MARION BULLER:** Yes. We  
18 will reconvene at three o'clock.

19 **MS. SARAH BEAMISH:** Three o'clock.

20 --- Upon recessing at 2:46 p.m.

21 --- Upon reconvening at 3:10 p.m.

22 **MS. JENNIFER COX:** The next party is  
23 Pauktuuitit for 13 minutes.

24 **MS. BETH SYMES:** Good afternoon. My name is  
25 Beth Symes, and I represent Pauktuutit, the Inuit women of

1 Canada, the Labrador Inuit women, Saturviit, the Ottawa  
2 Inuit Children's Centre and the Manitoba Inuit Association,  
3 and I'm going to try and focus on prevention, prevention of  
4 violence and death for Inuit women and girls.

5 I want to thank you, Jackie and Christine,  
6 for coming. One of the really memorable times was hearing  
7 the story in Rankin Inlet of the death of Jessica Michaels  
8 who was an Inuk girl from Chesterfield Inlet taken into  
9 care in Winnipeg, and she became trafficked and probably  
10 was killed. And so the services that you do has a range  
11 that is geographically probably even bigger than you think.  
12 But her story was told beautifully by her cousin's sister.  
13 So thank you.

14 **VALERIE GIDEON, Previously Affirmed:**

15 **CROSS-EXAMINATION BY MS. BETH SYMES:**

16 **MS. BETH SYMES:** Dr. Gideon, I'm going to be  
17 concentrating my questions on you and as it relates to  
18 Inuit, Inuit women.

19 The health care that -- would you agree  
20 with me that health care is an essential service for all  
21 Canadians?

22 **DR. VALERIE GIDEON:** I would.

23 **MS. BETH SYMES:** And that includes Inuit  
24 women?

1 DR. VALERIE GIDEON: Yes, I would agree.

2 MS. BETH SYMES: And that the failure to  
3 provide health care is actually a breach of right to life,  
4 lint, and the security of the person?

5 DR. VALERIE GIDEON: So -- so that's a  
6 legal -- more a legal question. And I -- what I would say  
7 is that the provision of health care services for Inuit  
8 women is extremely important for their ability to thrive.

9 MS. BETH SYMES: Thank you. The standards  
10 of health care, I'm a bit confused about what you have  
11 written in the overview. So the standard of health care on  
12 page 1 says to attain health levels comparable to other  
13 Canadians living in similar locations. Now, is that for  
14 Inuit, the standard as compared to non-Inuit living in,  
15 say, a remote community such as, I don't know -- let's pick  
16 Hall Beach. Is that the standard that you say Inuit women  
17 can achieve? That's all?

18 DR. VALERIE GIDEON: So comparability  
19 is -- definitely has its pitfalls because in many  
20 circumstances across Canada, there are no comparable  
21 circumstances with respect to where Indigenous people live.  
22 So, really, it's about achieving -- and closing the gap is  
23 often language that people use whereby there should be a  
24 comparable state of health outcomes at minimum with respect  
25 to Indigenous peoples and non-Indigenous peoples in Canada,

1 and that is something that I think most people would agree  
2 with, and certainly there are many political commitments  
3 that have been made. And it's written over and over with  
4 respect to policy documents.

5 But when we were developing the strategic  
6 plan for First Nations Inuit health, the National Inuit  
7 Committee on Health really advised that it is about healthy  
8 community members, families, healthy communities, healthy  
9 nations, and that -- however those communities are defining  
10 health, really, that is what we should be supporting and  
11 what we should be aspiring to.

12 **MS. BETH SYMES:** It's not a race to the  
13 bottom.

14 **DR. VALERIE GIDEON:** Pardon me?

15 **MS. BETH SYMES:** It is not a race to the  
16 bottom for Inuit women in terms of health care.

17 **DR. VALERIE GIDEON:** No. So --

18 **MS. BETH SYMES:** (Indiscernible).

19 **DR. VALERIE GIDEON:** -- the goal is to  
20 continue to improve health outcomes for Inuit women and  
21 Inuit across Ananaakatiget -- or regardless of where they  
22 live in Canada.

23 **MS. BETH SYMES:** Dr. Gideon, isn't the only  
24 appropriate standard for health care for Inuit women to be  
25 the standard of health care for all Canadians? Isn't that

1 the aspiration?

2 **DR. VALERIE GIDEON:** So the issue is what  
3 would you define as a standard of health care for all  
4 Canadians? I would just say that that's, again, the  
5 pitfalls of comparability. So what would be an acceptable  
6 basket of services for an urban-based non-Indigenous  
7 population may be very different to what an Inuit community  
8 needs. An Inuit community may need higher degrees of  
9 services for mental wellness, as an example. They may need  
10 more family-centered care.

11 So I would just say that I don't think  
12 that -- I've never heard from the National Inuit Committee  
13 on Health a desire to define a national standard of care.  
14 What I have heard is we are developing our strategies. We  
15 are developing the needs and -- or we are identifying our  
16 needs and the strategies required to meet them, and we  
17 would like federal, provincial, and territorial governments  
18 to respond effectively to support us in addressing those  
19 needs.

20 **MS. BETH SYMES:** Well, Dr. Gideon, we've  
21 heard over the last year stories from Inuit families,  
22 talking about the very poor quality of physical health and  
23 the abysmal quality of mental health services in Inuit  
24 Ananaakatiget. And you've -- you've read those stories,  
25 haven't you?

1 DR. VALERIE GIDEON: I've certainly --

2 MS. BETH SYMES: (Indiscernible).

3 DR. VALERIE GIDEON: Yes, absolutely.

4 MS. BETH SYMES: And let's just look  
5 objectively at some numbers because qualitative things are  
6 always tricky. You'd agree with me that the life  
7 expectancy of an Inuit woman in Canada is 11 years less  
8 than a non-Inuit woman in Canada?

9 DR. VALERIE GIDEON: So I haven't studied  
10 those statistics specifically or have the source validated  
11 before me, but I -- I certainly wouldn't argue that there  
12 is a gap in life expectancy between Inuit women and other  
13 Canadian women in the country.

14 MS. BETH SYMES: And you'd agree with me  
15 that the birthrate for Inuit women in Nunavut is almost  
16 twice the birthrate of Canadian women not in Nunavut?

17 DR. VALERIE GIDEON: I am aware that the  
18 birthrate among Inuit women is higher than other Canadian  
19 women.

20 MS. BETH SYMES: And that the infant  
21 mortality rate for Inuit children is three times the  
22 Canadian average?

23 DR. VALERIE GIDEON: Again, I am aware that  
24 there are higher infant mortality rates among Inuit  
25 compared to the mainstream Canadian population.

1                   **MS. BETH SYMES:** And I think that Census  
2 Canada but -- or Statistics Canada must be looking over  
3 your shoulders, Commissioners, because today, they released  
4 the violence rates for women in the three territories, as  
5 well as each province in Canada. And that the rate for  
6 Inuit women in Ananaakatiget -- pardon me, in  
7 Nunavut -- apologies -- is ten times the national average  
8 for all of Canada. Now, does that surprise you,  
9 Dr. Gideon, in terms of the rates of violence for Inuit  
10 women being many times the rates for Canadian women?

11                   **DR. VALERIE GIDEON:** It does not surprise me  
12 that Inuit women are at greater risks of violence.

13                   **MS. BETH SYMES:** Now, maybe because it's  
14 2018, you said that in developing health initiatives, NFIHB  
15 uses a gender-based analysis. You wrote that, didn't you?  
16 In your report?

17                   **DR. VALERIE GIDEON:** I spoke about how all  
18 federal departments are implementing gender-based plus  
19 analysis in the development of policies or programs and  
20 services.

21                   **MS. BETH SYMES:** And do you also --

22                   **DR. VALERIE GIDEON:** It's a mandatory  
23 element. Sorry.

24                   **MS. BETH SYMES:** Sorry. It's mandatory?

25                   **DR. VALERIE GIDEON:** Yeah.

1                   **MS. BETH SYMES:** And you said that your  
2 department looks at issues and solutions through a gendered  
3 lens? Is that right?

4                   **DR. VALERIE GIDEON:** It is part of the  
5 mandatory GBA plus assessment.

6                   **MS. BETH SYMES:** I was really taken by your  
7 description of these partnership tables where having  
8 Indigenous people at the decision-making table, not just to  
9 give their input, not just to advise, but also to be part  
10 of or be a decision-maker. That's what you described,  
11 right?

12                   **DR. VALERIE GIDEON:** That's correct. It's  
13 variable with respect to the mandate that are provided  
14 through leadership for these tables, but absolutely. Where  
15 possible, we have been including them with respect to the  
16 decision-making process at the branch level.

17                   **MS. BETH SYMES:** And that's the decision  
18 where and how health dollars will be spent?

19                   **DR. VALERIE GIDEON:** That's correct. There  
20 are decisions made, for instance, with the National Inuit  
21 Committee on Health with respect to where health dollars  
22 would be allocated. Now, the ITK board also plays a role  
23 in that. We're not at that table, but we understand that  
24 they are part of the decisions, as well.

25                   **MS. BETH SYMES:** Now, I understand from what

1       you said today that the two representatives of Indigenous  
2       people at the table are the AFN and ITK?

3                   **DR. VALERIE GIDEON:** So they are members of  
4       the committee, but they do go back and seek advice and also  
5       decisions of their regional organizations. So in the Inuit  
6       context, the National Inuit Committee on Health provides  
7       advice, as well, to the ITK board, and decisions are  
8       relayed back. So ITK at that table does not make the  
9       decision. ITK brings the information back and consults  
10      within the Inuit governance structure, and then comes back  
11      to us with the decision that has been agreed to at those  
12      tables.

13                   **MS. BETH SYMES:** And Pauktuutit, the voice  
14      of Inuit women in Canada, is not at that partnership table.

15                   **DR. VALERIE GIDEON:** The Pauktuutit is  
16      invited to the National Inuit Committee on Health. They are  
17      definitely in the room. I don't know the -- all of the  
18      interplays between Pauktuutit, specifically, and the  
19      National Inuit Committee on Health members or governance.  
20      Obviously within the First Nations Inuit health branch, we  
21      do not specify to First Nations or Inuit how to organize  
22      their decision-making process or their government  
23      structures. We rest back and recognize those government  
24      structures.

25                   **MS. BETH SYMES:** Dr. Gideon, I'm having

1 difficulty understanding how you're going to carry out your  
2 mandate to do a gender base analysis plus, or to look at  
3 this issue through a gendered lens, if you don't have Inuit  
4 women at the table with the right to vote, to say how the  
5 money is spent with respect to health.

6 **DR. VALERIE GIDEON:** So Inuit governments are  
7 represented on the National Inuit Committee on Health, and  
8 we respect and recognize their authority as Inuit  
9 governments to provide that decision-making to us.

10 **MS. BETH SYMES:** Well, Dr. Gideon, you told  
11 us that you use Pauktuutit's health care materials, in terms  
12 of provisions of services.

13 **DR. VALERIE GIDEON:** We have funded  
14 Pauktuutit to undertake various initiatives over the years  
15 that they have identified as priorities through their board  
16 of directors.

17 **MS. BETH SYMES:** Now, you know that  
18 Pauktuutit was without a contribution agreement from FNIHB  
19 from 2012 to 2017 under a previous government?

20 **DR. VALERIE GIDEON:** I -- I was not directly  
21 involved during that period, but I -- I am aware through  
22 their Executive Director, who communicated that to me in  
23 2017.

24 **MS. BETH SYMES:** And so now there is just one  
25 project that FNIHB has with Pauktuutit for \$150,000 on

1 sexual health?

2 **DR. VALERIE GIDEON:** I wouldn't be able to  
3 verify the number, but I -- I'm sure that's likely correct.  
4 The Minister -- our Minister has met with the Pauktuutit  
5 president, and I believe attended or is attending a board of  
6 director's meeting to discuss future partnership with  
7 Pauktuutit, and so it -- it continues to be something that  
8 we are open to discussing.

9 **MS. JENNIFER COX:** Excuse -- time's up.

10 **MS. BETH SYMES:** I still -- I'm sorry, thank  
11 you.

12 **MS. JENNIFER COX:** Thank you. So the next  
13 party is the Families for Justice. And 13 minutes as well,  
14 Mr. Registrar.

15 **MS. SUZAN FRASER:** Good afternoon,  
16 Commissioners. Good afternoon, witnesses. My name is Susan  
17 Fraser. I am here on behalf of 20 families, many of  
18 Canada's provinces, and from different territories across  
19 this land, and I have some questions for all of you. Quite  
20 grateful for you being here, and I'm -- so I'm going to be  
21 asking both from the families' perspective, and also on some  
22 broader issues.

23 Just starting with Jackie, Ms. Anderson.  
24 Thank you for your very beautiful description of the HOME,  
25 and for making it a home.

1 JACKIE ANDERSON, Previously Affirmed:

2 CROSS-EXAMINATION BY MS. FRASER:

3 MS. JACKIE ANDERSON: M'hm.

4 MS. SUZAN FRASER: And wanted to ask you to  
5 follow up on the question on the voluntary, so called  
6 voluntary service agreement, where children are given-up  
7 into care in order for them to have access to health  
8 services that they would not be able to access without being  
9 put into care, okay? In Ontario, that practice was outlawed  
10 because children were thought to be entitled to services.  
11 Would you support a recommendation outlying the practice of  
12 children being put into -- into voluntary care for the  
13 purposes of accessing health services?

14 MS. JACKIE ANDERSON: Yes, I would agree.

15 MS. SUZAN FRASER: Okay, thank you. And  
16 members of our group -- one member of the group of families  
17 described to the Inquiry her experience of coming into care.

18 MS. JACKIE ANDERSON: M'hm.

19 MS. SUZAN FRASER: Having a breakdown of the  
20 foster care placement and being sent from her First Nation  
21 to the city of Winnipeg on a bus, at the age of 12, where  
22 she came into contact with people who would come to exploit  
23 her.

24 MS. JACKIE ANDERSON: M'hm.

25 MS. SUZAN FRASER: Are you aware of this

1 practice continuing?

2 **MS. JACKIE ANDERSON:** I -- I would say so,  
3 yes. Again, we are seeing that recruiters are associating  
4 around places where the most vulnerable children and youth  
5 are, it is known. And I've heard a number of instances  
6 where bus depots, airports are also places of recruitment.

7 **MS. SUZAN FRASER:** Okay. So it would be  
8 recommendation for you that First Nations and Indigenous  
9 children be protected around places where they are  
10 vulnerable, which is backing it up a step that -- that child  
11 welfare not put them in situations like that.

12 **MS. JACKIE ANDERSON:** Absolutely.

13 **MS. SUZAN FRASER:** Okay. Are you aware of  
14 other children being put unescorted on public  
15 transportation?

16 **MS. JACKIE ANDERSON:** I -- I'm aware of one  
17 situation that an adult woman actually experienced that  
18 situation when she was very young.

19 **MS. SUZAN FRASER:** It's possible that we're  
20 talking about the same person because she is from the  
21 Winnipeg -- she did end up in Winnipeg. Also have heard in  
22 through the media, the practice of young girls being placed  
23 while in the care of the Children's Aid Society or the -- I  
24 can't remember the Manitoba name, Child and Family Services.

25 **MS. JACKIE ANDERSON:** M'hm.

1                   **MS. SUZAN FRASER:**    Being placed as a  
2                   residential placement in a hotel, when there are no foster  
3                   care or group home placements available.  Is this something  
4                   that you have heard about?

5                   **MS. SUZAN FRASER:**  In the past, yes, but it's  
6                   not a practice they currently use today.

7                   **MS. SUZAN FRASER:**  Okay.  Is it -- is it a  
8                   practice that is prohibited in -- to your knowledge?

9                   **MS. JACKIE ANDERSON:**  Yes, I believe so.

10                  **VALERIE GIDEON, Previously Affirmed:**

11                  **CROSS-EXAMINATION BY MS. FRASER:**

12                   **MS. SUZAN FRASER:**  Okay, Thank you.  I want to  
13                   just turn then to Dr. Gideon.  Dr. Gideon, you have  
14                   described this morning a myriad of promising sounding  
15                   strategies and initiative and practices that are emerging  
16                   from Indigenous Services Canada.  And you also mentioned in  
17                   your evidence this morning, and this is how I'd understood,  
18                   that it's not clear that -- of how the funding is making a  
19                   difference.

20                   **DR. VALERIE GIDEON:**  We have evidence with  
21                   respect to a series of evaluations, even that I referred to  
22                   this morning, such as the July 2016 evaluation of the mental  
23                   wellness suite of programs.  I talked about a number of  
24                   outcomes that have resulted from those investments.  I also  
25                   spoke about an evaluation that will be released publicly,

1       shortly with respect to clinical and client care, and that  
2       we've seen some demonstrated progress and outcomes from  
3       that. So I would not say that we do not have outcomes data,  
4       in fact we do in a number of areas.

5               I think health data is a -- the challenge  
6       with respect to a comprehensive picture of Indigenous health  
7       information, is that multiple government are involved in the  
8       delivery of services, and that there isn't a connection  
9       between all of those data collection systems. It is a --  
10      something that all governments are aware of. There isn't,  
11      also, an ability to disaggregate the information that's  
12      captured, for instance, in a lot of provincial or  
13      territorial health systems to specifically identify who is  
14      First Nation, who is Inuit, who is Métis, that also makes it  
15      a challenge. But wherever possible we are supporting  
16      partnerships to improve access to data that are driven by  
17      First Nations and Inuit, specifically, and Métis as well,  
18      who've just recently received funding in budget 2018 for  
19      Métis health data and surveillance.

20             Budget 2018 also committed to an Inuit  
21      health survey with ongoing resources in order to support  
22      Inuit to develop their own source of health information, and  
23      we also fund directly the First Nations information  
24      government centre to issue the Longitudinal Regional Health  
25      Survey. They have done that for a number of years. They've

1 just recently released their latest national report at  
2 conference a few months ago, and they're planning the next  
3 wave, so we are making investments for First Nations, Inuit,  
4 and Métis to collect their own data to -- under the OCAP  
5 principles: ownership control, access, and possession of  
6 information. So there is growing data with respect to  
7 health outcome measures.

8 **MS. SUZAN FRASER:** Okay. So that -- and that  
9 -- agree that it is a critic -- the health, in understanding  
10 health, is a critical part of understanding a person's well-  
11 being?

12 **DR. VALERIE GIDEON:** Absolutely.

13 **MS. SUZAN FRASER:** Okay. And it's also --  
14 health is -- also in how people are doing is also a critical  
15 part of understanding a community's well-being?

16 **DR. VALERIE GIDEON:** Yes, I would agree.

17 **MS. SUZAN FRASER:** Okay. And I understand  
18 that Indigenous Services Canada has a measure of social and  
19 economic well-being on reserves, called the Community Well-  
20 Being Index.

21 **DR. VALERIE GIDEON:** So the former --

22 **MS. SUZAN FRASER:** Have you heard of that?

23 **DR. VALERIE GIDEON:** Yes, I've heard of that.  
24 It -- it was developed through what was Indigenous and  
25 Northern Affairs Canada, to mirror the United Nations

1 Development Index and their methodology, in order to offer a  
2 comparability between international nations and First  
3 Nations with in the context of Canada. So it was one  
4 specific measure to offer some comparability within the  
5 United Nations Development Index. It's not, of course, the  
6 only measure that the federal government would take with  
7 respect to measuring health or socio-economic measures or  
8 statistics with respect to First Nations, Inuit, and Métis.

9 **MS. SUZAN FRASER:** Right. The -- the  
10 measurements of outcomes are important, and the Community  
11 Well-Being Index is something that Indigenous Service Canada  
12 uses in order to measure how communities are doing, fair?

13 **DR. VALERIE GIDEON:** It was actually  
14 developed with First Nations at that time. Because First  
15 Nations --

16 **MS. SUZAN FRASER:** I'm -- I'm sorry to cut  
17 you off, but I'm -- I'm not interested in the history of it,  
18 I'm just wondering, the question really was -- was whether -  
19 - Dr. Gideon, was whether this is something that Indigenous  
20 Services Canada uses to measure the socio-economic health of  
21 First Nations Communities?

22 **DR. VALERIE GIDEON:** The information has been  
23 provided in analysis, but I can't tell you, even most  
24 recently, when that would have been. So I -- I have not --  
25 my -- my knowledge of the Community Well-Being Index and the

1 use of it, is dated. It was when I was at the Assembly of  
2 First Nations.

3 **MS. SUZAN FRASER:** Okay. Because yesterday,  
4 and, Commissioners, I think I'm going to be -- you're going  
5 to be hearing more from me on this topic this week, so this  
6 is why I'm -- I'm leading this way. I expect to be able to  
7 tender, later in the week, the Auditor General's Report.  
8 And the Auditor General, I expect, we're going to hear  
9 through that report, if it's received by this Inquiry,  
10 that --

11 **DR. VALERIE GIDEON:** Excuse me.

12 **MS. SUZAN FRASER:** -- that there -- there is  
13 an incomprehensible failure in Canada to address the gaps in  
14 First Nations community as against Indigenous -- not --  
15 Indigenous people as against non-Indigenous people, all  
16 right? And so -- and the Auditor General goes directly in  
17 looking at the economic -- the social economic Well-Being  
18 Index as -- and is critical of it not including health. So  
19 are you -- do you have any knowledge as to why the Community  
20 Well-Being Index does not include health?

21 **DR. VALERIE GIDEON:** At the time, and the  
22 knowledge that I have, which again, dates back to when I was  
23 at the Assembly of First Nations, they were developing a  
24 methodology that mirrored what the United Nations was using  
25 in terms of the Human Development Index. So it was not a

1 deliberate exclusion of health, it was trying to achieve  
2 comparability with respect to a global measurement tool.

3 **MS. SUZAN FRASER:** All right. And I also  
4 understand that -- that the -- and I ask you to consider  
5 this -- this point, the Auditor General says that,  
6 Indigenous Services Canada is not using the data that is  
7 readily available in order to provide a comprehensive  
8 picture of the health of First Nations Communities. I'm  
9 paraphrasing. I can give you the exact --

10 **DR. VALERIE GIDEON:** So I haven't read the  
11 report. It was released yesterday, and I was travelling.  
12 These reports are embargoed and only shared with certain  
13 officials prior to them being released. So I'm afraid I  
14 can't comment. I have not had the opportunity to read the  
15 report.

16 **MS. SUZAN FRASER:** All right. It -- what the  
17 Auditor General said, and I don't expect you to know it, but  
18 I want to know, what he's critical about is that the  
19 department could have used the volumes of available data  
20 from multiple sources, I think you've given us information  
21 about some of those sources, to more comprehensively compare  
22 well-being relative to other Canadians and First Nations  
23 communities but did not. So  
24 in -- in terms of using data, do you have any knowledge as  
25 to why the department would not use this available data,

1 which you've told us is quite rich in comparing Indigenous  
2 Canadians to non-Indigenous Canadians?

3 **DR. VALERIE GIDEON:** The data that I was  
4 referring to was specific to health. So my knowledge is  
5 limited, and I don't have the expertise to answer that  
6 question with respect to other areas of the department.  
7 Acknowledging that we have just been transferred into the  
8 creation of a new department of Indigenous Services Canada,  
9 so my knowledge has been grounded and my long-standing  
10 experience in working in First Nations and Inuit Health  
11 specifically, I'm more familiar with health data than other  
12 sources of information.

13 **MS. SUZAN FRASER:** All right. You -- you  
14 said in your evidence that there's much more to be done, or  
15 words to that effect, that you recognize that there's a -- a  
16 lot of work to be done. But I -- I don't have time to go  
17 into that. I want to ask you this last question as to  
18 whether you're -- you're familiar with the Child's Rights  
19 Impact Assessment, and whether that's something that your  
20 department uses to assess the impact of its programs?

21 **DR. VALERIE GIDEON:** I'm not familiar with  
22 it. What is the source of it?

23 **MS. SUZAN FRASER:** Child's Rights Impact is a  
24 tool that is available. It's promoted by the -- through  
25 UNICEF Canada, other organizations. It's a way of assessing

1 a government's compliance with child -- children's rights  
2 and convention rights.

3 **DR. VALERIE GIDEON:** So I'm not familiar with  
4 it, but I think it's something we should -- we would bring  
5 to the senior management table.

6 **MS. SUZAN FRASER:** You would support a  
7 recommendation, that in addition to using a gender-based  
8 analysis, that -- that the programs be evaluated with a view  
9 to child's rights? And in -- impact on child's rights?

10 **DR. VALERIE GIDEON:** We make decisions with  
11 First Nations and Inuit representatives at the table. And  
12 so what I would say is that, if it's of an interest to them,  
13 we would certainly look at it within the context of the  
14 senior management table with First Nations and Inuit.

15 **MS. SUZAN FRASER:** Right. And I  
16 appreciate --

17 **MS. JENNIFER COX:** Counsel, time is up.

18 **MS. SUZAN FRASER:** Oh, thank you. My -- the  
19 clock still shows seconds, so I just -- if -- if that's --  
20 thank you.

21 **MS. JENNIFER COX:** It's negative. The next  
22 party is the Regina Treaty Status Indian Services. And they  
23 have 21 minutes.

24 **VALERIE GIDEON, Previously Affirmed:**

25 **CROSS-EXAMINATION BY MS. BEAUDIN:**

1                   **MS. ERICA BEAUDIN:** Are we -- same issue as  
2                   yesterday. Good afternoon. Thank you to the Elders,  
3                   drummers, and singers for their prayers and songs we've all  
4                   been privilege of. Is what -- as well, once again, as a  
5                   citizen of Treaty 4, I acknowledge the continued welcome to  
6                   Treaty 7 and bring well wishes from our Treaty area. I will  
7                   walk softly on your lands. My name is Erica Beaudin. I'm  
8                   the Executive Director of the Regina Treaty Status Indian  
9                   Services. I have several questions; therefore, I'm going to  
10                  speak faster than I normally do. And please feel free to  
11                  answer yes or no if it's an easy answer. So question one  
12                  is, Dr. Gideon, *wela'lin* for your presentation this morning.  
13                  It was very educational, and I appreciate the information.  
14                  I would like to provide a bit of background, oh, as I'm  
15                  talking about, I'm wasting my own time. I would like to  
16                  provide a bit of background before I get to my questions.  
17                  The tribal councils who own my organization, own and operate  
18                  two adult domestic violence safe shelters; a hospital, the  
19                  All Nations Healing Hospital that you talked about this  
20                  morning; a social housing corporation; an economic  
21                  development corp.; a youth treatment facility; and as well  
22                  as a casino. As their urban services delivery agency, we  
23                  provide womb to tomb services including accredited adult  
24                  education, training and an employment agency, various  
25                  restitution programs, a family support centre, and programs

1 prioritizing various priorities. Two of these programs that  
2 we have contribution agreements with is for the Indian  
3 residential school and missing and murdered Indigenous women  
4 and girls programming to family members, survivors, and  
5 loved ones.

6 At our tribal council, that being the File  
7 Hills Qu'Appelle Tribal Council, we're committed to wrap-  
8 around care for all people who access our services. In  
9 working with FNIHB, it is often difficult to provide  
10 comprehensive case management to our people when we're bound  
11 by CAs, and I'll use the term CAs, if you don't mind, that  
12 are very specific in their deliverables. Do you believe  
13 that CAs, that Tribal Councils, or organizations assigned to  
14 deliver services, should have CAs that allow for more  
15 flexibility so that the agreements can meet the needs of the  
16 clients for better outcomes?

17 **DR. VALERIE GIDEON:** Yes, I do.

18 **MS. ERICA BEAUDIN:** If so, how could this be  
19 accomplished, or are there current opportunities that  
20 haven't been mentioned?

21 **DR. VALERIE GIDEON:** So we are very open to  
22 looking at more block funding agreements for Tribal  
23 Councils. In the past those were offered more to  
24 communities, but a few years ago we opened it up to  
25 PTOs -- or political territorial organizations -- for the

1 French translators, and also offering that to Tribal  
2 Councils.

3 So I think with the richness of the degree  
4 of capacity and governance of the organization that you've  
5 described, it seems to fit very well with that opportunity.  
6 So you would be able to do a comprehensive plan of the  
7 priorities of the community members that you're serving and  
8 be able to direct funds to those priorities without being  
9 tied to any cluster or program silos.

10 **MS. ERICA BEAUDIN:** Thank you. My  
11 organization has had a CA with FNIHB for the Indian  
12 residential school program for several years. I'd like to  
13 commend FNIHB for the ability to meet the needs of our  
14 clients in a more wholistic way. In my mind all other CAs  
15 should have the types of ability for eligible expenditures  
16 for the sake of survivors and families of survivors.

17 Saying all of this, one trend that emerged  
18 in our time working with IRS survivors, that many have  
19 experienced loved ones who are, were missing and/or  
20 murdered. Conversely, every single family we've worked  
21 with in the area of missing and murdered Indigenous women  
22 and girls are survivors or intergenerational survivors of  
23 Indian residential school, that's 100 percent.

24 Do you believe that FNIHB should utilize the  
25 Indian residential school program and expand it so that it

1 includes MMIWG, and if it is included, increase resources,  
2 including program training and human resources to agencies  
3 who are meeting these specific needs of survivors?

4 **DR. VALERIE GIDEON:** I believe that that's a  
5 recommendation of the interim report of the commission,  
6 which the government is currently in development of its  
7 response, and that will be considered as part of the  
8 response.

9 **MS. ERICA BEAUDIN:** Okay. You mentioned the  
10 IRS program has been extended for another three years.  
11 Does FNIHB understand and are you moving towards healing  
12 programs for -- whether it's IRS, maybe MMIWG, that could  
13 be decades long in length, and acknowledge the types of  
14 long-term healing that survivors require to move beyond  
15 survival?

16 **DR. VALERIE GIDEON:** So recent federal  
17 budget investments have provided some ongoing -- most of  
18 them, ongoing funding, so that it actually is part of our  
19 base. The Indian residential school health support  
20 program, because it was tied specifically to a court order,  
21 is associated with that, but a lot of the mental wellness  
22 investments that I described earlier are part of our core  
23 permanent funding, so they can be utilized for decades long  
24 planning for Tribal Councils or communities.

25 **MS. ERICA BEAUDIN:** Thank you. Often times

1 we hear that ISC or FNIHB fund mainly on-reserves programs.  
2 Many Indigenous people live in urban areas. Is FNIHB  
3 studying the unique needs of urban Indigenous people and  
4 creating, supporting or adjusting programs that would best  
5 serve their needs?

6 **DR. VALERIE GIDEON:** So this is a huge  
7 priority of our Minister, she's spoken about it several  
8 times, how do we provide better reach to community members  
9 that are living outside their communities, sometimes for  
10 shorter or longer term durations. So, for instance, as  
11 part of the budget 2018 investments with respect to  
12 addressing addictions issues for high risk communities, one  
13 of the areas that we're specifically looking at is how do  
14 we ensure that there is that outreach to community members  
15 that are living outside their communities.

16 **MS. ERICA BEAUDIN:** Thank you. I understand  
17 that health districts receive monies to serve the needs of  
18 Indigenous people in cities. Overall, do you believe the  
19 health districts are meeting the needs of urban Indigenous  
20 clients?

21 **DR. VALERIE GIDEON:** You mean within the  
22 context of the provincial context?

23 **MS. ERICA BEAUDIN:** Yes.

24 **DR. VALERIE GIDEON:** You know, I just -- all  
25 I could say is that I think that, you know, in speaking

1 with First Nations representatives across Saskatchewan at  
2 the health director and at the leadership level, they have  
3 expressed concerns that they are not receiving a sufficient  
4 amount of services that are adapted to their needs within  
5 the provincial health services context.

6 **MS. ERICA BEAUDIN:** How could FNIHB work  
7 with Indigenous organizations, Tribal Councils, leadership,  
8 to better meet the needs of the people who require  
9 healthcare services in urban areas?

10 **DR. VALERIE GIDEON:** Well, we actually have  
11 a 2008 memorandum of understanding that was signed with the  
12 Provincial Government with First Nations leadership and  
13 ourselves, specifically to develop a First Nations health  
14 and wellbeing plan, which was endorsed by all Chiefs and  
15 Assembly and Federal and Provincial Ministers. So we have  
16 a tripartite table in Saskatchewan specifically to  
17 support -- to do our part, but also to support First  
18 Nations to advance their interests with respect to  
19 provincial health services.

20 **MS. ERICA BEAUDIN:** Thank you. You spoke of  
21 increased mental health teams that are being supported by  
22 FNIHB, are any of these in urban areas?

23 **DR. VALERIE GIDEON:** So, yes, but I -- in  
24 Saskatchewan I know that communities have access to the  
25 mental wellness teams, but I'm sorry, I just off the top of

1 my head cannot confirm for you if in Saskatchewan we have  
2 one that is close to an urban centre or run by a Tribal  
3 Council in an urban centre. I believe that we do, I  
4 believe that the Saskatoon Tribal Council, as an example,  
5 but I would have to verify that information just off of the  
6 top of my head.

7 **MS. ERICA BEAUDIN:** Are there any plans, or  
8 do you believe that the department should have more in the  
9 urban areas?

10 **DR. VALERIE GIDEON:** I think that what we  
11 need to think about is a continuum of service for First  
12 Nations that -- so that it isn't -- it doesn't create a  
13 barrier, which government is responsible for funding what,  
14 and that essentially funding available by the two arms of  
15 government are brought together and provided to First  
16 Nations so that they can serve their community members  
17 regardless of where they live.

18 So an example is the British Columbia First  
19 Nations Health Authority, where because of their incredible  
20 partnership with regional health authorities across the  
21 province and provincial ministries, and also with the  
22 Federal Government, they are able to leverage that funding  
23 to offer those types of flexible interventions and  
24 strategies so that they can reach their community members  
25 living outside their communities.

1                   **MS. ERICA BEAUDIN:** Thank you. You  
2 discussed addiction services this morning. What is the  
3 priority of FNIHB to fund agencies to have dedicated NNADAP  
4 workers to meet the addictions services needs of urban, in  
5 particular, the MMIWG families?

6                   **DR. VALERIE GIDEON:** I'm sorry, do you mean  
7 First Nation service discovery agencies or child and family  
8 service agencies?

9                   **MS. ERICA BEAUDIN:** Whatever it would look  
10 like.

11                   **DR. VALERIE GIDEON:** Just First Nations  
12 agencies. I think what we would be doing with the new  
13 investments, for instance, is bringing that to the regional  
14 partnership committee that we have in Saskatchewan where  
15 all Tribal Councils have the opportunity to participate and  
16 bring -- as well as the Federation of Saskatchewan Indian  
17 Nations, Indigenous Nations and so forth, and actually come  
18 together to talk about what are the best areas of  
19 investment, right? So that there is that flexibility and  
20 First Nations can derive where there's those investments  
21 should be.

22                   **MS. ERICA BEAUDIN:** Okay, thank you. So  
23 you're talking about STAG, the STAG table of the --

24                   **DR. VALERIE GIDEON:** No, we actually had --

25                   **MS. ERICA BEAUDIN:** -- FSIN?

1           **DR. VALERIE GIDEON:** So STAG is absolutely a  
2 critical partner, but we actually have a regional  
3 partnership committee that the Saskatchewan regional office  
4 has invited folks to participate in so that they can  
5 transparently share information about funding, operational  
6 plans and so forth, and where they can invite feedback and  
7 hopefully share decision making with respect to where funds  
8 are invested.

9           **MS. ERICA BEAUDIN:** Thank you. Speaking  
10 specifically of MMIWG, our organization has worked with  
11 some families for up to 14 years and we have now just  
12 started to work with fourth generation survivors.  
13 Wraparound agencies like ours walk with families from  
14 sometimes the day a person has gone missing, right to  
15 assisting families to learn how to live and be independent  
16 again.

17                   What -- what possibilities are there for  
18 FNIHB to create opportunities for agencies and  
19 organizations working in this comprehensive and years long  
20 process with families to know that families won't fall  
21 through the crack on their healing journey, due to either,  
22 A, lack of funding or underfunding by government agencies  
23 such as FNIHB?

24           **DR. VALERIE GIDEON:** Oh, that's an -- it's  
25 an excellent question. One of the ways in which this could

1       happen is by having comprehensive funding agreements that  
2       brings together multiple sectors of education, social,  
3       health, so that you have more global agreements where you  
4       have that flexibility to design services that are  
5       wraparound for families.

6                   I think that is the goal of the new  
7       department of Indigenous Services Canada, is to be able to  
8       offer those types of opportunities where before we had  
9       silos, where we were separated by two different departments  
10      and also even within departments by sectors. So I think  
11      the -- the reason for establishing the new department, or  
12      one of them, is to bring together all of the needs and  
13      support systems for families so that First Nation service  
14      delivery agencies can support them and provide that  
15      wholistic approach to service delivery.

16                   **MS. ERICA BEAUDIN:** Thank you. This is a  
17      bit off the path of the questions I've been asking. Our  
18      young women become vulnerable when they leave home, there  
19      are many reasons for this, but acceptance and confidence in  
20      our place -- of our place in community can be one of the  
21      reasons. When a young woman enters womanhood, this is very  
22      difficult for her, especially if she doesn't live with a  
23      trusted woman. Simple items such as birth control and  
24      feminine hygiene supplies are not accessible. Or even the  
25      self-care measures that can promote healing and strong

1 identity. How can FNIHB play a role in supporting the  
2 confidence of young woman through programing or eligible  
3 expenditures and current programming, so that young women  
4 receive these items without embarrassment, so that in -- in  
5 essence, their vulnerabilities will lessen?

6 **DR. VALERIE GIDEON:** So that's an interesting  
7 question, because within Saskatchewan in particular, First  
8 Nations communities do manage their own health services, and  
9 they have flexibility with respect to supplies, equipment or  
10 whatever it is that they wish to purchase with respect to  
11 supporting families. So I think I would need to speak with  
12 the Tribal Council in more detail with respect to what are  
13 the gaps that they're seeing and -- and why that can't be  
14 offered within the context of their agreements, because they  
15 do have the highest degree of flexibility that's offered  
16 outside of a self-government agreement to be able to design  
17 health services and benefits to -- that matches the needs of  
18 the population.

19 **MS. ERICA BEAUDIN:** Okay. Thank you. The  
20 reason why I ask that question is that we have several,  
21 especially in the north, many communities where this is an  
22 issue for our young women. And in the south, we actually  
23 have drives in order to get those -- those types of things  
24 that young women need, and then we send them to the north.

25 **DR. VALERIE GIDEON:** Okay.

1                   **MS. ERICA BEAUDIN:** So there is that need in  
2                   Saskatchewan, in the north for sure.

3                   **DR. VALERIE GIDEON:** Okay.

4                   **MS. ERICA BEAUDIN:** So our organization works  
5                   directly with families of MMIWG. I've been told  
6                   by -- I've been told one of their wishes for resources is a  
7                   family treatment facility where families could stay up to  
8                   six months that concentrates on PTSD, intergenerational  
9                   traumas, addictions, life skills, et cetera. All being  
10                  delivered on the land, and grounded in traditional ceremony,  
11                  language and arts. Do you believe this dream could be a  
12                  reality for these families? And if so, what would be the  
13                  process?

14                  **DR. VALERIE GIDEON:** Family treatment is  
15                  absolutely needed and where we've had family treatment  
16                  centre's that have been developed, including one in isolated  
17                  community, it has been very successful with respect to  
18                  outcomes. So you know, I mean, it's -- it's -- do I believe  
19                  that it's a possibility? I like to believe that everything  
20                  is a possibility. We have to start from that perspective to  
21                  provide hope. It is very important to do that. I think we  
22                  would need a partnership model, and I think it is something  
23                  that we would be very open to meeting with the Tribal  
24                  Council about to discuss how we would get started in terms  
25                  of a planning effort.

1                   **MS. ERICA BEAUDIN:** Thank you so much, Dr.  
2                   Gideon.

3                   **JACKIE ANDERSON, Previously Affirmed:**

4                   **CROSS-EXAMINATION BY MS. BEAUDIN:**

5                   **MS. ERICA BEAUDIN:** Ms. Anderson, *Mashi Cho*  
6                   for your presentation this morning. It was in the early  
7                   2000s that I toured your facilities, and I was very  
8                   impressed and inspired by both the youth and the staff.  
9                   It's often difficult to create long-term programming for the  
10                  youth when CBO's, community-based organizations, we are  
11                  often juggling several grants and contribution agreements.  
12                  Many of them only for months long initiatives, and  
13                  definitely not many past a year. Is this -- do you find  
14                  this to be true?

15                  **MS. JACKIE ANDERSON:** It was important that  
16                  with our HOME's is that there's not a timeframe for how long  
17                  our young people can actually reside in our HOME's. Again,  
18                  recognizing the fact that healing doesn't happen overnight.  
19                  Christine, for example, resided with us at Little Sisters  
20                  for almost four years.

21                  **MS. ERICA BEAUDIN:** M'hm. I'm speaking  
22                  specifically about contribution agreement as opposed to  
23                  length of stay for -- for youth.

24                  **MS. JACKIE ANDERSON:** Okay. In -- within --

25                  **MS. ERICA BEAUDIN:** Full grants, contribution

1 agreements, those types of things. Like, for example, if  
2 you bring in a beading project.

3 **MS. JACKIE ANDERSON:** M'hm.

4 **MS. ERICA BEAUDIN:** And it usually comes from  
5 a small grant that has a lot of reporting requirements  
6 attached to it.

7 **MS. JACKIE ANDERSON:** Okay. We do -- we do  
8 have within our organization some of those small grants.  
9 And as I mentioned earlier, these are not things that we can  
10 bring to our people and to our young people and run it for a  
11 short period of time and say it's done, it's over. If we  
12 want to engage and bring our young people back to their  
13 identity and to their culture, and if that means teaching  
14 them how to make their skirt or teaching them how to do  
15 beading or make their moccasins, it's not something that is  
16 a very short-term, you know, project. One off of one  
17 program. It needs to be an ongoing.

18 **MS. ERICA BEAUDIN:** Right. As well, have you  
19 noticed the amount allowed for administration? Staffing is  
20 decreasing, and we are expected to do more with less. The  
21 only more we have experienced is more reporting for those --  
22 those types of grants. Would you say this has been your  
23 experience?

24 **MS. JACKIE ANDERSON:** Well, Child and Youth  
25 Care Workers in itself are not -- are not paid a lot for the

1 work that we do, and the extra work that we do. I'm not  
2 sure what you're asking in regards to administrative grants.

3 **MS. ERICA BEAUDIN:** Several times when we  
4 have these contribution and grants, and it has been my  
5 experience, and I was seeing if it was your experience, that  
6 we are expected to do more with less. So we can't bring on  
7 extra staffing. We have more administration with less  
8 dollars towards the administration. And we're expected to  
9 do more, basically five cents on the dollar.

10 **MS. JACKIE ANDERSON:** Yes, absolutely. We  
11 run into those situations, and again it's not always having  
12 the capacity to respond to the needs of our families and our  
13 young people.

14 **CHRISTINE DUMAINE, Previously Affirmed:**

15 **CROSS-EXAMINATION BY MS. BEAUDIN:**

16 **MS. ERICA BEAUDIN:** Okay. Thank you. Ms.  
17 Dumaine, I'm not quite sure if your community is Ojibwe or  
18 Cree?

19 **MS. CHRISTINE DUMAINE:** Ojibwe.

20 **MS. ERICA BEAUDIN:** So *Miigwetch* for your  
21 courage and telling your story this morning. The first time  
22 I stood here, I disclosed some very personal information  
23 about my journey from young adulthood. And not only did my  
24 voice shake, but I almost broke down. So thank you for  
25 adding your voice to legitimize and support the lived

1 experiences many of us Indigenous women live.

2 In the discussion this morning, you spoke of  
3 your -- your agency, your HOME, and I'm not Ojibwe so I'm  
4 -- I don't want to butcher how the HOME is called, provided  
5 and how the HOME had provided years' long and supportive  
6 services for you and because of this, you are able to create  
7 a life you are comfortable and safe in. You now work at the  
8 HOME and you are giving back. Would you state that the best  
9 opportunity for other youth women or families who are  
10 struggling would be long-term uninterrupted services?

11 **MS. CHRISTINE DUMAINE:** Yes.

12 **MS. ERICA BEAUDIN:** Ms. Dumaine, how  
13 important on the scale of one to ten is the accessibility to  
14 Indigenous traditions, languages, and customs to create a  
15 strong identity for our youth and women?

16 **MS. CHRISTINE DUMAINE:** Okay. Can you say  
17 that again?

18 **MS. ERICA BEAUDIN:** How important on a scale  
19 of one to ten is the ability to access Indigenous  
20 traditions, languages and customs to create a strong  
21 identity for our young people and our women?

22 **MS. CHRISTINE DUMAINE:** It's -- I would say  
23 ten, 'cause it's very important.

24 **MS. ERICA BEAUDIN:** Okay. Ms. Dumaine, you  
25 also spoke of legitimacy of helpers and helping agencies

1 even though you didn't frame it that way. I've heard this  
2 many times from many other individuals and families. Many  
3 agencies have had generations of people who have paid  
4 mortgages, schooling and vehicles off the misery industry of  
5 our people. That is basically off the suffering of where  
6 we're going when we go seek help. Many of them are non-  
7 Indigenous, or the wily agencies often put one brown face on  
8 their board to state they're Indigenous. Do you believe  
9 funding agencies should add to their eligibility  
10 requirements, and that there should be some sort of  
11 requirement by agencies to prove they are legitimate helpers  
12 of vulnerable children, youth and families? So in other  
13 words, how should the voice of the people who are accessing  
14 services be heard and listened to right down to the legal  
15 agreements that agencies sign?

16 **MS. CHRISTINE DUMAINE:** I don't -- I'm not  
17 too sure on -- like, can you give me an example?

18 **MS. ERICA BEAUDIN:** So do you -- how do you  
19 believe that voice like, your voice as a young -- when you  
20 went to the HOME, your voice even now as a person of lived  
21 experience and has gone back to the HOME, how do you believe  
22 that that voice should be heard even with the funding  
23 agencies to make it part of that legal obligation that  
24 agencies provide these services?

25 **MS. CHRISTINE DUMAINE:** I'm not sure. Like,

1 I'm not too sure. I -- like, I can't -- I don't know what  
2 you're saying. Like --

3 **MS. ERICA BEAUDIN:** Okay.

4 **MS. JENNIFER COX:** So are you asking how  
5 would she be reported? The staff -- the staff --

6 **MS. ERICA BEAUDIN:** Like, how do you -- how  
7 would you like to be heard to make sure that agencies do  
8 what they say that they are going to do for youth?

9 **MS. CHRISTINE DUMAINE:** Maybe tell my story  
10 to them and let them know how I felt when I was little.

11 **MS. ERICA BEAUDIN:** Okay. Thank you very  
12 much. I'm actually ten seconds left, so thank you to  
13 everyone on the panel today. May you journey home safely  
14 and find your home's fires burning strong and bright when  
15 you get home. Thank you very much.

16 **MS. JENNIFER COX:** So the next party is the  
17 Manitoba Murdered and Missing Indigenous Women and Girls  
18 Manitoba Coalition and 13 minutes.

19 **MS. CATHERINE DUNN:** Good afternoon,  
20 Commissioners. My name is Catherine Dunn and my questions  
21 this afternoon are going to be restricted to Ms. Anderson  
22 and Ms. Dumaine.

23 **CHRISTINE DUMAINE, Previously Affirmed:**

24 **CROSS-EXAMINATION BY MS. DUNN:**

25 **MS. CATHERINE DUNN:** Firstly, Ms. Dumaine,

1       you stated this morning that, if you had a recommendation,  
2       and you did have a recommendation for the Inquiry, that you  
3       would like to see rehabilitative residential centres for  
4       youth under age 18. Is that correct?

5                   **MS. CHRISTINE DUMAINE:** Correct.

6                   **MS. CATHERINE DUNN:** Why did you make that  
7       recommendation?

8                   **MS. CHRISTINE DUMAINE:** I know we have AFM in  
9       Winnipeg, but we just need something, like, on sacred land  
10      with teaching, ceremony. Something where a family can go in  
11      right away, not wait 60 days.

12                  **MS. CATHERINE DUNN:** And in your view,  
13      waiting lists for addiction treatment -- why is that a bad  
14      thing?

15                  **MS. CHRISTINE DUMAINE:** Please, can you say  
16      that again?

17                  **MS. CATHERINE DUNN:** Why is having to wait to  
18      get addiction treatment not a good thing?

19                  **MS. CHRISTINE DUMAINE:** Because they can --  
20      they can get worse.

21                  **MS. CATHERINE DUNN:** And it -- would it be  
22      fair to say that, when you have reached a decision to turn  
23      away from alcohol and drugs, that it is important to have  
24      people respond to that decision immediately?

25                  **MS. CHRISTINE DUMAINE:** Yes.

1                   **MS. CATHERINE DUNN:** All right. Because if  
2                   you don't respond immediately, it may be that you won't make  
3                   that decision again in 60 days? Is that fair?

4                   **MS. CHRISTINE DUMAINE:** Correct.

5                   **MS. CATHERINE DUNN:** Thank you.

6                   **JACKIE ANDERSON, Previously Affirmed:**

7                   **CROSS-EXAMINATION BY MS. DUNN:**

8                   **MS. CATHERINE DUNN:** My questions now are for  
9                   Ms. Anderson. Ms. Anderson, you have a great deal of  
10                  knowledge in the area of sexual exploitation, and in  
11                  particular, as part of your background, you were part of the  
12                  development of Tracia's Trust, Manitoba's sexual  
13                  exploitation strategy. Is that correct?

14                  **MS. JACKIE ANDERSON:** Yes.

15                  **MS. CATHERINE DUNN:** Do you know who Tracia  
16                  was?

17                  **MS. JACKIE ANDERSON:** Yes. She was a young  
18                  Indigenous woman who, unfortunately, was taken from her  
19                  community and put into care of Child Family Services in  
20                  programs that didn't understand who she was and what she was  
21                  experiencing. And unfortunately, she's no longer here with  
22                  us.

23                  **MS. CATHERINE DUNN:** And this young girl  
24                  committed suicide, did she not?

25                  **MS. JACKIE ANDERSON:** Yes.

1                   **MS. CATHERINE DUNN:** And if I recall  
2 correctly, she was 15.

3                   **MS. JACKIE ANDERSON:** Yes.

4                   **MS. CATHERINE DUNN:** Thank you. And Tracia's  
5 Trust came about as a result of the -- the inquest into the  
6 death of that young person. Is that fair to say?

7                   **MS. JACKIE ANDERSON:** It actually started  
8 prior.

9                   **MS. CATHERINE DUNN:** Okay.

10                  **MS. JACKIE ANDERSON:** But it was formalized  
11 in 2008, where, again, summits were held in the north and  
12 the south to provide recommendations of what else was needed  
13 within our province to address the issue.

14                  **MS. CATHERINE DUNN:** And in terms of the  
15 young people that come to your programs, would it be fair to  
16 say that -- is there a -- I know you -- what -- what is the  
17 common age of young people coming to your programs?

18                  **MS. JACKIE ANDERSON:** The common age of  
19 referrals that are coming into -- in our home is between 14  
20 and 16. However, when you're looking at the average age of  
21 -- of exploitation, we're looking at anywhere from 12 to 13  
22 years old.

23                  **MS. CATHERINE DUNN:** All right. And can you  
24 speak about the issue of addiction for the young people who  
25 come to your program? Is that a common symptom that they



1                   **MS. CATHERINE DUNN:** And would it be fair to  
2 say that the young people who come into your program have  
3 high degrees of mental health issues other than trauma?

4                   **MS. JACKIE ANDERSON:** Absolutely, because, I  
5 mean, just with the trauma they're experiencing, the mental  
6 health issues that are attached to that as well as the  
7 addictions, the drugs, there's the drug-induced -- that's  
8 also affecting them.

9                   **MS. CATHERINE DUNN:** And would you say that  
10 these issues that you have described in your evidence now  
11 and this morning, that is, addictions, trauma, mental health  
12 issues, are issues that are not easily addressed in short  
13 periods of time?

14                   **MS. JACKIE ANDERSON:** Correct, and again, as  
15 I spoke earlier, you're looking at, you know, anywhere up to  
16 90 days to access an adult treatment centre. You know, we  
17 have different tools for our young people, but when our  
18 young people are saying, I want help, I want it now, you  
19 need to be able to provide it now.

20                   **MS. CATHERINE DUNN:** And with the young  
21 people who come into your program, are you the only  
22 organization that is able to provide culturally appropriate  
23 services for sexually exploited Indigenous youth?

24                   **MS. JACKIE ANDERSON:** Well, we are an  
25 Indigenous organization, as I mentioned.

1                   **MS. CATHERINE DUNN:** Right.

2                   **MS. JACKIE ANDERSON:** Hands of Mother Earth  
3 is the only rural traditional healing lodge that we know  
4 across Canada that is providing culture and ceremony and  
5 healing on sacred land.

6                   **MS. CATHERINE DUNN:** How important, in your  
7 view, is the issue of culture and culturally appropriate  
8 services?

9                   **MS. JACKIE ANDERSON:** It's -- it's priority.  
10 Again, you know, what we learn is our young people are not  
11 connected to their spirit, and when their spirit is  
12 wandering, that's when the hurt and vulnerabilities comes  
13 into their lives.

14                   **MS. CATHERINE DUNN:** And if you have  
15 culturally appropriate services to provide to your young  
16 people, that also has a positive effect or decreases the  
17 issues of addiction, trauma, and other mental health issues.  
18 Is that fair?

19                   **MS. JACKIE ANDERSON:** Yes, it does decrease  
20 their risk.

21                   **MS. CATHERINE DUNN:** So the very factor of  
22 using culturally appropriate services such as those that  
23 your Indigenous organization provides is one thing that hits  
24 a number of serious issues. By that, I mean if you are able  
25 to provide your services in a culturally appropriate way,

1 you can speak to addictions, trauma, and mental health at  
2 the same time.

3 **MS. JACKIE ANDERSON:** Yes.

4 **MS. CATHERINE DUNN:** In terms of the funding  
5 that you have, you've mentioned that it is difficult at  
6 times to have appropriate funding mechanisms because of the  
7 length of time that various programs, such as your own, are  
8 -- are provided for. Is that fair?

9 **MS. JACKIE ANDERSON:** For our homes?

10 **MS. CATHERINE DUNN:** Yes.

11 **MS. JACKIE ANDERSON:** Well, again, we're  
12 provincially funded for Hands of Mother Earth and Honouring  
13 the Spirits of Our Little Sisters. What I was referring to  
14 earlier are these pilot projects that we're, you know, where  
15 organizations are getting short-term funding to do  
16 programming and to mobilize communities, and then there's no  
17 more funding.

18 **MS. CATHERINE DUNN:** Could you give us an  
19 example of what type of short-term programs your  
20 organization provides?

21 **MS. JACKIE ANDERSON:** Well, I mean, we look  
22 at, as I mentioned earlier, I'm -- I'm thinking this would  
23 probably be the top of my head that I can think of is within  
24 -- we get short-term funding to be able to provide youth  
25 leadership and engagement for community youth, and often

1 those are funding projects for six months or for a year. So  
2 again, when you're working with your -- these young people,  
3 working through, building their capacity, there needs to be  
4 constant post-support to continue to help them with  
5 opportunities to build their strengths and their gifts.

6 **MS. CATHERINE DUNN:** And self-esteem is not  
7 necessarily built in a year or two, is that fair to say?

8 **MS. JACKIE ANDERSON:** Very fair.

9 **MS. CATHERINE DUNN:** And often, on their  
10 journeys, you -- your organization tries to provide positive  
11 life experiences such -- you mentioned going to Edmonton  
12 mall, et cetera. Is that fair?

13 **MS. JACKIE ANDERSON:** Yes.

14 **MS. CATHERINE DUNN:** And that is comparable  
15 to a family experience for these young people, and it  
16 doesn't necessarily translate to a budget line on your  
17 financing application.

18 **MS. JACKIE ANDERSON:** Right.

19 **MS. CATHERINE DUNN:** And what that means is  
20 that you have a lot of off-the-table or out-of-pocket  
21 expenses to provide life-empowering experiences for your  
22 young people.

23 **MS. JACKIE ANDERSON:** Yes.

24 **MS. CATHERINE DUNN:** And who -- who provides  
25 that out-of-pocket money or that off-the-table expense? Who

1 do you get that money from?

2 **MS. JACKIE ANDERSON:** Well, I guess it really  
3 depends. Like, we do a lot of, like, internal fundraising.  
4 You know, we might sometimes receive some support through  
5 philanthropy. But again, we -- we do our -- our yearly  
6 program planning to identify the needs and the wishes of our  
7 young people and create what that looks like, and then start  
8 doing our fundraising to be able to make that a reality.

9 **MS. CATHERINE DUNN:** And the -- -- the  
10 problem, although Winnipeg and Manitoba is a very generous  
11 in terms of providing funds, you can't always build a  
12 budget on hoping what you're going to get from a  
13 fundraising event; is that fair?

14 **MS. JACKIE ANDERSON:** Yes.

15 **MS. CATHERINE DUNN:** And as a result, your  
16 young people may not get the programming that they ask you  
17 for and that you encourage them to ask you for as part of  
18 their journey to become independent young adults?

19 **MS. JACKIE ANDERSON:** Yes.

20 **MS. CATHERINE DUNN:** You mentioned that you  
21 currently have two group homes, and there are ten  
22 beds -- or is it 12 beds in total?

23 **MS. JACKIE ANDERSON:** Are you talking about  
24 the -- that's specialized for sexually exploited children  
25 and youth?

1                   **MS. CATHERINE DUNN:** Yes, I am, sorry.

2                   That's what I am --

3                   **MS. JACKIE ANDERSON:** Homes, yes. Beds.

4                   **MS. CATHERINE DUNN:**

5                   (Indiscernible) -- exactly. Yeah. So how many beds is it?

6                   **MS. JACKIE ANDERSON:** Twelve beds in total  
7                   between the two.

8                   **MS. CATHERINE DUNN:** Twelve beds. How many  
9                   sexually exploited youth do you think there are in Manitoba  
10                  at the present time?

11                  **MS. JACKIE ANDERSON:** I -- I couldn't even  
12                  give you a number. I mean, you're looking at, you know,  
13                  the visible and the non-visible exploitation, which is  
14                  always hard to track. But absolutely, a very high number  
15                  of -- of young people under the age of 18.

16                  **MS. CATHERINE DUNN:** Would you put that  
17                  number in the hundreds or in the thousands or can you say?

18                  **MS. JACKIE ANDERSON:** I would say in the  
19                  hundreds, for sure.

20                  **MS. CATHERINE DUNN:** All right. And in  
21                  order to access -- and you would, I think -- and I think  
22                  you've made it clear this morning, but in your opinion,  
23                  your program is very successful?

24                  **MS. JACKIE ANDERSON:** It's very successful.  
25                  And again, when I, you know, look at, you know, my little

1 sisters who once used to give me a hard time and push me  
2 away and keep me out of their lives, and they're sitting  
3 beside me, you know, and -- and working with me and  
4 supporting their little sisters, that's something to  
5 celebrate.

6 **MS. CATHERINE DUNN:** And what is sitting  
7 beside you is your work and her work?

8 **MS. JACKIE ANDERSON:** Absolutely. She was a  
9 very resilient young woman who knew what she wanted, and  
10 once she let her walls down and allowed us to love her,  
11 she -- she grew.

12 **MS. CATHERINE DUNN:** And can you tell me in  
13 terms of allowing her to grow and to fulfill her own  
14 dreams, how important was it that she experience her own  
15 culture?

16 **MS. JACKIE ANDERSON:** Extremely important.  
17 And I remember her when she first came in at the age of 13,  
18 not even knowing where she was from, you know, not having  
19 memories of her community, her First Nations community, not  
20 ever attending a ceremony or sitting at a drum or using  
21 medicines. And that was something that we immediately, you  
22 know, provided her. And as she took her time to -- to  
23 engage in that, that became part of her healing and her  
24 strength.

25 **MS. CATHERINE DUNN:** You mentioned --

1                   **MS. JENNIFER COX:** Counsel, sorry. Time's  
2 up.

3                   **MS. CATHERINE DUNN:** Thank you.

4                   **MS. JENNIFER COX:** The next party is the  
5 Aboriginal Women's Action Network with 13 minutes.

6                   **JACKIE ANDERSON, Previously Affirmed:**

7                   **CROSS-EXAMINATION BY MS. BLANEY:**

8                   **MS. FAY BLANEY:** Thank you. Good afternoon.  
9 My name is Fay Blaney, and I am with the Aboriginal Women's  
10 Action Network. Thank you, Jackie, for your presentation.  
11 I was very moved by it, and a lot of my questions will be  
12 directed to you.

13                   **MS. JACKIE ANDERSON:** Okay.

14                   **MS. FAY BLANEY:** I listened with keen  
15 interest as you spoke about how you used terminology. And  
16 I know that some of the women from your organization that  
17 came out to Vancouver when we were preparing for this  
18 Inquiry also addressed this issue of the use of  
19 terminology.

20                   **MS. JACKIE ANDERSON:** M'hm.

21                   **MS. FAY BLANEY:** And you were saying that  
22 you prefer not to use the word "prostitution" because it is  
23 so normalized as a form of violence, and that the use of  
24 the term "prostitution" in some ways obscures sexual  
25 exploitation. I'm just wondering if you can tell us more

1 about the use of that terminology.

2 **MS. JACKIE ANDERSON:** The -- the correct  
3 terminology that -- or sorry, that we use within our  
4 province as directed by our survivors? I guess just more  
5 to elaborate that when you -- and this is what we hear from  
6 your survivors and those young women that we were, you  
7 know, facilitating to come into our homes or sharing with  
8 us that when, you know, they're -- they're called, you  
9 know, a prostitute or prostituting yourself or working in  
10 the sex trade, that there was, like, an element of choice.  
11 And -- and that is something that is imperative for their  
12 healing to understand, that this was not a choice, it's  
13 others taking advantage of them and the shame that's often,  
14 you know, carried with using that terminology.

15 So in order for us to have started to help  
16 our -- our young people heal, it was to take -- create that  
17 education and awareness of -- of where they are and to help  
18 them be able to let go of all that shame and blame that  
19 they've been carrying over the years through their  
20 victimization.

21 **MS. FAY BLANEY:** Okay. Thank you. And I  
22 was really pleased to hear that there have been -- I think  
23 you said 100 convictions?

24 **MS. JACKIE ANDERSON:** Yes, last year.

25 **MS. FAY BLANEY:** Last year. Of sexual

1 predators, pimps and johns.

2 **MS. JACKIE ANDERSON:** M'hm.

3 **MS. FAY BLANEY:** In Vancouver, the Vancouver  
4 Police Department refuses to enforce Bill C-36, the  
5 *Protection of Communities and Exploited Persons Act*. And  
6 so -- so there have been no arrests. There's no  
7 convictions because they refuse to enforce it.

8 **MS. JACKIE ANDERSON:** M'hm.

9 **MS. FAY BLANEY:** And so I'm just wondering,  
10 how were you able to work with your criminal justice  
11 system? How were you able to convince them to do their job  
12 and to uphold the law and why is it important to enforce  
13 this law?

14 **MS. JACKIE ANDERSON:** Again, when I talk  
15 about the partnership and the collaboration and the  
16 importance of relationships, with all sectors that are  
17 involved in protecting and standing up for our young  
18 people, our Sexually Exploited Youth Community Coalition  
19 that we have started over the years includes our police  
20 department and other different systems. So again, those  
21 relationships are really key and important, especially when  
22 you're operating a safe home for our young people because,  
23 often, our young people are afraid to speak to the police.  
24 However, they trust in us who we trust, and by having those  
25 established relationships with specific people within the

1 police, it really provides more of a safe place for our  
2 young people to be able to share what's going on in their  
3 lives. I mean, our young people will take us for a drive,  
4 and they'll show us where, you know, all the drug houses  
5 are or where girls are being exploited, but they're not in  
6 a place to be sitting on a stand and, you know, disclosing  
7 what's happening to them. But by us having those  
8 relationships with the police, coming into our home not  
9 just to enforce the law but to come have tea and bannock,  
10 you know, is very important for our -- for our young  
11 people.

12 So our police department is very active  
13 in -- in enacting this bill, and are partners are part of  
14 our Winnipeg Outreach Network.

15 **MS. FAY BLANEY:** M'hm. Well, I hope that  
16 they will support the continuation of this -- this law. So  
17 you were saying that the bill is somewhat inadequate, and I  
18 was wondering, like, what do you mean by that? What more  
19 can be added or included to make it more effective?

20 **MS. JACKIE ANDERSON:** It's -- it's something  
21 that is very, very useful today. I -- I do absolutely  
22 believe that there's still other aspects. I mean, again, I  
23 would like to see perpetrators immediately be given jail  
24 time, you know. And -- and I guess the other aspect is,  
25 you know, for our women, our women are, you know -- don't

1 want to be in those situations. However, what needs to  
2 happen is programs and services for our adult women. You  
3 know, when you turn 18 or you age out of care, you know,  
4 services shouldn't just be stopped. And -- you know, and  
5 unfortunately, there's not a lot of services for adult  
6 women, in particular in our province, a safe place where  
7 they can go to, a safe place for resources to maybe get  
8 them off the street and be able to take them somewhere  
9 where they're going to be nurtured, loved, and taken care  
10 of and get the services that they need.

11 **MS. FAY BLANEY:** Yeah, I think that's a  
12 prevalent theme that the Commissioners have heard, that  
13 there is inadequate programs and services for Indigenous  
14 women and girls, and especially I think there's inadequate  
15 attention being paid to us being able to have independent  
16 women's groups and organizations so that we can bring our  
17 voices forward. But we're not supposed to make  
18 submissions, so I better stick to my questions.

19 **(LAUGHTER)**

20 **MS. FAY BLANEY:** So just getting back to the  
21 topic of terminology. In BC we abolitionists, there's a  
22 good group of us, use the language of prostitution to  
23 underscore sexual exploitation of women and girls, and we  
24 see prostitution as being on the continuum of male violence  
25 against Indigenous women and girls -- well, against all

1 women and girls.

2 **MS. JACKIE ANDERSON:** M'hm.

3 **MS. FAY BLANEY:** And that the struggle that  
4 we have is with the pro sex groups that see this as a  
5 viable source of employment or work, sex work, and I just  
6 wanted to get your thoughts on that language, the term "sex  
7 work"?

8 **MS. JACKIE ANDERSON:** I mean, again, just  
9 coming from my experience of, you know, being with our  
10 young people and our experiential women. I've sat at  
11 tables to support them, I've -- I've listened to how  
12 language effects, you know, and interrupts even sometimes  
13 their healing triggers, you know, the healing that they  
14 have or where they're at, at that time, and it's just very  
15 important that what our women with lived experience are  
16 telling us, that, you know, that's something that we need  
17 to stand strong.

18 So as an ally and support to those women,  
19 it's important that, you know, if they're saying this is  
20 something that I need to stand strong and educate and  
21 correct when people within our province are, you know,  
22 using that language, then it's something I'm committed to  
23 do, to educate. And, again, I did share earlier that  
24 language is different all across the province, and that was  
25 a very common theme, you know, and when -- when they were

1 doing the visits across Canada with --

2 **MS. FAY BLANEY:** If I can pry just a little  
3 bit deeper, do you see that as a viable source of  
4 employment for Indigenous women and girls?

5 **MS. JACKIE ANDERSON:** No, I do not.

6 **MS. FAY BLANEY:** Okay. That's what I was  
7 trying to get at. So you spoke about the importance of  
8 autonomy for the young women that come into your  
9 homes -- and my time is running out so quick I see  
10 here -- and you -- I was going to give you examples of how  
11 you said that, but I'll leave that for now.

12 You were talking about the importance of  
13 them having some level of autonomy in their healing process  
14 and in their wellness, and I have to say that I agree from  
15 my feminist perspective that consciousness raising and  
16 understanding the dynamics of power and the way power  
17 works, oppression, exploitation. So I wanted to just get  
18 on record your thoughts about the importance of women only  
19 healing spaces, where, you know, there's a separate -- a  
20 clear separate and distinct place for survivors of violence  
21 and abuse and exploitation in doing their healing work, as  
22 opposed to having co-ed treatment centres?

23 **MS. JACKIE ANDERSON:** That was one of the  
24 direct recommendations when -- when we created the programs  
25 underneath Tracia's Trust, and it was very -- it was very

1 important that -- that there was a space that was created  
2 that would be safe for -- for our young women.

3 I mean, a very high number of exploiters,  
4 traffickers that are harming our young people are men, and  
5 it was important to them, especially in a children and care  
6 facility, that their caregivers were -- were women, were  
7 aunties, were kokums.

8 **MS. FAY BLANEY:** And do you think that that  
9 concept of healing would apply to other areas, such as  
10 addictions or addictions treatment or exiting services or  
11 historic abuse groups?

12 **MS. JACKIE ANDERSON:** I would think so.  
13 Again, depending on the nature of -- you know, so, for  
14 example, I'll use domestic violence for example, we operate  
15 a program for men and we operate a program for women.

16 **MS. FAY BLANEY:** M'hm.

17 **MS. JACKIE ANDERSON:** We also see the value  
18 in, you know, relationships, so we do couples, you know, as  
19 also a part of -- of couples retreat as part of that  
20 healing. But our young women tell us if you put me in a  
21 circle with a bunch of boys or, you know, a bunch of men,  
22 I'm not going to be safe to be able to share my true  
23 truths.

24 **MS. FAY BLANEY:** Yeah, I'm really alarmed at  
25 that -- that way -- the way things are done where treatment

1 centres for addictions are co-ed, and often the offenders  
2 are there talking about their exploits in front of me who  
3 is a survivor.

4 **MS. JACKIE ANDERSON:** M'hm.

5 **VALERIE GIDEON, Previously Affirmed:**

6 **CROSS-EXAMINATION BY MS. BLANEY:**

7 **MS. FAY BLANEY:** And it definitely doesn't  
8 feel safe. So I have a minute left and I wanted to address  
9 some questions to you, Ms. Gideon. I have three questions,  
10 but I'm going to go right to my last one, and I might ask  
11 the other two if time permits. So I'm just wondering how  
12 your department is responding to the needs of Indigenous  
13 women and girls in large urban centres?

14 I'm wondering if -- I'm going to ask a bunch  
15 of questions all at once here. Is there any consideration  
16 of drawing on Jackie's expertise in developing women only  
17 spaces, where women survivors feel safe, or alternatively,  
18 to have the damaging effects of having both offenders and  
19 survivors in the same healing setting, is one of my  
20 questions? I have another one for you, but I'll --

21 **DR. VALERIE GIDEON:** I mean, we don't design  
22 specifically the -- the organization service delivery mix  
23 to the populations that they serve --

24 **MS. FAY BLANEY:** Okay.

25 **DR. VALERIE GIDEON:** -- with respect to our

1 funding parameters, so --

2 MS. FAY BLANEY: Okay.

3 DR. VALERIE GIDEON: -- that flexibility is  
4 offered.

5 MS. FAY BLANEY: Okay, that's the same  
6 answer I heard before. I'm going to ask you a different  
7 question then.

8 MS. JENNIFER COX: Your --

9 MS. FAY BLANEY: From a governance  
10 perspective -- pardon?

11 MS. JENNIFER COX: You're out of time.

12 MS. FAY BLANEY: It says 12 seconds over  
13 there.

14 MS. JENNIFER COX: Minus.

15 MS. FAY BLANEY: What? 17 -- okay, it's  
16 moving now, but it still had time over there. Okay.

17 UNIDENTIFIED SPEAKER: It's going in the  
18 negative and it's confusing people.

19 UNIDENTIFIED SPEAKER: Because it's red.

20 UNIDENTIFIED SPEAKER: It's going backwards.

21 MS. JENNIFER COX: So the next party is  
22 Eastern Door Indigenous Women's Association, and 13  
23 minutes.

24 CHRISTINE DUMAINE, Previously Affirmed:

25 CROSS-EXAMINATION BY MS. CLIFFORD:

1                   **MS. NATALIE CLIFFORD:** Good? All right.

2           I'm Natalie Clifford from the Eastern Door Indigenous  
3           Women's Association. We represent the interests of  
4           primarily Mi'kmaq and Maliseet women in the Atlantic  
5           Region, and where those interests align with other  
6           Indigenous women in that region as well.

7                   I'm going to just start with one quick  
8           question -- one quick question for Ms. Dumaine. Thank you  
9           very much for being here and sharing your story with us. I  
10          just wondered, what will you teach your kids to help them  
11          avoid being targeted by human traffickers?

12                   **MS. CHRISTINE DUMAINE:** Well, my son, he's  
13          ten, and I just keep -- like, he knows what I -- where I  
14          work and everything, and I just -- and my -- I have a  
15          four-year-old daughter, so it scares me to even think about  
16          that kind of stuff, like, what could happen to her, but I  
17          would -- I would educate her what I all know and what  
18          I -- like, what the girls at the HOME taught me as well.

19           **JACKIE ANDERSON, Previously Affirmed:**

20           **CROSS-EXAMINATION BY MS. CLIFFORD:**

21                   **MS. NATALIE CLIFFORD:** Thank you.

22          Ms. Anderson, I have a few quick questions for you. I'm  
23          curious about whether you're ever directly consulted by the  
24          ISC and FNIHB for your position as you've shared today,  
25          given your experience?



1 that, I'm sorry, I have no --

2 **MS. NATALIE CLIFFORD:** Based on your  
3 evidence, is it fair to say that you credit the solid  
4 support from a provincial Minister of your programming for  
5 its success?

6 **MS. JACKIE ANDERSON:** Well, we've had  
7 multiple Ministers over the years, and -- and I'm not, you  
8 know, into the politics and all that stuff. At the end of  
9 the day it's about our -- our young people, and -- and,  
10 yes, today we have very, very strong community support at  
11 all levels.

12 **MS. NATALIE CLIFFORD:** You mention you have  
13 215 -- 250 employees?

14 **MS. JACKIE ANDERSON:** Yes.

15 **MS. NATALIE CLIFFORD:** So just looking  
16 forward to next year, do they have jobs with their funding  
17 in place to employees?

18 **MS. JACKIE ANDERSON:** Yes, within our  
19 Children in Care programs they do.

20 **MS. NATALIE CLIFFORD:** Okay. Thank you.

21 **MS. JACKIE ANDERSON:** You're welcome.

22 **VALERIE GIDEON, Previously Affirmed:**

23 **CROSS-EXAMINATION BY MS. CLIFFORD:**

24 **MS. NATALIE CLIFFORD:** So, Dr. Gideon, the  
25 rest of my questions are for you.

1 I'm going to focus in on the example of  
2 mental health and contribution agreements because you've  
3 indicated that they are developed from community plans,  
4 correct?

5 **DR. VALERIE GIDEON:** That's right.

6 **MS. NATALIE CLIFFORD:** Can you define  
7 community for me, please?

8 **DR. VALERIE GIDEON:** So for those programs  
9 that are specific to First Nations communities, it's the  
10 First Nation community reserve base in the --

11 **MS. NATALIE CLIFFORD:** Reserves?

12 **DR. VALERIE GIDEON:** -- province.

13 **MS. NATALIE CLIFFORD:** And councils?

14 **DR. VALERIE GIDEON:** Yes, but there's also  
15 other organizations like political/territorial  
16 organizations or the equivalent of what would be a tribal  
17 council in regions also that provides services.

18 **MS. NATALIE CLIFFORD:** Okay. Can and  
19 individual group say in a city administering services for  
20 women and young people in that city, submit a community  
21 plan for a contribution agreement on mental health?

22 **DR. VALERIE GIDEON:** We do fund, under the  
23 Victims of Violence Initiative, or even under the Non-  
24 Insured Health Benefits Program service delivery  
25 organizations that are working in urban contexts.

1 Sometimes it's friendship centres or other organizations  
2 that have service delivery. So for instance in Winnipeg we  
3 do fund 24/7 youth shelter access. So there's -- there's  
4 examples of those types of initiatives.

5 Each region, as I mentioned, we have  
6 partnership committees, so for instance, in the Atlantic  
7 Region we have the Atlantic First Nations health  
8 partnership table that's existed since the '90s. It's a  
9 co-management table. There are a number of representatives  
10 from each of the First Nations regions that sit at that  
11 table and they make decision with respect to where funding  
12 should be targeted. So it's not always held at a community  
13 level. Depending on what the needs are and depending on  
14 what the most effective interventions are that are judged  
15 by the First Nations in that -- in that region.

16 **MS. NATALIE CLIFFORD:** Okay. Thank you.  
17 Can you speak to -- with that example of on the east coast,  
18 the effectiveness, then, of using mental health and  
19 contribution agreements as it currently plays out. Can you  
20 speak to the effectiveness of that right now in Nova Scotia  
21 and how that's playing out?

22 **DR. VALERIE GIDEON:** Sorry, I just lost the  
23 last part of the -- effectiveness in? Sorry?

24 **MS. NATALIE CLIFFORD:** Nova Scotia.

25 **DR. VALERIE GIDEON:** In Nova Scotia. Well,

1 I can speak to at a National level an evaluation that was  
2 done with respect to specific outcomes that I referenced  
3 earlier around increasing healthy behaviours awareness.

4 **MS. NATALIE CLIFFORD:** Okay. So do you know  
5 who sits at that table, then, the --

6 **DR. VALERIE GIDEON:** The Atlantic First  
7 Nations health partnership table?

8 **MS. NATALIE CLIFFORD:** Or the parties  
9 involved?

10 **DR. VALERIE GIDEON:** So there are First  
11 Nations representatives that are assigned by each of the  
12 sub-regions by leadership, so there are community Chiefs,  
13 political territorial organizations that are represented at  
14 that table, as well as, of course, some FHNIB regional  
15 executives.

16 **MS. NATALIE CLIFFORD:** So does it go back,  
17 then, to a reliance on a relationship with the regional  
18 Chiefs, say the AFN representative that sits at the  
19 national table?

20 **DR. VALERIE GIDEON:** The regional Chief is  
21 invited to participate, but it's actually the First Nations  
22 leaders Chiefs elected by communities. But then as an  
23 assembly they identify who the regional reps will be as a  
24 collective.

25 So, like, in -- in New Brunswick, the New

1 Brunswick Chiefs would get together and determine who their  
2 representatives would be at the table. In Nova Scotia the  
3 communities would get together and determine who their  
4 representatives are at the table.

5 **MS. NATALIE CLIFFORD:** Okay. So do you know  
6 who the representatives are that the chiefs and the AFN  
7 representatives have chosen at the Nova Scotia table?

8 **DR. VALERIE GIDEON:** We have that  
9 information in terms of -- I know some of them in terms of  
10 names, but I can't tell you the full list of members.

11 **MS. NATALIE CLIFFORD:** So do you think,  
12 then, it might be fair to say that it would be beneficial  
13 for the Commission if they're interested in understanding  
14 diversity of the way these agreements and funding is  
15 implemented across the country that they may need to hear  
16 from representatives from those jurisdictions?

17 **DR. VALERIE GIDEON:** I really can't presume  
18 to tell the Commissioners who they should hear from. I --  
19 I mean --

20 **MS. NATALIE CLIFFORD:** You can't speak to  
21 the diversity of implementation across the country  
22 yourself?

23 **DR. VALERIE GIDEON:** I can speak to each of  
24 the regional committees and who makes up the membership  
25 generally in terms of names. Like, Chief Candice Paul is

1 the co-chair, I know that.

2 **MS. NATALIE CLIFFORD:** Okay.

3 **DR. VALERIE GIDEON:** But in terms of all of  
4 the individuals that are part of that, we're talking about  
5 hundreds of people, so it would be difficult for me to know  
6 all of the names.

7 **MS. NATALIE CLIFFORD:** So when we're talking  
8 about service provision in cities, for example, and say  
9 there is an organization wishing to be heard -- wishing for  
10 you to hear their perspective on service provision and the  
11 gaps, is there any way for you to monitor how the regional  
12 tables or the provincial tables are actually selecting  
13 members or is it possible that individual service providers  
14 who may be interested in having input would fall through  
15 the cracks and not be heard by -- by your department?

16 **DR. VALERIE GIDEON:** Well, I mean, anybody  
17 can absolutely contact us and sit with us to talk about  
18 what needs exist in context and what priorities, and we can  
19 bring that information and -- and invite presentations at  
20 the partnership committee tables. My experience with these  
21 tables is that they're extremely open to hear from service  
22 delivery organizations with respect to what the needs are.  
23 And most First Nations leadership across the country are  
24 very concerned about how to support their members that are  
25 living in urban cities and urban contexts, and they want to

1 be able to provide them with service and reach them.

2 **MS. NATALIE CLIFFORD:** Okay. So the role of  
3 FNIHB is, just to confirm, is -- is like proper  
4 characterization to fill the gaps while respecting the role  
5 of other jurisdictions, being First Nations governance and  
6 provinces with respect to health?

7 **DR. VALERIE GIDEON:** That's a good way of  
8 expressing it, for sure.

9 **MS. NATALIE CLIFFORD:** Okay. So would you  
10 characterize that as in a positive responsibility on  
11 government or on Canada?

12 **DR. VALERIE GIDEON:** I -- I would  
13 characterize that as a positive responsibility.

14 **MS. NATALIE CLIFFORD:** Okay. Requiring  
15 action and research?

16 **DR. VALERIE GIDEON:** Yes, and which is -- I  
17 mean, the last three Federal budgets has made significant  
18 investments with respect to mental wellness, I think the  
19 government is recognizing its responsibility with respect  
20 to supporting First Nations and mental illness.

21 **MS. NATALIE CLIFFORD:** Okay. So I just want  
22 to go back to the idea of the round tables, and as you  
23 mentioned the Chiefs and you mentioned the name of a Chief  
24 who sits at the round table and chairs it. So is it  
25 possible that a grassroots women's organization who does

1 not necessarily have standing to deal directly with your  
2 department, and maybe whose interests don't align with  
3 those of the chiefs, and say the example again is that  
4 their -- that they would not be selected to sit at that  
5 table; correct?

6 **DR. VALERIE GIDEON:** They wouldn't  
7 necessarily -- they wouldn't sit at the table, but they  
8 could come in and present what are their ideas and  
9 solutions with respect to better servicing First Nations in  
10 -- in their province or in the city.

11 **MS. NATALIE CLIFFORD:** Okay. Make or give a  
12 presentation to that same round table that opted not to  
13 incorporate them in the discussion in the first place?

14 **DR. VALERIE GIDEON:** Well, it's not really  
15 about not agreeing to service delivery organizations  
16 specifically being part of it, but these are tables that  
17 represent First Nations leadership in terms of governments,  
18 and so it is a measure to share decision making with  
19 elected representatives --

20 **MS. NATALIE CLIFFORD:** Decide -- decide on  
21 funding allocations?

22 **DR. VALERIE GIDEON:** Correct, but it doesn't  
23 mean that there isn't collaboration with service delivery  
24 organizations.

25 **MS. NATALIE CLIFFORD:** Just a moment. I

1 just wanted to look at -- Ms. Anderson identified a really  
2 specific area of -- and I think it goes to the heart of the  
3 issue of our women experiencing a disproportionate amount  
4 of violence. This connection between women coming from  
5 remote communities to city centers -- and young people.  
6 It's not just women, but women, especially -- arriving in  
7 city centers and being specifically targeted, and the very  
8 disturbing evidence that traffickers and recruiters are  
9 listening for their accents to determine their isolation  
10 and vulnerability.

11 So I wondered, to me this sounds like a  
12 significant gap where the provinces aren't necessarily  
13 prepared to deal with this kind of specific vulnerability.  
14 The communities themselves, due to the remoteness, are, you  
15 know, not preparing these children. So is there a mandate  
16 within the ISC or a plan for, you know, health promotion  
17 and education specifically before children and women leave  
18 remote communities in this respect?

19 **DR. VALERIE GIDEON:** It's a good question.  
20 I think that we do have sources of funds that can help to  
21 support strategies. For instance, in Thunder Bay, we have  
22 initiatives with the high schools that First Nations youth  
23 from remote communities --

24 **MS. NATALIE CLIFFORD:** After they've come to  
25 the high school, though.

1                   **DR. VALERIE GIDEON:** But knowing that they  
2 are to come to the high school, to plan in advance services  
3 to -- to help support them, so targeted mental health  
4 counselling. We have a Suboxone program in the Thunder Bay  
5 high school, for instance, that First Nations are governing  
6 to help address at-risk behaviour. So there is planning in  
7 advance that can be made to make sure that there are  
8 support systems for individuals that have to come down for  
9 education or other reasons.

10                   **MS. NATALIE CLIFFORD:** Thank you. That's  
11 all my questions.

12                   **MS. JENNIFER COX:** So the next party is the  
13 Assembly of Manitoba Chiefs, and they have 13 minutes.

14 **VALERIE GIDEON, Previously Affirmed:**

15 **CROSS-EXAMINATION BY MS PASTORA SALA:**

16                   **MS. JOËLLE PASTORA SALA:** Good afternoon,  
17 Commissioners, Elders, family members. My name is Joëlle  
18 Pastora Sala. I am counsel to the Assembly of Manitoba  
19 Chiefs. Good afternoon, panel members. Thank you all for  
20 your presentations today.

21                   I'll be focussing my questions to  
22 Dr. Gideon. I hope to have time to ask you some questions,  
23 Ms. Anderson. Ms. Dumaine, out of respect for -- for you,  
24 I will not be asking you questions today, but on behalf of  
25 the Assembly of Manitoba Chiefs, I'd like to thank you for

1 sharing your voice and experience with us.

2 **MS. CHRISTINE DUMAINE:** Thank you.

3 **MS. JOËLLE PASTORA SALA:** Dr. Gideon. You  
4 stated that FNIHB derives its authority from the *Indian*  
5 *Health Policy* of 1979 and the Department of Health -- of  
6 *Health Act*, correct?

7 **DR. VALERIE GIDEON:** So it was the  
8 *Department of Health Act*. Of course, now we are within the  
9 context of the Department of Indigenous Services Canada,  
10 and enabling legislation for the creation of that  
11 department has not yet been introduced.

12 **MS. JOËLLE PASTORA SALA:** And it's the three  
13 pillars in the policy from 1979 that continue to guide the  
14 work of FNHIB?

15 **DR. VALERIE GIDEON:** Yes. But as I  
16 mentioned in 2012, we published a more comprehensive  
17 strategic plan in order to increase our commitments and  
18 also updating in the relevancy of the context.

19 **MS. JOËLLE PASTORA SALA:** But these three  
20 pillars continue to be at the root of your department's  
21 work?

22 **DR. VALERIE GIDEON:** It's still part of the  
23 mandate, absolutely.

24 **MS. JOËLLE PASTORA SALA:** Would it be  
25 correct to say that First Nations health services are

1 delivered as a matter of policy and are not entrenched in  
2 legislation?

3 DR. VALERIE GIDEON: That is correct.

4 MS. JOËLLE PASTORA SALA: And because of  
5 this, policies may change frequently, based on political  
6 mandates?

7 DR. VALERIE GIDEON: I have not seen in my  
8 20-some years in my career policy changes that have been  
9 significant within the context of the First Nations health  
10 branch mandate.

11 MS. JOËLLE PASTORA SALA: But it would be  
12 conceivable?

13 DR. VALERIE GIDEON: I think that it  
14 would -- conceivable.

15 MS. JOËLLE PASTORA SALA: Would it be  
16 possible?

17 DR. VALERIE GIDEON: It would be possible.

18 MS. JOËLLE PASTORA SALA: Are you  
19 generally -- generally familiar with the *Canada Health Act*?

20 DR. VALERIE GIDEON: I am familiar with the  
21 *Canada Health Act*.

22 MS. JOËLLE PASTORA SALA: If I describe this  
23 Act to you as the federal legislation which establishes  
24 criteria and conditions for insured health services and  
25 extended health care services under provincial law to

1 access cash contributions by the Federal government, that  
2 would be consistent with your understanding?

3 DR. VALERIE GIDEON: That would be  
4 consistent.

5 MS. JOËLLE PASTORA SALA: I'd like to just  
6 quickly read to you the five pillars of the *Canada Health*  
7 Act. Public administration, comprehensiveness,  
8 universality, portability, accessibility. Subject to  
9 check, is this familiar to you?

10 DR. VALERIE GIDEON: Yes.

11 MS. JOËLLE PASTORA SALA: In thinking of  
12 the mandate of NHI -- FNHI -- I'm -- I have trouble with  
13 acronyms, I apologize. Of your department, are you able to  
14 describe for me the relationship between the 1979 Indian  
15 Health Policy and the Canadian *Health Act*? Specifically,  
16 does the Canadian *Health Act* apply to First Nations living  
17 on reserve?

18 DR. VALERIE GIDEON: Yes, because First  
19 Nations populations on reserve, their population numbers  
20 are included within the overall per capita calculations  
21 on -- on the basis of which fiscal transfers are negotiated  
22 with provincial governments and territorial  
23 governments -- or provincial governments.

24 MS. JOËLLE PASTORA SALA: And so the  
25 principles that I read to you earlier would apply to First

1 Nations living on reserve?

2 **DR. VALERIE GIDEON:** There is no reason why  
3 it would exclude them, considering that their population  
4 numbers are included within the fiscal transfer  
5 calculations.

6 **MS. JOËLLE PASTORA SALA:** The mandate of  
7 your department is to ensure the availability of or access  
8 to health services for First Nations and Inuit communities,  
9 correct?

10 **DR. VALERIE GIDEON:** We provide services  
11 that are not offered through provincial/territorial health  
12 systems, yes.

13 **MS. JOËLLE PASTORA SALA:** And you would  
14 agree generally that there continues to be a gap for public  
15 and primary health care between on-reserve and off-reserve,  
16 including with respect to infrastructure, training, medical  
17 equipment, laboratory services, medical office assistants,  
18 pharmacy, et cetera?

19 **DR. VALERIE GIDEON:** Well, it is -- those  
20 responsibilities are often exercised through the First  
21 Nations Inuit Health Branch directly or through funding  
22 provided by the First Nations Inuit Health Branch.

23 **MS. JOËLLE PASTORA SALA:** My question was  
24 specifically whether you would agree that there continues  
25 to be a gap on -- between off and on reserve for those

1 services.

2 **DR. VALERIE GIDEON:** It's too general a  
3 question for me to answer definitively. There are areas  
4 where actually there are a higher per capita level of  
5 investment in First Nations communities than in an  
6 off-reserve context, so it's a very complicated question to  
7 answer.

8 **MS. JOËLLE PASTORA SALA:** What about with  
9 respect to infrastructure?

10 **DR. VALERIE GIDEON:** So, again, comparing  
11 the building of a hospital in Winnipeg to a building, you  
12 know, a primary health care facility in an isolated  
13 context, it's a difficult comparison to make. What I would  
14 say is that the level of health care infrastructure that's  
15 needed across First Nations communities is not yet  
16 adequate.

17 **MS. JOËLLE PASTORA SALA:** Okay. I'm going  
18 to come back to this theme a little bit later. Some of my  
19 colleagues have already mentioned or have asked you  
20 questions about Jordan's Principle. And Jordan's Principle  
21 relates to the provision of services for First Nations  
22 children, correct?

23 **DR. VALERIE GIDEON:** Yes.

24 **MS. JOËLLE PASTORA SALA:** I'm wondering if  
25 you could confirm whether or not Jordan's Principle applies

1 to jurisdictional disputes or gaps of services to First  
2 Nations adults.

3 **DR. VALERIE GIDEON:** Jordan's Principle  
4 currently applies to children.

5 **MS. JOËLLE PASTORA SALA:** To your knowledge,  
6 does your department or Indigenous Services Canada, are  
7 they considering the creation of a principle akin to  
8 Jordan's Principle which would prevent jurisdictional  
9 disputes or hot potato games for First Nation adults living  
10 on and off-reserve?

11 **DR. VALERIE GIDEON:** I don't have any  
12 knowledge of those discussions occurring.

13 **MS. JOËLLE PASTORA SALA:** You spoke briefly  
14 about the funding agreements or models for the provisions  
15 of health services. Can you confirm how the funding is  
16 identified, and specifically I'm wondering if you could  
17 clarify whether funding is established based on population  
18 or based on needs?

19 **DR. VALERIE GIDEON:** It's a combination of  
20 both. So it is -- as I mentioned, there are 114 programs  
21 that are funded through the First Nations Inuit Health  
22 Branch, and they vary with respect to how funding was  
23 initially provided. I mean, these are through decade-long  
24 processes. So while many programs were initially per  
25 capita-based, there were changes made in the '80s where it

1 included factors of isolation, for instance, or remoteness  
2 through the Berger formula. We also now include factors  
3 such as an aging population, for instance, through the home  
4 and community care program. So there are a variety of  
5 mechanisms through which funding has been allocated. Most  
6 recently, in Budget 2017, for instance, four initiatives  
7 relating to infectious diseases, we did look at disease  
8 incidents. So, for instance, around tuberculosis, the  
9 incidents of tuberculosis would drive the extent of  
10 investment in certain regions. So it is more complicated  
11 than just a per capita allocation.

12 **MS. JOËLLE PASTORA SALA:** And where would one  
13 go to to find out whether or not the allocation of services  
14 is based or funding is based on funding or needs? Where  
15 does one look?

16 **DR. VALERIE GIDEON:** Well, we would certainly  
17 be able to provide that information. We do it through our  
18 senior management table. But because there's been  
19 information over many years of periods, the individuals that  
20 would have had that information at the Assembly of Manitoba  
21 Chiefs, for instance, may have moved on, and it's hard to  
22 find that particular source. So it's something that we  
23 could -- that we would provide based on requests from First  
24 Nations.

25 **MS. JOËLLE PASTORA SALA:** Is it written?

1 Like, in a policy anywhere?

2 **DR. VALERIE GIDEON:** It -- we don't have one  
3 consolidated document.

4 **MS. JOËLLE PASTORA SALA:** I'd like to ask you  
5 a couple questions on non-insured health benefits. Is it  
6 correct to say that this is a program that exists as a last  
7 resort to capture those things that are not covered by other  
8 programs?

9 **DR. VALERIE GIDEON:** I would say that I would  
10 use the term "supplementary health benefits," so absolutely  
11 there are benefits that are not covered through provincial,  
12 territorial, or private insurance or employers' programs.

13 **MS. JOËLLE PASTORA SALA:** My client is being  
14 told by First Nations in Manitoba who are members -- or  
15 citizens of their member nations that the province and  
16 private insurance companies are also stating that their  
17 programs are of last resort. Is this something you could  
18 comment on or are familiar with?

19 **DR. VALERIE GIDEON:** I am familiar with  
20 certain jurisdictions doing that. There is -- we don't have  
21 a -- a -- we coordinate with other insurance plans where  
22 that is possible, and where it is not possible, we will  
23 provide the benefit.

24 **MS. JOËLLE PASTORA SALA:** I'm just -- I do  
25 have a lot more questions for you. I'm just going to ask

1 you one more. You mentioned some examples of increased  
2 First Nation and Inuit control over the design, planning,  
3 delivery, and evaluation of community programs and services.  
4 I'm wondering if your department has established benchmarks  
5 or targets to ensure equity in all of the regions in terms  
6 of co-management or governance approaches to ensure  
7 consistency.

8 **DR. VALERIE GIDEON:** We have not. We would  
9 have to do that, obviously, with First Nations. In fact,  
10 they would -- we would look to them to be able to do that,  
11 because it would not be appropriate for us to tell them how  
12 to govern within their own voices and their own leadership  
13 models. I think we have been receptive to whatever model  
14 works for them in terms of governance.

15 **MS. JOËLLE PASTORA SALA:** Thank you.

16 **DR. VALERIE GIDEON:** Thank you.

17 **JACKIE ANDERSON, Previously Affirmed:**

18 **CROSS-EXAMINATION BY MS. PASTORA SALA:**

19 **MS. JOËLLE PASTORA SALA:** Ms. Anderson, you  
20 spoke briefly about the large proportion of your sisters who  
21 have had the -- that you've had the opportunity to work with  
22 who are former or current children in care, correct?

23 **MS. JACKIE ANDERSON:** Yes.

24 **MS. JOËLLE PASTORA SALA:** And you spoke --  
25 and you gave us one example of the 14-year-old girl who had

1       been in 103 placements.

2                   **MS. JACKIE ANDERSON:**   M'hm.

3                   **MS. JOËLLE PASTORA SALA:**   I'm wondering  
4       whether you could provide additional information on the link  
5       that you have observed between child welfare and missing and  
6       murdered Indigenous women and girls.

7                   **MS. JACKIE ANDERSON:**   Oh.  That'd be a --  
8       well, again, I guess when you're looking at, you know,  
9       specialized services, that was one of the indicating factors  
10      from our advisory council that were young women or adults at  
11      the time when we were developing our two homes, is that  
12      their -- their risks, they felt, were extremely high when  
13      they were young and in care of Child and Family Services,  
14      being taken care of by caregivers that had no ability to be  
15      able to help them get away from the perpetrators or to start  
16      their healing or to have any understanding of what their  
17      needs were.

18                   So when I -- when I think about that and I  
19      hear the stories, you know, that they have shared about, you  
20      know, running from placements, as Christine mentioned  
21      earlier, you know, being threatened and told she was going  
22      to be locked up in secure care, how that increased her risk  
23      of going underground, which increased her vulnerability to  
24      be trafficked.  You know, whether provincially or  
25      nationally.  There's -- there's huge impacts to that, and at

1 the end of the day, it's about delivering strength-based,  
2 relationship-based care through an Indigenous lens of -- of  
3 survival for our young people, what they need.

4 **MS. JOËLLE PASTORA SALA:** That's great. I  
5 was going to ask you about recommendations, and I'll ask you  
6 if you wanted to add to that, but before, because my time is  
7 almost up, I just wanted to thank you for mentioning the  
8 work of the AMC and Our Circle to Protect.

9 **MS. JACKIE ANDERSON:** Yes, it was wonderful  
10 work.

11 **MS. JOËLLE PASTORA SALA:** And I wanted to ask  
12 you about whether you had any recommendations for the  
13 Commission, whether flowing from that work or from what  
14 you've just spoken about on child welfare, just to provide  
15 you that opportunity.

16 **MS. JACKIE ANDERSON:** I -- I just think  
17 again, like, I'm -- I haven't touched base with AMC over the  
18 last little while since they've done their Phase 3, but  
19 again, one of the things that I had recognized when I was  
20 going into the community is that our communities have such  
21 beautiful strengths, but they need a lot more awareness and  
22 they need to be mobilized and they need to be within their  
23 communities, in control of those community action plans.  
24 And I know that there was recommendations that were made in  
25 Phase 1, but I'm not sure if those were supported, because

1 of lack of funding. You know, such as developing tools in  
2 the language of that community. You know, again, awareness  
3 training on internet. All of those, again, all of those --  
4 if we're going to go to a community and ask them what their  
5 needs are, we need to be able to provide the resource to do  
6 so, to empower them to be able to sustain that protection  
7 within their community of their children.

8 **MS. JOËLLE PASTORA SALA:** Thank you all.

9 **MS. JENNIFER COX:** Commissioners, it's nearly  
10 five o'clock. We have four parties, including Commission  
11 counsel, left to do cross-examination, we have closing  
12 ceremonies ...

13 **(SHORT PAUSE)**

14 **CHIEF COMMISSIONER MARION BULLER:** We've  
15 decided to continue. We'd like to hear from at least two  
16 more parties. That will take us to approximately 5:30.

17 **MS. JENNIFER COX:** The next party has 17  
18 minutes and then they're in. So it'll probably be closer to  
19 quarter to six or so. The next party is Nishnawbe Aski  
20 Nation, Grand Council Treaty 3, Treaty Alliance Northern  
21 Ontario, with 17 minutes.

22 **MS. KRISTYN ORDYNIEC:** Good afternoon to the  
23 Commissioners, Chief Commissioner, Commissioners. I'd like  
24 to once again acknowledge on behalf of our clients, Grand  
25 Council Treaty 3 and Nishnawbe Aski Nation, the Treaty 7

1 territory as well as the Métis Nation Region 3. I'd also  
2 like to acknowledge that with me to this point was Nishnawbe  
3 Aski Nation Deputy Grand Chief Anna Betty Achneepineskum,  
4 who unfortunately had to leave to get back home.

5 I'd like to echo what my fellow parties  
6 withstanding had to say about Ms. Anderson and Ms. Dumaine's  
7 testimony today. Thank you on behalf of myself and my  
8 clients for your strength and transparency today.

9 **JACKIE ANDERSON, Previously Affirmed:**

10 **CROSS-EXAMINATION BY MS. ORDYNIEC:**

11 **MS. KRISTYN ORDYNIEC:** I just have one  
12 question for Ms. Anderson. When you have been working on  
13 the development of your -- the safe house, did you work with  
14 government partners as you were working towards your goals?

15 **MS. JACKIE ANDERSON:** Yes, to a degree  
16 because, again, we're -- we're funded through the province,  
17 so we were assigned a residential care licensing specialist.  
18 So when we were out looking and seeking for a potential  
19 property, we needed to have them with us to be able to  
20 identify risk, and what would need to happen to that  
21 environment in order to fit to residential care licensing  
22 standards.

23 **MS. KRISTYN ORDYNIEC:** Right. And are there  
24 any challenges you would identify from working with  
25 -- within government agencies you might be able to provide

1 best practices for for other organizations that may be --  
2 that may have similar goals?

3 **MS. JACKIE ANDERSON:** I think, again, it's  
4 -- it's important that you know, because we -- we have such  
5 a strong strategy within our province that there's, you  
6 know, a relationship between the community and through our  
7 -- our partners within the province, but I think what  
8 -- what we always need to keep in mind is that if -- if  
9 things need to be discussed for potential change that needs  
10 to be discussed at the community level.

11 **VALERIE GIDEON, Previously Affirmed:**

12 **CROSS-EXAMINATION BY MS. ORDYNIEC:**

13 **MS. KRISTYN ORDYNIEC:** Thank you, thank you  
14 again. The remainder of my time, I'm going to ask  
15 Dr. Gideon some questions, and given your testimony, so far,  
16 I probably already know the answer to this, but are you  
17 familiar with Nishnawbe Aski Nation and Grand Council Treaty  
18 3 Territory, and the historical and current challenges faced  
19 there, with respect to health services?

20 **DR. VALERIE GIDEON:** I certainly have had the  
21 privilege of working with many communities and leadership  
22 within both Treaty 3 and NAN, but I would never presume to  
23 fully know the challenges that they're experiencing.

24 **MS. KRISTYN ORDYNIEC:** Thank you. And -- and  
25 I just wanted to make sure that -- that you were aware of

1 the location that I am speaking of.

2 DR. VALERIE GIDEON: Yes.

3 MS. KRISTYN ORDYNIEC: Thank you. And you're  
4 aware over the last number of decades that there'd been  
5 suicide crises declared in NAN territory and Grand Council  
6 Treaty 3 territory, but also across the country?

7 DR. VALERIE GIDEON: Yes, I am aware.

8 MS. KRISTYN ORDYNIEC: Okay. And I -- I  
9 think that your early -- your earlier testimony referred to  
10 recent suicide crises as one of the catalysts for the NAN  
11 Charter of Relationship Principles that was executed.

12 DR. VALERIE GIDEON: That's what was  
13 communicated to me by Nishnawbe Aski Nation leadership.

14 MS. KRISTYN ORDYNIEC: Sure, thank you.  
15 Earlier, we heard from AFN council regarding the Wapekeka  
16 tragedy, which Wapekeka is a NAN community. So I'd just  
17 like to clarify for the record, that in the summer of 2016  
18 the survivors of suicide proposal was submitted to the  
19 government, and in the summer of 2017 the tragedy struck in  
20 Wapekeka. Thereafter, Wapekeka was provided funding.  
21 Previously, in response to a question Mr. -- Mr. Blain  
22 posed, you said, "It would not be for us, meaning the  
23 government, to declare an emergency in First Nation  
24 communities. It's up to them to do that." Is that correct?

25 DR. VALERIE GIDEON: That's correct. And

1 there is several Nishnawbe Aski Nation communities that have  
2 declared states of emergency specifically related to  
3 suicide.

4 **MS. KRISTYN ORDYNIEC:** Correct. So I -- I  
5 say all that to ask you to explain a government response  
6 that seems to wait for a First Nation to declare a state of  
7 emergency before it acts.

8 **DR. VALERIE GIDEON:** That's to declare the  
9 state of emergency. It doesn't mean that the government  
10 wouldn't proactively support communities if they identified  
11 risk factors and -- and brought those forward. I think we  
12 do try and collaborate with communities as much as possible  
13 with respect to supporting them, to address needs.

14 **MS. KRISTYN ORDYNIEC:** Sure. Just unpacking  
15 that a little bit, there have been suicide crises over the  
16 past number of decades, and there are risk factors that are  
17 known, so I -- I wonder if in response a community -- how it  
18 sees that it continues to have to declare a state of  
19 emergency before it's provided funding, and specifically I  
20 refer to Wapekeka.

21 **DR. VALERIE GIDEON:** So Wapekeka did have  
22 funding for mental wellness services through a block  
23 agreement, which is the highest level of flexible agreement  
24 we have outside of a grant process. Prior to the crisis,  
25 they had a multi-year funding agreement that enabled them to

1 allocate resources based on their targeted priorities and to  
2 carry over funds from year to year. They did have funding  
3 as part of that agreement for the survivors of suicide,  
4 annual gathering that they organized, but the proposal that  
5 they had sent in was for supplementary youth mental health  
6 counsellors. I think we have now a tracking system within  
7 the regional office to make sure that these proposals are  
8 addressed through Jordan's Principle, and specifically the  
9 Choose Life initiative, which Nishnawbe Aski Nation designed  
10 in collaboration with us, but it was through their  
11 initiative. And that was submitted to the Tribunal as a  
12 consent order --

13 **MS. KRISTYN ORDYNIEC:** Right.

14 **DR. VALERIE GIDEON:** -- and a response to  
15 Jordan's Principle on the decision.

16 **MS. KRISTYN ORDYNIEC:** And that was because  
17 there was a court order that orders that -- that sort of  
18 funding; that's correct?

19 **DR. VALERIE GIDEON:** Choose Life, actually,  
20 was initiated outside of a specific order. We developed it,  
21 well, based on NAN coming forward and requesting us to  
22 participate in that process, and NAN submitted it or asked  
23 us to participate in the consent being submitted to the  
24 Tribunal.

25 **MS. KRISTYN ORDYNIEC:** I'd like to move on to

1 -- to another segment, in respect of suicides have led to a  
2 number of inquests into deaths of -- of Indigenous youth;  
3 are you aware?

4 **DR. VALERIE GIDEON:** Yes. In Pikangikum, and  
5 I believe also -- I'm aware of the one in Pikangikum in  
6 particular, and also in Thunder Bay there was also a  
7 Coroner's Inquest with respect to youth.

8 **MS. KRISTYN ORDYNIEC:** That's right, and I'm  
9 just going to ask on a general basis --

10 **DR. VALERIE GIDEON:** Okay, sorry.

11 **MS. KRISTYN ORDYNIEC:** -- not in particular  
12 to any -- any inquest. And you're aware that as part of the  
13 inquest process, like this Inquiry, recommendations are made  
14 and come out of the inquest?

15 **DR. VALERIE GIDEON:** Yes.

16 **MS. KRISTYN ORDYNIEC:** What is the government  
17 policy on implementation of those recommendations, even  
18 though they are not legally binding?

19 **DR. VALERIE GIDEON:** We have always, in my  
20 experience in the ten years that I've been involved with  
21 respect to Ontario and First Nation Inuit Health Branch,  
22 proactively sought to address those recommendations.

23 **MS. KRISTYN ORDYNIEC:** And -- it -- would it  
24 be then your position that Indigenous Services Canada if  
25 there are recommendations that are directed to your branch

1 that come out of this Inquiry that you will also implement  
2 those?

3 **DR. VALERIE GIDEON:** I can't speak on behalf  
4 of the Minister, but I would say that we value the advice  
5 and the recommendations that will be provided by  
6 Commissioners, as we have done with the interim report, and  
7 it is informing the consideration of the government  
8 response.

9 **MS. KRISTYN ORDYNIEC:** Thank you. I -- I'd  
10 like to move to -- and it still has to do with suicide. Are  
11 you aware of how many youth healing centres there are in  
12 northern communities, so communities that serve -- NAN and  
13 Grand Council Treaty 3 communities?

14 **DR. VALERIE GIDEON:** I am aware of some of  
15 the centres. I don't have a specific number in my head, but  
16 we have been working with Treaty 3 leadership in particular  
17 because there is a gap with respect to a specific child or  
18 youth centre in that territory. And we are -- we have been  
19 working with Nishnawbe Aski Nation and both Treaty 3 to look  
20 at youth at risk and specific strategies, such as through  
21 the Choose Life initiative as an example where there are a  
22 lot of on the land initiatives that are being driven by  
23 communities.

24 **MS. KRISTYN ORDYNIEC:** Right. So -- so it's  
25 your position that going forward there are -- there are

1 certainly the intent that there would be youth healing  
2 centres in -- in that -- those communities?

3 **DR. VALERIE GIDEON:** Yeah, so we -- through  
4 the provincial government, they've recently gone through a  
5 process of sending out a call for proposals for youth  
6 treatment centres. They were able to fund a certain number,  
7 but not all the requests. They have shared those with us to  
8 see if we can provide resources for those centres that have  
9 not been able to be funded, and we're in the process of  
10 assessing those against the \$200 million that was just  
11 recently announced in budget 2018.

12 **MS. KRISTYN ORDYNIEC:** Thank you. With  
13 respect to collecting statistics on the tragedies of youth  
14 suicide, is there a database with respect to those  
15 statistics?

16 **DR. VALERIE GIDEON:** It's interesting. So  
17 there isn't currently one database, but Grand Chief Fiddler  
18 raised this when several NAN communities were going through  
19 a crisis state in 2016 and '17, and we developed a specific  
20 working group with Nishnawbe Aski Nation, the public health  
21 agency and ourselves, and other provincial partners. In  
22 order to explore a suicide surveillance system, the Public  
23 Health Agency of Canada has developed a suicide surveillance  
24 framework, and so we have been working in a tripartite way  
25 to be able to look at the adaptation of that suicide

1 surveillance framework, specifically for NAN communities.  
2 The Weeneebayko area health authority had a particular  
3 interest. They had already launched a population health  
4 data surveillance initiative, and so the public health  
5 agency has visited them and is working with them initially  
6 as -- as one of the areas of focus, so we've never forgotten  
7 in our working to address that particular need that has been  
8 highlighted several times by Grand Chief Fiddler.

9 **MS. KRISTYN ORDYNIEC:** Sure. And not only  
10 in NAN and Grand Council Treaty 3 communities, but is that  
11 an important aspect of the work that you're doing across  
12 Canada?

13 **DR. VALERIE GIDEON:** We would absolutely  
14 take the results of that particular initiative and broaden  
15 it to look at how we could apply it nationally.

16 **MS. KRISTYN ORDYNIEC:** Thank you. We talk a  
17 lot about what is culturally appropriate, and I -- and I  
18 know that there are a lot of new policies, new government  
19 initiatives that are coming out as we respond and as we  
20 deal with -- with health initiatives going forward. Is  
21 there any sort of definition in your policies that define  
22 what is culturally appropriate?

23 **DR. VALERIE GIDEON:** I think the best  
24 resource document would be the First Nations Mental  
25 Wellness Continuum Framework From a First Nations

1 Perspective, and that was developed as a partnership  
2 between First Nations representatives, First Nations mental  
3 health experts and also departmental representatives. So  
4 while it's not a policy, we refer to it a lot in our policy  
5 documents.

6 **MS. KRISTYN ORDYNIEC:** And I ask, would  
7 "culturally appropriate" extend to include infrastructure  
8 and not just the way a program may be delivered?

9 **DR. VALERIE GIDEON:** Yes, I would agree with  
10 that, absolutely.

11 **MS. KRISTYN ORDYNIEC:** My last set of  
12 questions would focus around a situation that occurred  
13 where an individual in a community required access to  
14 mental health supports that were specialized, so that those  
15 mental health supports were not available in the community.  
16 And we've heard testimony throughout the community hearings  
17 and throughout these expert hearings on how difficult it is  
18 for some community members to travel to urban centres to  
19 get those services, so the community decided to request  
20 that the mental health professional come into the  
21 community. And one of the responses received was that it  
22 takes too long for me to be reimbursed, so I am not able to  
23 come.

24 So I would ask if there is a certain -- a  
25 government policy around reimbursement and specifically

1 providing services to the communities when they don't have  
2 them?

3 **DR. VALERIE GIDEON:** Well, I'm surprised by  
4 that situation because with registered mental health  
5 providers we have regular ability to reimburse them for  
6 expenses. However, we don't -- the majority of service  
7 providers that are delivering mental health services are  
8 not directly paid for by us, they are paid for through  
9 First Nations organizations, Tribal Councils, Nishnawbe  
10 Aski Nation, (indiscernible) through the Sioux Lookout  
11 First Nations Health Authority, Kenora Chief's Advisory, so  
12 it would depend on that particular situation.

13 I certainly can say to you that we are  
14 always actively cognizant of the fact that we need to  
15 promptly pay service providers in order to ensure that they  
16 continue to be registered with the program and are  
17 participating in the delivery of services to clients, and  
18 that would include the Indian residential school health  
19 support program.

20 But, for instance, Treaty 3 delivers that  
21 program specifically to its members and there are health  
22 authorities also in NAN and Treaty 3 communities that are  
23 receiving those dollars directly so that they are able to  
24 contract service providers that they choose and that they  
25 feel are going to provide culturally competent services.

1           **MS. KRISTYN ORDYNIEC:** Right. And I would  
2 suggest that this was not one of those situations where the  
3 First Nation was able to provide their own services, but  
4 thank you for your answer.

5           And just lastly, with respect to  
6 specifically women's health and sexual assaults that may  
7 occur in communities, and the necessity of gathering  
8 evidence and information right away in those communities,  
9 are -- are communities provided with necessary supports to  
10 administer something like a rape kit?

11           **DR. VALERIE GIDEON:** The sexual assault  
12 kits, so they are -- in some jurisdictions the RCMP  
13 detachment has those kits and they were brought to the  
14 primary health care facility. So, you know, depending on  
15 how it's actuality regulated in the provinces, but in most  
16 provinces those kits are actually housed in the primary  
17 health care facility in the community.

18           **MS. KRISTYN ORDYNIEC:** And do you have any  
19 information as to whether the nurses that are in those  
20 communities are able to administer those kits, because I  
21 understand that there's special training that is required  
22 to do that?

23           **DR. VALERIE GIDEON:** Yes, so we have ensured  
24 even as recently as last year again, we do monitor that to  
25 ensure there is capacity in communities for sexual assault

1 kits to be utilized.

2 Now, that being said, there are many  
3 community members who prefer to be flown out when they're  
4 in that situation and they don't necessarily want to remain  
5 in the community, so that is also a consideration. So if  
6 the client consents and wishes to have those kits  
7 administered in the community, we are -- we would be able  
8 to do it in most cases, unless it's within the context of  
9 the RCMP detachment having the kit or whichever, but it is  
10 still -- we still run into the issue where clients don't  
11 necessarily want that to be administered in the community.

12 **MS. KRISTYN ORDYNIEC:** Thank you. And I'll  
13 just take my last few seconds to thank you very much for  
14 the work that you do, and to everybody on the panel and the  
15 Commission. Thank you.

16 **MS. JENNIFER COX:** The next party is  
17 *Directeur des poursuites criminelles et pénales* in French.

18 **MS. ANNY BERNIER:** *Je vais d'ailleurs vous*  
19 *laisser un peu de temps pour prendre le temps de mettre vos*  
20 *écoutateurs, parce que je vais effectivement parler en*  
21 *français.*

22 **MS. JENNIFER COX:** And 13 minutes,  
23 Mr. Registrar.

24 **MS. ANNY BERNIER:** *Alors, bonjour. Anny*  
25 *Bernier, Directeur des poursuites criminelles et pénales*

1       *pour le Québec, communément appelé DPCP.*

2                       *Alors, d'abord un très grand merci à tous*  
3       *les panelistes. Vous étiez extrêmement intéressantes.*  
4       *J'aimerais d'abord préciser que le DPCP n'a pas de témoins*  
5       *présents cette semaine. Par contre, nous avons... et*  
6       *quand je dis nous, je parle au nom de l'organisation, bien*  
7       *sûr... nous avons transmis une lettre aux avocats de la*  
8       *Commission le 2 mai dernier. Si vous me permettez, je vais*  
9       *vous lire les passages de cette... les deux premiers*  
10       *paragraphes de cette lettre simplement pour vous mettre en*  
11       *contexte. C'est une lettre qui a été envoyée dans le cadre*  
12       *d'une demande de témoins potentiels pour les audiences de*  
13       *cette semaine. Alors la lettre se lit comme suit :*

14                    *« Au cours des dernières années, le DPCP a*  
15                    *mis sur pied et participé à différents*  
16                    *programmes visant l'accessibilité et*  
17                    *l'accompagnement de clientèles fragiles et*  
18                    *vulnérables à travers le processus*  
19                    *judiciaire notamment avec les victimes et*  
20                    *les personnes souffrant de problèmes en*  
21                    *santé mentale. Il va sans dire que ces*  
22                    *initiatives impliquent la collaboration de*  
23                    *plusieurs procureurs chez nous, mais*  
24                    *également de différents intervenants issus*  
25                    *du système judiciaire et du réseau de santé*

1 des services sociaux. Ainsi bien que le  
2 DPCP souhaite collaborer activement aux  
3 travaux de la Commission, sans obtenir  
4 davantage de précisions quant aux programmes  
5 sur lequel ou lesquels les commissaires  
6 souhaitent traiter lors de cette audition,  
7 nous ne sommes malheureusement pas en mesure  
8 d'identifier le témoin approprié. Nous vous  
9 soumettons néanmoins la liste des différents  
10 programmes et directives pertinents du DPCP  
11 en Annexe 1 afin de faciliter le travail des  
12 commissaires en prévision de ces audiences  
13 et de la rédaction du rapport final. »  
14 Donc, cette lettre est malheureusement  
15 demeurée sans réponse. Nous n'avons donc personne cette  
16 semaine ici à faire entendre.

17 Alors, j'aimerais avoir votre autorisation  
18 afin de pouvoir déposer en preuve la lettre et son annexe  
19 puisque leur contenu contient une mine d'informations  
20 pertinentes aux audiences de cette semaine.

21 Je crois humblement que, tel que le  
22 mentionnait d'ailleurs Monsieur Phelps hier, les  
23 commissaires devraient pouvoir avoir le plus d'information  
24 pertinente possible pour dresser un portrait complet des  
25 services gouvernementaux offerts pas l'ensemble des

1        *au provinces et territoires.*

2                    *Je vous soumets le tout respectueusement,*  
3        *conformément aux règles de pratique de la Commission, soit*  
4        *le Legal Path. Je vous soulève les Règles 8 et 30 dans la*  
5        *version anglaise et les Règles 11 et 31 dans la version*  
6        *française. Il y a une petite incohérence au niveau de la*  
7        *numérotation et aussi au niveau de la traduction, mais on*  
8        *va rester avec les Règles 8 et 30 de la version anglaise,*  
9        *si vous le souhaitez.*

10                    *Les Règles, ce qu'elles disent, en fait,*  
11        *c'est que Règles de pratique sont flexibles et que les*  
12        *commissaires doivent pouvoir admettre tout élément de preuve*  
13        *pertinent, et ce même si ces éléments de preuve ne seraient*  
14        *pas admissibles devant un tribunal.*

15                    *Également, que les Règles de preuve ne*  
16        *doivent pas être appliquées selon leur sens stricte pour*  
17        *déterminer leur admissibilité.*

18                    *Par ailleurs, j'aimerais préciser que bien*  
19        *qu'un document pour préciser les Règles de pratique,*  
20        *notamment les Règles 56 et 66, a été transmis par les*  
21        *avocats de la Commission vendredi dernier, soit après des*  
22        *échanges qui ont eu lieu avec moi et les avocats. Ces*  
23        *règles visaient notamment les ajouts suivants. Je fais*  
24        *référence à l'article 56. La partie ajoutée était :*

25                    *« La partie ayant qualité pour agir*

1                    doit présenter un document en preuve  
2                    pendant le contre-interrogatoire d'un  
3                    témoin ou d'un expert. »

4                    Et la partie ajoutée à l'article 66 était...  
5                    cette partie est présente. Je lis le début de la phrase :

6                    « Les parties ayant qualité pour agir  
7                    qui entendent déposer des documents à titre  
8                    de pièces pendant... »

9                    Ici on a changé « les audiences » pour « le  
10                    contre-interrogatoire » :

11                    « ...le contre-interrogatoire doivent  
12                    en remettre copie... »

13                    Et cetera. Donc, deux portions ont été  
14                    ajoutées et modifiées. J'aimerais préciser qu'il s'agit de  
15                    droit nouveau qui est entré en vigueur vendredi, le 25 mai,  
16                    suivant des précisions des avocats de la Commission et que  
17                    cela ne figure pas dans les Règles de pratique de la  
18                    Commission.

19                    En conclusion, en tout respect pour  
20                    opinion contraire, dans l'esprit de collaboration qui  
21                    caractérise cette Commission, je vous demande de permettre à  
22                    mon organisation, le Directeur des poursuites criminelles et  
23                    pénales du Québec, de pouvoir déposer en preuve la lettre et  
24                    l'annexe préparées pour éclairer les commissaires quant aux  
25                    services en santé mentale et aux victimes offerts par le

1        *DPCP afin de permettre d'avoir le plus d'information*  
2        *pertinente possible pour vous permettre de soumettre les*  
3        *meilleures recommandations possibles.*

4                    *Merci. Et, pardon, je voudrais*  
5        *simplement souligner que j'ai naturellement respecté la*  
6        *Règle 66 et j'ai communiqué mon avis d'intention de déposer*  
7        *le tout comme preuve vendredi dernier.*

8                    *Merci.*

9                    **MS. CHRISTA BIG CANOE:** I would like to make  
10        an objection, so I'm going to suggest we stop the time at  
11        this point. And -- sorry. Commission Counsel would like to  
12        make -- actually, I'll have two objections. The first  
13        objection is a little more procedural. The intention of  
14        cross-examination was to cross-examine. There was not a  
15        motion properly put before you, but I believe that we should  
16        just deal with the issue. So I don't want it to be on a  
17        technical latch that this was not the proper form, nor was  
18        there notice of the motion, nor was it presented as a motion  
19        prior.

20                    So I'm going to suggest that I make the  
21        second objection, which is the objection to putting the  
22        material in, and I would like to provide the reasons why.  
23        Because they're not just unilateral, and I do respect -- and  
24        I will stop just 'cause I noticed Commissioner Audette, do  
25        you need your --

1                   **COMMISSIONER MICHÈLE AUDETTE:** Yeah. Yeah.  
2                   No. I'm answering your questions.

3                   **MS. CHRISTA BIG CANOE:** Okay. Perfect.  
4                   Thanks. So I would appreciate the opportunity to respond,  
5                   so the -- my objection on behalf of Commission Counsel is  
6                   the manner in which the exhibits being presented in this  
7                   form. And we understand and respect the cooperation that  
8                   the party is actually speaking to. And we don't believe  
9                   that -- that the documents are not important. They are  
10                  important, but there's other manners and means to put the  
11                  documents before the Commission.

12                  So we did re-apply and I feel at a loss  
13                  because I just learned of this motion this afternoon. And I  
14                  feel unprepared in that I could have actual exhibits to  
15                  respond to it, but my -- my friend here has presented the  
16                  letter and she read the letter in, which you have received a  
17                  copy is because a reply to putting these exhibits in on  
18                  Friday was that there were other means and that there were  
19                  no witnesses that could answer specifically the questions  
20                  that this document arises, and therefore we recommended that  
21                  there were a number of other means to get the documents  
22                  before the Commissioners. And I undertook and did actually  
23                  provide the documents to the Commissioners via e-mail in  
24                  response first to my friend, and then forwarding a copy to  
25                  Commissioners.



1                   whether national or international.

2                   And then it lists particular reports. And  
3 rule -- rule 33 actually gives you -- and I don't know if  
4 you want the opportunity to turn up the rules. Gives you the  
5 authority to rely on: (as read)

6                   Pre-existing reports, studies and other  
7 substantive materials as evidence to  
8 make findings of fact as Commissioners  
9 consider relevant to the discharge of  
10 their mandate.

11                   The documents that are being proposed is  
12 essentially a document created by the party that lists the  
13 programs they have. The ability to source it pursuant to  
14 rule 66 will be difficult as these witnesses will not have  
15 knowledge of those particular programs, nor would any other  
16 prior or future witnesses being hauled here.

17                   Having said that, you guys have the authority  
18 and ability to receive report and give it weight. Rule 4 of  
19 the Legal Path also -- and my friend had listed rule 8 --  
20 and can you help me? I -- rule 8 and rule --

21                   **MS. ANNY BERNIER:** 30.

22                   **MS. CHRISTA BIG CANOE:** 30, thank you -- in  
23 the French version which is 31 in the English. That in an  
24 ordinary course -- so rule 31: (as read)

25                   In the ordinary course, Commission

1 Counsel will call and question witnesses  
2 to testify at the Inquiry. Counsel for  
3 a witness may apply to the Commissioners  
4 to lead witness' evidence in-Chief if  
5 counsel is granted.

6 Is that the same rule that you intended?

7 **MS. ANNY BERNIER:** Pardon me?

8 **MS. CHRISTA BIG CANOE:** I don't know if  
9 that's the same rule you intended to cite.

10 **MS. CHRISTA BIG CANOE:** (as read)

11 can accept any information as evidence  
12 they decide will further object as of  
13 National Inquiry, including where that  
14 evidence might not be admissible in the  
15 court of law. The strict rule of  
16 evidence will not apply to determine  
17 admissibility of evidence, except with  
18 respect to the law of privilege  
19 immunity and respect to the cabinet  
20 confidences and statutory bars.

21 I do want to also bring up though two  
22 important rules that have to be considered. The first one  
23 is that rule 4: (as read)

24 All parties and their counsel agree to  
25 follow the rules as a condition of their

1 standing.

2 That first part, but in rule 4: (as read)

3 Subject to the various governing laws,

4 the conducts and procedures to be

5 followed at the National Inquiry is

6 under the complete control and

7 discretion of the Commissioners.

8 Rule 8 states: (as read)

9 The Commissioners may receive any and

10 all relevant inference.

11 This is a permissive clause. This does not  
12 say they shall receive. And so there -- although that the  
13 rules speak to the fact that you don't have to accept it in  
14 the same manner as a court of law would, there should be a  
15 principle approach taken to evidence in terms of when we're  
16 putting it to witnesses. So it's permissive, it's not  
17 shall. And if we look at a broader principle of evidentiary  
18 law and evidence, is there's -- and I'm talking broad  
19 principles. I would like to have cases before you, or some  
20 more authority, but on the short notice of the motion, I  
21 have been unable to do so.

22 Essentially, the -- one of the broader  
23 principles is that the material or evidence that goes before  
24 a witness, they should be able to answer, or have knowledge  
25 to speak to. So if she was to source the document to my

1 friends, and have them identify it, they would not be able  
2 to identify it because the creation of her parties.

3 And then they may be able to review it, but  
4 they wouldn't be able to speak to the intimate details of  
5 those programs, because as my friend has shared, there's not  
6 a member from her party that's actually on the panel of  
7 witnesses.

8 One of my concerns is that they have ability  
9 and opportunity to put this evidence to you in other manners  
10 and means, and by putting it to the witnesses before us  
11 today, it's not testable, so they won't be able to answer  
12 questions. We won't be able to explore the documents in any  
13 great detail. So in your weighing and balancing of the  
14 credibility of the evidence before these witnesses no  
15 different than if you were receiving them by virtue and  
16 using your authority under 33 or by provision H, because  
17 these witnesses will not be able to speak to that document.  
18 It's no different than if they submitted to you through  
19 another mechanism.

20 So putting it on the record -- and I'm not  
21 saying the sky is falling here, but by submitting this  
22 document in this particular process sets a precedent to  
23 allow any party -- because every party, all 101 of them,  
24 would have the ability -- and I believe in this part 2  
25 portion, there's 82 parties of which we have 32

1 here -- would then be able to create a document that talks  
2 to their programs and policies and submit it before any  
3 witness that may or may not be able to answer questions,  
4 and in this case would not be able to answer questions  
5 about their programs.

6 I would suggest the better result is to  
7 receive, absolutely receive it, but not in the context of  
8 evidence that's going before you in this format, which is  
9 to put evidence to witnesses and then have them answer  
10 questions, because the proper way to do it on a principled  
11 evidentiary basis is to make sure that questions can  
12 actually be answered about the evidence that's going in in  
13 this part of the process.

14 I do feel at a bit of a loss because I  
15 would like to give you some more citation on authority on  
16 this. Unfortunately, in the short duration and notice of  
17 when the motion would come up, I have been unable to. So  
18 for now, those are my submissions, and I thank you.

19 **Me ANNY BERNIER:** *Si vous me permettez,*  
20 *simplement pour répondre à ma consœur, en fait, c'est un*  
21 *peu... l'idée derrière tout ça c'est vraiment que nous*  
22 *voulions collaborer. Personne ne nous a donné d'indication*  
23 *pour pouvoir préciser quels témoins seraient pertinents.*

24 *Bien sûr nous aurions pu amener plusieurs*  
25 *témoins, mais une semaine n'aurait pas été suffisante pour*

1        *les entendre et le Québec et l'ensemble des 10 autres*  
2        *provinces et trois territoires, ainsi que toutes les*  
3        *parties ayant statut qui voulaient se faire entendre.*

4                    *Nous sommes dans une audience*  
5        *institutionnelle pour les services gouvernementaux. Je*  
6        *pense que l'objectif de la Commission comme telle c'est*  
7        *vraiment de connaître les détails les plus pertinents pour*  
8        *pouvoir vous guider.*

9                    *Ma consœur nous rappelle que les règles de*  
10       *la preuve déposée devraient passer par un témoin. Ça ne*  
11       *fait pas partie des règles de procédure de la Commission.*  
12       *Elle nous réfère aux Termes de Référence, au cadre de*  
13       *référence de la Commission comme tel. La lettre (h), je*  
14       *m'excuse, je l'ai regardée rapidement tout à l'heure, je ne*  
15       *trouve pas qu'il y a une grande pertinence au point que*  
16       *j'apporte aujourd'hui.*

17                   *Par ailleurs, la différence de pouvoir vous*  
18       *soumettre un document pour considération suivant*  
19       *l'article... la Règle 33, telle que mentionnée par ma*  
20       *consœur, oui, c'est certainement une façon de faire. Par*  
21       *contre, ce n'est pas un document qui devient déposé en*  
22       *preuve.*

23                   *Et puisque nous sommes toujours dans*  
24       *l'attente des règles qui entoureront le dépôt de mémoires,*  
25       *s'il y a dépôt de mémoire, vous me permettrez de vous*

1        *suggérer à quel point ceci a de l'importance pour mon*  
2        *organisation, que les éléments pertinents du DPCP puissent*  
3        *faire partie de la preuve lors des audiences sur les*  
4        *services gouvernementaux entendus cette semaine.*

5                    *Merci.*

6                    **MS. CHRISTA BIG CANOE:** So, sorry. I -- it  
7        was my objection. She had the right to respond, but I have  
8        a right to reply in relation to what she said, if I may  
9        actually exercise that right? So I agree. And I'm not  
10       sure if the translation was completely accurate. My  
11       friend's reference to the rules. Do you mean, like, the  
12       process for the next steps?

13                   **MS. ANNY BERNIER:** À propos des closing  
14       submission?

15                   **MS. CHRISTA BIG CANOE:** Gentlemen. Yes. So  
16       the rules -- the only reference to the rules in the -- in  
17       the legal path in relation to a party's right as it relates  
18       to closing submissions is in Section 25, which clearly  
19       states there is a right. We have not yet actually provided  
20       the procedure that will apply to parties with standing in  
21       their closing submissions, but the closing submissions and  
22       that process will be forthcoming.

23                   Also, just -- just in reply to my -- my  
24       friend's comments, there clearly is a Rule 66. So she did  
25       meet it in terms of the duration, like the 48 hours'

1 advance notice, but we also did -- Commission counsel did  
2 reply to that response, and we stated our position at that  
3 time. We did not get notice of a motion until today.

4 And I don't disagree. We do want this to  
5 be a cooperative process. So the objection I'm making is  
6 not because I don't value that -- the contents may, indeed,  
7 be very helpful for the party in their closing submissions  
8 or to point to resources. But I still would suggest that  
9 in this particular process where we're having witnesses  
10 provide oral testimony and evidence on their knowledge,  
11 it's not the appropriate forum. Thank you.

12 **CHIEF COMMISSIONER MARION BULLER:** Is the  
13 expectation that this document will be identified or spoken  
14 to by any of the witnesses? No? Okay. On that basis,  
15 then, for today's purposes, anyway, I appreciate it's been  
16 a very long day, and all of the witnesses are free to go  
17 for the day. And we look forward to seeing all of you  
18 again tomorrow morning at 8:30. So thank you very much  
19 for --

20 **UNIDENTIFIED SPEAKER:** We'll sort this out  
21 without you.

22 **CHIEF COMMISSIONER MARION BULLER:** Yeah.

23 **(LAUGHTER)**

24 **UNIDENTIFIED SPEAKER:** I have the answer.

25 **CHIEF COMMISSIONER MARION BULLER:** And we

1 need to caucus about this. We'll take about a ten-minute  
2 break. Thank you.

3 --- Upon recessing 5:37 p.m.

4 --- Upon reconvening at 5:54 p.m.

5 **CHIEF COMMISSIONER MARION BULLER:**

6 Ms. Bernier, Ms. Big Canoe, thank you for your submissions.  
7 We're not going rule on the motion today, of course. If  
8 parties wish to provide submissions, if they have anything  
9 to add to submission that have been made, we will accept  
10 those submissions in writing through Commission Counsel,  
11 and the deadline is 12 noon tomorrow for any written  
12 submissions from parties on the motion.

13 And can I emphasize that's only if you have  
14 anything to add to the submissions that have already been  
15 made. There will be no further submissions by Commission  
16 Counsel or Ms. Bernier. We will give our oral ruling by  
17 the end of the -- by the end of this hearing, so by the end  
18 of this week.

19 **MS. CHRISTA BIG CANOE:** May I just ask a  
20 procedural question in relation to Ms. Bernier's seven  
21 remaining minutes on cross-examination?

22 Am I to understand that she will be allowed  
23 to use those to proceed with the witnesses before us  
24 because she will now not be able to put these documents to  
25 these witnesses, but will be putting them potentially,

1 based on your ruling, to other witnesses, so I just want to  
2 ensure because her request was to put them before these  
3 witnesses. These witnesses will be completed their chief  
4 and cross-examination prior to your ruling.

5 **CHIEF COMMISSIONER MARION BULLER:** Okay.  
6 Ms. Bernier, if you have further cross-examination -- or  
7 any cross-examination, rather, of the witnesses that we  
8 heard from today, you may use your seven minutes tomorrow  
9 morning starting at 8:30.

10 **MS. CHRISTA BIG CANOE:** Thank you.

11 **CHIEF COMMISSIONER MARION BULLER:** Okay.

12 **MS. BETH SYMES:** May I address -- in your  
13 absence there was a lot of discussion amongst the other  
14 parties withstanding. I am not certain what is the nature  
15 or scope of what is being requested or of what you are  
16 considering. One of the questions is, what is the nature  
17 and scope of Rule 33, which is other documents that have  
18 not been identified by -- by a party.

19 **CHIEF COMMISSIONER MARION BULLER:**

20 Ms. Symes, I'm going to interrupt you because I want to  
21 make it very clear that if there are further submissions  
22 from parties we will accept those submissions, however they  
23 must be in writing and we must receive them by 12 noon  
24 tomorrow.

25 **MS. BETH SYMES:** Sorry, I'm not asking to

1 make submissions. What I'm simply asking is what is in  
2 dispute because, depending upon what the issues are, we may  
3 or may not want to make submissions. That's my question.

4 **CHIEF COMMISSIONER MARION BULLER:** Okay.  
5 The -- as I understand them, the specifics of the motion  
6 are -- or the --

7 **UNIDENTIFIED SPEAKER:** Objection.

8 **CHIEF COMMISSIONER MARION BULLER:** -- the  
9 decision sought by counsel is that the documents in  
10 question be admitted into evidence not through a witness at  
11 a hearing. Is that correct?

12 **MS. ANNY BERNIER:** It is correct.

13 **CHIEF COMMISSIONER MARION BULLER:** Okay.  
14 Thank you. And we will close for the day. We will  
15 reconvene tomorrow morning at eight o'clock for our  
16 wonderful opening. Thank you.

17 **MR. JASON GOODSTRIKER:** Thank you and  
18 congratulations to a very successful day to all of the  
19 Commission -- Commissioners. And I was -- I was just kind  
20 of excited about this afternoon, sorry I had to step out  
21 for a few moments, I had some work stuff to worry about,  
22 but my two girls that came in here, they're teenagers,  
23 they're 15 and -- one is older 15, the other one is  
24 younger, but they're very special to me, like each and  
25 every one of our children are special to us. But something

1 that nobody knows about is that I have six daughters and  
2 adopted children I have 20 all together, so these  
3 are -- you know, they're young people, they're very excited  
4 and they were happy to come down and to sit and to listen,  
5 even though it was a few moments. And hopefully if they  
6 skip school tomorrow I'm going to ask them to come back.

7 **(LAUGHTER)**

8 **UNIDENTIFIED SPEAKER:** No good.

9 **MR. JASON GOODSTRIKER:** But it's very  
10 pressing and thank you very much to all of the  
11 participants, all of the staff members for a successful  
12 day.

13 We will try our best again for tomorrow and  
14 for Friday coming in the -- so what I would just like to  
15 leave you all with, as many of you -- as it happens in all  
16 of the gatherings where we go to, I always encourage people  
17 to meet new people, meet new people that are important to  
18 not only this process, but down the road.

19 A lot of you don't know that Valerie Gideon  
20 and I, (indiscernible), we've been friends for nearly 20  
21 years now, and this is a very, very important undertaking.  
22 And you don't want to leave an event like this thinking,  
23 gee, I wish I would have said something, I wish I would  
24 have questioned this, I wish I would have (indiscernible)  
25 conversation.

1                   Anyway, in our closing I'm going to ask  
2                   these boys, this is -- these are -- we say Siksika  
3                   (indiscernible) they're the singers from Siksika, and one  
4                   thing that's very interesting about Blackfoot singing is  
5                   that many of our songs follow the contours of the land,  
6                   river ways, hills, mountains, and we have a unique melody  
7                   about our singing from -- that comes from (indiscernible).  
8                   We're very proud of it, so I'm going to ask the boys to --  
9                   just a good time song. (Indiscernible) that song. But  
10                  first off, I'm going to ask the Elders just to stand right  
11                  where you're at, and if you could say a closing prayer for  
12                  us. Again, I'm going to introduce Spike and Alvine Eagle  
13                  Speaker, Métis Elder, Henry (indiscernible), our Stony  
14                  Elder, my big brother there with the hat, that's, of  
15                  course, John Wesley, and he's an uncle of mine at the end,  
16                  the Elder from Tsuu T'ina. He's also the richest of those  
17                  Elder, Gerald Meguinis. He's got the most heart. Anyways,  
18                  come to Brave Eagle tonight, if you have time, or I'll ask  
19                  if you could just join with us and we're going to have a  
20                  word of prayer on behalf of our Elders. Okay.

21                               **MR. SPIKE EAGLE SPEAKER, MS. ALVINE EAGLE**  
22                               **SPEAKER, HENRY, JOHN WESLEY AND GERALD MEGUINIS:** (Speaking  
23                               in Native language).

24                               **MR. JASON GOODSTRIKER:** Louise, I'm sorry, I  
25                               don't want to leave out our Inuit Elders and our special

1 people that travelled here from such a far away away. I'll  
2 you if you would help us to put out the -- the --

3 **COMMISSIONER MICHÈLE AUDETTE:** Qulliq.

4 **MR. JASON GOODSTRIKER:** Qulliq. Qulliq.

5 (Indiscernible).

6 **UNIDENTIFIED SPEAKER:** Getting there.

7 **MR. JASON GOODSTRIKER:** Okay. I'm getting  
8 close. I'm -- I'm a bit better tomorrow.

9 **(LAUGHTER)**

10 **MR. JASON GOODSTRIKER:** So our Inuit Elder  
11 Louise Haulli to help us (indiscernible).

12 **MS. LOUISE HAULLI:** Blow it.

13 **MR. JASON GOODSTRIKER:** Oh, okay.

14 **(LAUGHTER)**

15 **MR. JASON GOODSTRIKER:** I don't make  
16 (indiscernible) grandmother, so. All right. Thank you.  
17 Thank you to Louise. Thank you. Give her a round of  
18 applause and to --

19 **(APPLAUSE)**

20 **MR. JASON GOODSTRIKER:** -- to the young Ms.  
21 Gladue (phonetic) back there, thank you again. Okay. So  
22 enjoy yourselves. We're going to sing a happy song. You  
23 could open the doors, you could start packing up, whatever.  
24 So have fun tonight, and enjoy Calgary.

25 --- Upon adjourning at 6:06 p.m.

LEGAL DICTA-TYPIST'S CERTIFICATE

I, Krystle Palynchuk, Court Transcriber, hereby certify that I have transcribed the foregoing and it is a true and accurate transcript of the digital audio provided in this matter.



Krystle Palynchuk

May 29, 2018